# Sentara RMH Medical Center

## COMMUNITY HEALTH NEEDS ASSESSMENT 2022

*We Improve Health Every Day*

SENTARA®

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# EXECUTIVE SUMMARY

As an organization, we are driven to improve health every day. And while we meet that mission through the healthcare services we provide to our patients, we understand that our greater purpose must include building trust and listening to the voices of individuals in the community to better understand the specific needs of those we serve. In 2021, Sentara RMH Medical Center (SRMH) began conducting the community health needs assessment by surveying community members, conducting focus groups with diverse populations and partnering with local health departments and community organizations.

> *"Each community Sentara serves is unique, and in order to drive lasting outcomes for the Shenandoah Valley it is important for us to partner with our community to identify the most significant health needs as an important step in achieving our mission of improving health every day."*
>
> ***Doug Moyer**, President of Sentara RMH Medical Center*

These assessments provide a snapshot of the health status of the residents in our communities, including information about key health and health-related problems. The community health needs assessment incorporates information from a variety of primary and secondary quantitative data sources and more importantly helps us to understand the disparities that exist in vulnerable populations.

We are grateful to the residents, faith-based organizations, businesses, clinics, nonprofits, government agencies, and others who devoted expertise and significant time helping us better understand these priorities identified and know we must be committed to working together to identify solutions. We further understand that the implementation strategies will be most successful by working with residents of the community so that we move closer to achieving health equity for all.

While there are many important community health problems, we are focusing our efforts on the key issues listed below. Considering factors such as size and scope of the health problem, the severity and intensity of the problem, the feasibility and effectiveness of possible interventions, health disparities associated with the need, the importance the community places on addressing the need, and consistency with our mission "to improve health every day," we have identified these priority health problems in our area, all of which have been exacerbated by the COVID-19 pandemic:

**SRMH Health Priorities for 2022-2025**

- Behavioral Health
- Chronic Disease
- Social Determinants of Health

The following comprehensive report goes into more detail about the assessment to include an introduction, social and economic factors, demographic and background information, health determinant data and incorporates extensive community survey and outreach.

# OVERVIEW

## We Improve Health Every Day

Sentara celebrates more than 130 years in pursuit of its mission "We improve health every day." Named to IBM Watson Health's "Top 15 Health Systems" in 2018 and 2021, Sentara is an integrated, not-for-profit health system of 12 hospitals in Virginia and Northeastern North Carolina, including a Level I trauma center, the Sentara Heart Hospital, the Sentara Brock Cancer Center, two orthopedic hospitals, and the Sentara Neurosciences Institute. The Sentara family also includes a medical group, Nightingale Regional Air Ambulance, home care and hospice, ambulatory outpatient campuses, advanced imaging and diagnostic centers, a clinically integrated network, the Sentara College of Health Sciences and Sentara Health Plans, comprised of Optima Health Plan and Virginia Premier Health Plan, serving 950,000 members in Virginia, and North Carolina. Sentara has more than 30,000 employees dedicated to improving health in the communities we serve, and was recognized as one of "America's Best Employers" by Forbes in 2018. Sentara is strategically focused on clinical quality and safety, innovation and creating an extraordinary health care experience for our patients and members.

### SENTARA AT A GLANCE

- Headquartered in Norfolk, Virginia
- 130-year not-for-profit history
- 12 hospitals
- One medical group
- 3,800+ provider medical staff
- 30,000+ team members
- Health plans (Optima Health and Virginia Premier)
- Outpatient campuses
- Urgent care centers
- Advanced Imaging Centers
- Home health and hospice
- Rehabilitation and therapy centers
- Nightingale air ambulance

# INTRODUCTION

## Sentara RMH Medical Center

Sentara RMH Medical Center began as Rockingham Memorial Hospital in 1912. Serving a seven-county area with a population of close to 218,000 residents, the 238-bed community hospital merged with the Sentara system in May of 2011.

> *"We approach every community and every partner with our ears and our hearts open. We're not here to provide prescriptive solutions. We're here to support and amplify the work of our partners in every way we can to improve more lives and inspire more hope for the future."*
>
> ***Sherry Norquist**, Director of Community Engagement & Impact*

### SENTARA CARES

Sentara cares about advancing health equity and ensuring that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives. We are guided by our understanding that our overall health is greatly influenced by where we are born and where we live, learn, work, play, worship, and age. In fact, these environmental factors account for nearly 80 percent of health outcomes, while direct healthcare accounts for only 20 percent.

Our purpose, then, calls us to address these issues on the ground every day where people live — not just when they are under our care. Only then can we help to eliminate health disparities and promote equitable access to nutritious foods, education, safe and affordable housing, and stable, rewarding job opportunities. We know such disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. However, through our partnerships we continue to make both immediate impact and lasting change for our communities.

### COVID-19 RESPONSE

As we embarked on this Community Health Needs Assessment (CHNA) process, the country and Virginia were focused on mitigating the COVID-19 pandemic. The impacts of COVID-19 are likely to affect community health and well-being beyond what is currently captured in available data. Sentara seeks to engage the community as directly as possible in prioritizing needs.

Sentara is committed to always keeping our patients, employees, and community members safe. We have developed extensive safety protocols and guidelines to ensure the patient/member receives the care they need at any Sentara facility. Sentara cares about improving the health and well-being of all individuals and the quality of life enjoyed by everyone in our community Sentara responds to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. We are committed to supporting, strengthening, and serving our communities.

### OUR PROCESS

Sentara developed a primary statistical data profile integrating claims and encounter data to assess the population's use of emergency services, preventive services, chronic health conditions, and cultural and linguistic needs. A secondary statistical data profile was created using advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures, mortality rates, incidences rates, and racial and ethnic composition because social factors are important

determinants of health. Our assessment includes a review of risk factors including obesity and smoking and health indicators such as infant mortality and preventable hospitalizations.

Research components for this assessment included the following data from the following sources:

- Alzheimer's Association
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- National Cancer Institute
- United States Census Bureau
  - American Community Survey 2019: 5-Year Estimates Data Profiles
- Virginia Department of Health
- Virginia Health Information, AHRQ Quality Indicators
- Virginia Department of Medical Assistance Services
- County Health Rankings 2021
- Weldon Cooper Center for Population Studies, UVA
- Sentara Claims Data
- Community Health Needs Assessment Survey
- Community Focus Groups

## OUR NEXT STEPS

SRMH works with several community partners to address health needs. Using the information from this community health needs assessment, SRMH will develop an implementation strategy to address the identified health problems. SRMH will track the progress of the implementation activities to evaluate the impact of these actions. The implementation progress report for the 2018 and 2021 CHNA is available at the end of this report.

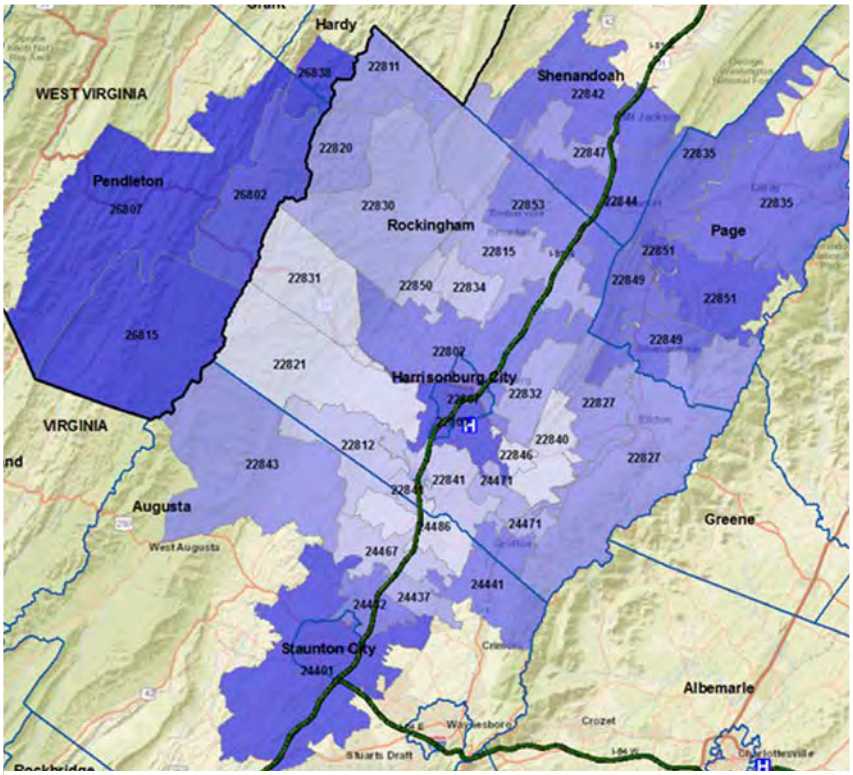
Information and assistance with navigating community resources is available through the Harrisonburg Community Resource Center, by calling 540-208-2941 or by visiting: https://strengthinpeers.org/community-resource-center/. By using this information, together, we will work to improve the health of the communities we serve.

Your input is important to us so that we can incorporate your feedback into our assessments. You may use our online feedback form available on the sentaracares.com website.

# COMMUNITY DESCRIPTION

## GEOGRAPHY

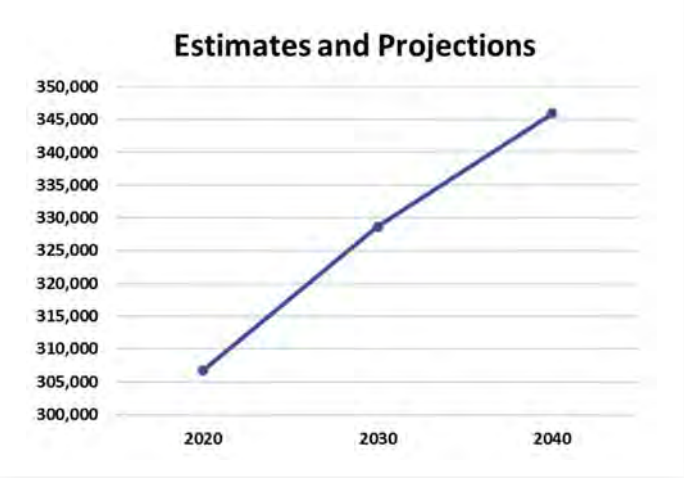
The geography of the service area includes two urban centers, Harrisonburg and Staunton, surrounded by rural counties, all bisected by a single major highway running along the Blue Ridge mountains. The total service area comprises 2,673 square miles, with Augusta and Rockingham counties being the second and third largest geographic areas in Virginia. There are many logistical challenges faced by these large geographic regions, including lack of public transportation, clustering of social, medical, and educational services, the time and expense of traveling to services, and logistical barriers such as lack of childcare and the inability to miss work. This area also faces challenges posed by the worst winter weather in the Commonwealth of Virginia, with a highway recognized by the Virginia Department of Transportation as the most dangerous in the state. Approximately 98% of the hospital's inpatients reside in this area although SRMH is seeing some expansion of its service area with a small but growing number of patients traveling from Pendleton and Hardy Counties in West Virginia to access the high-quality services it provides. Those patients comprise less than 2% of the patients receiving care at SRMH.




*SENTARA RMH MEDICAL CENTER SERVICE AREA*

## POPULATION CHANGE

The population of the service area is expected to grow between 2020 and 2040, although more slowly than the state as a whole and with an uneven distribution. Harrisonburg, the largest city, most urban locality, and home to James Madison University and Eastern Mennonite University, will see over twice the state growth rate. The service area also has three other institutions of higher education, Bridgewater College in southern Rockingham County, Blue Ridge Community College in northern Augusta County, and Mary Baldwin University in Staunton.




*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219*

*Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org*

## COMMUNITY SPECIFIC DEMOGRAPHICS (APPENDIX A)

***City of Harrisonburg*** has 51,814 residents with 22.2% of this population living in poverty and 13.0% uninsured. Of the population in this city, 29.6% are ages 0-19, 39.2% are ages 20-34, 22.4% are ages 35-64, 7.4% are ages 65-84, and 1.4% are aged 85 and over. 74.5% of the residents primarily speak English, while 25.5% speak another language in the home. The ethnicity for this population includes 82.6% White, 8.9% African American, 20.7% Hispanic, and 1.5% Asian.

***City of Staunton*** has 25,750 residents with 12.3% of this population living in poverty and 9.3% uninsured. Of the population in this city, 23.0% are ages 0-19, 18.8% are ages 20-34, 36.3% are ages 35-64, 18.9% are ages 65-84, and 2.9% are aged 85 and over. 94.1% of the residents primarily speak English, while 5.9% speak another language in the home. The ethnicity for this population includes 83.5% White, 11.4% African American, 3.3% Hispanic, and 1.4% Asian.

***County of Augusta*** has 77,487 residents with 8.3% of this population living in poverty and 10.0% uninsured. Of the population in this city, 21.8% are ages 0-19, 15.7% are ages 20-34, 40.4% are ages 35-64, 19.8% are ages 65-84, and 2.2% are aged 85 and over. 96.5% of the residents primarily speak English, while 3.5% speak another language in the home. The ethnicity for this population includes 91.0% White, 4.9% African American, .5% American Indian, 1.5% Asian, 0.1% Native Hawaiian, and 9.8% Hispanic.

***County of Page*** has 23,709 residents with 11.3% of this population living in poverty and 11.3% uninsured. Of the population in this county, 22.4% are ages 0-19, 15.3% are ages 20-34, 40.8% are ages 35-64, 19.3% are ages 65-84, and 2.2% are aged 85 and over. 97.9% of the residents primarily speak English, while 2.1% speak another language in the home. The ethnicity for this population includes 95.5% White, 2.2% African American, 2.2% Hispanic, and 0.5% Asian.

***County of Rockingham*** has 83,757 residents with 8.3% of this population living in poverty and 11.5% uninsured. Of the population in this county, 25.6% are ages 0-19, 16.7% are ages 20-34, 38.1% are ages 35-64, 17.2% are ages 65-84, and 2.4% are aged 85 and over. 91.0% of the residents primarily speak English, while 9.0% speak another language in the home. The ethnicity for this population includes 94.2% White, 2.5% African American, 7.4% Hispanic, and 1.0% Asian.

***County of Shenandoah*** has 44,186 residents with 10.1% of this population living in poverty and 10.2% uninsured. Of the population in this county, 23.1% are ages 0-19, 15.9% are ages 20-34, 37.4% are ages 35-64, 20.7% are ages 65-84, and 2.9% are aged 85 and over. 92.8% of the residents primarily speak English, while 7.2% speak another language in the home. The ethnicity for this population includes 93.6% White, 2.9% African American, 7.4% Hispanic, and 1.1% Asian.

*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219*
*Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org*

## POPULATION HIGHLIGHTS

The combined population of the service area is approximately 300,000. Harrisonburg is the densest population center in the region and the largest with 51,814 residents though both rural Augusta and Rockingham Counties have more residents. Rockingham County and Staunton experienced the largest population growth since 2010, an increase of 8.9% and 7.8%.

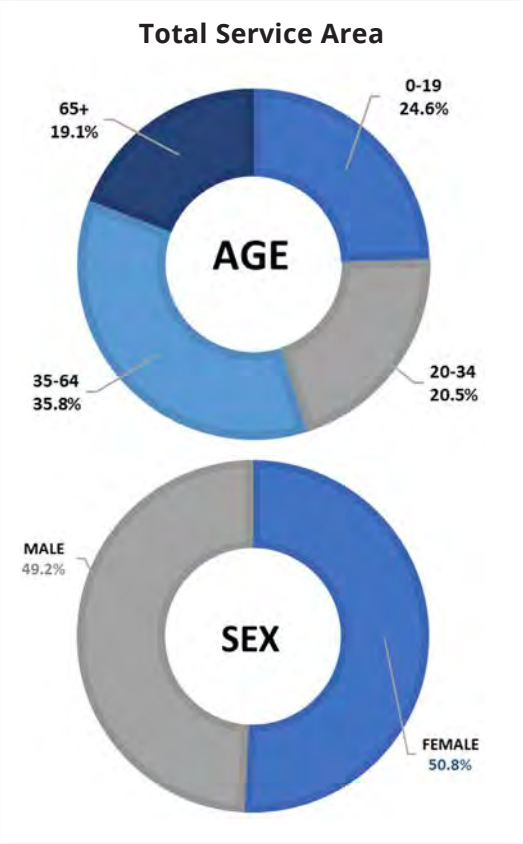
### *Age and Sex*

Out of the 306,703 community members living in the service area, most residents are between the ages of 35-64. The service area has a higher percentage of residents aged 65+ than the state.

There is also a slightly higher percentage of residents aged 19-64 than the state. Augusta and Rockingham Counties have the highest number of the senior population with 33,302 residents aged 65+. Rockingham County also has the highest percentage of the very elderly, aged 85+.

Similar to state demographics, there is a slightly higher percentage of residents born as female in the service area.

Rockingham County has the highest percentage of children, at 21.8%. There were 2,923 babies born in the service area in 2020. The majority of the births were in Rockingham County with 1,796 births in 2020. The population segments that represent children, young adults and working age adults vary only slightly from the statewide proportions.

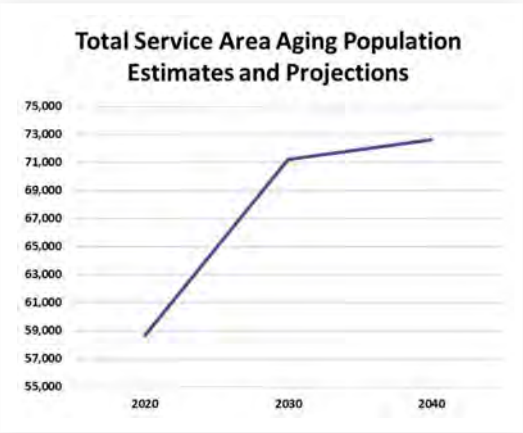



### *Aging Population*

It is well understood that older individuals are more likely to need more healthcare services, and a variety of services which are targeted toward that population. The population of the service area is aging faster than the rest of the state, as presented in the tables below. In 2020, 19.1% of the service area population is age 65+, while only 15.6% of the population of Virginia is 65+.

In 2030, the percentage of elderly in the service area is projected to increase to 23.2%, while Virginia will find 18.4% of its population age 65+. The trend reverses slightly by 2040, but the percentage in the area remains consistently 5% higher than in the whole of Virginia combined. Only Harrisonburg has a lower percentage of residents age 65+ than Virginia as a whole.

Research shows that the highest utilization of medical services is among elderly populations. Within this service area, the percentage




*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219*
*Virginia Department of Health Division of Health statistics https://apps.vdh.virginia.gov/HealthStats/stats.htm#tables*

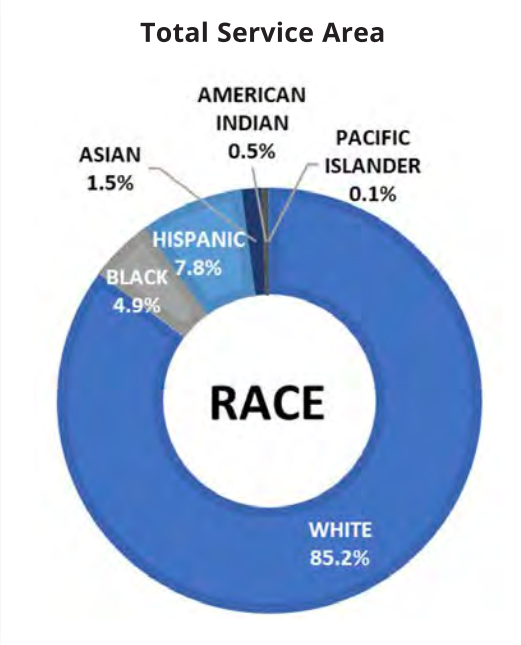
of the very elderly is highest in Staunton and Shenandoah County. It is important to note that though the percentage is highest in Staunton, the number of residents aged 85+ in 2020 was 740 compared to the number of residents in Shenandoah County being 1,242 and Rockingham County with 1,968 residents.

### *Other Demographic Features*

The overall percentage of the population who are veterans is lower here than average in Virginia, with 5.7% veterans living in the service area. Harrisonburg City has the highest percentage with 16.3%, and higher than the Commonwealth of Virginia with 12.6%. The median home value for the service area is less $220,000 which is also less than that of Virginia, which is $282,800. The median income and per capita income reflect a lower cost of living for the service area. There is a higher percentage of owner-occupied homes in Augusta, Page, Rockingham, and Shenandoah Counties compared to the state. The service area has fewer households with internet access, impacting remote learning opportunities and outcomes during the COVID-19 pandemic, as well as access to services. A higher percentage of the population of Staunton City, Augusta, Page and Shenandoah Counties have a disability than in the state overall. Most of the service area has a higher percentage of persons living in poverty, and the entire service area has lower percentage of college degrees when compared to the state.

## COMMUNITY DIVERSITY PROFILE

One of the primary characteristics of the service area is the presence of a refugee resettlement program in Harrisonburg, which creates both special needs and opportunities for collaborations and partnerships between organizations working to meet those needs. The result is a rich environment with multiple organizations focused on improving community health from different perspectives and care delivery paradigms.

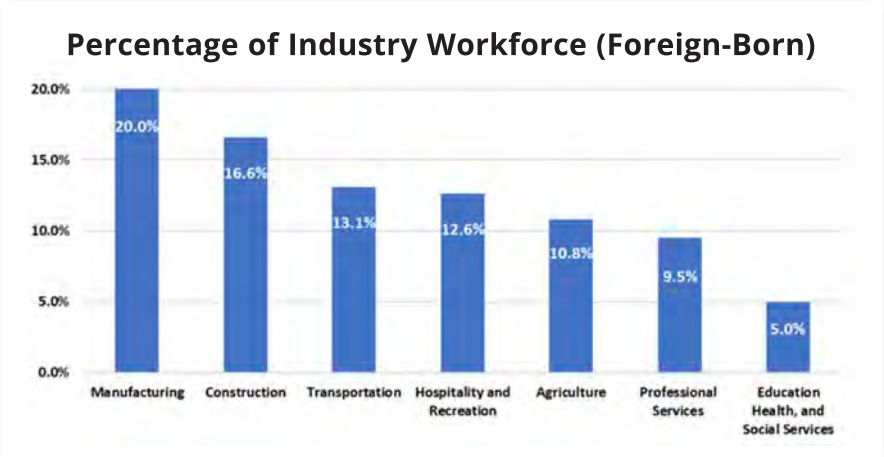



### *Ethnicity*

The population of the service area is overwhelmingly white, with Harrisonburg and Staunton as the most diverse communities (35.0% and 16.6% combined non-white and black respectively) followed by Shenandoah County, at 12.0% combined. The area has small Asian populations, but no other racial groups are represented in the area in any significant number.

The service area is home to a small Hispanic population, with Harrisonburg being higher than the state's level of Hispanic population at 20.7% compared to 9.8% statewide.

*Source: Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org*
*US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219*




Harrisonburg Metro Area data according to the U.S. Census Bureau's 2019: ACS 5-Year: (2018 data in parenthesis):

- In 2019, there were 13,773 foreign-born people living in the Harrisonburg metro area, 10.2% (9.7%) of the overall population.
- From 2016 to 2019, the foreign-born population in the Harrisonburg metro area grew from 12,599 to 13,773 (9.3%) while the total population of the area grew at a rate of 3.9%.
- Foreign-born workers represented 11.2% of the employed labor force and play an important role in several key industries in the region.
- In 2019, 18.8% (17%) of foreign-born people ages 25 and older held at least a bachelor's degree (compared to 31.2% of the U.S.-born population in Harrisonburg Metro Area and 38% in Virginia).
- In 2019, 41.6% of foreign-born households owned their own homes (compared to 64.5% of U.S.-born households) and 58.4% of foreign-born households were renters.

## *Preferred Language*

English is the primary language spoken in the service area. As of 2020, 90.7% of the population being served identified as English speaking. Per the 2014 American Community Survey five-year estimates, Spanish was the second language identified in the community being served, with Harrisonburg having the highest percentage of Spanish speaking residents at 7.9% speaking English less than well.

## *School Systems*

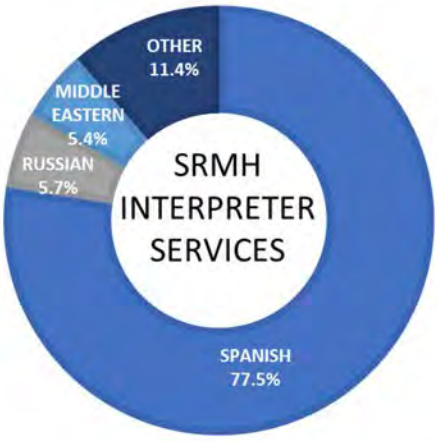
The nearest school systems to SRMH are the Harrisonburg City Public Schools (HCPS) and Rockingham County Public Schools (RCPS). These school systems are rich in diversity with students from many countries around the world and whose primary language is not English, according to enrollment data provided by each school system:

- Harrisonburg City Public Schools:
  - 53 unique countries of birth (compared to state average of 56)*
  - 57 unique languages of origin (compared to state average of 58)
  - 131 HCPS students speak more than one language in addition to English
- Rockingham County Public Schools:
  - 33 unique languages of origin
  - 44 unique countries of birth

*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219; Virginia Department of Health Culturally and Linguistically Appropriate Health Care Services; US Census Bureau American Community Survey Five-Year Estimates, 2014 vintage; https://apps.vdh.virginia.gov/omhhe/clas/leppopulation/; US Census Bureau 2019: ACS 5-Year Estimates;*

### *Cultural and Linguistic Needs*

It is important to note that non-English-speaking populations are vulnerable. Non-English-speaking populations are disproportionately among the lowest socioeconomic status populations, have higher risk of certain chronic conditions, are often linguistically and culturally isolated, and live with less income and lower education than their English-speaking counterparts. The language barrier makes it difficult for these populations to understand, interpret, and implement preventive recommendations and navigate the healthcare system.




Source: SRMH 2021 Sentara Language Line Usage Report

Departments within Sentara and SRMH continue to work closely with one another to ensure all communication to patients and family members is in the preferred language, offering interpreter services when needed. Sentara provides its patients and their families with qualified interpreters for languages other than English, as well as American Sign Language (ASL). In 2021, SRMH had 36,262 requests for interpreter services. The highest percentage of interpreter services were for Spanish speaking individuals.

### *Health Equity*

The CHNA analyzes differences by race and ethnicity, language needs, age, gender, income, and housing. A dedicated focus on health equity allows for a better understanding of community needs. Equity continues to be an issue and is rapidly evolving in health care systems as global health crises and ongoing disparities impact local communities. Health equity work highlights awareness, education and access to care or lack thereof, across racial, ethnic, gender, and geographic groups, and how implicit or unconscious bias among providers affects treatment decisions and outcomes. Where people live can influence educational and occupational opportunities impacting financial stability, which affect their well-being and quality of life.

***Inequities*** *occur when barriers prevent people from reaching their full potential.*

***Health disparities*** *are the differences in health status between groups of people.*

***Health equity*** *provides everyone the opportunity to attain their highest level of health.*

*Source: American Public Health Association (APHA), apha.org/topics-and-issues/health-equity*

The Health Equity team analyzes economic status, access to health care, transportation, and other social determinants of health to identify potential causes of health inequity in our communities. Partnerships are formed with community leaders and organizations, physicians, and all Sentara facilities to achieve more equitable health care.

Priorities include measurement of disparities and factors that contribute to them, and development and implementation of an action plan to reduce disparities in care. This includes screening and diagnosis rates for chronic health issues such as hypertension and diabetes, and prevalence of prostate and breast cancers in communities of color, utilization rates for treatments and development of initiatives for communities of color, immigrants, patients who are unsheltered and other marginalized groups, including LGBTQ+ persons and individuals with disabilities.

# SOCIAL DETERMINANTS OF HEALTH

Sentara seeks to transform the lives of our neighbors by focusing on the root factors that affect our health beyond the clinical care we receive.

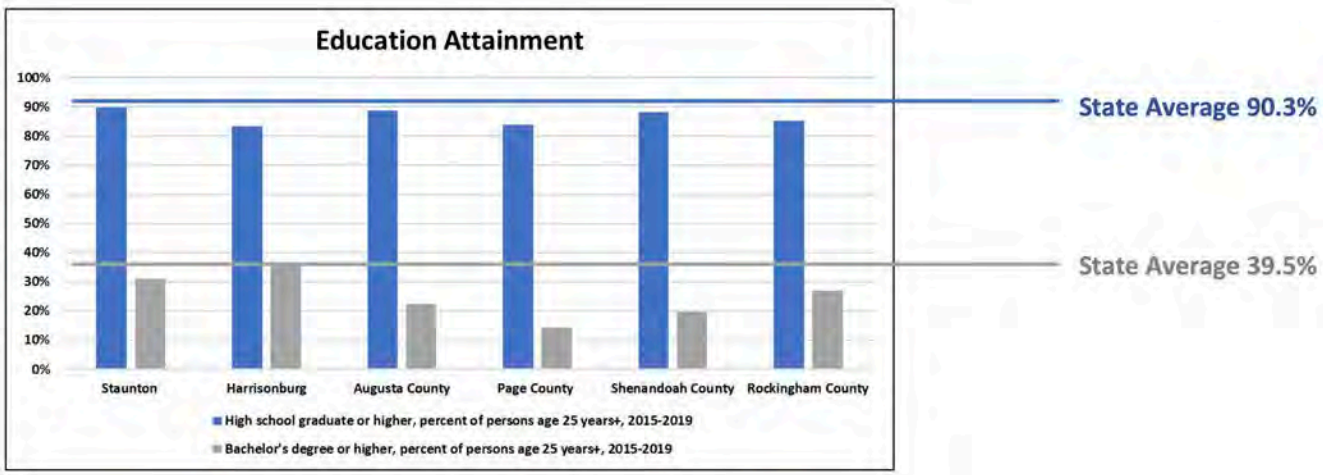
Sentara works to:

- Fill the unprecedented need for behavioral health practitioners in the field and ensure greater access behavioral health services for children, families, and adults.
- Secure consistent, equitable access to nutritious food every day and in times of emergency need.
- Support targeted training and development programs for higher-paying skilled careers.
- Develop more robust emergency and scattered housing solutions in our communities.
- Dismantle barriers to accessing health and human services in traditionally underserved populations.


to

## *Education*

Education is the basis for stable employment, and financial stability is the foundation for a sustainable household, which provides for the health needs of family members. Staunton and Augusta County have the highest percentage of individuals aged 25+ with less than a high school diploma, while Harrisonburg has the highest percentage of residents with advanced or professional degrees.




*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219*

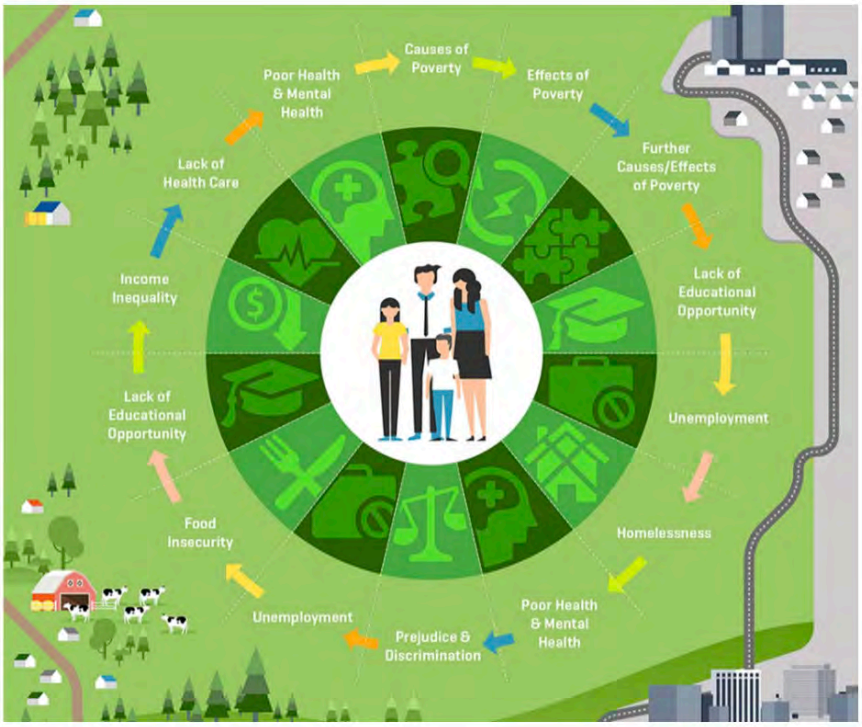
**The Cycle of Poverty**

Poverty continues because it reproduces existing patterns of circumstances, opportunities, and effects.

The causes of poverty lead to consequences that make it more likely that the individual – or their offspring – will experience poverty in the future.

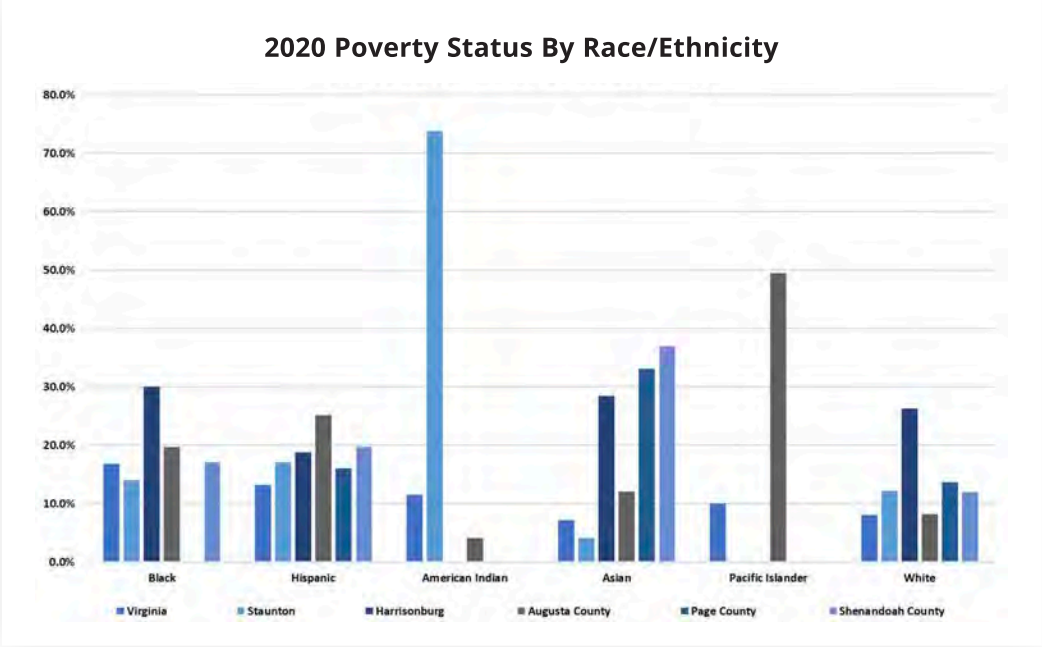
Generational poverty is a vicious cycle in which each generation is unable to escape poverty because of a lack of resources to put toward the effort.

Rural Poverty vs Urban Poverty | Social Workers | AU Online (aurora.edu)




## *Poverty*

While simple poverty rates tell us something about the residents of the service area, when inserting race as a factor, we see the racial disparities that constrain residents of the service area in their ability to support and sustain healthy, functioning households for themselves and their children. As with Virginia as a whole, African Americans, Hispanics, and American Indians are more likely to live in poverty compared to white Americans.

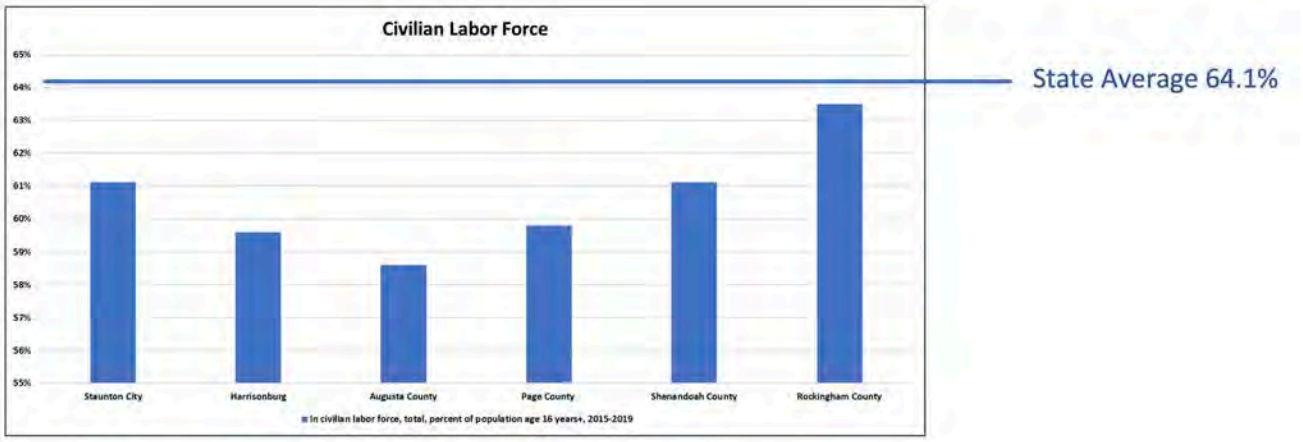



Augusta and Rockingham County residents are less likely to live in poverty than other area residents. Harrisonburg residents are more likely to live in poverty than other cities and counties in the service area by a significant margin, and an even bigger contrast with the Commonwealth of Virginia.

*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219; US Census Bureau 2019: ACS 5-Year Estimates;*

## Employment

Central to a healthy community is an economy that supports individuals in their efforts to live well. The service area is below the state average of residents in the civilian labor force. Of those in the civilian labor force, the percentage of female residents is also lower than the state average.




## Medicaid & FAMIS, Medicare, Medicare & Medicaid Enrollment

Out of the 626,398 members newly enrolled in Medicaid in the Commonwealth of Virginia in January 2022, 463,967 are below 100% of the federal poverty level and 162,431 are between 101-138% of the federal poverty level. The total service area has a higher percentage of members on Medicaid and FAMIS compared to Virginia with the highest percentage living in Staunton and Page County.

In 2019, there were 31,126 community members age 65+ living in the service area receiving Medicare and 1,520 receiving both Medicare and Medicaid. As the aging population grows in this service area, so will the need for these services.

| Medicaid and FAMIS 2022/Medicare and Medicaid 65+ 2019 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Virginia | Total Service Area | Staunton | Harrisonburg | Augusta | Page | Shenandoah | Rockingham |
| Medicaid Enrollment (Below 138% FPL) | 622,280 | 22,880 | 2,554 | 3,563 | 5,957 | 2,433 | 3,513 | 4,860 |
| Medicaid Percentage | 7.2% | 7.4% | 9.9% | 6.8% | 7.6% | 10.2% | 7.9% | 5.8% |
| FAMIS (Below 138% FPL) | 1,347,010 | 48,937 | 4,860 | 8,805 | 11,352 | 4,808 | 8,078 | 11,034 |
| FAMIS Percentage | 15.6% | 15.9% | 18.8% | 17.0% | 14.7% | 20.3% | 18.3% | 13.2% |
| Children Enrolled in Medicaid/FAMIS (Below 138% FPL) | 813,229 | 30,099 | 2,612 | 5,959 | 6,756 | 2,697 | 4,947 | 7,128 |
| Children Enrolled in Medicaid/FAMIS Percentage | 9.4% | 9.8% | 10.1% | 11.5% | 8.7% | 11.4% | 11.2% | 8.5% |
| 65+ Medicaid (Below 138% FPL) | 83,149 | 2,705 | 348 | 498 | 533 | 327 | 501 | 498 |
| 65+ Medicaid Percentage | 0.9% | 0.8% | 1.4% | 1.0% | 0.7% | 1.4% | 1.1% | 0.6% |
| 65+ Medicare and Medicaid | 56,810 | 1,520 | - | - | 352 | 251 | 496 | 421 |
| 65+ Medicare and Medicaid Percentage | 4.6% | 3.4% | - | - | 2.3% | 5.2% | 5.5% | 2.8% |
| Persons in Poverty | 9.2% | 11.3% | 12.3% | 22.2% | 8.3% | 11.3% | 10.1% | 8.3% |

*Source: Virginia Medicaid Department of Medical Assistance Services; (As of January 15, 2022) https://www.dmas.virginia.gov/data; US Census Bureau QuickFacts Table 2020; (2020 Small Area Income and Poverty Estimates (SAIPE)); US Census Bureau 2019: ACS 5-Year Estimates; Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data*

# COMMUNITY INSIGHT

Having an active, supportive and engaged community is essential to creating the conditions that lead to improved health. Residents of the service area are highly engaged in matters important to the community. There were approximately 250 invitations sent out to key stakeholders and 57 (a 23% response rate) in 49 separate organizations representing service providers, policymakers and underserved communities responded by filling out the survey. Not only does SRMH appreciate their input, but we recognize the importance of their willingness to participate in efforts to enhance life in our community.

## COMMUNITY SURVEY

| Survey Respondents Community Representation |
|---|
| **Role in the Community** |
| Healthcare |
| Community Non-profit Organization (Food bank, United Way, etc.) |
| Education |
| Local Government or Civic Organization |
| Business Representative |
| Faith-based Organizaton |
| Law Enforcement/Fire Department/Emergency Medical Services |
| Individual |
| Additionally, respondents identified themselves as active in the community in a number of ways that give each one important insight into the function and health of the community: |
| Active with United Way, Rotary International, Faith in Action, Fairfield Mediation Center |
| Advocacy |
| As a convener of local businesses and organizations to address community issues, especially around workforce development |
| Attend Church |
| Caregiver |
| Community Member |
| Community Paramedicine and collaborative efforts to avoid 911 use |
| Community volunteer |
| Daytime homeless services |
| education |
| food pantry, financial assistance with utilities, travelers aid, weekly meal for the homebound, holiday cheer, dental assistance, literacy |
| Granting agency for non-profit anti-poverty services |
| Remote Area Medical Clinic steering committee member |
| Landowner, community volunteer |
| Medication access |
| Mental health therapist |
| Nonprofit |
| Healthcare human services also providing support groups, education and first responder training |
| SNF |
| social worker |
| Volunteer and Chamber of Commerce, library, etc. |
| Services for children subjected to sexual abuse and their caregiver families |

Representatives of the following organizations participated in the study:

| Organizations Represented in Response to the Sentara RMH Medical Center CHNA Survey 2021 | |
|---|---|
| Adagio House | HCHC |
| Augusta County Circuit Court Clerk's Office | Church World Service |
| Augusta County schools | Impact Living Services |
| AVA Care of Harrisonburg | Institute for Innovation in Health and Human Services at JMU |
| Blue Ridge Area Food Bank | InterChange Group, Inc. |
| Blue Ridge Community College | James Madison University and VPAS |
| Blue Ridge Free Clinic | JMU, IIHHS, Community Health Education |
| Brain Injury Connecsitons of the Shenandoah Valley | Our Community Place |
| Bridge of Hope Harrisonburg-Rockingham | Page County DSS |
| Business Owner, UMA Inc. | Pendleton Community Care |
| Caitlin Batchelor, DDS, PC | Pendleton County Commission |
| CAPSAW | RCPS |
| Central Shenandoah Valley Office on Youth | Remote Area Medical Clinic, Zetta Presbyterian Church |
| City of Harrisonburg Government & City Fire Department | Rockingham County Public Schools |
| Collins Center | Sentara Medical Group |
| Elkton Area United Services | Sentara RMH Behavioral Health Out-patient |
| Faith in Action | Sentara RMH Medical Center |
| First Step - A Response to Domestic Violence | Shenandoah County Public Schools |
| Gemeinschaft Home | Sunnyside |
| Generations Crossing | United Way of Harrisonburg and Rockingham County |
| Harrisonburg Health and Rehab | Valley Children's Advocacy Center |
| Harrisonburg Rescue Squad | Valley Program for Aging Services |
| Harrisonburg Rockingham Community Services Board | VPAS |
| Healthcare for the Homeless Suitcase Clinic | Way to Go |

As expected, many of these organizational representatives wear multiple hats, meaning the true reach of this survey into the community is broader than the listed organizations. Additionally, focus groups were held to get more in-depth perspectives on the health of the community.

## KEY STAKEHOLDER SURVEY RESULTS

For this CHNA report, we assembled the most pressing community needs identified in previous CHNA efforts and took a deeper dive into each one of them. The initial question on the survey asks respondents to identify the most important health issues by category. Then, each category was pulled apart to see what challenges it encompassed. The results are displayed in the tables below. Each question allowed respondents to identify other needs that may not have been included in the question. Those responses are shown in the bottom sections of the tables.

| Choose 4 Areas of Health Concern You Believe are Most Important for Your Community | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Behavioral/Mental Health Needs | 53 | 89.8% |
| Social/Economic Needs | 40 | 67.8% |
| Access to Care | 30 | 50.8% |
| Health Equity and Disparities | 28 | 47.5% |
| Chronic Health Conditions | 24 | 40.7% |
| Children's Health Needs | 17 | 28.8% |
| Health Needs of the Elderly | 16 | 27.1% |
| Acute Illness/Emergency Care | 13 | 22.0% |

| Other Health Needs |
|---|
| Access for adult medicaid dental care since medicaid has been expanded |
| Any condition requireing specialized assessment or intervention |
| Caregiver support and respite needs |
| Crisis intervention |
| Culturally competent care |
| Long term care for dementia |
| Dental care |
| Help navigating healthcare system |
| Retention of doctors |
| Elder care in their homes |
| End of life care |
| Housing / safe, sanitary shelter |
| Services addressing injury, violence, substance abuse, physical inactivity, nutrition, obesity |
| Lab services to be reestablished in the area |
| Medical debt and medication cost |
| Preventive health services |
| Services addressing sexual abuse |
| Services addressing teen pregnancy |
| Services addressing transportation challenges, vision, prenatal family planning, financial planning |
| Trauma center |

The general category of behavioral health garnered the most concern, with 89% of respondents choosing that item. The 2018 CHNA response rate choosing mental/behavioral health was 83%, indicating a rise in awareness of the need. New this year, a category labeled Social/Economic Needs was included to recognize the growing understanding that healthcare and wellness extend beyond the hospital doors to the surrounding world.

## *Behavioral Health Needs*

| Behavioral Health Needs | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Access to outpatient counseling services for depression, anxiety and other mental disorders | 42 | 71.2% |
| Access to inpatient care in a crisis | 27 | 45.8% |
| Having enough counselors to serve all who need help | 27 | 45.8% |
| Provider capacity -- enough psychiatrists to treat all those who need care | 26 | 44.1% |
| Services for substance abuse identification and treatment | 24 | 40.7% |
| Residential treatment facilities, permanent supportive housing | 23 | 39.0% |
| Counseling services for children in schools (eliminating transportation barrier) | 16 | 27.1% |
| Access to medication for behavioral health needs | 14 | 23.7% |
| Services for adults with cognitive/developmental disabilities | 11 | 18.6% |
| Survivorship services for trauma, violence, major medical events, grief/loss, etc. | 8 | 13.6% |
| Stigma attached to accessing services | 8 | 13.6% |
| Violence prevention services including parent education | 7 | 11.9% |

| Other Behavioral Health Needs |
|---|
| Community camp / meeting venue for support groups / holistic healing |
| Counseling for children with problematic sexual behaviors |
| Education! |
| Financial support |
| Frequent repeat users of 911 typically have behavioral or mental health needs. Lack of compliance with medication/access to housing seem to exacerbate these health needs |
| More school counselors are required by the state but there are none available to hire! |
| Outpatient psychiatric providers that accept Medicaid, more access to emergency inpatient psych services |
| Reducing the stigma for accessing mental health services |
| Services for patients with complex behavioral/mental health needs as well as medical needs |
| Strong linkages between behavioral health services available and local colleges that can refer students to those services |
| Support for foster care, whether relative or other |
| Support for outpatient Partial Hospitalization Program or Intensive Outpatient Program |

Responses include concerns for adult and children's services, which will be explored more thoroughly in a chart below, and identified the need for more outpatient and inpatient services, driven at least in part by a lack of providers.

### *Social/Economic Needs*

The second most identified need among the initial list, include factors that are widely known as the "social determinants of health." Transportation was the need most often cited, which is not surprising in a rural area that sprawls across the Blue Ridge Mountains. Concerns about income in various forms are present in most of the choices, but the responses focused on meeting basic needs.

| Concerns Associated with Socioeconomic Factors | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| transportation | 40 | 67.8% |
| Housing security (low income housing, housing for the elderly/disabled, rent and utility assistance | 39 | 66.1% |
| enough money to cover basic expenses | 28 | 47.5% |
| long term, chronic poverty | 25 | 42.4% |
| food security (grocery store within traveling distance, transportation, money to purchase food | 20 | 33.9% |
| services to prevent or address violence, domestic, social, child abuse | 18 | 30.5% |
| services for low literacy individuals | 16 | 27.1% |
| services for the homeless | 15 | 25.4% |
| access to education and job training opportunities | 15 | 25.4% |
| access to services in languages other than english | 14 | 23.7% |
| community support networks such as churches, neighborhood groups, civic organizations, clubs | 7 | 11.9% |

| Other Socioeconomic Concerns |
|---|
| Affordable, accesible childcare and Pre-K |
| Follow-up after care |
| 60% of Harrisonburg's population and 40% of Rockingham County live paycheck to paycheck per UW ALICE report |

## Access to Care

| Concerns Associated with Access to Care | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Insurance coverage/ability to pay for care | 42 | 71.2% |
| Distance from provider/transportation | 38 | 64.4% |
| Being able to get needed medications (financial assistance) | 25 | 42.4% |
| Access to dental care | 21 | 35.6% |
| Navigation to make sure all needed services are accessed | 21 | 35.6% |
| Getting care when/where it is convenient for the patient | 18 | 30.5% |
| Having enough primary care providers to serve the community | 17 | 45.8% |
| Prompt access to specialty care providers | 15 | 25.4% |
| Having access to the internet to receive monitoring and follow-up, or to have appointments | 12 | 20.3% |
| **Other Access to Care Concerns** | | |
| Several respondents took a moment to list concerns, reiterating the need for transportation, access to specialty providers, navigation services and the need for more healthcare providers in general | | |

## Health Equity Needs and Concerns

Two questions were asked in an effort to identify factors that impact the patient experience: What is needed to improve health equity, and how do specific factors impact the quality of care that the patient receives?

| Needs Associated with Health Equity | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Case management / navigation services | 36 | 61.0% |
| Having to choose between which health services a person can afford | 32 | 54.2% |
| Access to primary care during business or extended hours (getting off work to get access) | 29 | 49.2% |
| Availability of service in languages other than English | 28 | 47.5% |
| Need to understand who all the different doctors/instructions/medications/procedures fit toget | 25 | 42.4% |
| Having providers of gender/race/ethnicity that represent the community population | 20 | 33.9% |
| Stigma around accessing certain types of care | 17 | 28.8% |
| Discrimination against minority/marginalized groups | 11 | 18.6% |
| **Other Health Equity Concerns** | | |
| Ability for services to go to consumers/patients rather than them have to access service in uncomfortable institutional settings | | |
| Ageism | | |
| A lot of the issues are due to socioeconomic factors that the hospital won't be able to solve alone. I think health literacy of the patient is a factor that affects quality of care | | |
| Healthcare services require personal navigation assistance by someone known to the patient | | |
| Insurance vs. uninsured | | |
| LGBTQ+ need health services designed for them. Obese people face a lot of stigma in accessing and receiving care. The furniture (waiting area seating, medical table etc.) and equipment is also not very accommodating | | |
| Proper listening from providers regarding patient concerns and health conditions | | |
| Stigma still placed on addictions and mental health | | |
| There is not enough understanding of older adults once they arrive at a hospital. They are often sedated and prescribed medications that are contraindicated | | |
| We need to look at the systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expressin, and other dimensions of individual and group identity | | |

The most frequently chosen need was navigation that assists individuals in understanding a healthcare system that may be foreign to them either because they are immigrants, or because they have not often accessed care in their lives. Financial concerns were the second most identified factor and may prevent individuals from seeking needed care.

The second question ranks personal characteristics that may identify an individual as a member of a minority or otherwise vulnerable group and impact the care they receive. The most chosen factor likely to impact the quality of care is language, with 47 of 57 respondents agreeing that it impacts their healthcare experience. Linked to language, immigration status was the second most often chosen factor. While other factors were noted to impact care, only language generated a strong response.

Given the international characteristics of the community (see diversity profile) and the consequences of getting medical advice and instruction confused due to linguistic barriers, these responses are consistent.

| Ranking of Personal Characteristics that May Affect the Quality of Care Received -- Health Equity | | | | | | | |
|---|---|---|---|---|---|---|---|
| Agree Rank | Factor | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | # Agree or Strongly Agree |
| 1 | Language | 1 (1.7%) | 6 (10.2%) | 5 (8.5%) | 33 (55.9%) | 14 (23.7%) | 47 |
| 2 | Immigration Status | 4 (6.8%) | 7 (11.9%) | 12 (20.3%) | 25 (42.4%) | 11 (18.6%) | 36 |
| 3 | Education | 3 (5.1%) | 8 (13.6%) | 14 (23.7%) | 25 (42.4%) | 9 (15.3%) | 34 |
| 4 | Disabilities | 2 (3.4%) | 11 (18.6%) | 13 (22.0%) | 27 (45.8%) | 6 (10.2%) | 33 |
| 5 | Age | 4 (6.8%) | 9 (15.3%) | 16 (27.1%) | 23 (39.0%) | 7 (11.9%) | 30 |
| 6 | Race/Ethnicity | 8 (13.6%) | 9 (15.3%) | 14 (23.7%) | 19 (32.2%) | 9 (15.3%) | 28 |
| 7 | Sexual Orientation | 9 (15.3%) | 7 (11.9%) | 17 (28.8%) | 19 (32.2%) | 7 (11.9%) | 26 |
| 8 | Gender | 10 (16.9%) | 9 (15.3%) | 24 (40.7%) | 10 (16.9%) | 6 (10.2%) | 16 |
| 9 | Religion | 8 (13.6%) | 13 (22.0%) | 29 (49.2%) | 6 (10.2%) | 3 (5.1%) | 9 |
| | | Most Frequent Choice | | Second Most Frequent Choice | | 3 Leading Factors | |

## *Chronic Health Needs*

Ranked fifth of the eight initial health categories, chronic health conditions are most often associated with aging. An aging population may have more chronic conditions and be more concerned with services to ensure that they are well managed.

Diabetes, obesity, and heart disease, among the most common chronic conditions, are identified as the most concerning. Cancer, now becoming classed as a chronic condition as treatment and management procedures are becoming more successful, is listed just above pulmonary concerns such as COPD and asthma.

| Concerns Associated with Chronic Disease | | |
|---|---|---|
| Area of Concern | # Responses | % Respondents |
| Diabetes/metabolic syndrome | 35 | 59.3% |
| Obesity | 35 | 59.3% |
| Heart disease | 26 | 44.1% |
| The availability and accessibility of management programs for chronic conditions | 22 | 37.3% |
| Transitional housing, permanent supportive services | 21 | 35.6% |
| The availability and accessibility of prevention and early detection screenings and programs | 18 | 30.5% |
| Pain/fatigue | 15 | 25.4% |
| Cancer | 14 | 23.7% |
| Chronic obstructive pulmonary disease (COPD) | 11 | 18.6% |
| Physical disabilities resulting in a need for assistance with daily life (blindness, wheelchair use, etc.) | 10 | 16.9% |
| Asthma | 4 | 6.8% |
| Arthritis | 4 | 6.8% |

| Other Chronic Disease Concerns |
|---|
| Addictions |
| Alzheimer's/dementia |
| Behavioral mental health services availability |
| Hypothyroidism |
| Child disabilities and therapies that are easily accessible |
| Psychiatric conditions |

## *Children's Health Needs*

Behavioral health services represent two of the three most frequently identified health needs of children. Access to pediatricians and specialists, parent education and other services are also identified. Other needs listed by respondents include childcare, teen pregnancy services and joy – reflecting the grim environment of the last two years as children's routines and school experience has been upended.

| Health Needs of Children | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Counseling or therapeutic behavioral/mental health services for children | 35 | 59.3% |
| Poverty-related services (food security, housing, access to reliable child care) | 30 | 50.8% |
| Diagnostic behavioral/mental health services for children | 27 | 45.8% |
| Emergency behavioral/mental health services for children | 25 | 42.4% |
| Substance abuse treatment for youth/adolescents | 20 | 33.9% |
| Education on healthy habits for children (nutrition, sleep, behavior, socialization) | 18 | 30.5% |
| Access to dental care | 15 | 25.4% |
| Prompt access to specialists | 14 | 23.7% |
| Same day appointments with pediatricians | 7 | 11.9% |
| Off-hours answers to questions (help line, etc.) | 6 | 10.2% |
| Developmental delay/school readiness services | 6 | 10.2% |
| Support groups for the parents of children with similar health conditions | 5 | 8.5% |
| Navigation services for children's care | 5 | 8.5% |

| Other Children's Health Needs |
|---|
| Services to prevent child abuse |
| Access to appropriate medical evaluation and treatment for children who are suspected victims of child abuse |
| Affordable child care |
| Dental care |
| Joy |
| Parent education |
| Pediatricians need to do a better assessment during physicals to assess developmental delay. Too often this is missed and services not provided. |
| Pediatric SANE services |
| Services to address teen pregnancy |

### *Health Needs of the Elderly*

The service area is aging faster than the Commonwealth of Virginia. The need for services for the elderly is expected to grow through time. Yet this category was ranked seventh of the eight initial categories, perhaps indicating that services are being provided in the region and therefore not causing much concern. Bridgewater Retirement Community and Valley Program for Aging Services collaborated on a Senior Community Needs Assessment in 2019, which spawned the Valley Senior Success Coalition actively addressing the priority issues which emerged from that assessment.

| Health Needs of the Elderly | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Transportation | 38 | 64.4% |
| Access to services not covered by Medicare (dental, vision, hearing, etc.) | 36 | 61.0% |
| Behavioral health services | 31 | 52.5% |
| Social networking and support | 21 | 35.6% |
| Home safety/home modifications to age in place or accommodate disability | 21 | 35.6% |
| Health services designed for the special needs of the elderly | 19 | 32.2% |
| Navigation services | 17 | 28.8% |
| Access to healthy food and other social services | 16 | 27.1% |
| Getting clear medication/follow-up instructions | 7 | 11.9% |
| Education on aging well (classes, groups, printed material, etc.) | 6 | 10.2% |

| Other Health Needs of the Elderly |
|---|
| Affordable housing |
| Cancer support system, preventive care |
| Caregiver support and financial support |
| In-home care, respite care, and relief for in-home caregivers |
| Long term care |
| Progressive aging facilities from non-assisted living to end of life care |
| Lower medication costs |
| Support for grandparents raising grandchildren |
| Planning for end of life needs |
| Training for older adults and caregivers to help manage the medical conditions of those they care for |
| Lab services reestablished in the area |

### *Acute Care Needs*

Of least concern among the needs presented in the initial question, the need for acute care raises concerns around financial stability while dealing with an episode of acute illness. Additionally, need for post-care services, specifically help with managing at home, is identified.

| Concerns Associated with Acute Care Needs | | |
|---|---|---|
| **Area of Concern** | **# Responses** | **% Respondents** |
| Ability to pay for a health emergency/health insurance | 44 | 74.6% |
| Loss of pay due to missing work because of illness | 39 | 66.1% |
| Job loss due to illness | 29 | 49.2% |
| Having support at home in case of hospitalization | 26 | 44.1% |
| Distance from emergency room | 12 | 20.3% |
| Infectious disease (see separate questions for COVID responses) | 5 | 8.5% |
| **Other Acute Care Concerns** | | |
| Overuse of ER | | |
| Help around the house /general chores | | |
| Limited support system at home after illness | | |
| Lack of emergency trauma services in the community especially during inclement weather when aeromedical services are unavailable. Additionally, the cost of using aeromedical services can be prohibitive despite the financial assistance provided by the various flight service providers. Morbidity/mortality of trauma patients is higher in our community when the helicopters are unavailable due to the distance required to drive to UVA and the delays in patient transfer from RMH. EMTALA transport etc. | | |

While there is overlap and repetition among the categories of healthcare needs and concerns, it demonstrates that healthcare is a complex process, strongly connected to the other aspects of our community lives. As healthcare and CHNAs evolve, we anticipate a growing ability to identify and address genuine emerging needs.

## *COVID-19*

While this assessment brings focus to an array of healthcare issues, the monumental issue in 2020-2021 has been the COVID-19 pandemic, caused by the novel coronavirus that entered the country at the end of 2019. Rather than question respondents about their own personal experience with the disease as there are clinical surveys that collect that sort of information, we wanted to see how COVID-19 has impacted community resources and services. The two questions below demonstrate how COVID-19 has changed the way we think of healthcare.

| COVID-19 Impact on Your Community | | |
|---|---|---|
| **COVID-19 Concerns** | **# Responses** | **% Respondents** |
| Isolation from friends and family | 42 | 71.2% |
| Disruption of community schools | 42 | 71.2% |
| Loss of employment | 25 | 42.4% |
| How to keep family members safe | 23 | 39.0% |
| The physical impact of the virus on the body | 17 | 28.8% |
| Support for family members at home if patient is hospitalized | 15 | 25.4% |
| Loss of housing/becoming homeless | 14 | 23.7% |
| Not able to afford medical care/medication | 14 | 23.7% |
| Inability to access non-healthcare services | 12 | 20.3% |
| **COVID-19 Impact on your organization's operations** | | |
| Addition to safety/cleaning routines | 51 | 86.4% |
| Remote work/meetings | 48 | 81.4% |
| Increase in workplace anxiety | 36 | 61.0% |
| Changes in work hours/staff schedule | 35 | 59.3% |
| There is more need for our services now than before COVID-19 | 29 | 49.2% |
| Reducing the number of clients/customers we could serve | 25 | 42.4% |
| Changing the physical layout of work space | 25 | 42.4% |
| Staff reductions/increases | 20 | 33.9% |
| Anticipate receiving more funding to do our work than before COVID-19 | 13 | 22.0% |
| Changing the type of work performed | 11 | 18.6% |
| **Other COVID-19 Concerns** | | |
| Anti-maskers and anti-vaxxers | | |
| Concerned about prolonged use of masks and the negative impact this will have on one's health | | |
| Cost incurred to provide PPE | | |
| Increase in substance use, depression and anxiety | | |
| Long term impact on people due to isolation | | |
| Refusal of community to wear masks or stay at home | | |
| Vaccine hesitancy in this area. Falsehoods being perpetuated, turning the virus into a political statement. Lack of masking | | |

# COMMUNITY FOCUS GROUPS

In addition to the online surveys for community insight, SRMH carried out a series of more in-depth Community Focus Groups to obtain greater insight from diverse stakeholders and community members.

### *Methodology*

Focus groups were promoted, electronically and by word of mouth, to hospital patients and visitors, existing hospital and community groups, and partner organizations. Input was also sought from other populations in the community, including representatives of underserved communities and consumers of services. The questions below were utilized at each focus group session.

- What are the most serious health problems in our community?
- When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?
- Who has the health problems? What groups of individuals are most impacted by these problems?
- What keeps people from being healthy? In other words, what are the barriers to achieving good health?
- What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?
- How has the COVID-19 pandemic worsened the health issues in our community?
- What more can be done to improve health, particularly for those individuals and groups most in need?

SRMH held five focus group sessions and two key informant interviews between April and July 2021. The number of participants ranged from 4-17.

### Focus Groups

- United Way ALICE Coalition: local health and human services agencies and community non-profits
- Harrisonburg-Rockingham Healthcare Safety Net Coalition Behavioral Health subcommittee: leaders of behavioral health services agencies and behavioral health clinicians
- SRMH Patient Family Advisory council: patients and family members of patients.
- Valley Senior Success Coalition: organizations serving the older adult population, skilled nursing facilities and rehab locations, home health agencies, and retirement communities.
- RMH Foundation advisory board: healthcare providers and representatives from local businesses, major employers, and academic institutions.
- Key informant interviews specifically targeted mental health treatment and needs of the immigrant and refugee communities.

### Demographics

The 59 participants ranged between the ages of 17 and over 65.

### Methodology

Due to the COVID-19 pandemic, three focus groups were held virtually and two were held in person when safety protocols allowed. Each focus group had a facilitator guiding discussions through the seven previously prepared questions. Additional staff took detailed notes to capture the information shared.

### *Results*

Mental health, financial instability, lack of providers and access concerns were brought up in every focus group. For a detailed summary of the focus group sessions see Appendix D. A brief summary of the key findings for each topic is presented below.

| TOPIC | KEY FINDINGS |
|---|---|
| **What are the most serious health problems in our community?** | • Increased substance abuse, suicides, overdoses, isolation, poor mental health because of the pandemic<br>• Very behind in preventative services, cancer screenings, immunizations, unintended pregnancies, more severe pediatric dental problems<br>• Children's needs for behavioral health services, young children with very unregulated behavior<br>• Increased dysregulation<br>• Virtual learning has led to many students totally disengaging, no eyes on them, reports of increased anxiety and depression<br>• Complications from obesity and sedentary lifestyle and risk behaviors such as smoking<br>• Mental health: access to affordable treatment, lack of diagnosis and care, resulting unemployment, disconnect between prescribing physician and counselor – 2 different appointments, two different agendas, lack of sustained care to ensure stay on meds,<br>• Shortage of health care workers, especially aides; also fewer health care workers/case managers providing in-home services because of COVID-19<br>• Same-day access to care<br>• Long wait times to see providers (primary care, specialty care, behavioral health)<br>• Cancer<br>• Childhood hunger<br>• Teens: lack of sleep, addiction to social media, sexual health and teen pregnancy, self-injury, mental health – lack of care and stigma, debilitating anxiety<br>• Lack of knowledge of how and where to access healthcare services – lack of ability to access services/resources for a variety of reasons – including lack of transportation<br>• Older adults: caregiver stress, having to choose which conditions to treat due to cost, need for health navigator services, hard to access care because of limitations on insurance network, lack of providers with expertise in geriatrics<br>• Transportation, especially given distance to certain specialty care<br>• Chronic conditions: uncontrolled diabetes, heart disease, COPD<br>• Safe housing for seniors and supports for 'aging in place'<br>• Lack of awareness of resources available after skilled nursing including hospice and palliative care<br>• Not enough capacity to meet demand for interpreter services and case managers to assist with bills and navigating the healthcare system<br>• Lack of access to affordable dental care<br>– Social determinants – housing, employment for special populations (re-entry programs), detox and sobering housing |

| TOPIC | KEY FINDINGS |
|---|---|
| **When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?** | • Housing and social support<br>• Employment and benefits<br>• Transportation<br>• Sufficient housing<br>• Education<br>• Childcare<br>• Lifestyle choices/lack of healthy behaviors<br>• Income<br>• Healthy food/adequate food |
| **Who has the health problems?**<br>**What groups of individuals are most impacted by these problems?** | • Low income households – especially BIPOC/immigrant community who have lost jobs or have had jobs more likely to be shut down<br>• Unsupervised children (more so during COVID-19 and virtual schooling)<br>• Kids whose parents are not engaged<br>• Women – trying to work from home or have quit jobs<br>• Those who suffer trauma, and young people who experience violence, victims of domestic violence<br>• Older adults, isolated, fewer support systems, all barriers apply to them<br>• Mentally impaired and behaviorally challenged<br>• The isolated who can't access services<br>• Refugees suffering trauma due to displacement, threats and witnessing lots of violence, and immigrants with low English proficiency<br>• Those with low literacy levels<br>• Those with a culture (family or community) of neglect, who don't access preventive or early care<br>• Mental/behavioral health patients who lack substance abuse services and counselors, especially young patients<br>• Homeless, especially homeless seniors<br>• Veterans – lacking transportation, insurance, mental health services, access to stabilizing medications (leads to self-medication)<br>• People of color and non-English speakers<br>• Re-entry population |

| TOPIC | KEY FINDINGS |
|---|---|
| **What keeps people from being healthy?**<br><br>**What are the barriers they face with taking care of their health and accessing care?** | • The high cost of care<br>• Medicare system far more complicated than most understand, with changes every year<br>• Fragmented care<br>• Not having additional income to spend on counseling/mental health services<br>• Transportation, services are not easy for rural residents to access, especially those in areas outside of Harrisonburg/Rockingham CDA<br>• Cycle of unhealthy practice, generational culture of neglect, family members who prevent access<br>• Long appointment wait time and lack of extended hours for primary care<br>• Working families not having childcare, more grandparents taking on childcare responsibilities<br>• More children left unsupervised, has contributed to behaviors, truancy, teen pregnancies, lack of support for families means they don't have the tools, knowledge they need to help<br>• Immigrant/refugee cultural barriers – different knowledge and expectations<br>• Language, especially first point of contact, interpretation services not used consistently<br>• Lack of knowledge about service types and availability – lack of knowledge about hospital charity care policies – especially true for non-English speakers<br>• Fractured and dysfunctional families – lack of parental engagement<br>• Lack of access to nutritious food<br>• Lack of access to distant specialists |

| TOPIC | KEY FINDINGS |
|---|---|
| **What is being done in our community to improve health and reduce barriers?**<br><br>**What resources exist in the community?** | • Telehealth has helped increase access in many cases, including parents who would not otherwise keep appointments because children were now at home<br>• Schools collaboration with social services & CPS to develop plans and follow-up for children, services for families<br>• Schools have provided food for students throughout the pandemic<br>• Food banks adapting to deliver food<br>• New Blue Ridge Free Clinic<br>• Suitcase Clinic<br>• RAM Clinic<br>• Churches and parish nurses; food banks and clothes/DME closet<br>• VPAS transportation program<br>• Sliding scale or scholarships for activities for seniors; adult day care<br>• Vaccine clinics, collaborations with health care providers, guidance from Health Dept<br>• Collaborations with agencies and non-profits – community capacity building<br>• New HRCSB facility<br>• Parks and green spaces<br>• VICAP counseling<br>• Some community pediatricians have gotten education on dysregulation and have been able to evaluate children<br>• Some funders moved toward unrestricted funding during COVID-19, really helped agencies whose needs/services changed – example: United Way H-R; also increased opportunities for funding through TCF and City of Harrisonburg (through CARES Act allocation) |

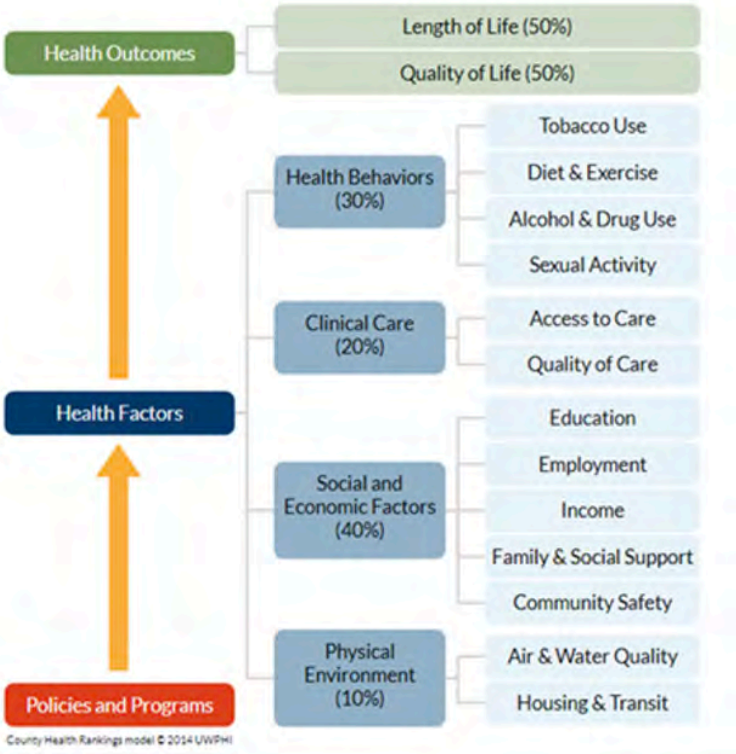
| TOPIC | KEY FINDINGS |
| --- | --- |
| **How has the COVID-19 pandemic worsened the health issues in our community?** | • Pandemic has highlighted the gaps we already had in the community – psychiatry, evaluation/diagnostic services, there's nowhere to refer, slows the whole system down<br>• Missed wellness visits, health concerns/issues were put off<br>• Increased medical complexity and level of acuity is worse, patients waiting to access healthcare as long as possible and requiring more treatment<br>• Uncontrolled diabetes, retinopathy<br>• Substance use, job loss, increase of stress, stimulus money increases substance use<br>• Isolation, loneliness, depression<br>• Older adults faced cognitive decline with social isolation<br>• Students: inability to connect with peers, faculty & staff have limited ability to reach them with resources, academic stress, not being able to focus, ADHD, depression when there was previously no diagnosis<br>• People eating less healthy, more fast food/take out<br>• Disproportion of low-income, BIPOC were essential workers and were higher risk of getting COVID-19<br>• Child abuse and neglect – increased but difficult to detect because children not in school, after school programs |

| TOPIC | KEY FINDINGS |
|---|---|
| **What more can be done to improve health, particularly for those individuals and groups most in need?**<br><br>**Are there specific opportunities or actions our community could take?** | Crisis support<br>• Parenting education and behavioral intervention training – teaching behavior strategies for home<br>• Masters level mental health professionals – residency programs for therapists, clinical social workers<br>• Retain physicians<br>• Address lack of provider capacity for mental/behavioral health care<br>• Address lack of provider capacity for primary care, specialists<br>• More emphasis on mental health in nursing and physician training<br>• Group therapy resources for those who have finished individual therapy but need<br>• additional support<br>• Support groups for parents/caregivers of children with behavioral health challenges, i.e. autism<br>• RAM Clinic more often<br>• More preventative care – healthcare has become too reactive<br>• Help navigating technology, especially for older adults<br>• More mental health telephone support, can be informal – such as ARROW project out of Staunton, work with clients who need escalation to more professional help<br>• Respite care and support for caregivers<br>• Community Paramedic program<br>• More help for refugees and immigrants coming to our community, especially language services<br>• Volunteer recruitment – many community organizations lost volunteers because they were often older<br>• Health education – especially for underserved populations; getting out into the community and connecting with diverse groups (age, race/ethnicity, homeless, etc)<br>• Partnering with other organizations and building trust<br>• Opportunities to get used to safely congregating again, lots of people have lived with a prevailing sense of anxiety; more people are looking for ways to contribute, for purposeful work/volunteering<br>• Work with pastors and local clergy to reach the most people<br>• Helping to create a greater awareness of where you can go for help – catchy ads or media spots, pointing people to resource hubs<br>• More training opportunities for community members and students who speak other languages to become interpreters |

# HEALTH STATUS INDICATORS

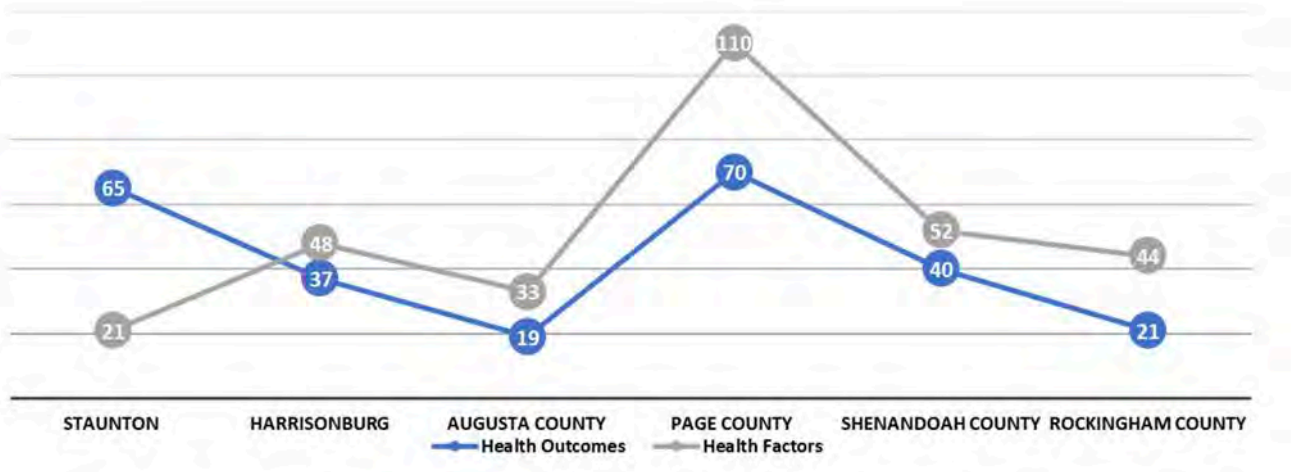
## *County Health Rankings*

Health Indicators were viewed on County Health Rankings. The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors). Explore the Model to learn more about these measures and how they fit together to provide a profile of community health.




- There are many factors that influence how well and how long people live.
- The County Health Rankings model (right) is a population health model that uses data from different sources to help identify areas of concerns and strengths to help communities achieve health and wellness.
- The Rankings provides county-level data on health behavior, clinical care, social and economic and physical environment factors.

The graph below shows the Health Outcomes Rank and Health Factors for the communities in the service area of Staunton, Harrisonburg, Augusta County, Page County, Shenandoah County and Rockingham County (Appendix B).




*Source: County Health Rankings 2021, https://www.countyhealthrankings.org/*

### *Health Status Indicators*

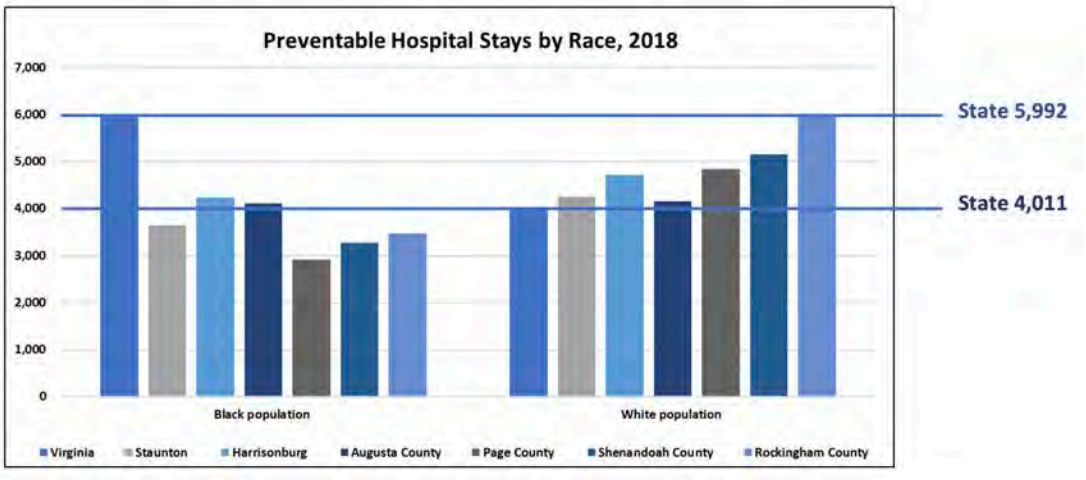
Below are key health status indicators for the counties representing the service area. Here indicators can be explored for a comparison to other nearby localities, change over time, race/ethnicity, and gender, where available. In addition, more indicators are often available through the link and Appendix B.

The key health status indicators are organized in the following data profiles:

A. Access to Health Services Profile
B. Mortality Profile
C. Risk Factor Profile
D. COVID-19 Profile
E. Maternal and Infant Health Profile
F. Older and Aging Adults
G. Cancer Profile
H. Diabetes Profile
I. Behavioral Health Profile
J. Community Violence and Gun Violence Profile

## ACCESS TO HEALTH SERVICES PROFILE

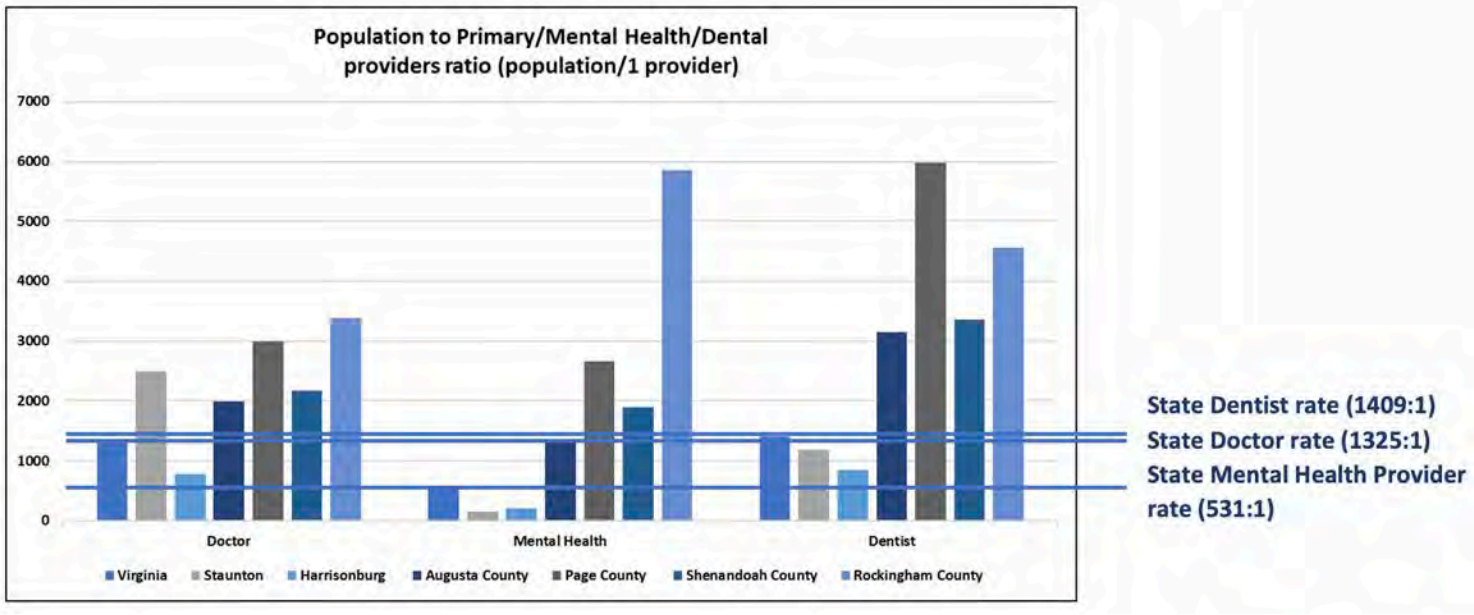
Access to quality and affordable health care is important to an individual's health. Health insurance and local care resources can ensure access to care. If outpatient care in a community is poor, then people may be more likely to overuse the hospital as their main source of care, resulting in unnecessary hospital stays. Typically, areas with higher densities of primary care have lower rates of hospitalizations for these ambulatory care sensitive conditions. Increasing access to primary care is key solution to reducing these unnecessary and costly hospital stays and improving the health of the community.




*Source: County Health Rankings 2021, Rankings and Documentation; *Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.*

### *Provider Ratio*

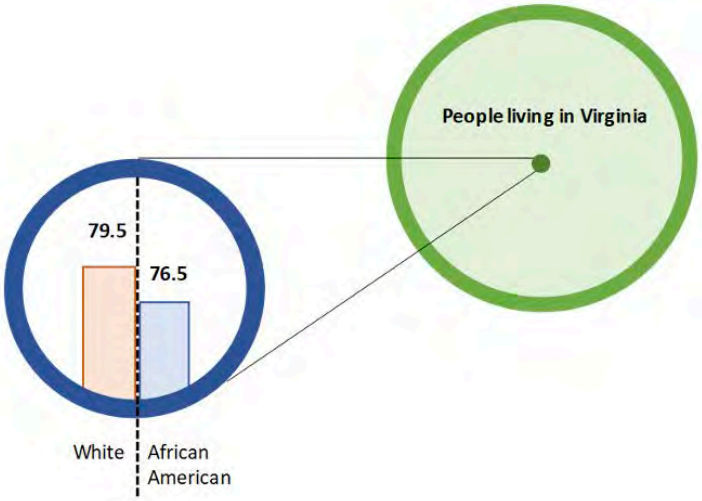
The rate of primary care and dental care provider rates were examined in the service area. The ratios for population to primary care providers were higher than the state (1325:1) in some of the localities in the service area. The population ratio for dental care providers were also higher than the state (1409:1) in some localities. Fewer providers suggest concerns with access to health care, including oral health, throughout the service area. The percentage of people with health insurance was lower than the state percentage of 10% in some localities. Harrisonburg City, Page County, Shenandoah County and Rockingham County had higher percentages of uninsured. The preventable hospital stay rate among Medicare beneficiaries was highest in Rockingham County, followed by Shenandoah County, which suggest that there may be challenges with access to primary and outpatient care.




*Source: County Health Rankings 2021, Rankings and Documentation;*

## MORTALITY PROFILE

The life expectancy for a person living in the Commonwealth of Virginia is 79.5. York County has a slightly higher life expectancy than the state (82.5). It is important to note there is a racial/ethnicity disparity related to life expectancy among African American populations. Life expectancy for African Americans compared to white populations is anywhere from 1 to 3 years less in the service area (Appendix B).




Leading causes of death in localities of the service area were examined. In 2019, heart disease and cancer were the top causes of death in the service area.

In the service area, the crude death rate from all causes was mostly greater than the rate in the state overall. For the Counties of Staunton, Augusta, Page, Shenandoah, and Rockingham, the top two causes of death had a crude death rate higher than the rate for Virginia, with the exception of Harrisonburg City.

**Leading Causes of Death Per 100,000, Age-adjusted per 100,000 Population**

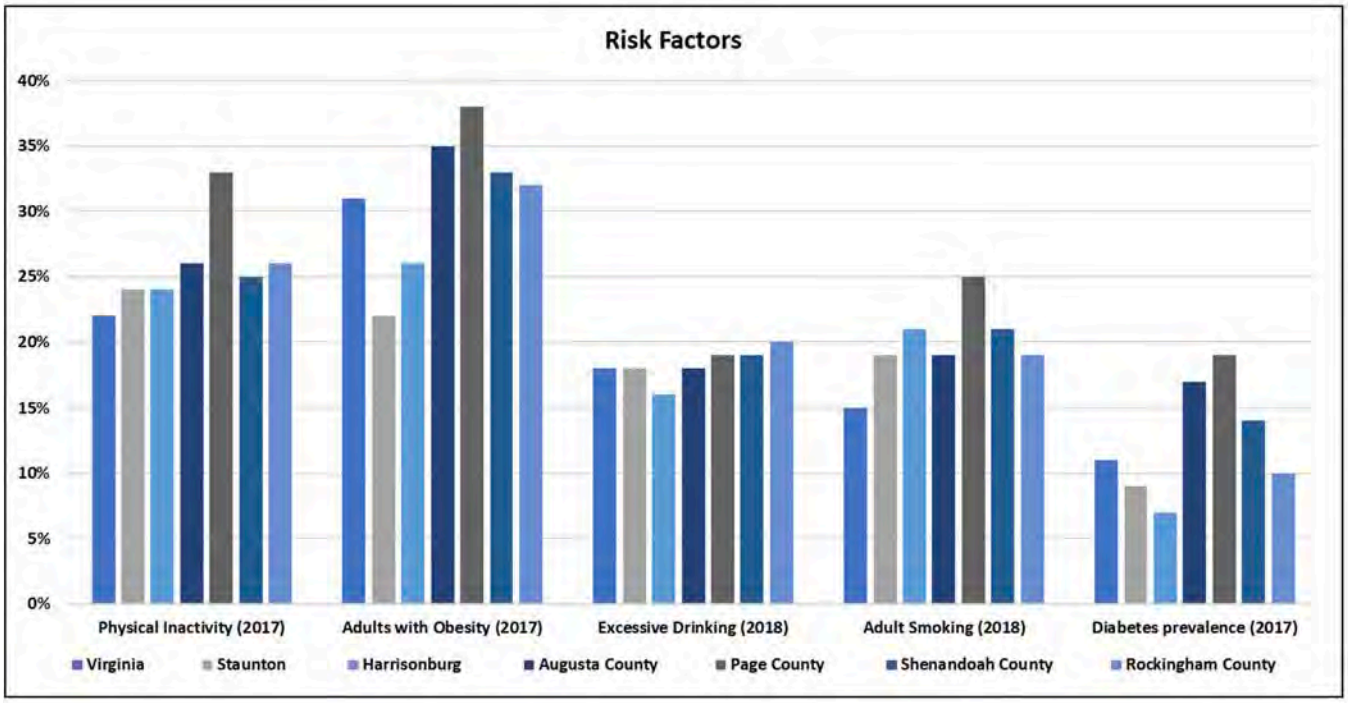
| | Crude Death Rate | All Causes | Heart Disease | Cancer | Respiratory Diseases | Accidents | Stroke | Alzheimer's Disease | Diabetes | Suicide | Chronic Liver Disease | Hypertension and Renal Disease |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staunton | Prevalence Rate | 1472.0 | 373.0 | 300.8 | 100.3 | 64.2 | 88.2 | 108.3 | 32.1 | 16.0 | 20.1 | 12.0 |
| | Numerator (count) | 367 | 93 | 75 | 25 | 16 | 22 | 27 | 8 | 4 | 5 | 3 |
| Harrisonburg | Prevalence Rate | 603.6 | 135.8 | 141.5 | 20.7 | 35.8 | 39.6 | 32.1 | 20.7 | 3.8 | 3.8 | 9.4 |
| | Numerator (count) | 320 | 72 | 75 | 11 | 19 | 21 | 17 | 11 | 2 | 2 | 5 |
| Augusta County | Prevalence Rate | 1004.5 | 227.6 | 197.2 | 66.2 | 52.9 | 49.0 | 45.0 | 35.7 | 19.9 | 13.2 | 13.2 |
| | Numerator (count) | 759 | 172 | 149 | 50 | 40 | 37 | 34 | 27 | 15 | 10 | 10 |
| Page County | Prevalence Rate | 1351.4 | 326.3 | 326.3 | 62.8 | 54.4 | 100.4 | 50.2 | 41.8 | 12.6 | 29.3 | 8.4 |
| | Numerator (count) | 323 | 78 | 78 | 15 | 13 | 24 | 12 | 10 | 3 | 7 | 2 |
| Shenandoah County | Prevalence Rate | 1203.7 | 245.3 | 272.8 | 68.8 | 66.5 | 66.5 | 80.2 | 34.4 | 20.6 | 18.3 | 4.6 |
| | Numerator (count) | 525 | 107 | 119 | 30 | 29 | 29 | 35 | 15 | 9 | 8 | 2 |
| Rockingham County | Prevalence Rate | 909.1 | 224.5 | 184.3 | 39.0 | 51.3 | 58.6 | 46.4 | 25.6 | 17.1 | 11.0 | 13.4 |
| | Numerator (count) | 745 | 184 | 151 | 32 | 42 | 48 | 38 | 21 | 14 | 9 | 11 |
| Virginia | Prevalence Rate | 822.9 | 176.1 | 176.0 | 42.9 | 46.8 | 44.7 | 30.8 | 27.5 | 13.3 | 12.1 | 9.6 |
| | Numerator (count) | 70,242 | 15,035 | 15,024 | 3,662 | 3,993 | 3,819 | 2,626 | 2,351 | 1,135 | 1,037 | 816 |


*Data Source: Virginia Department of Health, Division of Health Statistics, Virginia statistics 2019, received 1-13-2019*

## RISK FACTOR PROFILE

Smoking percentages and frequent mental health distress were higher for the residents living in the service area compared to Virginia values. Conversely, the percentage of adults who drink excessively was higher in Page, Shenandoah and Rockingham Counties compared to the Commonwealth of Virginia, but lower in Staunton City, Harrisonburg City and Augusta County.

Obesity and physical inactivity percentages were higher for the service area compared to Virginia overall, although access to exercise opportunities was higher than the state in Staunton City and Harrisonburg City. Diabetes was higher in Augusta, Page and Shenandoah Counties, but lower in Staunton City, Harrisonburg City and Rockingham County. Food insecurity percentages are lower in Augusta, Shenandoah and Rockingham Counties compared to the state. Limited access to healthy food was highest in Rockingham County at 6%, compared to the state at 4% (Appendix B). Obesity is a concern because it increases the risk of diabetes, heart disease, stroke, and some cancers. It is also associated with poor mental health outcomes and reduced quality of life.

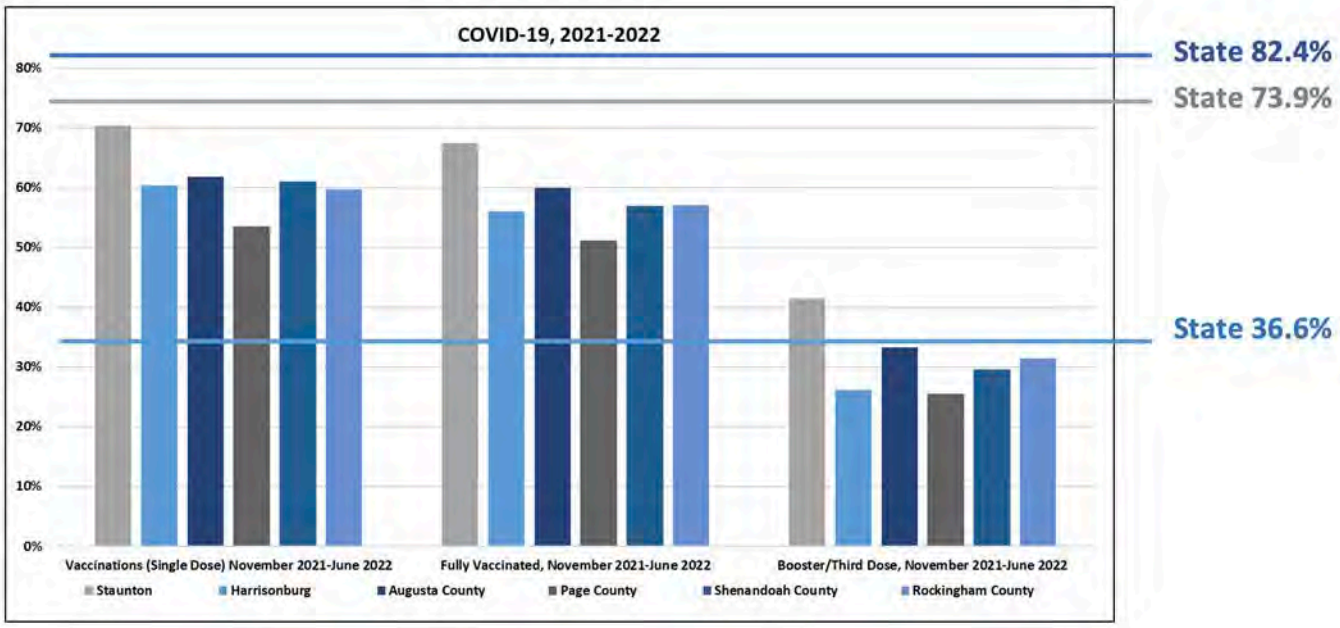



*Source: County Health Rankings 2021, Rankings and Documentation*

## COVID-19 PROFILE

In 2020, the nation faced the COVID-19 pandemic. This contagious disease impacted the health of the communities. People infected with the virus may experience mild to moderate respiratory illness and recover without medical treatment. However, some people will become seriously ill, requiring medical attention and possible hospitalization. People with underlying medical conditions are at a higher risk for developing serious illness while infected with COVID-19, as well as a higher risk for death (World Health Organization, 2022).

Between August 27, 2020 and June 15, 2022, the Commonwealth of Virginia had 1,830,122 cases with 20,448 deaths. Between May 2021 and June 2022, Augusta County had the highest rate of cases at 18,129 per 100,000 residents and Page County had the highest rate of deaths at 267.4 per 100,000 residents. As of June 2022, Staunton had the highest percentage of residents with a single dose and two doses of the vaccine, though still below the percentage for the state.




## MATERNAL AND INFANT HEALTH PROFILE

Unsupported and under-supported young families face many negative health outcomes and predict many long-term health challenges as time goes on, so looking at the way families begin can help us understand the current and future health of the community. Compared to Virginia values, residents of Augusta, Page and Shenandoah Counties had high percentages of babies born with low and very low weight births. The infant mortality rate was greater in Augusta County compared to Virginia (Appendix B). While teen births are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates. The non-marital birth rate is slightly higher than the Virginia rate in Staunton City, Harrisonburg City, Page and Shenandoah Counties. While this does not carry the stigma that it once did, it may indicate the degree of support for both the mother and the infant.

*Source: World Health Organization, Coronavirus disease (COVID-19); Virginia Department of Health, COVID-19 Data in Virginia, Dashboard; Virginia Department of Health Division of Health statistics*

## OLDER AND AGING ADULTS PROFILE

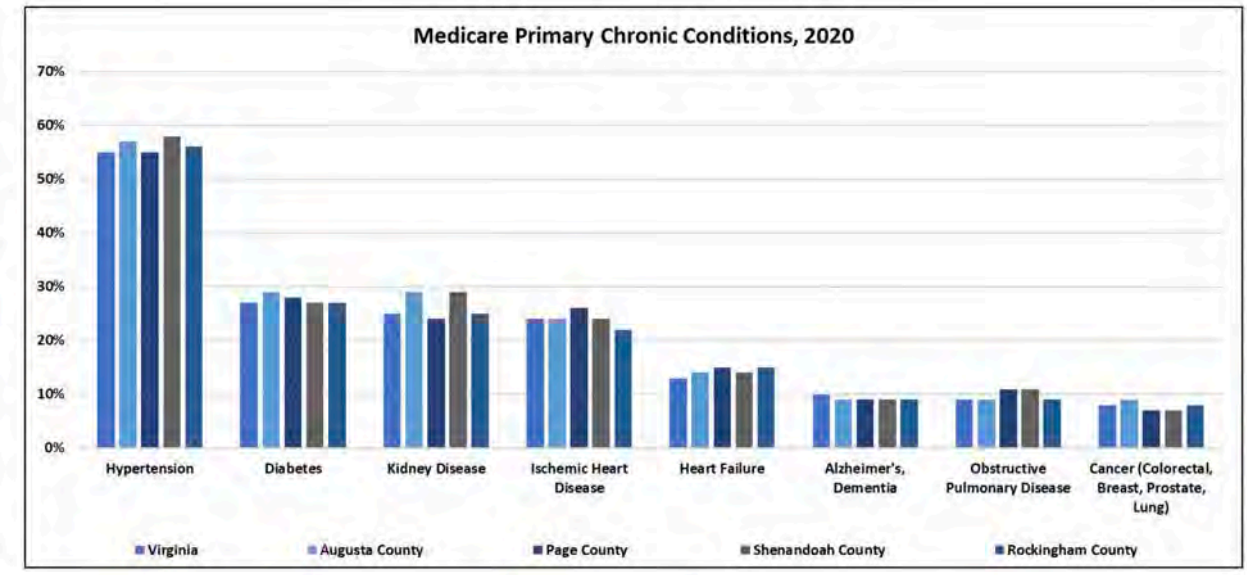
In many communities, older adults are the fastest growing segment of the population. Challenges come with an aging population, including health related factors and other factors that ultimately impact health. The Medicare population was seen for multiple conditions during 2020. Hypertension and diabetes were the top conditions seen in the services area having higher percentages in most localities than the state. Kidney disease and heart conditions also showed high percentages for the Medicare population utilizing hospital services.

The percentage of persons under 65 with Alzheimer's disease and dementia diagnoses living in Staunton City, Harrisonburg City and Shenandoah County is higher than the state. The percentage of Medicare beneficiaries over age 65 treated for Alzheimer's disease or dementia was slightly higher in Staunton City, Harrisonburg City, and Augusta County compared to Virginia (Appendix B). Per the Alzheimer's Association there is a projected estimated increase of 26.7% by 2025 in prevalence of the number of people age 65+ receiving an Alzheimer's disease diagnosis in the Commonwealth of Virginia. This is important to note as it will impact the aging population's health, quality of life, healthcare demand and costs.

***1 in 3 seniors dies with Alzheimer's or another dementia. It kills more than breast cancer and prostate cancer combined.***

*Source: Alzheimer's Association, 2022*

Advance Care Plans are for adults to specify their medical wishes and/or designate someone as their legal medical decision-maker in the event they cannot communicate and advocate for themselves. While many team members working within the healthcare industry understand the importance and value of Advance Care Plans, it is evident within the acute care setting that our community members may not have that same understanding until it is too late. Currently, within the Commonwealth of Virginia, there are 41,380 active registrants with Advanced Care Plans filed within the USLWR (US Living Will Registry). Sentara has 70,236 active registrants with Advanced Care Plans on file within the USLWR with 1,736 of those completed for residents of the service area.




*Source: Centers for Medicare & Medicaid Services, Data.cms.gov *Data unavailable for cities; Alzheimer's Association, 2022 Alzheimer's Disease Facts and Figures, Virginia Alzheimer's Statistics; Virginia Alzheimer's Commission, AlzPossible Initiative; United States Living Will Registry*

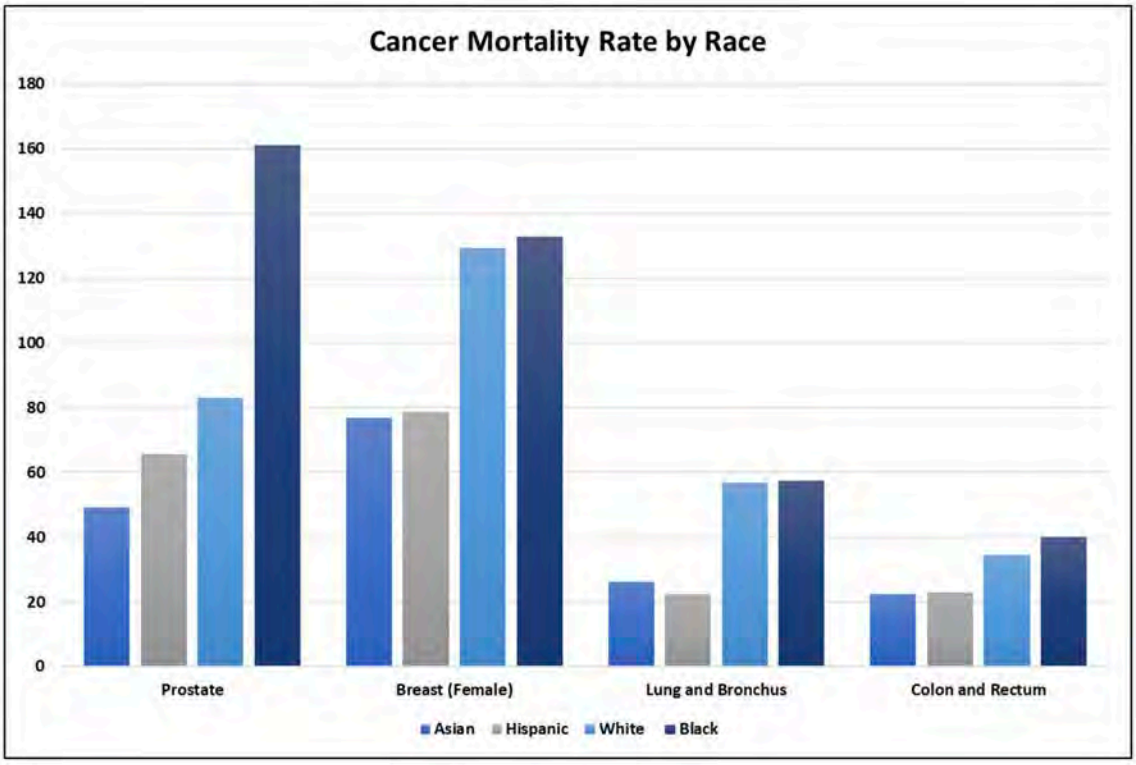
## CANCER PROFILE

Death and incidence rates for a variety of cancer types were examined since cancer is a leading cause of death in the service area. Compared to the previous 5-year collective rates for both incidence and mortality from the leading types of cancer, some of the service area is trending down with fewer cases and lower death rates. However, the cancer incidence rate in Staunton and Harrisonburg City were mostly higher than the state. The cancer death rate in Staunton City and Shenandoah County are above the state rate.

***Breast cancer is the most common cancer diagnosed among US women and is the second leading cause of death among women after lung cancer.***

*Source: American Cancer Society*

Mortality rates were highest among lung, breast, prostate, and colon cancers, though these are not the only ones on which Sentara will focus efforts. The trend for these cancers is falling compared to the previous 5-year period. However, mortality rates for African Americans diagnosed with breast cancer is rising compared to previous years (Appendix B). Prostate cancer and breast cancer are the leading cause of cancer death for African Americans living in Virginia. See the below graph showing the mortality disparities among races. The community outreach programs educating and providing cancer screenings, as well as medical developments, are having an impact. Efforts will need to focus on populations at higher risk of this disease.




*Data Source: NIH National Cancer Institute, 2014-2018 Incident Rate Report for Virginia*

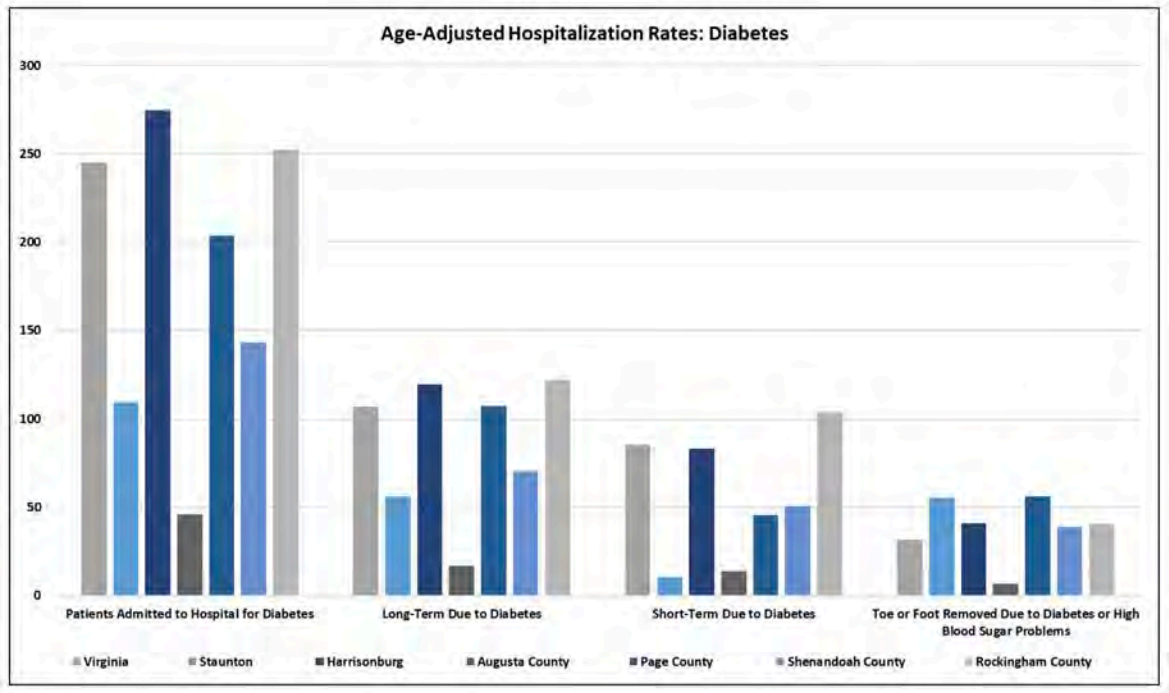
## DIABETES PROFILE

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the United States and is the 7th leading cause of death (CDC, 2021). Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity also remain key risk factors. Diabetes is a top cause of death in the service area. Here we examine additional related indicators.


***Diabetes is also associated with increased risk of certain types of cancer, such as liver, pancreas, uterine, colon, breast, and bladder cancer.***

*Source: CDC, 2019*

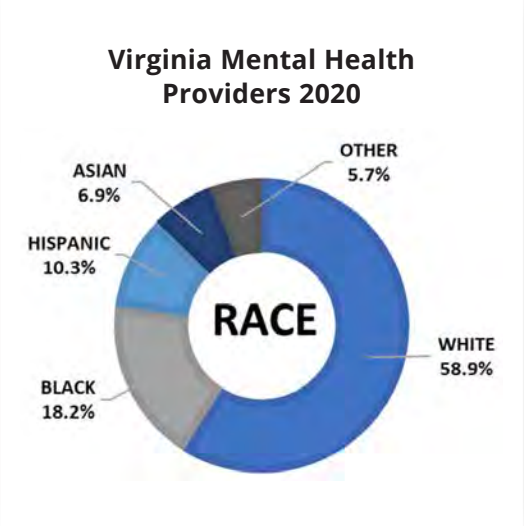
The percentage of adults with diabetes living in Augusta, Page and Shenandoah Counties is higher than the state percentage of 11%. SRMH examined hospitalization rates due to diabetes and found the age-adjusted hospitalization rates due to diabetes was above the state rate of 245.03 in Harrisonburg City (274.45) and Rockingham County (252.18). Both localities also have high hospitalization rates due to short-term and long-term complications of diabetes higher than the state. It is also important to note that the rate of patients with a toe or foot amputated due to diabetes or high blood sugar problems was higher than the state in Staunton City, Harrisonburg City, Page County, Shenandoah County and Rockingham County with worsening trends in Staunton City and Page County.




*Data Source: Centers for Disease Control and Prevention, Diabetes; Diabetes Report Card, 2019;*
*Virginia Health Information (VHI), AHRQ Quality Indicators;*
**Risk-Adjusted Rate per 100,000 Population*

## BEHAVIORAL HEALTH PROFILE

Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined Emergency Department visits for 2021 to gain a better understanding of the mental health crisis communities have been facing during the COVID-19 pandemic. In 2021, SRMH Emergency Department saw a patient frequency of 1,972 for people, aged 18+, with a behavioral health diagnosis. Of the 1,972 visits 18.1% presented with suicidal ideations and 12.8% with major depressive disorder.




"In early 2021, emergency department visits in the United States for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019" (Office of Surgeon General, 2021). SRMH saw a patient frequency of 290 for youth, age 0-17, present with a behavioral health diagnosis. Of the 290 visits 40.3% presented with suicidal ideations and 16.2% with major depressive disorder.

The COVID-19 pandemic has worsened mental health among youth and adults with increasing anxiety, depression, and stress. Loss off freedoms due to social distancing, masking, and isolating negatively impacted the most vulnerable increasing emergency department visits due to a lack of mental health providers to assist with therapy and development of coping skills. Most of the service area has fewer mental health providers per person compared to the state (531:1), Augusta County (1349:1), Page County (2656:1), Shenandoah County (1896:1) and Rockingham County (5853:1). Staunton City and Harrisonburg City are doing better with mental health providers per person (151:1, 209:1) (Appendix B). It is also important to note that the mental health workforce is nearing retirement age, which will negatively impact provider capacity. There is also a need for a more racially and ethnically diverse mental health workforce to provide racially concordant care. (Appendix B).

*Source: County Health Rankings 2021, Rankings and Documentation , Virginia Health Care Foundation*

## COMMUNITY VIOLENCE AND GUN VIOLENCE PROFILE

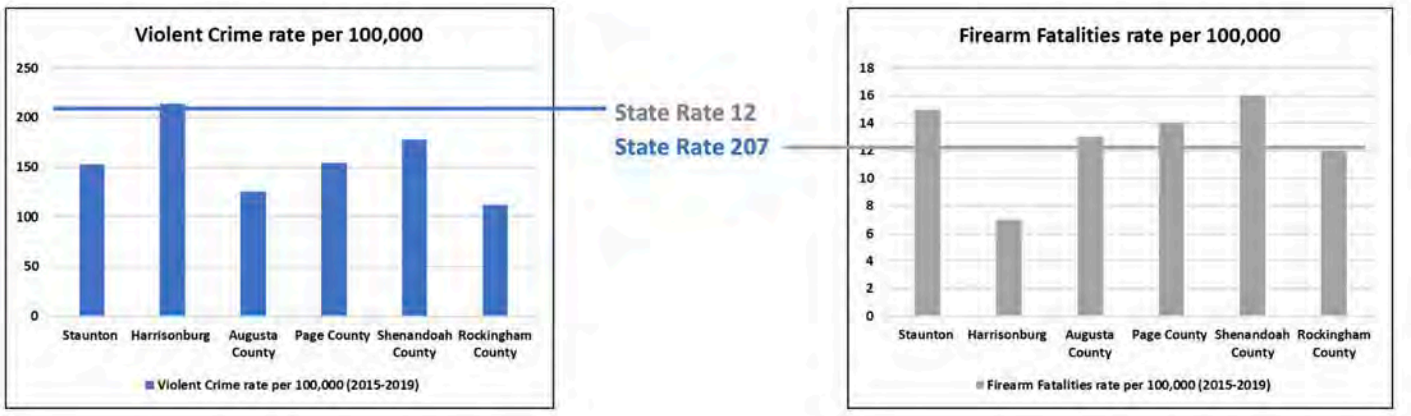
Violent crimes such as gun violence, robbery, or aggravated assault have socio-emotional impact on people. Physical and emotional symptoms can occur such as sleep disturbances, increase in feelings of distress, anger, depression, inability to trust, and significant problems with family, friends, or coworkers. Violent crimes can hinder the pursuit of healthy behaviors such as outdoor physical activities. Chronic stress has been associated with violent crimes and increases prevalence of certain illnesses such as upper respiratory illness and asthma. This can have life-long impact on the health of the individual.

> ***"Firearm injury is a leading cause of death for youth in the United States."***
>
> *Source: Andrews AL, et al. Pediatrics. Feb. 28, 2022*

The violent crime rate in Harrisonburg City was much higher compared to the state rate of 207 violent crime offenses per 100,000 population (Appendix B).

Gun violence alone is a top contributor to premature death. Deaths due to firearms are considered largely preventable; as a result, gun violence has been identified as a key public health issue by national agencies. A study published by American Academy of Pediatrics (2022) showed an increase in pediatric deaths due to firearms. The study also showed a disparity among African American youth who are "14 times more likely to die of firearm injury compared with their White peers" (Andrews AL, et al. *Pediatrics*. Feb. 28, 2022).

When deaths were examined for localities within the service area, the rate was higher than the state rate for firearm fatalities per 100,000 population, with the exception of Harrisonburg City and Rockingham County.




*Source: County Health Rankings 2021, Rankings and Documentation*

# 2018 & 2021 IMPLEMENTATION STRATEGY PROGRESS REPORT

The previous community health needs assessment identified several health issues. The SRMH implementation strategy progress report was developed to identify activities to address health needs identified in the 2018 and 2021 CHNA report through primary and secondary data sources. This section of the CHNA report describes these activities.

For reference, the list below includes the 2018 and 2021 CHNA health needs that were prioritized to be addressed by SRMH in the 2018 and 2021 implementation strategy.

- Access to Services
- Behavioral Health and Substance Use
- Chronic Disease Prevention and Management

SRMH is monitoring and evaluating progress to date on its 2018 and 2021 implementation strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Please note that the 2018 and 2021 community health needs assessment implementation strategy process was disrupted by COVID-19, which has impacted all of our communities.

## STRATEGY PROGRESS

SRMH continues to collaborate with community partners to help meet the needs of our community, though some of these efforts were placed on hold during the pandemic. Collaborative efforts to identify ways to collaborate on initiatives to avoid duplication of resources and better meet the needs of our community will begin again at the end of 2022.

### *Access to Services*

SRMH continues work to increase access to needed primary care, specialty care, and other healthcare services for uninsured and underinsured patients. In 2021, SRMH helped with planning and fundraising for the Harrisonburg Remote Area Medical (RAM) clinic. In addition to the usual dental, vision, and medical services provided by RAM, SRMH raised funds to provide 20 sets of dentures to patients who need them. RAM has developed COVID-19 protocols to safely provide these services during the pandemic. SRMH Continuum Care Management community-based services also continues to be offered to patients with heart failure and COPD via virtual visits during the pandemic.

The RMH Foundation exists solely to support SRMH and enhance its mission to improve health and promote wellbeing. SRMH has been able to significantly improve the care patients receive because of gifts from our caring and generous community. 100 percent of donations directly benefit patients and our community through the purchase of new equipment and support of compassionate programs. Since its beginning in 1975, the Foundation has directed millions in donated funds to support a wide variety of needs at the hospital.

In 2021, SRMH Safe at Home program provided free or reduced medical alert devices to eligible older adults to help them safely age in place, with 117 seniors assisted. SRMH Mobile Mammography provided 1,587 mammograms at 118 events at 46 unique locations through the service region. Due to COVID-19, the van was unavailable between March and June. Mammography Screening programs provided 323 women free

mammograms (201 through Every Woman's Life and 122 through the RMH Foundation). SRMH Pharmacy processed an estimated $603,900 in medications for patients unable to afford their medications through our drug donation partnership with Sirium. SRMH continued involvement with the Healthcare Safety Net Coalition which included the hospital President, Director of Integrated Care Management & Community Health Services, Community Health Project Manager, and Director of Behavioral Health.

RMH Foundation strategic investments:

- Healthcare for the Homeless Suitcase Clinic (serves ~ 300 unduplicated patients per year): Funded 1 Nurse Case Manager position
- Strength in Peers Safe & Secure Healing Program: funding for short-term hotel stays to allow homeless patients to recover and receive case management and peer support services.
- The Free Clinic of Harrisonburg-Rockingham County: medications for patients
- Valley Program for Aging Services: transportation program to help seniors get to medical appointments, grocery and pharmacy, and other services.

### *Behavioral Health*

SRMH continues to improve health outcomes and continuity of care for patients and family members experiencing mental health challenges. In 2021, SRMH Outpatient Pharmacy Consumer Drug Take Back Bin collected and disposed of 512.9 pounds of unused medications.

SRMH Behavioral Health services included:

- Counseling services: 407 new visits, 2,700 follow up for individual; 748 group visits
- Clinical Psychology assessments: 225 new visits; 1,631 testing hours
- Bereavement services: 297 new patient visits
- LIFE Recovery addiction treatment services: patients over age 13 who have already completed intensive treatment
- Partial Hospitalization Program: 423 admissions
- Intensive Outpatient Program: 166 admissions (services suspended for part of the year due to COVID-19)
- Psychiatric Emergency Team services (Emergency Department-based): 2,788 adult assessments; 130 child/adolescent assessments
- Inpatient: 729 admissions, average length of stay 5.5 days

SRMH partnered with James Madison University to host a Viewpoints on Health event with author David Sheff. Due to COVID-19, the event was changed to virtual and rescheduled to March of 2021. Event goals were to increase community awareness of addiction as a disease and provide Continuing Medical Education to providers.

The Shenandoah Valley Maternal Mental Health Coalition, a network of local maternal-child health providers, mental health professionals, nursing leaders, and others, in partnership with Postpartum Support Virginia, met virtually each quarter with 15-25 average in attendance.

### *Chronic Disease Prevention and Management*


SRMH continues to work to increase the capacity of primary care in the service area to manage chronic disease, improve health outcomes and continuity of care for patients and implement best practice prevention strategies to reduce the burden of chronic disease morbidity and mortality. In 2021, SRMH provided diabetes education during outpatient visits with 865 unduplicated patients seen with an average change in Hemoglobin A1c values from 8.87 (baseline at consult) to 7.94 at 6-month participation in DSME program. Diabetes education was also provided during inpatient visits with 1,139 patients seen and most patients left with follow-up diabetes education when an outpatient visit appointment was made.

SRMH provided additional educational opportunities in 2021:

- Matters of the Heart community education event: 150 attended
  - Alan Johnson, MD: "Atrial Fibrillation and Stroke Reduction Options"
  - Michael Scholfied, MD: "Nutrition and Lifestyle for Managing Chronic Disease"
- Diabetes Prevention Program: piloted a virtual DPP model for the Virginia Department of Medical Assistance Services, 10 participants
- Child Obesity Prevention: Safe Routes to School grant (Virginia Department of Transportation grant) activities – pandemic limited some activities/participation:
  - National Bike to School Day: 3 schools participated with 1,100 students involved
  - International Walk to School Day: 20 students participated
  - Bike Safety Education: 4 schools participated with 2,200 students involved
- Toward No Tobacco (TNT) curriculum taught to all 7th and 8th graders in Harrisonburg City and Rockingham County Public Schools by SRMH Respiratory Therapist – pivoted to a virtual learning module delivered with the health curriculum.

## GRANTMAKING AND COMMUNITY BENEFIT

In the 2018 and 2021 Implementation Strategy process, Sentara and hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grant making, in-kind resources, collaborations, and partnerships. Sentara is focused on supporting organizations and projects that address prominent social determinants of health and promote health equity by eliminating traditional barriers to health and human services. Sentara strongly encourages grant proposals that align with one or more of the following priorities:

- Housing
- Skilled Careers
- Food Security
- Behavioral Health
- Community Engagement


Sentara is aware of the significant impact that our organization has on the economic vitality of our communities. In 2020, Sentara invested nearly $256 million in our communities. Sentara invested $20 million in health and prevention programs, $45 million in teaching and training of healthcare professionals, $11 million in philanthropic giving and $180 million in uncompensated patient care. In 2021, Sentara invested $245 million in the communities; $16 million in community giving, $23 million in health and prevention programs, $45 million in teaching and training of healthcare professionals and $167 million in uncompensated patient care.

Clearly, the definition of community health is broader than simply medical care. As more is learned about the role of social determinants of health, more opportunities will arise to influence population health through engaging in community building approaches to care. Beyond the scope of SRMH alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. Sentara and SRMH are committed to finding innovative, responsive, and successful strategies to address these challenges, to fulfill our mission to improve health every day.

## Community Health Needs Assessment References

### *Community Demographics*

#### GEOGRAPHIC DATA

USA.com, Virginia State Population Density

#### POPULATION DATA

Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data

Research Group of the Weldon Cooper Center for Public Service, July 2019, Demographics

US Census Bureau; 2019: Census - Table Results

US Census Bureau QuickFacts Table 2020, Virginia Quick Facts

US Census Bureau QuickFacts Table 2020; (2020 Small Area Income and Poverty Estimates (SAIPE))

US Census Bureau, Small Area Income and Poverty Estimates (SAIPE). SAIPE (census.gov)

Virginia Department of Health Culturally and Linguistically Appropriate Health Care Services; US Census Bureau American Community Survey Five-Year Estimates, 2014 vintage; CLAS

Virginia Medicaid Department of Medical Assistance Services; Data (As of January 15, 2022)

### *Health Indicators*

#### ADVANCE CARE PLANNING

The United States Will Registry, https://www.theuswillregistry.org/

#### ALZHEIMER'S AND DEMENTIA

Alzheimer's Association, Virginia Alzheimer's facts

Virginia Alzheimer's Commission, AlzPossible Initiative

#### CANCER

NIH National Cancer Institute, 2014-2018 Incident Rate Report for Virginia, Cancer Profile; 2014-2018 Mortality Rate Report for Virginia, Cancer Profile

#### COVID-19

Virginia Department of Health, COVID-19 Data in Virginia, Dashboard

### DIABETES

Center for Disease Control and Prevention, Diabetes

Center for Disease Control and Prevention, Diabetes Report Card 2019

Virginia Health Information, AHRQ Quality Indicators

### MATERNAL AND INFANT

Virginia Department of Health Division of Health statistics

***Reviews***

Annie L. Andrews, Xzavier Killings, Elizabeth R. Oddo, Kelsey A.B. Gastineau, Ashley B. Hink; Pediatric Firearm Injury Mortality Epidemiology. *Pediatrics* March 2022; 149 (3): e2021052739. 10.1542/peds.2021-052739. Retrieved from https://pubmed.ncbi.nlm.nih.gov/35224633/ on April 11, 2022.

Herron, M. (2019). Deaths: Leading Causes for 2017. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_06-508.pdf on April 11, 2022.

Office of the Surgeon General (OSG). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory [Internet]. Washington (DC): US Department of Health and Human Services; 2021. PMID: 34982518. Retrieved from https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf on April 11, 2022.

Virginia Health Care Foundation. (January 2022). Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce. Retrieved from https://www.vhcf.org/wp-content/uploads/2022/01/BH-Assessment-Final-1.11.2022.pdf on April 11, 2022.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