



COMMONWEALTH of VIRGINIA

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March 31, 2026

MEMORANDUM

TO: The Honorable Abigail D. Spanberger
Governor of Virginia

The Honorable Don Scott
Speaker of the House, Virginia House of Delegates

The Honorable L. Louise Lucas
President pro tempore, Senate of Virginia

FROM: Michael Desjadon
Chair, State Board of Health

SUBJECT: 2025 State Board of Health Annual Report

This report is submitted in compliance with the Code of Virginia § 32.1-14, which states:

The Board shall submit an annual report to the Governor and General Assembly. Such report shall contain information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia, including but not limited to, health status indicators, the effectiveness of delivery of health care, progress toward meeting standards and goals, the financial and geographic accessibility of health care, and the distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need. Such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

MD/KB
Enclosure

Pc: The Honorable Marvin B. Figueroa, Secretary of Health and Human Resources

2025

BOARD OF HEALTH ANNUAL REPORT

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY



VIRGINIA DEPARTMENT OF HEALTH

PREFACE

The Code of Virginia § 32.1-14 tasks the Board of Health with submitting an annual report to the Governor and General Assembly containing information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia. The Code specifies that such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality. The report was drafted by the Virginia Department of Health on behalf of the Board of Health.

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EXECUTIVE SUMMARY

The Code of Virginia § 32.1-14 tasks the Board of Health with submitting an annual report to the Governor and General Assembly. This report must include comprehensive information on the Commonwealth’s vital records and health statistics, along with a thorough analysis and summary of the health care issues affecting citizens of the Commonwealth. The content of the report shall encompass, but is not limited to, health status indicators, assessments of the effectiveness of health care delivery, evaluations of progress made toward established health standards and goals, and analyses of both the financial and geographic accessibility of care and the distribution of health care resources across the state. Particular focus must be given to health care access for citizens residing in rural communities, inner-city areas, and other regions where residents face the greatest economic need. Additionally, the report must include detailed statistics and analyses of the health status and conditions of minority populations in Virginia, disaggregated by age, gender, and locality.

The 2025 Board of Health Annual Report has been prepared by the Virginia Department of Health (VDH) in fulfillment of this statutory obligation and on behalf of the Board of Health. This document offers an updated assessment of the current state of public health in Virginia and ongoing public health initiatives. Reflecting VDH’s overarching vision to make Virginia the healthiest state in the nation, the 2025 report reviews the Commonwealth’s performance in key health indicators against national averages and those of peer states, thereby providing a broader context for evaluating health outcomes and progress across the Commonwealth.

INTRODUCTION

REPORT MANDATE

Pursuant to Virginia Code § 32.1-14, the Virginia Department of Health (VDH) is submitting the following Board of Health Annual Report summarizing information on the Commonwealth's vital records and health statistics, as well as a comprehensive analysis and summary of significant health care issues impacting the citizens of the Commonwealth of Virginia. In accordance with the provisions of this section, the report is further required to include disaggregated statistical data and interpretive analysis pertaining to the health status and conditions of Virginia’s minority populations, stratified by age, gender, and geographic locality.

REPORT OUTLINE

This report provides a comprehensive overview of the health status of Virginians and evaluates statewide efforts to improve public health. The report begins with an introduction outlining the statutory mandate and the methodology used to assess health indicators. It includes an analysis of how Virginia compares with national health benchmarks, followed by detailed demographic data and vital health statistics. The report then explores the determinants of health, including education, access to care, economic conditions, and community context, laying the foundation for understanding health disparities. The report covers key public health concerns

such as maternal and child health, mental and behavioral health, and chronic and infectious diseases, with detailed breakdowns for specific conditions. Additional sections address the healthcare workforce and available incentives, and the document concludes with recommendations aimed at improving health equity and access across the Commonwealth. The appendix provides useful definitions and acronyms for reference.

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METHODOLOGY

For this report, VDH compiled and analyzed the most current data available pertaining to a range of healthcare issues affecting the residents of Virginia, as well as key indicators of overall health status. Comparative analyses were conducted to evaluate Virginia’s performance relative to other states and national benchmarks.

The selection of topics included in this report was guided by a deliberate focus on priority areas in which VDH has concentrated resources and efforts over the past year. To ensure the comprehensiveness and accuracy of the information presented, VDH engaged subject matter experts (SMEs) from the relevant divisions and offices. These experts were requested to provide updated data specific to their domains, summarize critical findings, describe significant programs currently in place, and offer related recommendations for future improvements. This collaborative approach allowed for a nuanced understanding of the current health landscape in Virginia and facilitated the identification of actionable strategies to address ongoing challenges.

ANALYSIS OF HOW VIRGINIA COMPARES

VDH is firmly committed to advancing its vision of Virginia becoming the healthiest state in the nation. Population health rankings provide a valuable and standardized tool to objectively assess how Virginia compares to other states, offering measurable data that can highlight strengths and pinpoint areas requiring focused attention or improvement across various health indicators. These rankings support data-driven decision-making and help guide public health strategies aimed at improving overall health outcomes for Virginians. (Table 1). According to America's Health Rankings (produced by the United Health Foundation), Virginia's overall health ranking has shown steady improvement:

2022 Annual Report: Virginia rank 19th
 2023 Annual Report: Virginia rank 18th
 2024 Annual Report: Virginia rank 15th

As with most national health rankings of this scope, the underlying data are the latest finalized figures available at the time of publication (typically reflecting outcomes from the prior one to three years), ensuring the composite picture remains highly reliable and comparable across all 50 states. The remainder of this report utilizes data directly collected by or available to VDH.

Table 1. How Virginia Compares Nationally with Key Health Indicators from 2022-2024 Reports.

Health Indicator	2022 Rank	2023 Rank	2024 Rank
2024 Rankings in the Top Half of U.S. States			
<i>Virginia's Overall Rank</i>	<i>14</i>	<i>19</i>	<i>15</i>
Uninsured (% of Population)	21	21	23
Severe Housing Problems (% of occupied housing units)	23	22	25
Poverty	6	13	12
Unemployment	15	15	19

Economic Hardship Index	5	8	9
Food Insecurity	5	13	13
Childhood Immunizations (% by age 24 months)	30	28	24
Flu Vaccinations (% ages 18+)	16	20	9
Dedicated Health Care Provider (% ages 18+)	25	22	22
Firearm Deaths	18	17	23
Suicides	10	9	10
Drug Related Deaths	24	24	17
Asthma	24	16	24
Cancer	19	35	17
Diabetes	19	38	17
Depression	31	27	25
Obesity	27	30	15
2024 Rankings in the Bottom Half of U.S. States			
HPV Vaccination HPV Vaccination (% ages 13-17)	19	26	27
Amount of Mental Health Providers	37	36	36
Homicides	16	26	27
Arthritis	27	27	28
Cardiovascular Disease	27	26	33
Chronic Kidney Disease	20	24	35
Chronic Obstructive Pulmonary Disease	26	30	30
High Blood Pressure	32	32	30
High Cholesterol	46	46	36

Data Source: American Health Rankings, 2024 Annual Report

In the 2024 report, Virginia ranked among the top ten states for three indicators: the economic hardship index, adult flu vaccination rates, and suicide death. On the other hand, Virginia ranked in the bottom half of states in the 2024 report for HPV vaccination, amount of mental health providers, homicides, arthritis, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease (COPD), high cholesterol, and high blood pressure. In addition, Virginia ranked highly for other socioeconomic indicators such as poverty but faces ongoing challenges with uninsured rates and improving housing problems. Preventative health care in Virginia showed modest improvements, with higher childhood vaccination rankings and an increase in adult flu vaccination coverage; however, HPV vaccination rankings have declined since the 2022 report. Chronic disease trends are mixed, with improvements in rankings for cancer, diabetes, and obesity, but setbacks for asthma, cardiovascular disease, and kidney disease.

DEMOGRAPHICS

The Commonwealth of Virginia consists of 133 localities, grouped by VDH into 35 health districts and 5 health regions. In Virginia, the total population is 8,715,698.¹ Compared to over 7.5 million residents living within urban areas, approximately 1.0 million residents live in

¹ U.S. Census Bureau. (2024). *American Community Survey: 2019–2023 (5-year estimates)*. <https://www.census.gov/programs-surveys/acs/>

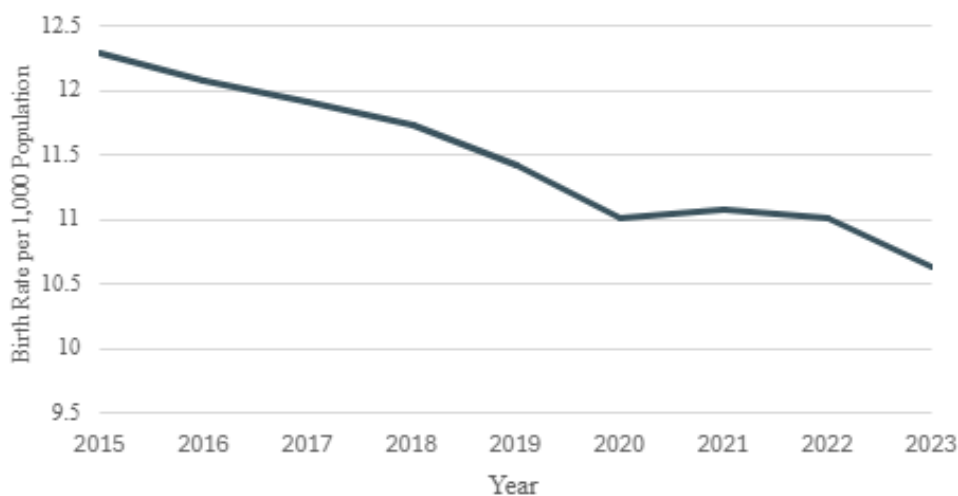
rural areas of Virginia. The Southwest region is primarily rural and the least populous of all health regions, while the Central and Northwest regions only have pockets of rural communities. The Northern region is primarily urban, densely populated, and relatively affluent, while the Eastern region has communities characterized by lower population density and high rates of economic challenges.

The population is almost evenly split by sex, with 4,409,697 million females (50.6%) and 4,306,001 million males (49.4%). In 2023, 59% of Virginians identified as non-Hispanic White, 18.4% identified as non-Hispanic Black, 10.7% identified as Hispanic (all races), 6.8% non-Hispanic Asian, 4.3% identifying as non-Hispanic with more than one race, 0.1% non-Hispanic American Indian or Alaska Native, and 0.1% Native Hawaiian and Pacific Islander. Virginia’s demographic profile reveals an increasingly diverse and aging population, with a wide variation across regions in terms of density, economic opportunity, and access to essential services.

VITAL RECORDS AND HEALTH STATISTICS

In 2023, Virginia recorded 92,652 live births, reflecting a birth rate of 10.63 per 1,000 people. Virginia’s birth rate has steadily declined over the past decade, dropping from over 12 births per 1,000 population in 2015 to just above 10.6 in 2023 (Figure 1). This trend mirrors broader demographic shifts seen nationwide, including delayed childbearing, smaller family sizes, and social and economic factors influencing fertility decisions.

Figure 1: Birth Rate in Virginia (per 1,000 Population) from 2015 to 2023

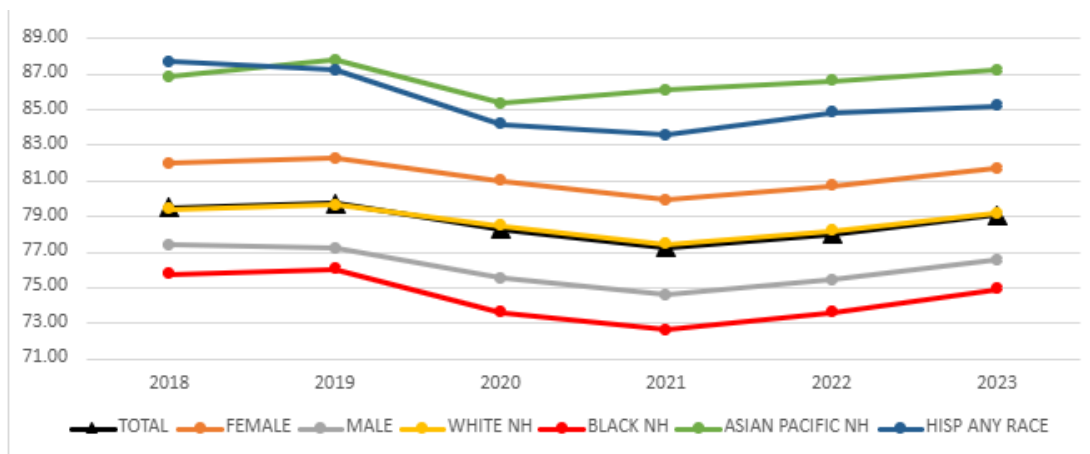


Data Source: The Virginia Department of Health, Office of Information Management

In 2023, Virginia recorded 78,141 deaths. The total number of deaths highlights the scale of mortality in the Commonwealth, while life expectancy trends reveal how social determinants, access to care, and structural inequities continue to shape population health. Monitoring both measures is essential for identifying at-risk populations, guiding prevention strategies, and promoting health equity across Virginia.

Life expectancy in Virginia has fluctuated in recent years, with sharp declines observed in 2020 and 2021 during the COVID-19 pandemic, followed by partial recovery through 2023. Despite these improvements, disparities remain evident across gender, race, and ethnicity. Asian and Pacific Islander residents consistently experience the highest life expectancy, averaging 87 years in 2024, while Black non-Hispanic residents face the lowest, with averages near 76 years in 2023. Females continue to outlive males, reflecting a persistent gender gap in longevity (Figure 2).

Figure 2: Life Expectancy by Gender, Race and Hispanic Origin from 2018 to 2024



Data Source: The Virginia Department of Health, Office of Information Management

Mortality in Virginia continues to be dominated by heart disease and cancer (Table 2). Together, these two conditions accounted for more than 31,000 deaths, with heart disease (16,449 deaths, 21.2%) narrowly surpassing cancer (15,287 deaths, 20.5%) as the top cause of mortality. These two causes alone represented more than two out of every five deaths in the state, underscoring the critical importance of chronic disease prevention and management strategies. More information is included in the Chronic Disease section of this report.

Table 2. Top 10 Leading Causes of Death in Virginia in 2023 (% of Total Deaths).

Leading Causes of Death	Number of Deaths	% of Total Deaths
Diseases of heart	16,449	21.23
Cancer	15,287	20.53
Accidents (unintentional injuries)	5,112	6.54
Cerebrovascular diseases	4,151	5.57
Chronic lower respiratory diseases	3,441	4.40
Diabetes mellitus	2,610	3.34
Alzheimer disease	2,289	2.93
Drug overdoses	2,151	2.89
Nephritis, nephrotic syndrome and nephrosis	1,561	2.00
COVID-19	1,368	1.75
Total Deaths in Virginia (2023)		78,141

Data Source: The Virginia Department of Health, Office of Vital Records

Beyond these leading causes, several other health conditions contributed significantly to mortality. Accidents and unintentional injuries were the third leading cause, responsible for 5,112 deaths (6.5%), reflecting ongoing concerns about injury prevention, roadway safety, and accidents attributed to being under the influence of substances. Cerebrovascular diseases, such as stroke, led to 4,151 deaths (5.6%), while chronic lower respiratory diseases accounted for 3,441 deaths (4.4%). These conditions emphasize the need for targeted interventions around cardiovascular health, smoking cessation, and environmental health factors. Other notable contributors included diabetes mellitus (2,610 deaths, 3.3%) and Alzheimer's disease (2,289 deaths, 2.9%), both of which reflect the intersection of aging populations and chronic health burdens. Drug overdoses claimed 2,151 lives (2.9%), making them one of the top ten causes of death in Virginia. This figure highlights the ongoing opioid crisis and reinforces the urgency of prevention, treatment, and harm reduction efforts across the state. Conditions such as kidney disease (1,561 deaths, 2.0%) and COVID-19 (1,368 deaths, 1.8%) also remain notable contributors to leading causes of death across the Commonwealth. While COVID-19 deaths have declined compared to prior years, the continued presence of the virus in the top ten causes of death demonstrates its lingering impact on public health.

Virginia registered 52,592 marriages and 23,191 divorces in FY2024; however, only 5,442 divorce certificates were requested and issued during the fiscal year.

CHRONIC DISEASES

Chronic diseases are the leading causes of illness, disability, and death in both Virginia and the United States. These conditions typically persist for one year or longer and require continuous medical care. Additionally, they can significantly restrict a person's ability to perform everyday activities. In 2023, there were 53,348 deaths among Virginians related to common chronic conditions. Heart disease and stroke are significant causes of death in Virginia, with hypertension and smoking, including electronic cigarette (e-cigarette) use, being considered as important risk factors that can contribute to poor health outcomes.

Chronic diseases affect a substantial portion of Virginia's population, with several conditions showing particularly high prevalence rates (Table 3). Nearly 40% of Virginians are affected by high cholesterol and over 35% of Virginians have been diagnosed with hypertension (high blood pressure). These cardiovascular risk factors highlight a significant public health concern, as heart disease has been the leading cause of death for Virginians (Table 2).

Other chronic conditions like arthritis (27.1%), diabetes (11.8%), current and lifetime asthma (10.2% and 15.9%, respectively), chronic obstructive pulmonary disease (COPD) (6.9%), and chronic kidney disease (4.2%) also contribute to the overall burden of chronic diseases, alongside cardiovascular conditions such as heart disease (4.3%) and stroke (3.7%).

By race, Black adult Virginians have the highest prevalence of asthma (current and lifetime), chronic kidney disease, chronic obstructive pulmonary disease, diabetes, hypertension, and stroke, while White adult Virginians have the highest prevalence of arthritis and high blood cholesterol. Additionally, females in Virginia exhibit the highest prevalence of arthritis, both current and lifetime asthma, COPD, and stroke, whereas males have highest prevalence of heart disease, high blood cholesterol, and hypertension. Prevalence rates for chronic kidney disease and diabetes were similar between females and males.

Overall, these figures emphasize the critical importance of targeted prevention, early detection, and effective management strategies for chronic diseases in Virginia to improve quality of life across the Commonwealth.

Table 3. Prevalence of Chronic Diseases in Virginia – Overall, By Race, and By Gender in 2023.

Chronic Disease	Total Prevalence (%)	Prevalence by Race (%)				Prevalence by Sex (%)	
		Black	Hispanic	White	Other	Female	Male
Arthritis	27.1	28.7	7.8	30.9	20.5	30.5	23.4
Asthma (Current)	10.2	12.5	6.6	9.6	12.4	13.1	7.1
Asthma (Lifetime)	15.9	17.4	12.3	15.0	20.0	18	13.6
COPD	6.9	8.0	N/A	7.5	5.3	7.4	6.5
Chronic Kidney Disease	4.2	6.3	N/A	4.1	N/A	4.3	4.2
Diabetes	11.8	16.5	6.2	11.9	8.7	11.8	11.9
Heart Disease	4.3	4.6	N/A	4.6	N/A	4.0	4.6
High Blood Cholesterol	39.3	36.2	28.6	42.1	38.8	37.5	41.3
Hypertension	35.6	45.0	17.5	37.4	25.3	33.7	37.6
Stroke	3.7	5.5	N/A	4.1	N/A	4.1	3.3

Data Source: The Virginia Department of Health, Office of Family Health Services

Chronic disease remains a significant public health problem in Virginia. Despite recent declines in mortality rates, both conditions continue to show stark disparities by race, sex, and age—especially among Black or African American residents and older adults. These findings underscore the importance of continued, targeted intervention through surveillance, prevention, and equity-focused cardiovascular programs. Addressing these chronic disease trends will require sustained investment, community engagement, and cross-sector collaboration.

HEART DISEASE

Heart disease was the leading cause of death in Virginia between 2019 and 2023. In 2023, 16,449 deaths were attributed to heart disease in Virginia. The age-adjusted mortality rate per 100,000 population for heart disease decreased from 165.5 deaths in 2021 to 152.5 deaths in 2023, which was a 9% decrease. While the state mortality rate from heart disease decreased in 2023, there continue to be groups in Virginia that are disproportionately affected:

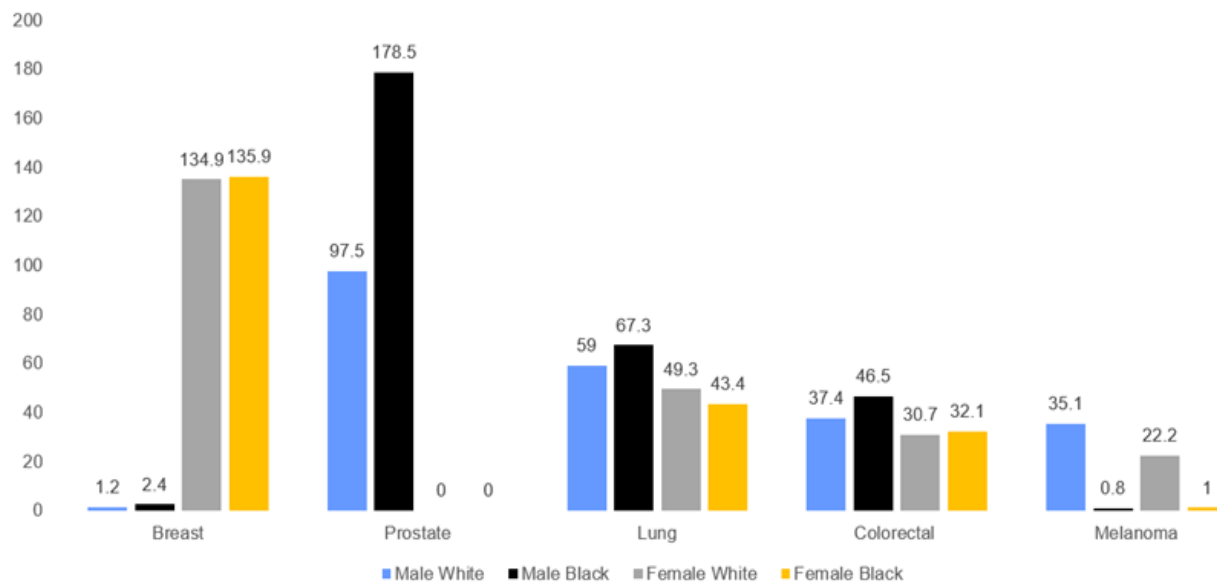
- The age-adjusted mortality rate among Black or African Americans was 185.2 deaths per 100,000 population, 21% higher than the overall state mortality rate.
- Males had an age-adjusted mortality rate of 184.5 per 100,000 population, 47% higher compared to 125.1 deaths per 100,000 for females.
- The highest age-adjusted mortality rate from heart disease was observed in Virginians 75 years and older, with 97.6 deaths per 100,000 population.

CANCER

In 2023, cancer was the second leading cause of death among Virginians and remains a major concern for chronic disease, with an all-sites incidence rate of 415 per 100,000 between 2019 and 2023. Prostate cancer has the highest incidence rate, particularly among Black males (178.5 per 100,000), followed by White males (97.5 per 100,000). Breast cancer is the most

common cancer among women, with incidence rates nearly identical for White females (134.9 per 100,000) and Black females (135.9 per 100,000). Lung cancer incidence is highest among Black males (67.3 per 100,000), while colorectal cancer affects both sexes and races more evenly, though rates are slightly higher in Black populations. Melanoma is most common among White males (22.2 per 100,000) and White females (35.1 per 100,000), with very low incidence among Black populations (Figure 3).

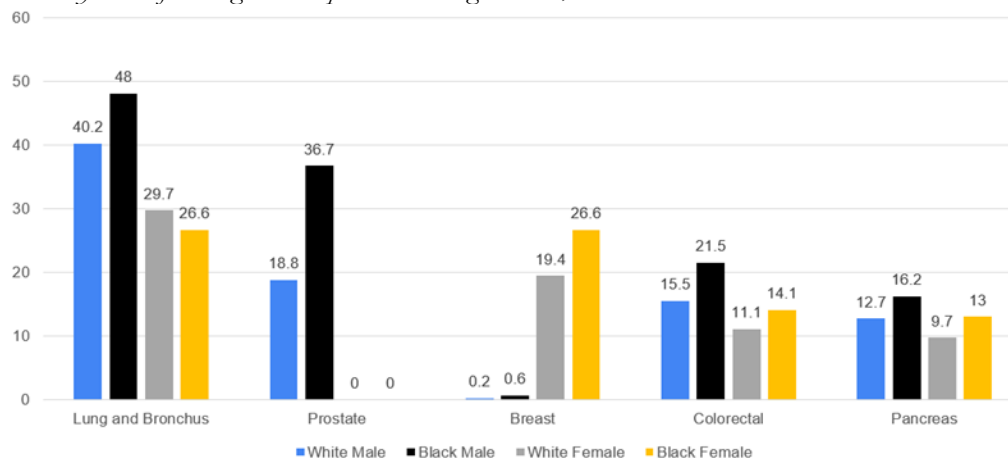
Figure 3. Incidence Rate for Virginia's Top Five Leading Cancers, 2018-2022



Source: Virginia Cancer Registry

Lung and bronchus cancer is the leading cause of cancer mortality, with Black males experiencing the highest mortality (48 per 100,000), followed by White males (40.2 per 100,000). Prostate cancer mortality is almost double among Black males (36.7 per 100,000) compared to White males (18.8 per 100,000). Despite approximately equal incidence, breast cancer deaths are highest among Black females (26.6 per 100,000), exceeding White females (19.4 per 100,000). Colorectal cancer mortality is elevated in Black males (21.5 per 100,000), while pancreatic cancer shows notable mortality burdens across all groups, with the highest among Black males (16.2 per 100,000) (Figure 4). Overall, this data reveals that while cancer incidence varies by sex and race, mortality disparities are especially pronounced, with Black male populations bearing the greatest burden of deaths from prostate, lung, breast, and colorectal cancers.

Figure 4. Mortality Rates for Virginia’s Top Five Leading Cancers, 2019-2023



Source: Virginia Cancer Registry

VDH has established several programs designed to address cancer rates across the Commonwealth, including the Virginia Cancer Registry (VCR), Every Woman’s Life (EWL), and the Virginia Comprehensive Cancer Control Program (VACCCP). The VCR plays a central role in documenting the cancer burden across the Commonwealth and serves as the statewide repository of data on all individuals diagnosed or treated for cancer in Virginia. Mandated by the Code of Virginia (§§ 32.1-70, 32.1-70.2, and 32.1-71), the VCR provides the foundation for cancer surveillance, research, and evidence-based public health action, ensuring that Virginia remains equipped to monitor cancer trends and respond effectively to this ongoing public health challenge.

The EWL program is Virginia’s breast and cervical cancer screening program, designed to expand access to life-saving screening and diagnostic services for low-income, uninsured Virginians. Breast and cervical cancer screenings are among the most effective tools for reducing cancer mortality and health care costs. Biennial breast cancer screening for women aged 50–74 reduces breast cancer deaths by 26% compared to no screening. However, current resources fall far short of meeting need. According to 2022 Census data, 20,472 Virginia women aged 40–64 are eligible for EWL services, yet funding in FY25 allowed the program to serve only 6,471. This gap underscores the need for additional state investment to expand early detection resources for Virginia’s high-risk populations. Since its inception in 1997, EWL has made significant strides: serving more than 76,000 Virginians, delivering over 221,000 breast and cervical screenings, and diagnosing 3,915 breast and cervical cancers (including pre-cancers). Expanding this program would further reduce preventable morbidity and mortality and associated costs, ensuring equitable access to care for vulnerable populations.

The VACCCP leads collaborative efforts to reduce the cancer burden statewide through implementation of the Virginia Cancer Plan (VCP). Working closely with the Cancer Action Coalition of Virginia (CACV), the VACCCP focuses on prevention, early detection, diagnosis and treatment, survivorship and palliative care, and the unique needs of pediatric, adolescent, and young adult cancer populations. Recent efforts include installing 738 sunscreen dispensers statewide with educational support, increasing HPV vaccination rates by 27% through partnerships and quality improvement initiatives, and expanding psychosocial support for 388 cancer survivors through community-based funding. These efforts illustrate VACCCP’s

commitment to addressing cancer across the continuum of care while building healthier, more resilient communities.

Addressing cancer through surveillance, prevention, and control is a vital part of the state’s public health strategy. Many cancer risk factors overlap with other chronic conditions, making a comprehensive approach impactful. While evidence-based screening exists for four of the top five cancers in Virginia (breast, colorectal, lung, and prostate), disparities in late-stage diagnoses and mortality persist across geography, race, and sex. Additionally, as of January 1, 2025, Virginia is home to an estimated 483,190 cancer survivors needing continued support. To effectively address cancer-related issues across the full continuum of care, increased funding is needed to support the VDH cancer program.

DETERMINANTS OF HEALTH

EDUCATION ACCESS AND QUALITY

Educational attainment and student stability highlight important aspects of well-being in Virginia. Among residents over the age of 25, 5.1% have some high school education without earning a diploma, while 23.9% hold a high school diploma or equivalent. Higher education is also well represented, with 23.3% of Virginians earning a bachelor’s degree and 18.1% holding a graduate or professional degree. Despite these achievements, challenges remain for younger populations. During the 2024–2025 school year, 11,206 students in grades Pre-K through 12 were identified as lacking a fixed, regular, and adequate nighttime residence, with housing instability potentially inhibiting educational success.²

HEALTH CARE ACCESS AND QUALITY

In 2022, the state’s supply of primary care providers (84.6 per 100,000 residents) closely mirrored the national average (83.8 per 100,000 residents).³ In 2022, dental providers in Virginia (75 per 100,000 residents) slightly outpaced national figures (73.4 per 100,000 residents). Yet mental health care remained a weak spot, as of 2024, Virginia had 23,001 total mental health providers, (264 per 100,000 residents). While this is a significant number, it falls short of the national rate (332.6 per 100,000). This gap suggests that mental health services in Virginia may be less accessible compared to the national average, highlighting a potential area for resource expansion.

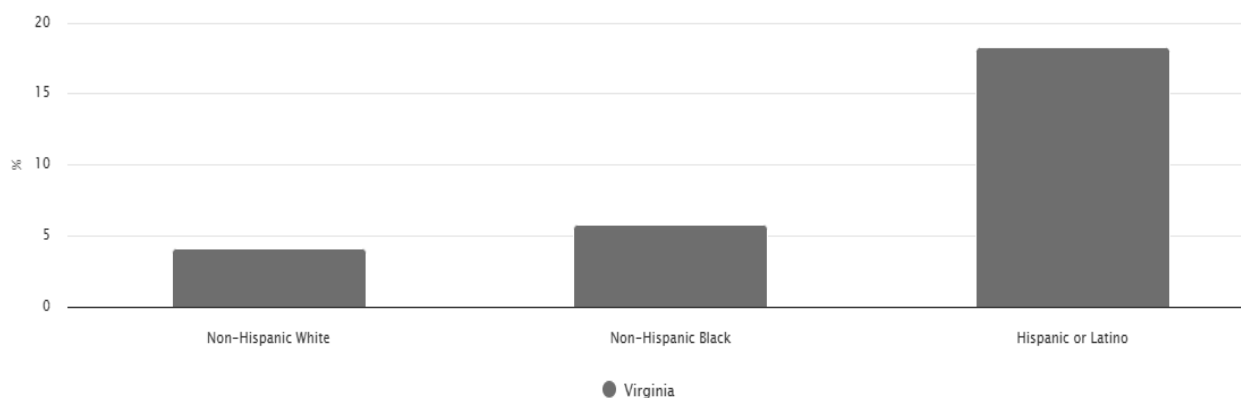
In 2023, Virginia had 87,873 uninsured children under the age of 19, accounting for 4.52% of the state’s child population. This is somewhat better than the national average of 5.35%. However, disparities in uninsured rates are evident across racial and ethnic groups in Virginia. Non-Hispanic White children had an uninsured rate of 4.10%, Non-Hispanic Black children had an uninsured rate at 5.8%, and Hispanic or Latino children faced the highest

² Virginia Department of Education. (2025). *Enrollment & demographics*. Virginia Department of Education. Retrieved October 3, 2025, from <https://www.doe.virginia.gov/data-policy-funding/data-reports/statistics-reports/enrollment-demographics>

³ American Medical Association. (2022). *AMA physician professional data and U.S. Census Bureau estimates of state population totals for 2022*. U.S. Census Bureau. <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html>

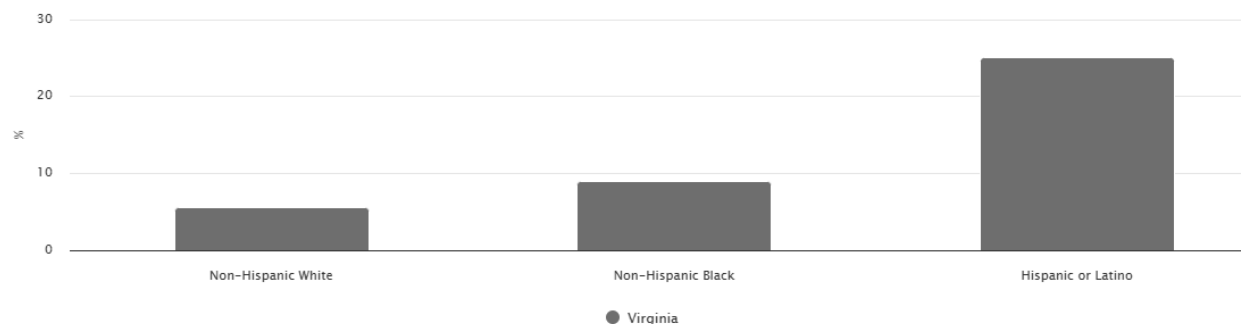
uninsured rate, 18.3% (Figure 5). Among adults aged 18-64 in Virginia, 8.60% (approximately 443,783 individuals) were uninsured, a rate below the national uninsured rate of 11.02%. Racial and ethnic disparities also persist in Virginia’s adult uninsured rates. Non-Hispanic White adults had a 5.6% uninsured rate, Non-Hispanic Black adults had a higher rate at 8.9%, and Hispanic or Latino adults experienced a substantially higher uninsured rate of 25% (Figure 6). These figures indicate significant disparities in health insurance coverage, especially among Virginia’s Hispanic or Latino children and adult populations, which stem in part from systemic barriers such as language access, immigration status, and employment in sectors less likely to offer health benefits.

Figure 5: Uninsured Population Under 19 in Virginia, by Race and Hispanic Ethnicity, Percent



Source: US Census Bureau, *Small Area Health Insurance Estimates*. 2023.

Figure 6: Uninsured Population Age 18- 64 in Virginia by Race and Hispanic Ethnicity, Percent



Source: US Census Bureau, *Small Area Health Insurance Estimates*. 2023.

Even among the insured, affordability remains a challenge. Over 634,000 Virginia adults (9.2% of the population) delayed medical care due to cost, underscoring that coverage alone doesn’t guarantee access. For Virginia to move toward greater health equity, it must address not only provider shortages, insurance gaps, and cost of care, but also the racial and economic disparities that exist throughout those and other factors.

State Telehealth Plan

Virginia’s Statewide Telehealth Plan, as outlined in § 32.1-122.03 (B) of the Code of Virginia, mandates the development and maintenance of a comprehensive telehealth strategy by

the State Board of Health. This plan aims to promote an integrated approach to the introduction and use of telehealth and telemedicine services across various sectors, including hospitals, primary care facilities, schools, and emergency medical services. The Board is required to consult with the Virginia Telehealth Network (VTN) or a similar Virginia-based nonprofit organization to provide direct consultation, track implementation, and facilitate updates to the plan as medical practices and technologies evolve to support telehealth efforts across the Commonwealth. The original (2021-2025) version of the Plan was adopted by the Board of Health in 2021. Starting in 2024, VDH and VTN worked with relevant stakeholders to review and revise the original version in the development of the 2026-2030 version of the Plan. The updated version was approved by the Board of Health in June of 2025.⁴

State Rural Health Plan

The Virginia State Office of Rural Health (VA-SORH) was established in 1991 with the purpose of creating, funding, and supporting a quality and sustainable rural healthcare infrastructure across the Commonwealth of Virginia. Operating within VDH's Office of Health Equity. The office's mission centers on partnering with rural communities to identify effective strategies and solutions that promote the health and prosperity of rural Virginians. To fulfill this mission, VA-SORH provides vital technical assistance (TA), regulatory updates, resources, and fosters opportunities for collaboration with communities statewide. In response to evolving rural health needs and those that developed amid the challenges of the COVID-19 pandemic, VA-SORH developed the 2022-2026 Virginia Rural Health Plan with input from key stakeholders. This plan emphasizes the strengths of Virginia's rural communities and focuses on seven priority areas: education, broadband access, nutrition and food security, healthy moms and babies, access to healthcare services, behavioral health including substance use disorder and recovery, and employment and workforce development. From the seven priority areas, the Virginia State Office of Rural Health has selected three to study and monitor longitudinally: nutrition and food security, healthy moms and babies, and employment and workforce development. These focus areas provide a comprehensive evaluation of the overall health and well-being of Virginia's rural communities and represent domains where the VDH holds the greatest influence. Looking ahead, a new plan is anticipated to be drafted in 2026 to continue addressing rural health priorities in Virginia.

HOUSING, TRANSPORTATION, AND ECONOMIC SECURITY

In 2023, an estimated 834,836 Virginians, about 10% of the state's population, lived below the federal poverty level (FPL). Approximately 1,964,400 people (23%) lived below 200% of the FPL. Economic hardship has profound implications for health, as lower income is often associated with reduced access to healthcare, nutritious food, safe housing, and preventive services, all of which contribute to health outcomes and life expectancy. The GINI Index measures income inequality, with scores ranging from 0 (perfect equality, where everyone has the same income) to 1 (perfect inequality, where one person has all the income). Using this index, Virginia scored 0.47, which reflects disparities in how resources are distributed across the state. High inequality can contribute to social stratification, stress, and unequal access to health-promoting opportunities, further perpetuating disparities in health outcomes.

⁴ Virginia Department of Health. (2025). *Virginia State Telehealth Plan 2026–2030*. <https://www.vdh.virginia.gov/content/uploads/sites/4/2026-2030-State-Telehealth-Plan.pdf>

Virginia maintains one of the lower homelessness rates in the nation. At 8 per 10,000 people, the state’s homelessness rate is significantly below the national average of 19.4 per 10,000, ranking Virginia 5th lowest among all 50 states. Despite this, an estimated 7,141 individuals experience homelessness in the Commonwealth, including 1,153 children less than 18 years old, 389 veterans, and 3,454 individuals identifying as Black/African American.

Housing affordability is another critical determinant of health. In 2023, more than 887,500 households in Virginia (27% of all households) were considered cost burdened, indicating that they spent more than 30% of their income on housing. High housing costs can force families to make difficult trade-offs between paying for shelter and covering other essentials such as healthcare, transportation, or food. Similarly, reliable transportation is essential for accessing medical care, employment, education, and grocery stores. In Virginia, 199,529 households (6%) did not have access to a motor vehicle in 2023.⁵

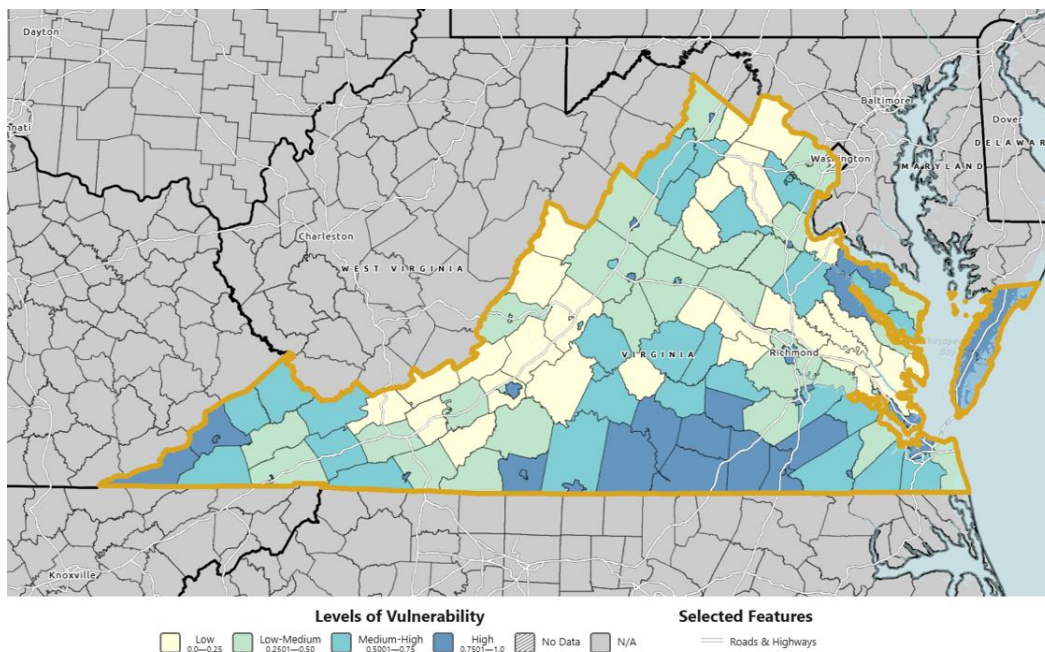
Food access and security are closely related to economic pressures, including housing and transportation. In Virginia, 44.9% of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits include children, while 18.1% of births in 2023 reported use of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Together, these data points illustrate the interconnected challenges of housing, homelessness, and food insecurity, all of which directly affect the well-being of Virginia families⁵.

SOCIAL AND COMMUNITY CONTEXT

The Social Vulnerability Index (SVI) is used to identify communities that are considered to be more “at-risk,” with a score of zero indicating low vulnerability and a scale of one indicating high vulnerability. Communities with higher vulnerability may be less able to prepare for, respond to, and recover from emergencies, whether they are natural disasters, environmental hazards, or public health crises. Virginia’s SVI score of 0.39 in 2022 reflects moderate vulnerability when considering combined demographic and socioeconomic factors such as poverty, transportation access, and housing conditions (Figure 7). Addressing these interconnected housing, transportation, and economic challenges is vital for improving health equity and building resilient communities across the Commonwealth.

⁵ U.S. Census Bureau. (2024). *American Community Survey: 2019–2023 (5-year estimates)*. <https://www.census.gov/programs-surveys/acs/>

Figure 7: Social Vulnerability Index (SVI) in Virginia



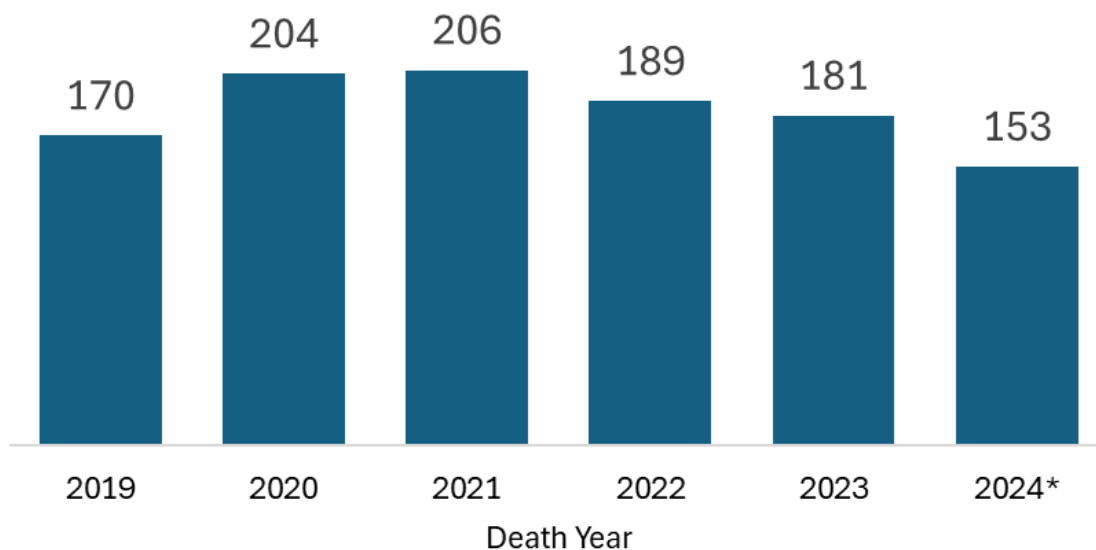
MENTAL HEALTH

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. 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, with both mental and physical health impacting overall health and can increase the risk for developing many types of chronic conditions.

YOUTH SUICIDE PREVENTION

In Virginia, youth suicide prevention is a coordinated, multi-agency effort led by the VDH under the authority of Code of Virginia § 32.1-73.7. According to the Virginia Youth Survey, 33.4% of public high school students reported feeling sad or hopeless almost every day for two or more weeks in 2023, a significant increase from 25.7% in 2013. Feelings of sadness or hopelessness peaked among public high school students in 2021, at 38.2%. Almost one in five (18.4%) of Virginia public middle school students who responded to the Virginia Youth Survey also reported their mental health as not good most of the time or always. From 2019 to 2023, suicide deaths among Virginia residents aged 10-24 years peaked in 2021 at 206 deaths (Figure 8); on average, there were 190 suicide deaths among Virginia youth each year. Most suicide deaths among youth were male (82%), White (61%), older youth aged 20-24 years (60%), and by firearm (58%) from 2019 to 2023. Preliminary data from 2024 show there were 153 suicide deaths among Virginia residents aged 10-24 years, a 15% decrease from 2023.

Figure 8: Suicide Deaths Among Virginia Residents Aged 10-24 years, 2019-2024



*indicates preliminary data

Source: Virginia Department of Health, Division of Health Statistics

The VDH Suicide Systems Project (SSP)

In Virginia, youth suicide prevention is a coordinated, multi-agency effort led by the VDH under the authority of Code of Virginia § 32.1-73.7. The Suicide Systems Project (SSP) is an upstream prevention program which acts as a federal passthrough, TA hub, and leader in the coordination of suicide prevention efforts across the Commonwealth. Since 2001, the VDH SSP has received funding through a variety of cooperative agreements from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), Office of Women’s Health, and Health Resources and Services Administration Maternal Child Health Division (HRSA MCH) to address gaps in the suicide prevention continuum of care. This program does not receive any dedicated state funding for the prevention of youth suicide.

The VDH SSP, housed within the Office of Family Health Services’ Division of Prevention and Health Promotion, takes a systems approach to addressing suicide, recognizing that no single linear strategy can fully resolve the issue. Instead, the SSP employs a multipronged, dynamic framework that emphasizes shaping the environments in which Virginians live and interact to reduce the likelihood of suicide attempts before they occur. This proactive, prevention-oriented approach is well-suited to the public health workforce, which has long relied on data collection, identifying drivers of poor health outcomes, and navigating complex systems to improve health. Through its TA hub model, the SSP supports suicide prevention efforts across diverse environments by providing training, capacity building, gap identification, policy development, best-practice guidance, and partner convening to strengthen comprehensive strategies for suicide prevention across the Commonwealth.

Virginia Mental Health Access Program (VMAP)

The Virginia Mental Health Access Program (VMAP) is a statewide initiative partially funded by the VDH designed to bolster mental, behavioral, and emotional health support across

Virginia. VMAP focuses on supporting infants, children, adolescents, young adults, as well as pregnant and postpartum individuals by equipping medical providers with the tools, training, and consultation services needed to improve mental health outcomes.

VMAP addresses critical barriers to access, with 100% of the state’s localities being designated as mental health professional shortage areas. Additionally, about 65% of pediatricians report that they lack sufficient training in pediatric mental health. In response, VMAP has trained over 1,100 primary care providers to screen, diagnose, and manage pediatric mental health concerns and offers a VMAP Line that provides same-day mental health consults and care navigation support for providers.

As of 2024, 2,313 primary care providers (PCPs) were registered with VMAP. A 26% increase from the previous year. VMAP enabled 8,236 calls through its consult line, resulting in 5,476 mental health consultations and 9,859 care navigation requests, directly supporting 6,691 pediatric patients.

MATERNAL AND CHILD HEALTH

INFANT MORTALITY

Infant mortality rate (IMR) is defined as the death of a baby before reaching one year of age, per 1,000 live births. Between 2021 and 2024, Virginia’s IMR remained stable from 5.9 deaths per 1,000 live births (566 infant deaths) to a preliminary estimate of 6.0 deaths per 1,000 live births in 2024 (561 infant deaths). In 2021, Black or African American infants had the highest rate at 10.0 deaths per 1,000 live births—more than double the rates for White infants (4.6) and Asian or Pacific Islander infants (3.9). Hispanic infants experienced a higher rate at 6.5, reflecting broader inequities in maternal and child health. By 2024, preliminary data show mixed progress across groups. Infant mortality decreased slightly among Asian or Pacific Islander infants (from 3.9 to 3.7) and White infants (from 4.6 to 4.3), while the rate among Hispanic infants fell from 6.5 to 5.4. In contrast, the rate for Black or African American infants increased to 12.2, further widening an already significant disparity. These patterns highlight the ongoing need for targeted, equity-focused interventions to improve outcomes for disproportionately affected communities.

Strategies such as supporting the development of health practices like transportation safety, safe sleep habits, and supporting mom and baby with information, resources, and referrals are needed to reduce the IMR in Virginia.

MATERNAL MORTALITY

Maternal mortality rate (MMR), as defined by the World Health Organization (WHO), refers to the death of an individual during pregnancy or within 42 days following the end from causes related to or aggravated by the pregnancy or its management. However, this definition may not fully capture the broader scope of mortality experienced by pregnant and postpartum individuals, particularly in cases where complications arise beyond the 42-day window or where social determinants contribute to adverse outcomes. Maternal deaths do not only represent profound personal loss but also serve as a critical indicator of the effectiveness and responsiveness of a healthcare system.

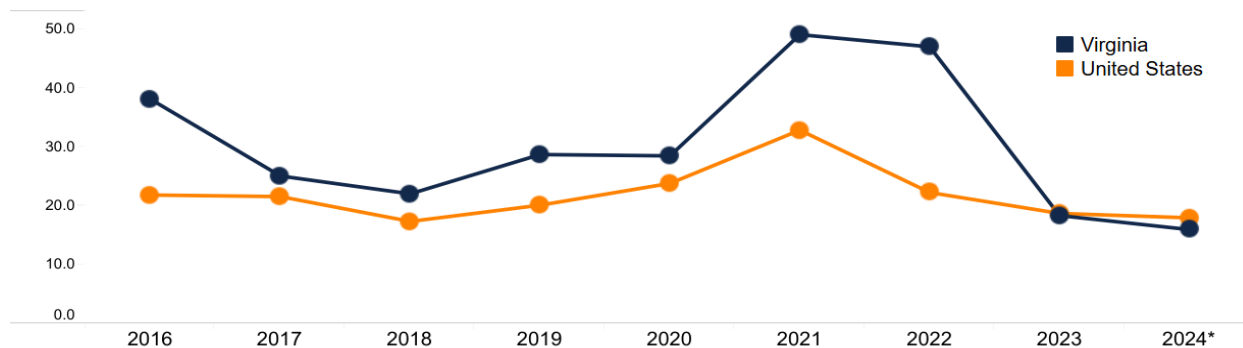
In 2021, Virginia’s MMR fell from 47.1 deaths per 100,000 live births (47 maternal deaths) to a preliminary estimate of 16.0 deaths per 100,000 live births in 2024 (15 maternal deaths), with improvements across all racial and ethnic groups (Figure 9). Despite this, Black or African American mothers consistently faced the highest MMR: 101.6 in 2021, which was more than double the state average, declining to 52.4 in 2024 according to preliminary data, which is still over three times higher than the statewide rate.

Other racial and ethnic groups also saw substantial improvements. The MMR for Hispanic mothers dropped from 26.6 in 2021 to 5.9 in 2024, while the rate for White mothers declined from 41.9 to 8.3 over the same period. The rate for Asian or Pacific Islander mothers remained relatively stable, decreasing slightly from 13.6 in 2021 to 13.3 in 2024. These trends show overall improvement but highlight persistent disparities that require targeted action to improve maternal health outcomes.

Figure 9: Annual Trends of Maternal Mortality Rate in Virginia and United States from 2016-2024

Annual Trends of Maternal Mortality Rates per 100,000 Live Births

*2024 data is considered preliminary and subject to change.



Source: Virginia Department of Health, Division of Health Statistics

Maternal Mortality Review Team (MMRT)

VDH has established programs designed to address maternal mortality, including the Maternal Mortality Review Team (MMRT), which plays a critical role in safeguarding the health and lives of women in Virginia by identifying, reviewing, and analyzing all pregnancy-associated deaths in the Commonwealth. Established in 2002 as a partnership between the Office of Family Health Services and the Office of the Chief Medical Examiner, the MMRT was codified in 2019 under § 32.1-283.8 of the Code of Virginia. The MMRT reflects a broad spectrum of expertise, including physicians, midwives, nurses, social workers, dietitians, public health officials, hospital administrators, and representatives from professional associations and advocacy organizations. This diversity ensures a comprehensive evaluation of each case and supports the development of well-rounded, evidence-based recommendations.

The MMRT’s work is guided by the Pregnancy-Associated Mortality Surveillance System (PAMSS), which uses multiple data sources, including death certificates, birth and fetal death records, the Virginia Violent Death Reporting System, and medical and autopsy records to identify women who were pregnant within 365 days of their death. Each case undergoes a thorough review process to confirm eligibility, determine the circumstances surrounding the death, and assess contributing factors at the community, patient, healthcare facility, and provider levels. Using consensus decision-making, the MMRT evaluates whether each death was

pregnancy-related, whether it was preventable, and what specific changes in care could have improved outcomes.

Through this review process, the MMRT generates actionable recommendations to improve clinical practices, strengthen healthcare systems, address community-level barriers, and inform public health policy. The MMRT's work has direct implications for reducing preventable maternal deaths, improving maternal health outcomes, and advancing health equity for women across Virginia. By bridging the gap between data and intervention, the MMRT serves as both a watchdog and a catalyst for change in maternal health care statewide.

Virginia Mental Health Access Program (VMAP) for Moms+

VDH has also established the Virginia Mental Health Access Program (VMAP) for Moms +, an expansion of the VMAP program possible due to additional funding in 2023 and 2024. Perinatal mental health issues are the leading cause of maternal mortality in America and, when ignored, can lead to adverse health outcomes, including preterm delivery and difficulty bonding with the child. VMAP Moms + focuses on pregnant and postpartum individuals by equipping medical providers with the tools, training, and consultation services needed to improve mental health outcomes. VMAP for Moms+ launched to provide additional support to providers caring for pregnant and postpartum patients and their families. VMAP for Moms+ also initiated Perinatal Education for Advanced Clinical Expertise (PEACE), a training that assist practitioners aid mental health conditions in pregnant and postpartum individuals. The first PEACE training was successfully piloted in November 2024.

Community Doulas

Community doulas help lower maternal mortality rates by improving access to care through system coordination and navigation. Virginia was the 4th state in the nation to offer community doula services as a benefit for Medicaid members. Leaders from both VDH and the Department for Medical Assistance Services (DMAS) collectively provided input and direction into both the state certification and reimbursement processes. Both initiatives went into full effect in early 2022. To date, there are 217 state-certified doulas, and the majority of these doulas serve Medicaid members and other underrepresented communities across the Commonwealth, which addresses disparities in maternal mortality.

Maternal and Child Health Dashboard

In 2025, VDH released two new dashboards to track maternal mortality and pregnancy-associated deaths, as well as an upgraded Maternal and Child Health (MCH) Dashboard that breaks down preterm birth, infant mortality, low birthweight and prenatal care data by region, race, and ethnicity. These dashboards serve as a next key step to raise awareness and push for systemic changes to improve maternal outcomes for Black women.

Women, Infant, And Children (WIC)

The special supplemental nutrition program for women, infants, and children (WIC) is designed to improve health outcomes for pregnant women, infants, and children under the age of five by promoting nutrition and access to health services. WIC provides nutrition education, breastfeeding promotion and support, supplemental nutritious foods, counseling at WIC clinics,

and screening and referrals to other health, welfare, and social services. To be eligible for the WIC program, applicants must meet categorical, residential, income, and nutrition risk requirements.

Maternal, Infant, And Early Childhood Home Visiting (MIECHV)

The Maternal, Infant, And Early Childhood Home Visiting (MIECHV) Program supports pregnant women, families, and at-risk parents of children from birth to age five by connecting them with resources and helping them build the skills needed to raise healthy, school-ready children. The program enhances maternal and child health, prevents child abuse and neglect, promotes positive parenting, and supports early childhood development and school readiness. Administered by VDH and overseen by the Virginia home visiting consortium, MIECHV provides funding to expand evidence-based home visiting services and strengthen early childhood systems at both the state and local levels. Between September 30, 2024, and September 29, 2025, the MIECHV program served 1,451 adults and 1,253 children across 1,378 households. Postpartum care improved year over year: in FY24, 53.9% of mothers received a postpartum visit with a healthcare provider within eight weeks of delivery, compared to 66.2% in FY25.

Healthy Start Program

The Virginia Healthy Start Initiative, known as Loving Steps, is part of a national effort to improve the health and well-being of pregnant and postpartum women, infants, and families. This program focuses on communities experiencing persistently high infant mortality rates (IMR) and significant perinatal health disparities. Loving Steps operates in Norfolk, Petersburg, Portsmouth, Hopewell, and Westmoreland County, locations chosen because of persistently high infant mortality rates and significant perinatal health inequities

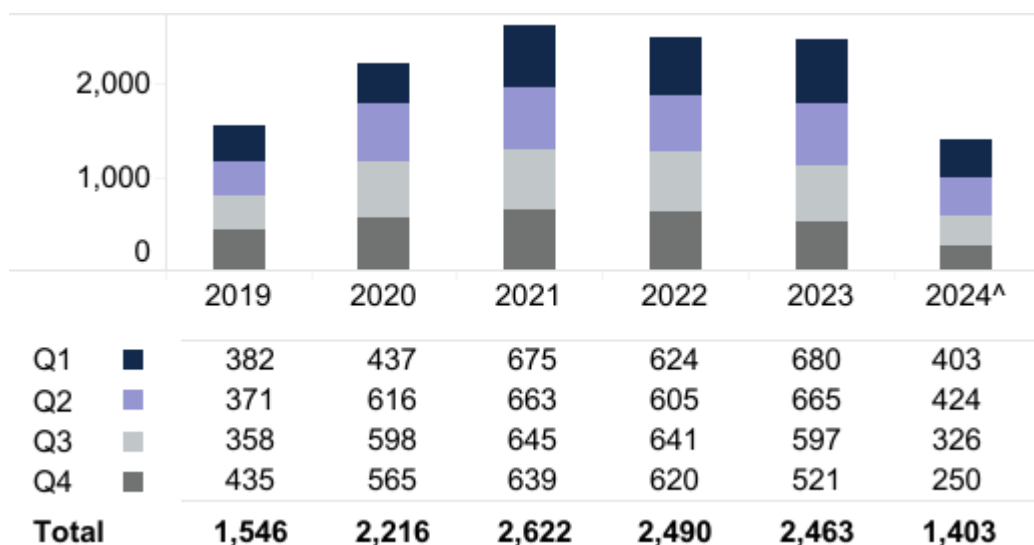
Loving Steps is grounded in the Five Healthy Start Approaches, which guide its interventions and community partnerships. The program focuses on improving women's health before, during, and after pregnancy; promoting high-quality, standardized maternal and infant health services; and strengthening family resilience by engaging both parents and addressing the underlying stressors that contribute to poor birth outcomes. Loving Steps also works to achieve collective impact by serving as a community hub that coordinates partners and drives systemwide improvements. Accountability is strengthened through continuous quality improvement, performance monitoring, and evaluation.

Through these coordinated strategies, Loving Steps supports case management, care coordination, education, screening, and referrals that directly benefit participating families. Recent progress demonstrates the program's impact: between April 1, 2024, and March 31, 2025, 80.4% of enrolled clients completed a postpartum visit, an important measure for preventing complications and supporting long-term maternal well-being. Ultimately, Loving Steps plays a crucial role in reducing preventable infant deaths, improving maternal health, and expanding opportunities for healthier pregnancies and births in communities across Virginia.

SUBSTANCE USE AND OVERDOSE

From 2019 to 2023, Virginia experienced 11,389 drug overdose deaths from all substances, with a crude death rate of 26.4 per 100,000 population in 2023. In that year alone, there were 2,463 drug overdose deaths, marking a 1% decrease from 2022, though still below the 2021 peak of 2,622 deaths (Figure 10). Nearly 79% of these 2023 deaths involved fentanyl, fentanyl analogs, or tramadol, highlighting the ongoing impact of synthetic opioids. Preliminary 2024 data (as of June 2025) indicate 1,403 drug overdose deaths among Virginia residents, representing a 43% decrease from 2023.

Figure 10: All-Drug Death Count Among Virginia Residents by Quarter (2019-2024)



Data Sources: Virginia Department of Health, Office of Family Health Services

The burden of substance use is also reflected in healthcare utilization. In 2020, Virginia recorded 7,725 hospitalizations related to drug overdoses (89.92 per 100,000 population) and 6,447 hospitalizations for substance use disorder (SUD) (75.05 per 100,000). In 2023, there were 21,881 drug overdose emergency department visits, a 2% decrease from 2022, and 31,360 substance use-related incidents requiring emergency medical services (EMS) to respond. Injection drug use remains a major risk factor for infectious disease transmission, contributing to 30% of acute hepatitis C cases and 55 new HIV diagnoses in 2023 (6% of all new HIV cases).

This data underscores the complex and interconnected health impacts of substance use in Virginia, emphasizing the need for sustained prevention, treatment, harm reduction, and recovery strategies across the Commonwealth.

Naloxone Distribution Program

In FY 2025, VDH’s Naloxone Distribution Program provided 158,700 naloxone kits and 355,390 harm reduction test strips, an increase of 10% and 15%, respectively, compared to FY 2024. Notably, VDH expanded program offerings this fiscal year, including offering an additional type of test strip (nitazene test strips; offered in addition to fentanyl, benzodiazepine,

and xylazine test strips) and offering select partners access to an additional strength/formulation of naloxone (nasal naloxone 8 mg; VDH also offers nasal naloxone 4 mg and intramuscular naloxone).

In FY 2025, all of VDH's naloxone partners began using a new application and ordering portal, custom built by the Office of Information Management. This portal has significantly streamlined application and order review, improved communication with partners, and increased data quality for the program. This has allowed VDH to cope with the increased interest in naloxone; VDH maintained agreements with 837 partners in FY 2025, a 30% increase from FY 2024.

VDH continues to share programmatic data with partners, particularly local health departments through a quarterly newsletter. VDH also circulates a quarterly report for local health districts with more detailed data relevant to the health planning region. VDH also maintains a data dashboard for local health districts to view up-to-date information about naloxone and test strip distribution. VDH employs robust communication with partners, including attending conferences, hosting webinars, and holding small group and one on one discussions to hear concerns and raise awareness of naloxone access in Virginia.

Comprehensive Harm Reduction (CHR)

Comprehensive Harm Reduction (CHR) is a core component of Virginia's public health response to the opioid crisis and associated infectious diseases. CHR provides services to people who use drugs and are not yet ready or able to stop using. Services include syringe access, HIV/HCV/STI testing, overdose prevention, linkage to treatment, and other supportive services. As of 2025, Virginia has 15 authorized CHR sites, including four local health districts, two Veterans Administration hospitals, and nine community-based organizations.

Over the past year, CHR services expanded with the authorization of new sites, including Community Access Network (Lynchburg), Nationz Foundation (Henrico, Richmond, and Petersburg), and Strength in Peers (Augusta County, Waynesboro, and Staunton). In FY 2025, 5,987 unique participants made 31,505 visits to CHR sites. These sites distributed over 1.5 million sterile syringes, 11,659 naloxone kits, 12,621 fentanyl test strips, and 129,040 condoms. Participants reported 2,536 overdose reversals, a slight increase from the previous year. Linkages to care included 4,605 connections to mental health or substance use disorder services, 228 to hepatitis C treatment (a 53% increase from the prior year), and five to HIV treatment.

Nonfatal and fatal drug overdoses remain a significant public health issue in Virginia. VDH continues to coordinate an agencywide drug overdose prevention response, including active monitoring and surveillance, primary prevention and rescue initiatives, and CHR efforts. Virginia continues to build upon its substance use disorder work, expertise, and lessons learned from its Centers for Disease Control and Prevention (CDC) previous and current cooperative agreement funding, while simultaneously aligning with shifts in the overdose epidemic. Chapter 487 of the 2025 Acts of Assembly also directed VDH to report certain information to the Department of Health Profession's Prescription Monitoring Program (PMP) when a patient has experienced a nonfatal opioid overdose. Once finalized, this expansion to PMP data will allow prescribers and other providers to make more informed clinical decisions regarding narcotics and other substances with the potential for addiction or misuse.

Opioid Impact Registry

The Code of Virginia § 54.1-3408 directs VDH to develop a Commonwealth opioid impact reduction registry. This registry includes a list of nonprofit organizations that work to reduce the effects of opioid use in the Commonwealth. As part of this effort, VDH has established a process for determining which organizations should be included, defines the criteria and metrics for inclusion, and assesses the administrative burdens local governments face when procuring services from these organizations in a timely manner.

In alignment with the recommendations provided by the Opioid Impact Registry Report to the General Assembly, 211 Virginia is expanding to serve as the registry. Coordinated through the Virginia Department of Social Services, 211 Virginia is a free, confidential service that connects individuals with information about available community services throughout the Commonwealth, including assistance with substance use. 211 Virginia has launched a landing page specifically for substance abuse resources and is currently working to expand substance use referral blocks. Between June and July of 2025, 211 Virginia piloted a prompt asking platform users if they needed support with substance use, which, if selected, would activate a second prompt providing an option for additional information. As a result, 211 Virginia completed almost 1,500 referrals to 350 resources within a 2-month period.

SMOKING AND E-CIGARETTE USE PREVALENCE

Smoking remains the single largest preventable cause of death and disease, increasing the risk of heart disease, stroke, lung disease, and many types of cancer. Current smoking prevalence among adults 18 years and older in Virginia declined from 14.0% in 2019 to 10.9% in 2023; however, regional disparities remain. In 2023, three out of five regions of Virginia had a smoking prevalence higher than the state (10.9%). Southwestern region of Virginia had the highest smoking prevalence (15.5%), followed by Central region (14.6%) and Eastern region (11.0%) (Table 4).

Table 4. Prevalence of Adults Smokers in Virginia by Region, 2019-2023.

‘Current Smoker’ Prevalence Among Adults in Virginia					
Region	2019	2020	2021	2022	2023
Virginia	14.0%	13.6%	12.4%	12.1%	10.9%
Central	14.9%	13.7%	14.8%	13.6%	14.6%
Eastern	16.2%	15.6%	14.4%	13.7%	11.0%
Northern	8.6%	6.8%	5.5%	6.3%	6.5%
Northwestern	14.1%	15.3%	13.0%	12.5%	9.8%
Southwestern	19.8%	21.3%	19.3%	18.4%	15.5%

Virginia Department of Health, Behavioral Risk Factor Surveillance Survey.

E-cigarette use among adults 18 years and older in Virginia peaked at 7.7% in 2022 and declined slightly to 7.0% in 2023. Two regions of Virginia had a prevalence of e-cigarette use higher than the state prevalence in 2023, including Southwestern Virginia (8.7%) closely followed by Central Virginia (8.6%) (Table 5).

Table 5. Prevalence of Adult E-Cigarette Users in Virginia by Region, 2019-2023.

'Current E-Cigarette' Prevalence Among Adults in Virginia					
Region	2019	2020	2021	2022	2023
Virginia	6.4%	5.2%	6.8%	7.7%	7.0%
Central	5.3%	3.2%	7.5%	9.5%	8.6%
Eastern	7.9%	7.5%	8.3%	8.7%	7.0%
Northern	4.1%	4.3%	5.0%	4.9%	5.7%
Northwestern	6.9%	4.9%	8.0%	8.4%	6.1%
Southwestern	9.1%	6.0%	5.8%	8.5%	8.7%

Virginia Department of Health, Behavioral Risk Factor Surveillance Survey.

VDH currently has several programs actively supporting prevention efforts, including the Cardiovascular Health and Stroke Programs, Virginia Stroke Care Quality Improvement Initiative, and the Tobacco Control Program and Cessation Services. Building statewide capacity for population-based chronic disease prevention by funding chronic disease staff at VDH would assist the agency in implementing chronic disease prevention activities, convene clinical-community partnerships to address health disparities, and strengthen data surveillance and monitoring of chronic disease trends and interventions

INFECTIOUS DISEASES

RESPIRATORY ILLNESSES

The 2024-2025 respiratory disease season (including influenza, COVID-19, and RSV) highlighted the persistent and unpredictable burden of respiratory illness on public health and healthcare systems. In Virginia, respiratory illness activity peaked later than in the previous two seasons, during the week ending February 8, 2025. COVID-19 activity remained lower than in prior winters, while influenza activity surged sharply after a delayed onset. Virginia reported six influenza-associated pediatric deaths for the 2024-25 respiratory season, the highest since the 2019-2020 season.

Unusual respiratory illnesses and clinical presentations emerged during the season, including a significant rise in pediatric pneumonia and severe influenza-associated medical complications. In September 2024, Virginia surveillance systems detected a significant rise in emergency department and urgent care visits for pediatric pneumonia. In response, VDH partnered with the Division of Consolidated Laboratory Services (DCLS) to conduct enhanced surveillance and laboratory testing, which identified a range of pathogens, primarily

rhinoviruses/enteroviruses and *Mycoplasma pneumoniae*. In February 2025, CDC issued an alert regarding an increase in influenza-associated encephalopathy (IAE), including acute necrotizing encephalopathy (ANE). VDH identified five cases of IAE in Virginia following a national call for cases. Additionally, VDH observed a notable increase in influenza-associated myositis (difficulty walking) and sialadenitis (inflammation of the salivary gland), particularly among children. These situations prompted rapid public health responses, including enhanced surveillance and targeted communication with healthcare providers and the public. VDH's Respiratory Illness Dashboard, launched in September 2020, integrates multiple data streams to a comprehensive view of respiratory disease trends across Virginia. Public health messaging is amplified through immunization events, paid media campaigns, clinician letters, news releases, and social media outreach. In February 2025, VDH implemented a regulatory variance to Virginia's COVID-19 disease reporting and control regulations. This removed the requirement to report individual COVID-19 cases. This decision aligned with the current epidemiological context and supported a reduced reporting burden for clinicians in Virginia.

In March 2024, a multistate outbreak of influenza A(H5N1) virus in dairy cows raised concerns about public health and U.S. food system integrity. In response, VDH developed emergency response plans, and activated an Incident Command Structure during two H5 detections in birds in Virginia. VDH monitored over 200 individuals exposed to avian influenza and enhanced influenza surveillance systems to improve detection potential. VDH also provided timely recommendations and education to both the public and healthcare providers. While no human or cattle cases have been reported in Virginia to date, the situation underscores the importance of interagency coordination, early detection, and rapid response capabilities.

The 2024-2025 respiratory season demonstrated the unpredictable nature of respiratory pathogens and the critical need for sustained investment in surveillance systems, workforce capacity, immunization infrastructure, and public communication. The season highlighted vulnerabilities in public health infrastructure when rescinded federal funding led to an 83% reduction (10 staff members) of the VDH respiratory disease team in March 2025. Support for the workforce and these programs is essential to protect Virginians and ensure a resilient public health response to both seasonal and emerging threats.

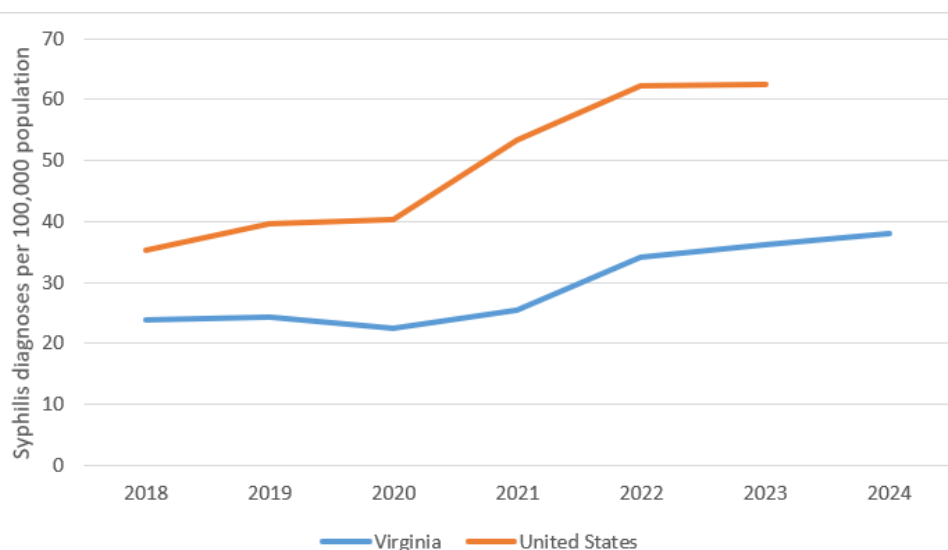
Ahead of the 2025-2026 season, VDH launched "The Little Things" campaign, which brings small but powerful health habits to life by personifying them as unique, helpful characters — each representing an action including: washing hands, covering coughs, or getting immunized. These playful figures work together to promote simple, everyday behaviors that help prevent the spread of respiratory illnesses. By making health habits fun, memorable, and approachable, the campaign encourages people of all ages to adopt small actions that can make a big difference. The campaign materials are available in English and Spanish. The campaign will be shown as a Public Service Announcement campaign and in 45 movie theaters across Virginia.

SYPHILIS

Since 2010, acquired (adult) syphilis rates have been rising in Virginia and across the United States (Centers for Disease Control and Prevention, 2023). Data on nationwide syphilis rates for 2024 were not available when this report was published; however, Virginia 2024 data was included. The increase has been particularly steep since 2020, with syphilis diagnoses surging significantly (Figure 11). In Virginia, the rate of new syphilis diagnoses increased 60.2% from 2020-2024 compared to a nationwide increase of 54.7% between 2020-2023. In 2024, the rate of

syphilis was 38.1 cases per 100,000 population in Virginia. Nationwide, there were 62.5 cases per 100,000 population in 2023. Between 2018 and 2023, syphilis rates rose by 77.6% nationwide and 51.5% in Virginia. The rate increased by another 5.1% from 2023 to 2024 in Virginia, leading to a total increase of 59.2% from 2018 to 2024. VDH has also observed concerning changes in self-reported use of opioids and other drugs. As the number of cases of early syphilis in Southwest Virginia increased 51% from 2022 to 2024, the percentage of cases involving self-reported injection drug use also increased, from 6.9% to 9.6%. Between 2022 and 2024, the percentage of cases of early syphilis involving self-reported cocaine use in the prior 12 months doubled in every health planning region except eastern Virginia, which saw a tripling of cases involving self-reported opioid use.

Figure 11. Acquired Syphilis Rates per 100,000 Residents in Virginia and U.S., 2018-2024



Data Sources: Virginia Department of Health, Centers for Disease Control and Prevention

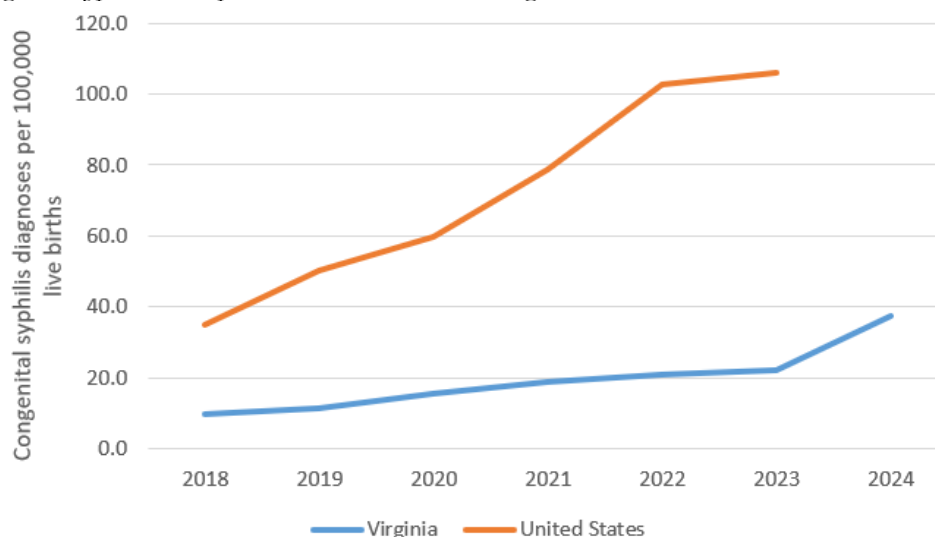
Alongside worsening rates of syphilis, losses of federal funding and pharmaceutical rebates that supported the STI workforce in prior years have negatively impacted VDH’s ability to adequately staff its public health response. Between January 2023 and July 2025, the total number of STI surveillance staff available to receive and process new reports of syphilis morbidity shrunk by 30%, and the number of disease intervention specialists available to reach out to individuals diagnosed with syphilis to ensure they and their partners receive timely and appropriate testing and treatment shrunk by 19%.

VDH’s Syphilis Incident Management Team (IMT), formed in December 2023, has played a key role in responding to increases in morbidity. The regional syphilis response task force in eastern Virginia worked with the Sentara and Riverside health systems to integrate electronic prompts to order syphilis testing in their electronic health record system, resulting in a significant increase in tests ordered. VDH’s Division of Pharmacy Services, working closely with the Division of Disease Prevention, succeeded in maintaining an adequate supply of injectable syphilis treatment for all patients referred to public health throughout a multi-year national shortage. The IMT staged rapid syphilis testing pilots for women of reproductive age at community-based harm reduction sites and worked with the manufacturer of the nation’s first FDA-approved syphilis self-test to stage statewide pilots using donated test kits.

CONGENITAL SYPHILIS

Congenital syphilis (CS) cases in the United States in 2023 reached the highest level seen since 1992.⁶ At the national level, cases increased each year of the last decade. Virginia has seen a similar upward trend in CS diagnoses, though its rates remain lower than the national rates (Figure 12). In 2023, Virginia's CS rate was 22.0 cases per 100,000 live births, compared to the national rate of 105.8, with a more gradual increase in Virginia. Between 2018 and 2023, Virginia's CS rates rose by 120%, while the national rate increased 203%. From 2023 to 2024, CS rates in Virginia saw a concerning 71% increase. This indicates that in Virginia, congenital syphilis rates increased 276% between 2018-2024, exceeding the national rate of increase. Data for the national CS rate in 2024 was not available at the time this report was published.

Figure 12: Congenital Syphilis Rates per 100,000 Livebirths in Virginia and Nationwide



Data Source: Virginia Department of Health, Centers for Disease Control and Prevention

In response to increases in CS rates, VDH's Division of Disease Prevention (DDP) established the Perinatal Surveillance Coordinator (PSC) position in 2019. The PSC reviews all open syphilis investigations involving pregnant women to ensure prompt and adequate treatment and partner services. The PSC also follows up with providers on all positive syphilis test results in newborns to ensure they get proper evaluation and care.

In 2021, DDP established the Congenital Syphilis and Perinatal HIV Case Review Board (CRB), which consists of a diverse group of public and private health professionals. The CRB meets annually to review CS and perinatal HIV cases with the purpose of identifying barriers, missed opportunities, and gaps in care to develop recommendations to address systemic issues and prevent future CS cases. VDH has also issued several letters to healthcare providers to alert them of the rising rates of CS and provide guidance on CDC screening and treatment recommendations.

⁶ Centers for Disease Control and Prevention. (2024). Sexually Transmitted Infections Surveillance, 2023. Retrieved from CDC: Centers for Disease Control and Prevention: https://www.cdc.gov/syphilis/about/index.html?CDC_AAref_Val=https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.ht

MEASLES

Between March and September 2025, VDH responded to a series of measles cases linked to international travel. In March, two Maryland residents were diagnosed with measles following overseas travel, prompting VDH to manage public exposures at Dulles International Airport and other locations in Northern Virginia. Fortunately, no secondary cases were identified. On April 19, VDH confirmed a measles case in a preschool-aged child from Northwest Virginia who had also traveled internationally. The investigation identified over 100 contacts across several healthcare settings. VDH coordinated post-exposure prophylaxis and implemented quarantine recommendations for non-immune individuals, successfully preventing any secondary transmission.

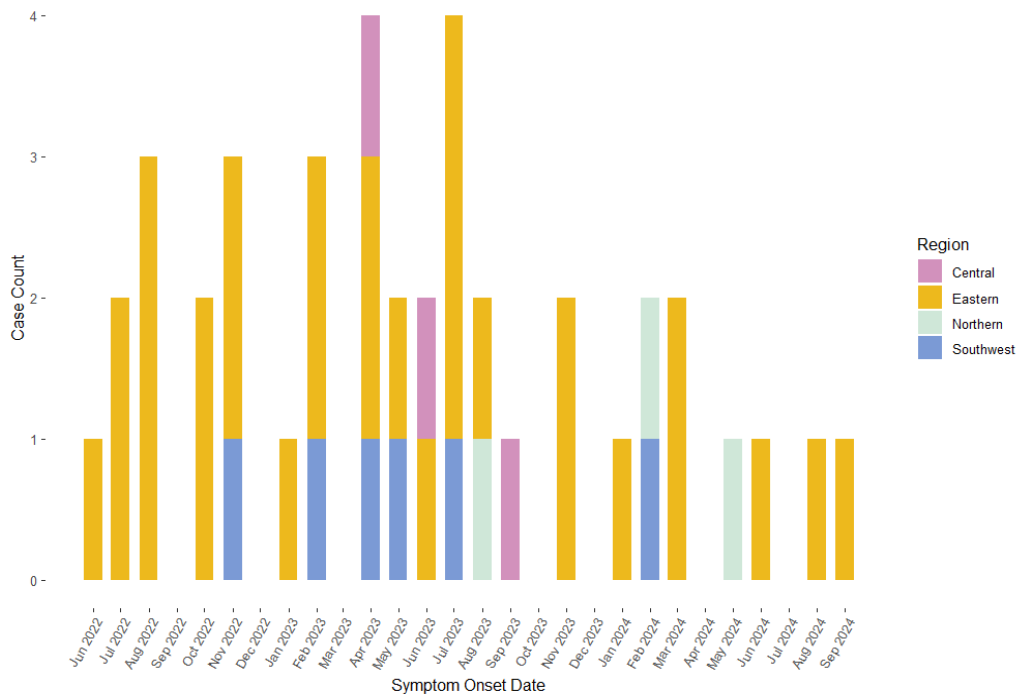
In May, a second measles case in Northwest Virginia involved a teenager with recent international travel, prompting a large-scale response that identified over 350 contacts across public spaces and two healthcare facilities. Working closely with UVA Hospital, VDH provided post-exposure prophylaxis and issued quarantine guidance to contain the spread. A single secondary case was later reported on June 5 in a young child in the same region. In late August, VDH confirmed the state's fourth measles case of the year in a school-age child from the Eastern Region, also with recent international travel. For both outbreaks, VDH issued regional news releases to inform the public about possible exposure locations.

MENINGOCOCCAL DISEASE

Meningococcal disease, caused by the bacterium *Neisseria meningitidis*, is a serious illness that manifests primarily as meningitis or meningococemia (a bloodstream infection). Of the six *N. meningitidis* serogroups — A, B, C, W, X, and Y — responsible for most meningococcal disease worldwide, four serogroups (B, C, W, and Y) circulate in the United States. In recent years, multiple factors have contributed to shifting trends in meningococcal disease epidemiology, including changes in antimicrobial resistance patterns and the emergence of new strains in populations not previously associated with meningococcal infection.

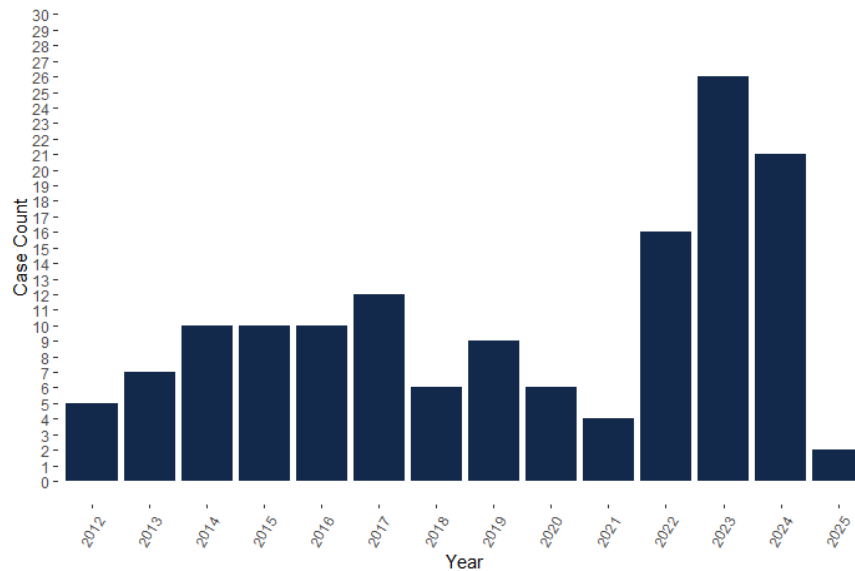
Since 2022, Virginia has reported an increase in cases of meningococcal disease primarily attributed to a statewide outbreak of *N. meningitidis* serogroup Y sequence type 1466 (NmY ST1466) that was first identified in Eastern Virginia in June of that year. From June 2022 – September 2024, 41 outbreak cases were reported across Eastern (29), Southwest (6), Central (3) and Northern Virginia (3), including eight fatalities (Figure 13). During the preceding 10 years, Virginia averaged only eight meningococcal disease cases per year (Figure 14). Meningococcal disease trends returned to pre-outbreak levels in January 2025, though the strain associated with this outbreak continues to circulate in Virginia and nationally.

Figure 13: Meningococcal Disease Outbreak Cases June 2022- September 2024



Data Source: The Virginia Department of Health, Office of Epidemiology

Figure 14: State Meningococcal Disease Outbreak Cases 2012-2025



Data Source: The Virginia Department of Health, Office of Epidemiology

Most outbreak cases occurred in people ages 30–60 years (64%), Black or African American people (76%), and people with HIV (12%). Thirty-nine patients (95%) were unvaccinated against *N. meningitidis* serogroup Y. This outbreak demonstrated the potential for *N. meningitidis* to spread in populations not previously considered at high risk for meningococcal infection, such as adults 30-60 years. An undefined at risk population made

vaccination efforts challenging. While post-exposure prophylaxis (PEP) antibiotics helps prevent secondary cases, CDC does not routinely recommend vaccinating close contacts. In this outbreak, the MenACWY vaccination of close contacts was recommended for contacts 11 years of age and older in addition to PEP to prevent additional cases among a population presumed to be at risk.

In 2023, Virginia's public health lab began whole genome sequencing (*N. meningitidis*), to support outbreak detection and response. The recent outbreak underscored the need for better meningococcal vaccine coverage in high-risk groups, especially people with HIV, consistent with national trends for *NmY ST1466*. VDH targeted HIV providers to promote MenACWY vaccination and advised local health departments to follow ACIP guidelines for vaccines and PEP. This investigation was published in CDC's *Morbidity and Mortality Weekly Report (MMWR)* in October 2024. Since 2020, antibiotic-resistant *N. meningitidis* strains have risen in Virginia, now causing over half of cases in Northern Virginia.

VDH shared this recommendation with the provider community via clinician letter in April 2024. Additional cases have been identified in Southwest and Eastern Virginia since 2024, including an outbreak of a penicillin-resistant strain in Roanoke City in March 2025. Two cases were identified, including 1 fatality, among employees of a food processing facility. Following a swift public health investigation, over 150 contacts received PEP, and 101 contacts received meningococcal vaccine. VDH continues to monitor penicillin-resistant *N. meningitidis* and partners with CDC and neighboring jurisdictions to update PEP guidance.

HEALTH CARE WORKFORCE INCENTIVES

The VDH Health Workforce Unit, housed within the Office of Health Equity, plays a vital role in supporting healthcare professionals across the Commonwealth. The unit administers 15 distinct workforce incentive programs designed to recruit, retain, and support healthcare providers, particularly in underserved communities. These programs collectively manage \$18.3 million in state general funds and \$822,000 in federal funds, with all state funds eligible for rollover into the next fiscal year.

During FY 2024, the General Assembly directed VDH to establish Virginia's Earn to Learn (ETL) Nursing Education Acceleration Program. The ETL program provides funding to educational institutions in the Commonwealth that offer Virginia Board of Nursing-approved nursing education programs for pre-licensure Registered Nurses (RN) and Licensed Practical Nurses (LPN) to foster collaborative clinical training arrangements between grant recipients, hospitals, and health providers. Through these partnerships, RN and LPN students participate in a paid clinical apprenticeship that enables them to earn a wage comparable to their current level of practice while training to obtain a higher certification level.

The first cohort of Earn to Learn grantees were comprised of 13 academic institutions. Originally funded from September 2024 through December 2025. Ten of the grantees have requested to extend their contracts through June 30, 2026, to implement Earn to Learn. Applications for the second cohort were open through May 30, 2025, and reviewed in June. Both J. Sargent Reynolds and Piedmont Virginia Community Colleges were selected to join Cohort 2. VDH currently has a plan in place to obligate the remaining \$7.59M from FY25 and FY26

before the 2026 General Assembly Session concludes. The vast majority of these funds will be eligible for Cohorts 1 & 2 to expand and continue their ETL efforts in state FY27.

Additionally, annual funding for VDH’s Nursing Preceptor Incentive Program, designed to reduce the shortage of registered nurse clinical education opportunities and establish new preceptor rotations for nursing students was increased from \$500,000 in FY2022 to \$3.6 million in FY2025, and anesthesiology was added as a priority “high demand” field. In 2023, the per-slot incentive amount was increased from \$1,000 to \$5,000.

EMERGENCY MEDICAL SERVICES

The VDH Office of Emergency Medical Services (OEMS) is responsible for planning and coordinating an effective and efficient statewide EMS system. OEMS is responsible for the licensing of EMS agencies and vehicles, the certification and training of all levels of EMS personnel (EMTs, Paramedics), and coordination with the State EMS Advisory Board on the development of the State Board of Health’s EMS regulations. Further, OEMS manages critical specialized systems, including the designation of hospital Trauma Centers, and provides essential funding, technical support, and guidance to regional EMS councils and local rescue agencies, thereby guaranteeing quality emergency medical response across Virginia.

LOCAL HEALTH DISTRICT CLINICAL SERVICE DELIVERY

VDH is a centralized health department and operates through a network of 35 Local Health Districts (LHDs), each responsible for delivering public health services tailored to their community’s needs. LHDs serve a wide range of functions, including providing immunizations, public health surveillance, communicable disease investigations, sexually transmitted infection management, and environmental health inspections to improve public health across Virginia. To further demonstrate the impact of clinical services provided by the LHDs across the state, the tables below present data on clinical encounters for core public health programs provided by the districts.

LHDs across Virginia continue to play a critical role in preventive healthcare by providing a wide range of clinical and public health services. In FY25, LHDs administered a total of 137,025 immunizations, underscoring their commitment to disease prevention (Table 6). The most frequently administered vaccines were Tdap vaccinations (26,535 doses) and meningococcal (21,585 doses) vaccinations. In addition to immunization services, LHDs conducted 91,312 sexually transmitted infection (STI) tests and treatments (Table 7). Among these STI services, chlamydia and gonorrhea tests were the most common (24,681), followed by HIV (20,598) and syphilis (20,168) testing encounters. These efforts support the early detection, treatment, and prevention of STIs within local communities. LHDs also provided 40,218 family planning encounters during FY25, with the most frequent services being Depo-Provera administration (11,556) and pregnancy testing (10,370) (Table 8). Additionally, a total of 254,533 tuberculosis (TB)-related encounters were reported, with the most frequent being office visits (78,376), which include medication pick up or a consultation with a client (Table 9). TB education sessions (63,390) were the second most common type of encounter. These services highlight ongoing efforts to prevent and manage TB across the Commonwealth.

Table 6. Number of Immunizations Provided By LHDs in FY25.

Immunization Type	Number of Vaccines Provided
COVID-19	7,071
Influenza	1,745
Hepatitis A	11,963
Hepatitis A & B	300
Hepatitis B	10,662
Haemophilus influenza type B (Hib)	1,936
Human Papillomavirus 9	16,133
Meningococcal	21,585
Measles, Mumps, Rubella, and Varicella	10,196
Pneumococcal	3,797
Polio	11,741
Rabies	1,487
Rotavirus	965
Respiratory Syncytial Virus	205
Smallpox & Mpox	464
Tetanus, Diphtheria, and Pertussis (Tdap)	26,535
Varicella	9,831
Zoster	409
Yearly Totals	137,025

Data Source: Virginia Department of Health, Office of Community Health Services.

Table 7. Number of STI Testing and Treatments Provided By LHDs in FY25.

Activity Type	Number of STI Testing or Treatment Services Provided
Azithromycin Treatment	412
Bicillin Treatment	3,744
Ceftriaxone Treatment	1,639
Chlamydia and Gonorrhea Testing	24,681
Contact Investigation	2,141
Doxycycline Treatment	3,396
Contact Referral due to Exposure	4,223
Expedited Partner Treatment	70
Hepatitis Testing	9,027
Herpes Testing	370
HIV Testing	20,598
HSV Testing	843
Syphilis Testing	20,168
Yearly Totals	91,312

Data Source: Virginia Department of Health, Office of Community Health Services.

Table 8. Number of Family Planning Encounters at LHDs in FY25.

Activity Type	Number of Family Planning Encounters
Depo-Provera	11,556
Gyn Pap Test	3,899
Long-Acting Reversible Contraceptive (LARC) Removal, Insertion, or Removal with Insertion	4,667
Patches and rings	385
Pills	5,552
Pregnancy test	10,370
Vaginal Smear	3,789
Yearly Totals	40,218

Data Source: Virginia Department of Health, Office of Community Health Services.

Table 9. Number of Latent Tuberculosis (TB) Infections and Active TB Client Encounters at LHDs in FY25.

Activity Type	Number of Latent TB Infection and Active TB Client Encounters
Case Management	15,170
File Status	79
Home Visit	5,506
Laboratory	39,913
Observed Therapy	14,585
Office Visit	78,376
Radiology	465
TB Assessment	10,482
TB Education	63,390
TB Medication	8,799
TB Screening	17,758
Telehealth Visit	10
Yearly Totals	254,533

Data Source: Virginia Department of Health, Office of Community Health Services.

RECOMMENDATIONS

The 2025 Board of Health Annual Report highlights the overall health status of the Commonwealth, guided by the VDH's vision of making Virginia the healthiest state in the nation. Achieving this vision requires ongoing monitoring of core health indicators, alongside consistent tracking of specific diseases and conditions each year. The annual report remains a vital tool for communicating progress on health measures throughout Virginia and could benefit from broader dissemination. This report also identifies key opportunities for the state to advance solutions addressing several urgent health challenges facing the Commonwealth. These

recommendations focus on leveraging resources effectively, integrating social determinants of health, and prioritizing vulnerable populations to achieve equitable health outcomes statewide. Implementation of these recommendations will require the State Board of Health and VDH to work effectively with a wide range of public health stakeholders. Recommendations are as follows:

Social Determinants of Health:

- Improve access to care by reducing transportation, geographic, and digital barriers through community-based services, such as establishing public transit partnerships or utilizing ride-sharing services, and expanding connectivity through supporting mobile clinics, telehealth, and investing in broadband access to reduce digital divides.
- Advance equitable care delivery by promoting culturally responsive practices, language access, and routine screening for social needs with clear referral pathways.
- Support education and workforce development by strengthening health literacy and creating health career pipeline programs.
- Address housing instability by increasing support for permanent supportive housing.
- Promote food security initiatives by integrating nutrition education into healthcare and other community programs, screening for food insecurity, and expanding WIC and nutrition program participation, with targeted outreach to underserved populations.

Maternal and Child Health:

- Enhance support for pregnant and postpartum individuals with substance use challenges by integrating peer recovery and perinatal into care settings.
- Strengthen workforce capacity through training for support professionals (e.g. doulas, community health workers, peer support specialists) working with this population.

Youth Suicide Prevention :

- Expand prevention efforts for youth by addressing the unique needs of young people following high school, including those entering the workforce, military, or higher education.
- Ensure VDH undergoes strategic planning by convening a taskforce to update the Virginia Suicide Prevention Plan every three years, focusing on preventing suicide through youth-specific strategies.
- Improve access to mental health care by strengthening the mental health workforce in Virginia and increasing the accessibility of mental health resources.
- explore public-private partnerships to close care and communication gaps between school, parents, and care resources

Substance Use and Overdoses

- Support high-demand harm reduction services by ensuring adequate staffing and resources to maintain quality and accessibility of high-volume CHR sites.
- Continue efforts to partner with local community partners to enhance availability of needed resources (i.e., providing naloxone and distributing test strips)

Chronic Diseases:

- Strengthen statewide chronic disease prevention by enhancing public health capacity, fostering clinical-community partnerships, and improving data surveillance to address disparities.
- Facilitate timely data sharing of cancer registry data to researchers and academic centers who use the data to advance cancer research.

Infectious Diseases:

- Sustain comprehensive surveillance for respiratory and other infectious diseases using advanced tools and monitoring systems.
- Maintain robust outbreak detection through active and passive disease surveillance.
- Promote and facilitate increased vaccination uptake for key vaccine preventable diseases to reach herd immunity thresholds.
- Focus immunization efforts on vulnerable and high-risk populations to reduce health disparities

APPENDIX A: CODE OF VIRGINIA § 32.1-14

§ 32.1-14. Annual report

The Board shall submit an annual report to the Governor and General Assembly. Such report shall contain information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia, including but not limited to, health status indicators, the effectiveness of delivery of health care, progress toward meeting standards and goals, the financial and geographic accessibility of health care, and the distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need. Such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.

APPENDIX B: ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

ACS – American Community Survey	EWL - Every Woman’s Life
ANE – Acute Necrotizing Encephalopathy	FPL – Federal Poverty Level
CAMS - Collaborative Assessment and Management of Suicidality	FY – Fiscal Year
CAVC – Cancer Action Coalition of Virginia	HRSA MCH – Office of Women’s Health, and Health Resources and Services Administration Maternal Child Health Division
CDC – Centers for Disease Control and Prevention	IAE – Influenza-associated Encephalopathy
CHR – Comprehensive Harm Reduction	IMR – Infant Mortality Rate
CRB – Congenital Syphilis and Perinatal HIV Case Review Board	IMT – Incident Management Team
CS – Congenital Syphilis	MIECHV – The Maternal, Infant, and Early Childhood Home Visiting Program
COPD – Chronic Obstructive Pulmonary Disease	MMR – Maternal Mortality Rate
DCLS – Division of Consolidated Laboratory Services	MMRT – Maternal Mortality Review Team
DDP – Division of Disease Prevention	PAMSS– Pregnancy-Associated Mortality Surveillance System
DIS – Disease Intervention Specialists	PEP – Post-exposure Prophylaxis
EMS – Emergency Medical Services	PCP – Primary Care Providers
PEACE – Perinatal Education for Advanced Clinical Expertise	VACCCP –Virginia Comprehensive Cancer Control Program
PMP –Virginia Prescription Monitoring Program	VA-SORH – Virginia State Office of Rural Health
PSC – Perinatal Surveillance Coordinator	VCP – Virginia Cancer Plan
SAMHSA – Substance Abuse and Mental Health Services Administration	VCR – Virginia Cancer Registry
SME – Subject Matter Expert	VDH – Virginia Department of Health
SNAP – Supplemental Nutrition Assistance Program	VMAP – Virginia Mental Health Access Program
SSP – Suicide Systems Project	VTN – Virginia Telehealth Network
SUD – Substance Use Disorder	WGS – Whole Genome Sequencing
SVI – Social Vulnerability Index	WHO – World Health Organization
TA – Technical Assistance	WIC – Women, Infants, and Children

APPENDIX C: ADDITIONAL DETAILS

America’s Health Rankings

America’s Health Rankings is an annual report that provides a comprehensive assessment of the nation’s health on a state-by-state basis. It is prepared by the United Health Foundation, a private, non-profit foundation dedicated to improving health and health care. Drawing on data from national and state-level sources, such as the CDC and U.S. Census Bureau, the report evaluates a wide range of health indicators to highlight public health strengths and challenges across the U.S.

The Social Vulnerability Index (SVI)

The Social Vulnerability Index (SVI), a tool developed by the CDC, is used to help identify communities that may need more support before, during, or after disasters such as hurricanes, disease outbreaks, or other public health emergencies. The SVI uses U.S. Census data from the American Community Survey to rank census tracts on 15 social factors, such as poverty, disability status, minority status, and crowded housing. The social factors are then grouped into four themes: socioeconomic status, household composition and disability, minority status and language, and housing type and transportation. The index ranges from 0 to 1, where 1 represents a community that is highly vulnerable and most at-risk and 0 represents a community that is not vulnerable and is the least at-risk. Communities with higher vulnerability may be less able to prepare for, respond to, and recover from emergencies, whether they are natural disasters, environmental hazards, or public health crises. These rankings help public health officials allocate resources more effectively and prioritize communities that are most at risk.

Virginia Youth Survey (VYS)

Through a five-year grant provided by the CDC and in collaboration with the Virginia Foundation for Healthy Youth, the Virginia Youth Survey (VYS) is a statewide survey administered by VDH every odd year in randomly selected Virginia public schools. The VYS has been developed to monitor priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults within the Commonwealth. VYS is a part of broader efforts to monitor and promote adolescent health at the state and local levels that are designed to improve the well-being of young people across the state.