

Sentara RMH Medical Center

Community Health Needs Assessment 2025

**Serving the Virginia counties of Augusta, Page, Rockingham,
and Shenandoah; the Virginia cities of Harrisonburg and
Staunton; and West Virginia's Pendleton County.**



Table of contents

Executive summary	3
Introduction	8
Community description	14
Locality demographics of our community	14
Community input	24
Health status and prioritization	28
Health indicators	28
Prioritization	33
Conclusion	33
Supplemental resources	34
2023-2025 implementation strategy progress summary	34



Executive summary

Sentara RMH Medical Center (SRMH) has been a trusted health care provider for the central Shenandoah Valley since 1912. Our mission is to “improve health every day.” To fulfill this mission, we regularly conduct a Community Health Needs Assessment (CHNA) to better understand the health challenges and priorities of those we serve.

This report focuses on the seven localities located within the SRMH service area: the Virginia counties of Augusta, Page, Rockingham, and Shenandoah; the Virginia cities of Harrisonburg and Staunton; and West Virginia’s Pendleton County. This assessment offers a comprehensive view of the region’s health by gathering insight from community conversations, a community survey, and health data. By listening to the voices of local residents and partnering with community organizations, we aim to address health disparities and ensure that all residents have access to the high-quality health care that they deserve.

Work on the 2025 CHNA for SRMH began in 2024. The priorities identified by local residents align with past SRMH assessments, as well as assessments conducted in neighboring communities. People in the area are eager to see continued efforts to improve access to behavioral health services,

Top priorities



Behavioral health



Chronic conditions



Social determinants of health

enhance resources for managing chronic conditions, and take a broader approach to health. This includes initiatives focused on social factors like housing, transportation, and food security, which can greatly impact overall health.

Every three years, Sentara conducts a thorough Community Health Needs Assessment for each of our inpatient hospitals and outpatient surgical centers across Virginia and Northeastern North Carolina. This important tool helps us to identify the strengths and assets within each community, including key local partners. By working together, we can address the challenges and seize the opportunities highlighted in the report to improve community health.

Looking at the data

Community demographics of the 310,781 persons living in the service area,* which includes the cities of Harrisonburg and Staunton, and the counties of Augusta, Page, Rockingham, and Shenandoah.

Racial profile, 2023

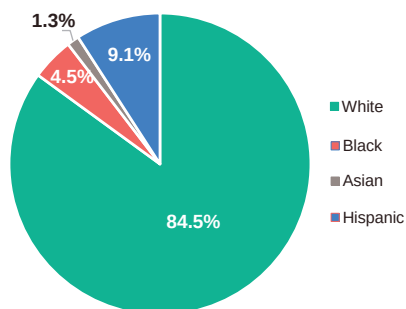


Figure 1

Source: United States Census Bureau

Population by age, 2019-2023

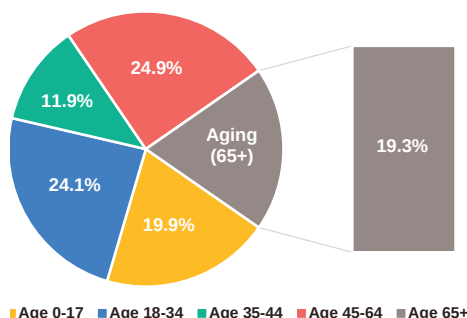


Figure 2

Population change from 2020-2023

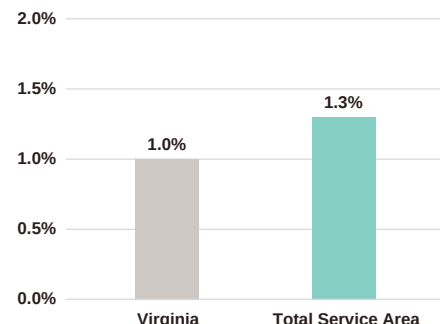


Figure 3

Determinants of health include:

Population age 18-64 without medical insurance, percentage

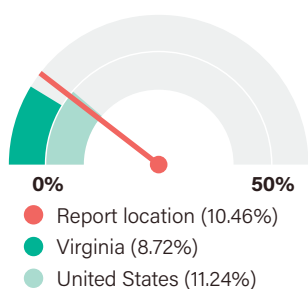


Figure 4

Primary care providers, rate per 100,000 population

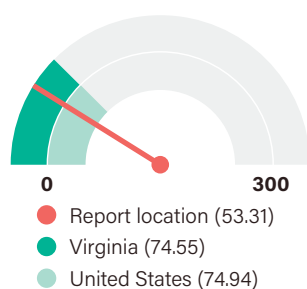


Figure 5

Population on poverty, percentage

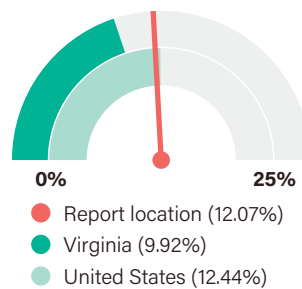


Figure 6

Mental health care providers, rate per 100,000 population

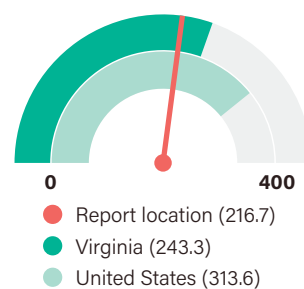
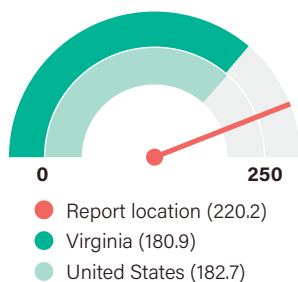


Figure 7

Source: Virginia's Plan for Well-Being, Virginia Community Health Improvement Data Portal

Top health concerns include:

Cancer mortality, crude death, rate per 100,000, total population



Figures 8

Disease of heart deaths, rate per 100,000, total population

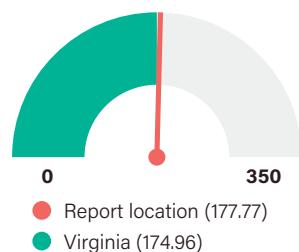


Figure 9

Hospitalizations with diabetes, rate per 100,000, total population

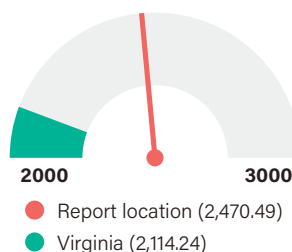


Figure 10

Hospitalizations with hypertension, rate per 100,000, total population

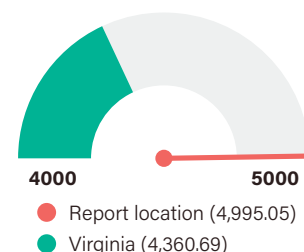


Figure 11

Source: Virginia's Plan for Well-Being, Virginia Community Health Improvement Data Portal

*Service area totals exclude Pendleton County, WV, due to differences in and access to state databases.

Key findings

This assessment considers community demographics and other factors that influence the overall health of our communities. The report draws on data from County Health Rankings, including health factors, health outcomes, and key health indicators, to provide a comprehensive view of community well-being.¹ These rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. 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 is a population health model that uses data from a variety of sources to identify strengths and areas of concern to help communities achieve optimal health and wellness outcomes.

Demographics

Of the total population in the service area, 84.5% of residents are White, 4.5% are Black, 9.1% are Hispanic, and 6.5% are multiple races (total exceeds 100% due to rounding and multiple races selected in the census). The age profile for the population closely mirrors, yet slightly differs, from that of the Commonwealth of Virginia. Within the next ten years, the total population in the service area is estimated to increase by almost 7% — an estimated addition of roughly 19,000 residents.³

Social and economic factors

We recognize that a community's health outcomes are driven by a variety of factors beyond the clinical care provided in hospitals and other health care settings. Keeping this in mind, our CHNA includes information on education, employment, poverty, and public health insurance enrollment of residents in the service area.

County Health Rankings model

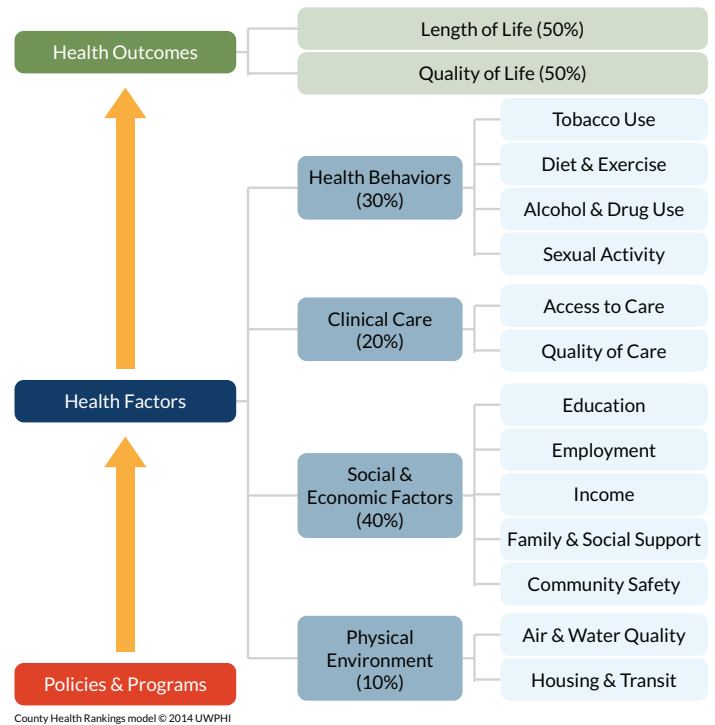


Figure 12

Source: [County Health Rankings model © 2014 UWPHI](#)

Education and employment

Education supports stable employment and financial stability for individuals and their families. As of the 2023 U.S. Census, 88.0% of the residents in the service area were high school graduates, compared to 91.3% of Virginia residents. According to the 2019-2023 American Community Survey, only 34.0% of residents in the service area hold advanced or professional degrees compared to 49.3% statewide.

As of the 2023 U.S. Census, 66.8% of residents in the service area participated in the labor force, slightly above the state average of 65.6%. Of total service area residents, the percentage of female residents in the civilian labor force (58%) is lower than the state average (61%).

Poverty

Poverty creates barriers to accessing health care, healthy foods, and safe living environments, resulting in lower quality of life and negative health outcomes.

As of the 2023 U.S. Census, residents living in the service area are more likely to live in poverty (12.0%) compared to the rest of Virginia (10.2%). The combination of socioeconomic factors and racial inequalities has a negative impact on health outcomes for individuals and families in this area. Similar to Virginia as a whole, People of Color living in the service area are more likely to live in poverty compared to White residents. In the service area, Black (30.2%) and Hispanic (18.9%) residents experience a higher rate of poverty compared to White residents (10.7%).

Community insight

To ensure community voices are heard, we partnered with the Central Shenandoah Health District and Church World Services Harrisonburg (CWS Harrisonburg) to distribute a community insight survey and conduct focus groups with community members.

Community survey

From September through November 2024, we conducted community outreach to share the digital survey link and engaged local partners to complete paper surveys, which resulted in 532 residents living in the service area participating. We appreciate the time and contributions these individuals made to help enhance health and well-being in our community.

Top concerns identified included:

- Mental health/stress
- Chronic conditions: Hypertension, obesity, and diabetes
- Dental/oral health

Barriers to accessing health care and resources:

- Out-of-pocket costs
- Could not get an appointment/wait for an appointment was too long
- Insurance challenges: Did not cover what was needed, provider did not accept, or no health insurance
- Lack of transportation

Focus groups

Leaders from SRMH and the Central Shenandoah Health District conducted community conversations from November 2024 through March 2025 to gain more in-depth insights from community stakeholders on their health concerns and health care barriers. We intentionally promoted these focus groups to diverse populations to obtain feedback from participants truly representative of the communities we serve.

Top concerns identified included:

- Mental and behavioral health
- Chronic diseases and conditions
- Dental/oral health
- Access: Navigating the health care system and associated resources

Health status

We viewed health status indicators from the 2024 County Health Rankings data and documentation to gain a better understanding of the clinical concerns community members face. When and where data was available, SRMH paid particular attention to the disparities affecting historically marginalized populations.

Life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. In the Virginia communities served by SRMH, the average life expectancy is 78.6 — similar to the state average. It is important to note disparities affecting Black residents. The average life expectancy of Black residents in Harrisonburg (76.0), Staunton (74.1), and Rockingham County (76.1) is three to five years less than White residents living in the service area.¹

Access to health services is limited by the low numbers of primary care and mental health providers in this community. The need for access to mental health services continues to grow. In 2024, 1,962 adults and 125 youth visited the SRMH emergency room for behavioral health concerns. Of those patients, 19.5% of the adults and 35.2% of the youth reported suicidal ideations.

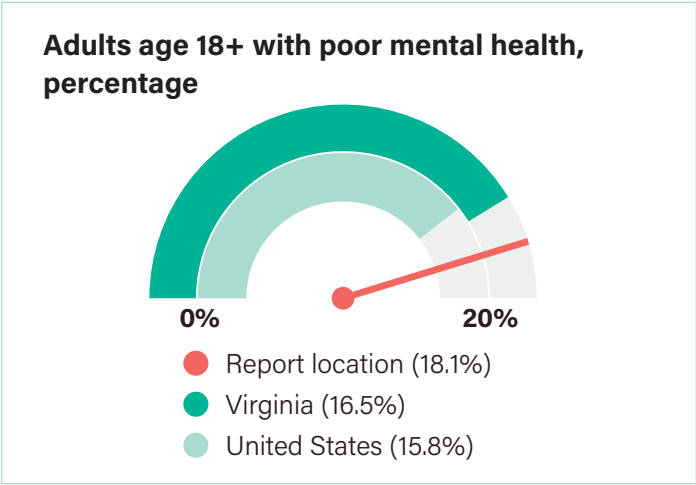


Figure 13 Source: Virginia's Plan for Well-Being, Virginia Community Health Improvement Data Portal

Top health conditions driving hospitalizations at SRMH include hypertension, stroke, diseases of the heart, mental health, and drug overdose. Leading causes of death include heart disease, cancer, COVID-19, stroke, and accidents. Risk factors for chronic conditions

include substance use, obesity, limited access to healthy foods, and physical inactivity.

Focus areas

Sentara Cares is the community engagement and impact arm of Sentara Health. Our goal is to advance health and ensure that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives. We are focusing our resources on the key issues listed below based on identified health disparities, the availability of effective interventions, community input, and alignment with our mission to “improve health every day.”

The remainder of this report provides more detail about the 2025 assessment, including social and economic data, demographic information, and health determinant data. Throughout this document, we have incorporated extensive information obtained through the community survey and stakeholder outreach.

Sentara Cares community benefit and building efforts enhance SRMH health priorities for 2026-2028

Sentara priorities	Socioeconomic needs	Health needs	SRMH priorities
	Housing	Behavioral and mental health	
	Food security	Chronic conditions	
	Skilled careers	Social determinants of health	

Increasing needs

Table 1 Sentara cares priorities for grant opportunities and SRMH implementation strategy priorities for 2026-2028.

Endnotes

¹County Health Rankings & Roadmaps: Rankings Data & Documentation. Accessed October 10, 2024. <https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>.

²United States Census Bureau. QuickFacts. [www.census.gov](https://www.census.gov/quickfacts/fact/table/harrisonburgcitycountyvirginia,stauntoncitycountyvirginia,augustacountyvirginia,pagecountyvirginia,rockinghamcountyvirginia,shenandoahcountyvirginia/PST045223). Accessed February 10, 2025. <https://www.census.gov/quickfacts/fact/table/harrisonburgcitycountyvirginia,stauntoncitycountyvirginia,augustacountyvirginia,pagecountyvirginia,rockinghamcountyvirginia,shenandoahcountyvirginia/PST045223>.

³University of Virginia Weldon Cooper Center for Public Service. (2022). Virginia Population Projections. Retrieved from <https://coopercenter.org/virginia-population-projections>. Accessed October 10, 2024.

Introduction

Sentara Health

Sentara Health, an integrated, not-for-profit health care delivery system, celebrates more than 130 years in pursuit of its mission - "we improve health every day." Sentara is one of the largest health systems in the U.S. Mid-Atlantic and Southeast, and among the top 20 largest not-for-profit integrated health systems in the country, with 30,000 employees, 12 hospitals in Virginia and Northeastern North Carolina, and the Sentara Health Plans division which serves more than 1 million members in Virginia and Florida. Sentara is recognized nationally for clinical quality and safety and is strategically focused on innovation and creating an extraordinary health care experience for our patients and members. Sentara was named to IBM Watson Health's "Top 15 Health Systems" (2021, 2018), and was recognized by Forbes as a "Best Employer for New Grads" (2022), "Best Employer for Veterans" (2022, 2023), and "Best Employer for Women" (2020).¹

Sentara RMH Medical Center (SRMH)

Located in Harrisonburg, VA, SRMH is a 238-bed community hospital serving a seven-county area with nearly 316,000 residents throughout the central Shenandoah Valley.

Proudly serving the community since 1912 as Rockingham Memorial Hospital, we became Sentara RMH Medical Center in 2011 after joining the Sentara Health system. Over the years, we've continually evolved to meet the changing health care needs of our community.

Sentara at a glance

- **Headquartered in Hampton Roads**
- **Outpatient campuses**
- **135-year not-for-profit history**
- **Urgent care centers**
- **12 hospitals**
- **Advanced Imaging Centers**
- **One medical group**
- **Home health and hospice**
- **3,800+ provider medical staff**
- **Rehabilitation and therapy centers**
- **30,000+ team members**
- **Nightingale Regional Air Ambulance**
- **Sentara Health Plans**

As part of this ongoing commitment to excellence, Sentara RMH is honored to have earned Magnet® recognition, a prestigious credential that underscores our dedication to quality patient care. We also collaborate closely with local non-profits, schools, and community groups to further improve the health and well-being of those we serve.

At Sentara RMH, one thing remains constant: our commitment to providing exceptional care for our community. We specialize in a wide range of services, including behavioral health, cancer care, heart and vascular services, emergency medicine, maternity services, women's health, neurology, orthopedics, pulmonology, wound healing, and weight loss surgery.²

Sentara Cares

Our mission goes beyond just providing care to patients – it's about addressing health issues every day in the places where people live, work, and play. We aim to eliminate health disparities and promote equitable access to healthy food, education, safe and affordable housing, and stable, rewarding job opportunities. We understand that health disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. Through our partnerships, we are making a real, lasting impact on the health of our communities.³

Since 2021, Sentara Cares has provided significant investment in the SRMH service area through grants for community partners that increase access to health care, behavioral health services, healthy food, housing solutions, and workforce development through skilled career training.

Through funding from Sentara Cares, Sentara RMH formed an innovative partnership with Strength in Peers, a local peer support organization, to create a respite home on the hospital campus. Renovations for the home were funded by the RMH Foundation, enabling SRMH to offer a safe, supportive

space where homeless patients can recover after hospital discharge while receiving case management and peer support services from Strength in Peers.

Community care

Sentara Community Care launched in 2022 to expand access to care and improve the health of communities across the Commonwealth. Our goal is to break down traditional barriers to health and wellness by offering convenient and consistent medical services, along with additional support, in the neighborhoods that need it most. These services include primary care for all ages, behavioral health and social care services, health and wellness education, food and housing assistance, and health care navigation.

In 2023, Sentara Community Care partnered with Harrisonburg City Public Schools (HCPS) to open its first location in Harrisonburg, housed within the HCPS Welcome Center. The clinic provides essential primary care and vaccinations to students entering the local school system and their families. Building on this commitment to increase access to health care in community settings and reduce barriers to care, Sentara launched a mobile clinic in 2024 to bring health

“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, MSN, RN-ACM, Executive Director of Community Engagement & Impact





care directly to underserved neighborhoods and key community hubs such as food pantries, churches, and other vital resource centers.

With the continued support of the RMH Foundation, Sentara RMH is strengthening its commitment to community health by collaborating with local safety net providers to enhance access to essential health care services.

For more than a decade, the RMH Foundation has supported the Healthcare for the Homeless Suitcase Clinic — an innovative, mobile health care team that delivers medical services directly to homeless shelters throughout the community. This initiative plays a critical role in helping individuals manage chronic health conditions and obtain necessary medications.

In 2024, the Foundation began renovations of a vacant clinic space in downtown Harrisonburg, previously occupied by the community's free clinic. This strategic effort aims to address significant gaps in timely care

through the development of Rocktown Health, a collaborative care hub.

The new clinic unites several key partners under one roof:

- Healthy Community Health Centers (HCHC) will provide same-day access primary care as the area's Federally Qualified Health Center.
- Sentara RMH, in partnership with the Master Center for Addiction Treatment, has expanded access to substance use treatment, responding to a growing and urgent community need.
- Strength in Peers will establish a Community Resource Center, offering peer support and navigation services for individuals facing behavioral health challenges.

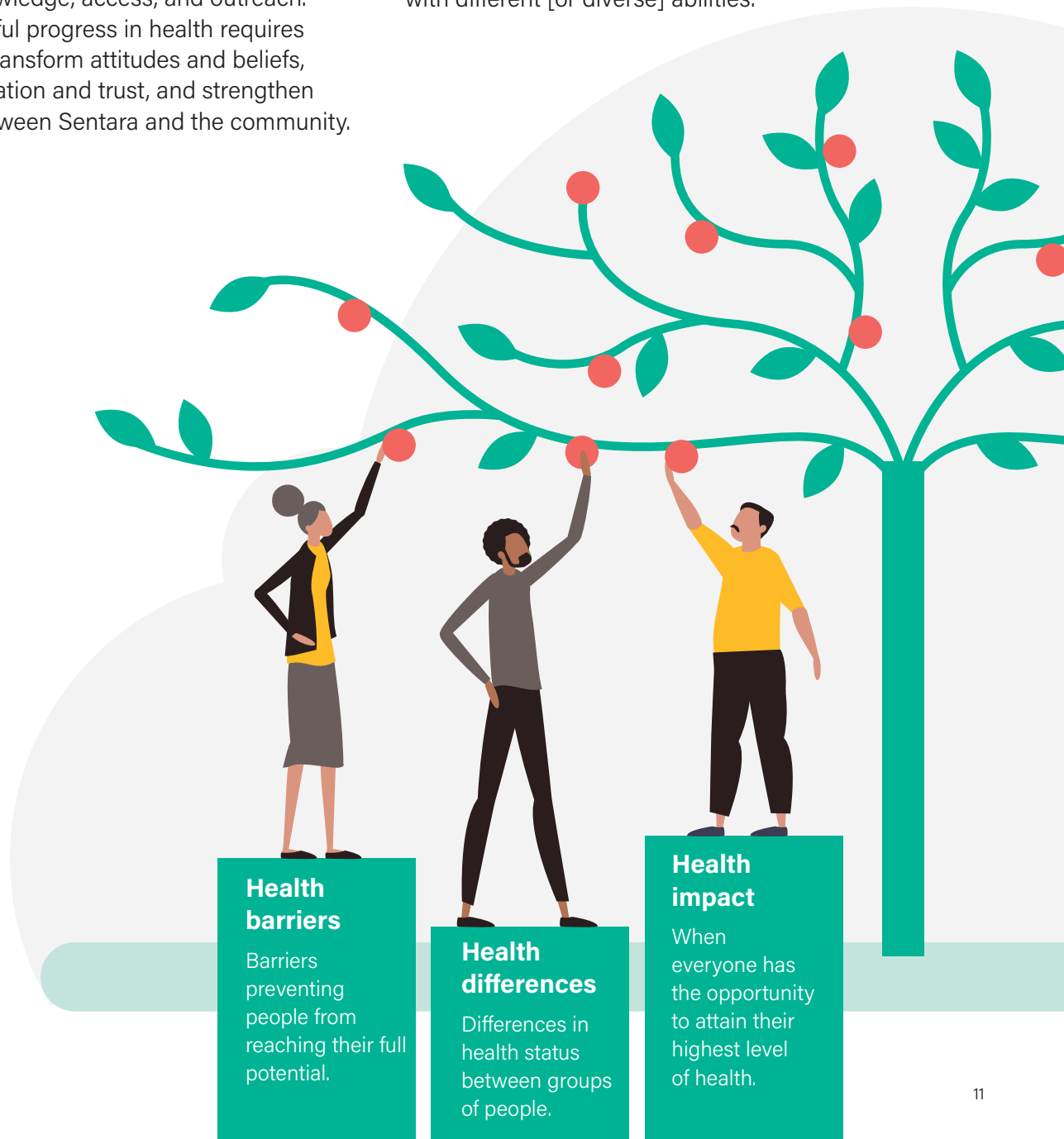
Collectively, these efforts reflect a shared commitment to a healthier, more equitable community — where all individuals, regardless of circumstance, have access to compassionate, coordinated, and timely care.

Health impact

By identifying the most pressing health concerns within a community, this assessment prioritizes health interventions across all racial, ethnic, gender, age, language, geographic, and socioeconomic groups. Health impact not only looks at population health but also examines resources to advance health based on community insight. Our work aims to improve awareness, education, and access to care while considering how hidden tendencies in decision-making affect treatment outcomes.

As health care shifts toward a value-based model, we are committed to addressing health disparities and closing gaps in knowledge, access, and outreach. Achieving meaningful progress in health requires ongoing efforts to transform attitudes and beliefs, improve communication and trust, and strengthen trustworthiness between Sentara and the community.

Sentara collaborates with community organizations, faith leaders, academic institutions, government agencies, and clinicians to develop initiatives to address social determinants of health, reduce health disparities, and improve the health and well-being of the communities we serve. Our efforts focus on improving screening and diagnosis rates for health issues, such as hypertension, diabetes, and prostate cancer; increasing access to and utilization of treatment; and supporting health initiatives that benefit historically marginalized groups, including immigrant populations, individuals experiencing homelessness, sexual orientation and gender identity (SOGI) populations, and individuals with different [or diverse] abilities.



Health barriers

Barriers preventing people from reaching their full potential.

Health differences
Differences in health status between groups of people.

Health impact

When everyone has the opportunity to attain their highest level of health.

Assessment	Description
Qualitative data	We survey our community members and hold focus groups to discuss community conditions, health, and needs. We ask our community members about their personal circumstances—like having a safe place to live, healthy and accessible food, social connections, and other daily essentials—and connect them to community resources.
Quantitative data	We collect demographic and health indicator data to identify differences in community and health outcomes. We look at the data to better inform our community health improvement work.

Process overview

Mobilizing for action through planning and partnerships

The National Association of County and City Health Officials (NACCHO) has implemented a community-driven strategic planning process for improving community health called Mobilizing for Action through Planning and Partnerships (MAPP). This framework includes engaging community partners in the collection and review of qualitative and quantitative data from trusted local and national sources. In doing so, participating partners can clearly define the conditions that support or obstruct wellness and identify resources to address obstacles.⁴

We began the MAPP process at SRMH by engaging community partners, developing support teams, and creating a shared vision with common values. Community partners included the Central Shenandoah Health District and CWS Harrisonburg. Sentara worked collaboratively with partners to engage community members through survey completion and focus groups, collecting responses to be used for prioritizing health needs. We then collected and analyzed data to identify strategic priorities and formulate goals and strategies to address health concerns.

Our process

Sentara conducts these comprehensive assessments to provide a snapshot of the health status of residents in our communities, including information about key health and health-related challenges and opportunities. Each Community Health Needs Assessment incorporates information from a variety of primary and secondary quantitative data sources to help us understand the disparities that affect vulnerable populations.



Sentara created a data profile that includes how people use emergency and preventive care, their ongoing health problems, and any cultural or language requirements they might have. A secondary statistical data profile uses advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures, mortality rates, prevalence rates of chronic illnesses, and racial and ethnic composition. Our assessment includes a review of risk factors, including obesity, smoking, and other health indicators.

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

- Centers for Medicare & Medicaid Services
- County Health Rankings (2024)
- National Cancer Institute
- United States Census Bureau
- Virginia Department of Health
- Virginia Medicaid, Virginia Department of Medical Assistance Services
- Virginia's Plan for Well-Being: Virginia Community Health Assessment
- Weldon Cooper Center for Population Studies, University of Virginia
- CHNA survey and focus groups

Our next steps

We collaborate with a number of community partners to tackle local health challenges. Using insights gathered from this assessment, SRMH, together with our partners, will develop an implementation strategy to address the identified health issues and improve overall community well-being. The implementation strategy progress report for the 2022 CHNA is available at the end of this report.

Resource information is available from:

- The Community Resource Center (540-208-2941 or strengthenpeers.org/services/communityresourcecenter)
- RockBurg Feeds (rockburgfeeds.org),
- People Helping People (540-433-7286 or phpharrisonburg.org)
- 2-1-1 Virginia
- Virginia's Plan for Well-Being

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 future assessments. You may use our online feedback form available on sentara.com.

Endnotes

¹ Sentara Health. About Sentara. Accessed October 10, 2024. <https://www.sentara.com/aboutus.aspx>.

² Sentara Health. Sentara RMH Medical Center. Accessed March 7, 2025. <https://www.sentara.com/hospitalslocations/sentara-rmh-medical-center>.

³ Sentara Cares. Strengthening Communities. Accessed October 10, 2024. <https://sentaracares.com>.

⁴ National Association of County and City Health Officials. Accessed October 10, 2024. Mobilizing for Action through Planning and Partnerships (MAPP). <https://www.naccho.org/#:~:text=Mobilizing%20for%20Action%20through%20Planning%20and%20Partnerships%20%28MAPP%29,health%20issues%20%20and%20identify%20resources%20to%20address%20them>.

Community description

Locality demographics of our community

Sentara RMH is located in Harrisonburg, Virginia, serving a community of 316,810 people across a 3,370.22 square mile report area.¹ The primary and secondary service areas include the Virginia cities of Harrisonburg and Staunton, the Virginia counties of Augusta, Page, Rockingham, and Shenandoah, and West Virginia's Pendleton County. The service region boundaries are defined this way because many health indicators in the report are only available at the city/county level, not at the zip code level, although much of the data represents the entire SRMH service area.



Community-specific demographics

As of the 2023 U.S. Census, the Harrisonburg population was 51,082, with 23.8% of residents living in poverty and 13.2% uninsured. Age demographics include 17.1% of residents between the ages of 0-17, 44.8% ages 18-34, 20.4% ages 35-54, and 17.7% ages 55 and older. English is the primary language for 86.3% of residents. The racial and ethnic profile for the city is 66.5% White, 7.6% Black, and 23.1% Hispanic.

For Staunton, there is a population of 25,915, with 18.8% of residents living in poverty and 7.2% uninsured. Age demographics include 19.2% of residents between the ages of 0-17, 22.41% ages 18-34, 24.36% ages 35-54, and 34.1% ages 55 and older. English is the primary language for 93.5% of residents. The racial and ethnic profile for the city is 80.1% White, 11.0% Black, and 4.4% Hispanic.

For Augusta, there is a population of 78,247, with 8.2% of residents living in poverty and 7.4% uninsured. Age demographics include 18.7% of residents between the ages of 0-17, 19.2% ages 18-34, 24.9% ages 35-54, and 37.2% ages 55 and older. English is the primary language for 95.0% of residents. The racial and ethnic profile for the city is 90.0% White, 4.3% Black, and 3.8% Hispanic.

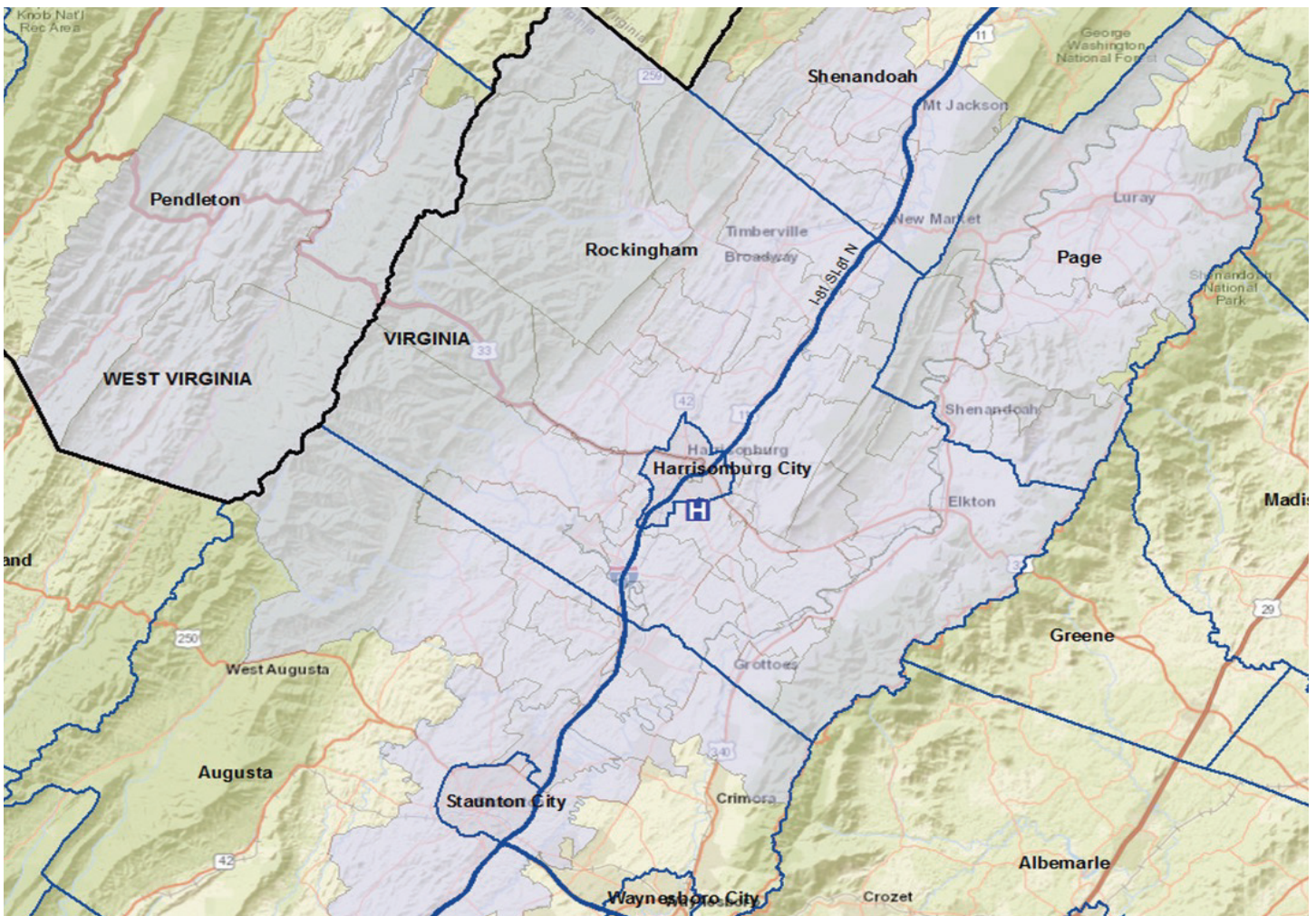
For Page, there is a population of 23,741, with 14.2% of residents living in poverty and 9.0% uninsured. Age demographics include 19.9% of residents between the ages of 0-17, 18.1% ages 18-34, 24.6% ages 35-54, and 37.4% ages 55 and older. English is the primary language for 96.6% of residents. The racial and ethnic profile for the city is 92.5% White, 1.9% Black, and 2.4% Hispanic.

For Rockingham, there is a population of 86,568, with 10.1% of residents living in poverty and 9.3% uninsured. Age demographics include 22.2% of residents between the ages of 0-17, 21.0% ages 18-34, 23.6% ages 35-54,

and 33.3% ages 55 and older. English is the primary language for 96.3% of residents. The racial and ethnic profile for the city is 88.1% White, 2.5% Black, and 8.9% Hispanic.

For Shenandoah, there is a population of 45,228, with 9.9% of residents living in poverty and 8.6% uninsured. Age demographics include 21.4% of residents between the ages of 0-17, 18.5% ages 18-34, 23.8% ages 35-54, and 36.3% ages 55 and older. English is the primary language for 90.2% of residents. The racial and ethnic profile for the city is 87.0% White, 2.9% Black, and 8.8% Hispanic.

For Pendleton, there is a population of 6,029, with 13.9% of residents living in poverty and 9.2% uninsured. Age demographics include 18.9% of residents between the ages of 0-17, 14.4% ages 18-34, 21.4% ages 35-54, and 45.3% ages 55 and older. English is the primary language for 99% of residents. The racial and ethnic profile for the city is 94.9% White, 2.5% Black, and 1.1% Hispanic.



Looking at the data

Racial and ethnic profile, 2019-2023

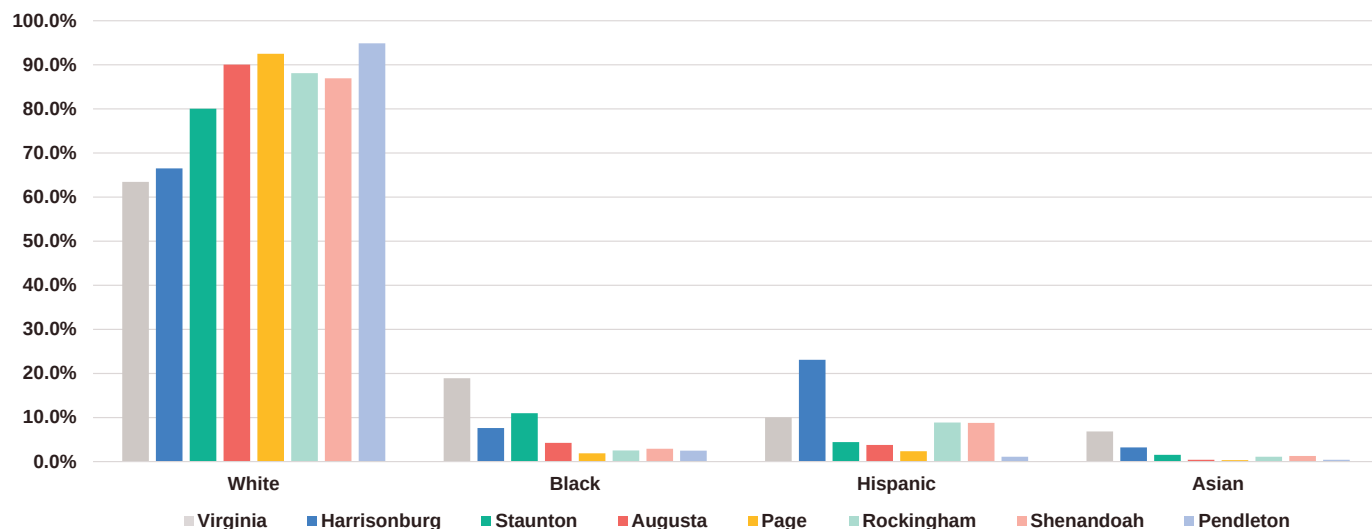


Figure 1 Source: Virginia's Plan for Well-Being, U.S. Census Bureau

Population by age, 2019-2023

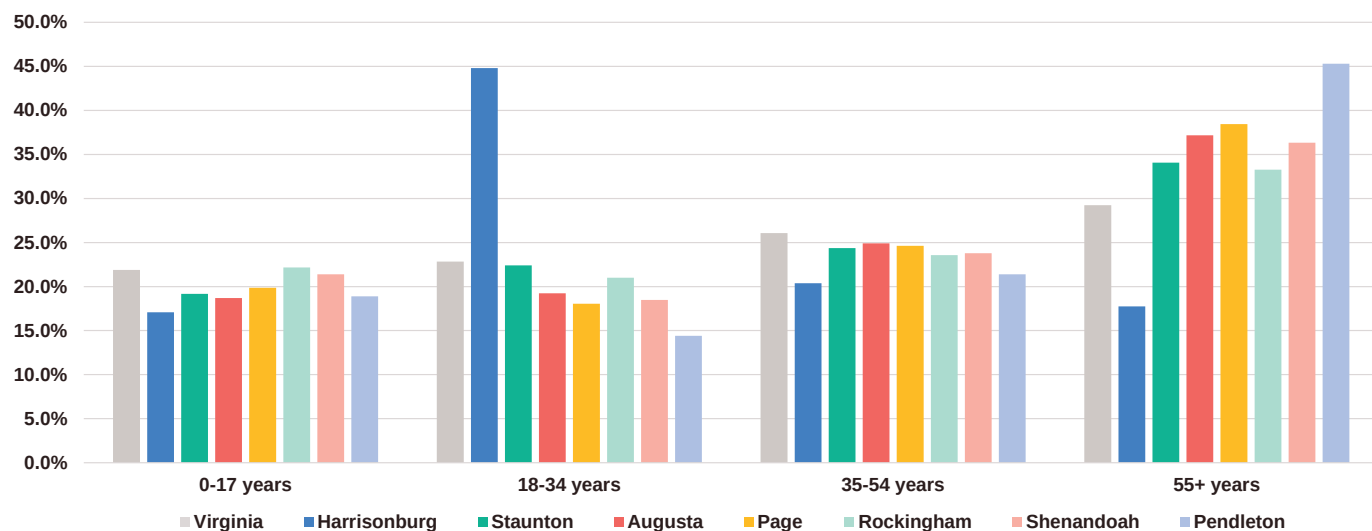


Figure 2 Source: Virginia's Plan for Well-Being, U.S. Census Bureau

Median household income, 2019-2023

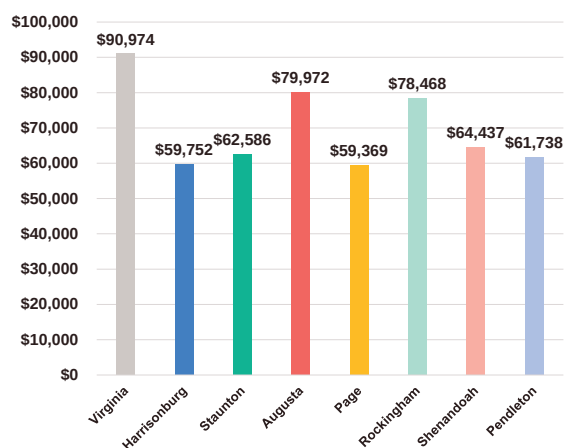


Figure 3 Source: U.S. Census Bureau

Poverty (all ages), 2023

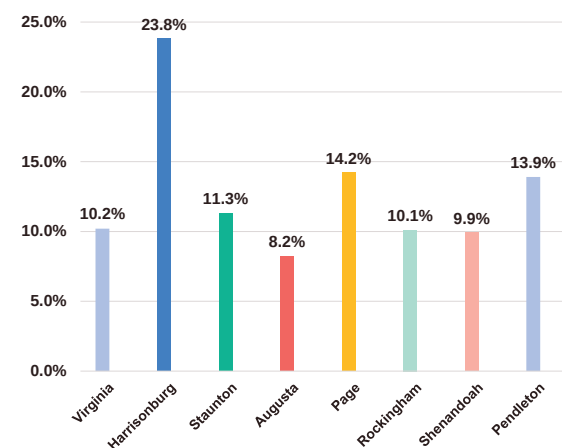


Figure 4 Source: U.S. Census Bureau

Population highlights

Population change

“Population projections provide an approximate idea of the expected future population size,” and, according to the University of Virginia’s Weldon Cooper Center for Public Service, the service area* is expecting an increase of an estimated 19,000 people within the next ten years.² These projections are based on “reliable and credible data.”²

Population change, 2035-2045

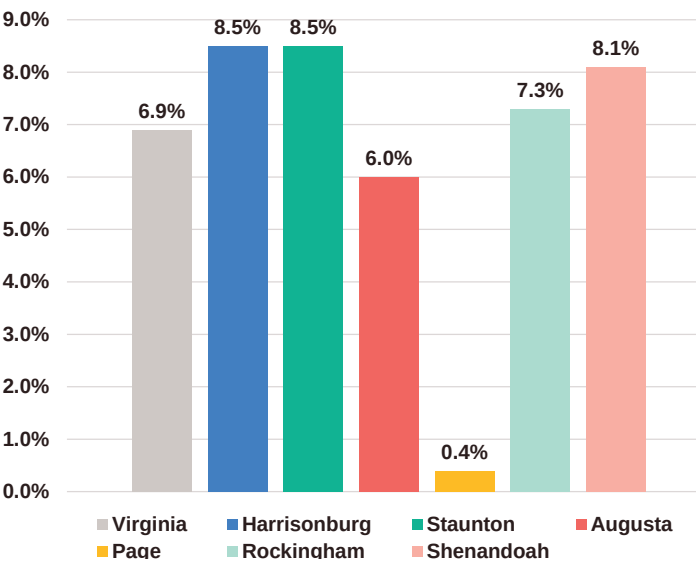


Figure 5 Source: U.S. Census Bureau

Age and sex

Per the 2023 U.S. Census, of the total population of 310,781 people living in the service area,* most residents are over the age of 45. The percentage of residents who are children between the ages of 0-17 is 19.9%, slightly lower than the state level of 21.9%. Male (49.4%) and female (50.6%) resident percentages are similar to Virginia percentages (49.5% male, 50.5% female), based on sex assigned at birth.

Aging population

Research shows the highest utilization of medical services is among the aging population (ages 65 and older) and the elderly population (ages 85 and older).

In 2023, 19.3% of the residents living in the service area* were ages 65 and older, compared to 16.3% in Virginia. Per the 2023 U.S. Census, Rockingham has the largest number of adults ages 65 and older in the service area, estimated at 16,959 residents. Estimates indicate the population of aging adults ages 65 and older living in the service area will increase to 22.5% by 2030.²

Other demographic features

According to the 2023 U.S. Census, Veterans only represent 5.5% of the population in the service area,* compared to 12.9% statewide. Slightly less households in the service area have computers (91.6%) and internet access (84.5%), decreasing access to remote learning, telehealth, and other resources. A slightly higher percentage of the population in the service area is living with a disability (12.0%) compared to the state overall (10.2%). The service area also has a higher percentage of persons living in poverty (12.0%) compared to Virginia overall (10.2%), and a lower percentage of residents with college degrees (34.0%) when compared to the state (49.3%).

Community diversity profile

A key feature of the SRMH service area is its refugee resettlement program, which brings unique needs and opportunities for collaboration among local organizations. This has fostered a diverse network of partners working to improve community health from various perspectives. To better understand the area’s cultural diversity, SRMH partnered with Church World Service Harrisonburg (CWS) to gather data and community feedback from refugee and immigrant populations.

According to CWS Harrisonburg, refugees from numerous Middle Eastern, African, Eastern European, and Central and South American countries have been resettled in the central Shenandoah Valley since 1988.

*Service area totals exclude Pendleton County, WV, due to differences in and access to state databases.

In 2023, there were an estimated 14,058 foreign-born people living in the Harrisonburg metropolitan area, 10.3% of the overall population.

The closest school systems to SRMH, Harrisonburg City Public Schools (HCPS) and Rockingham County Public Schools (RCPS), are vibrant and diverse. The schools serve students from around the world, many of whom speak a primary language other than English.

According to the most recent school enrollment data:

- HCPS: 60 different home languages and 73 different birth countries are currently represented⁸
- HCPS: 49.5% of students listed their home language as Spanish, while 34.6% of students listed their home language as English⁸
- RCPS: 50 different languages and 45 different birth countries of origin are currently represented
- RCPS: 37.1% of students reported a different language in addition to or in place of English at home

Foreign-born workers represent 12.2% of the employed labor force in Virginia and play an important role in several key industries in the region. Figure 7 outlines the impact of foreign-born workers on the area's workforce.

Racial and ethnic groups represented at HCPS

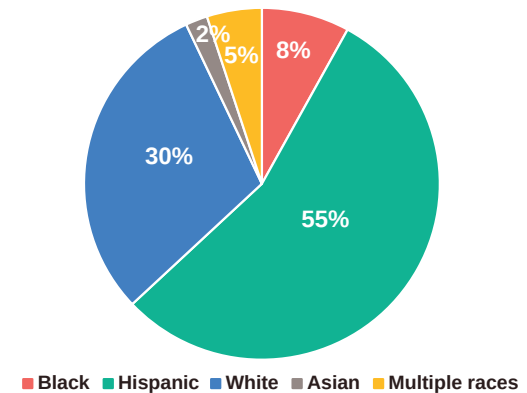


Figure 6 Source: HCPS Student Birth County

Foreign born population impact on workforce

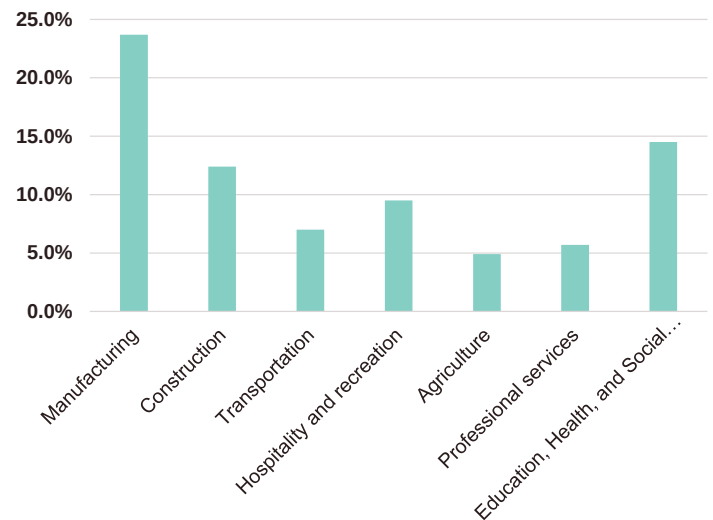


Figure 7 Source: U.S. Census Bureau

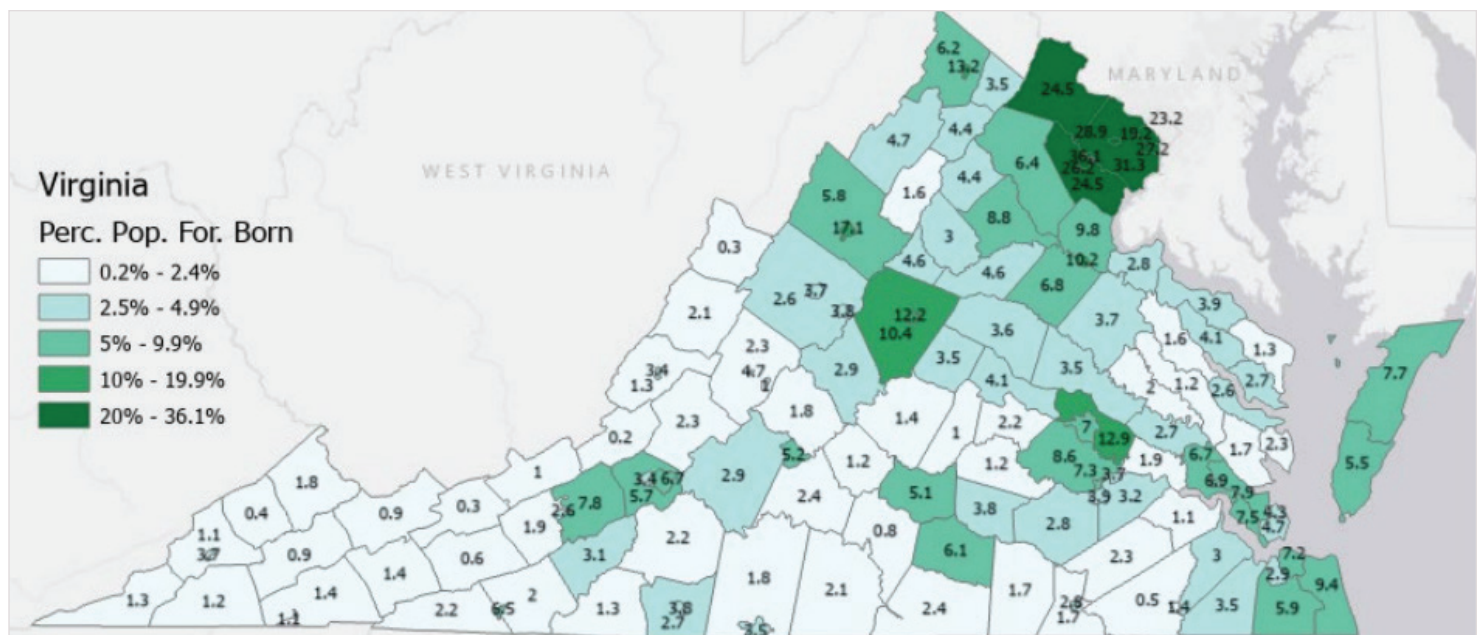


Figure 8 Barriers to Integration⁹



Race and ethnicity

The population of the service area* has a higher percentage of White (84.5%) residents than other races and ethnicities.³ The service area is also home to a small Hispanic (9.1%) population.³

Cultural and linguistic needs

English is the primary language spoken in the service area.* As of the 2023 U.S. Census, 95.4% of the population in the service area identified as English-speaking. Non-English-speaking populations are disproportionately represented in low socioeconomic groups, have poorer health outcomes, are more likely to have a disability, are often linguistically and culturally isolated, and have lower educational attainment compared to their English-speaking counterparts. Language barriers make it difficult for this population to understand, interpret, and benefit from information about their health.

Population with limited English proficiency, 2019-2023

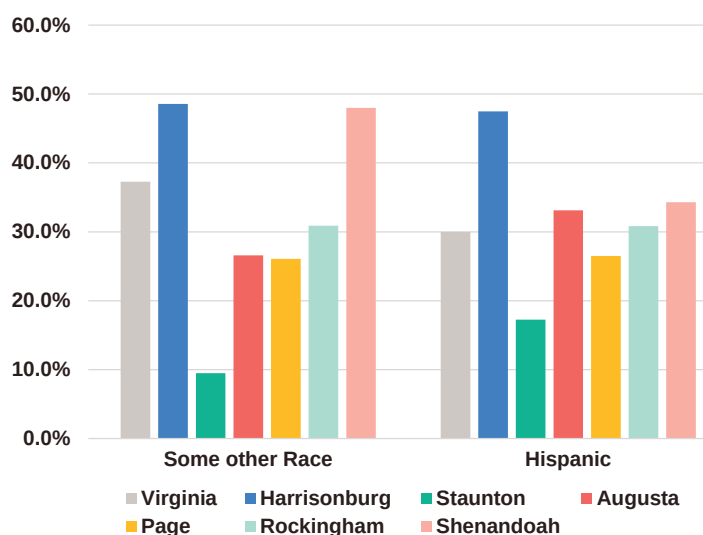


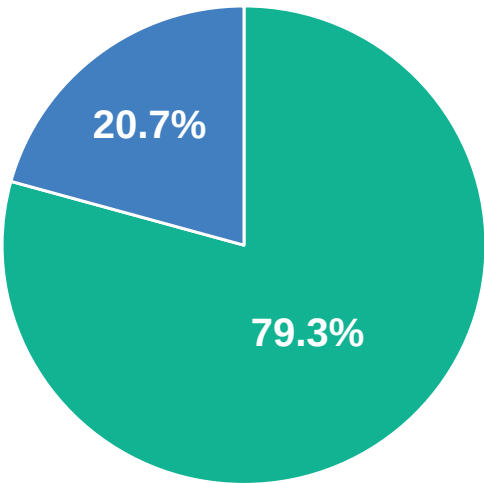
Figure 9 Source: U.S. Census Bureau

*Service area totals exclude Pendleton County, WV, due to differences in and access to state databases.



Sentara is committed to ensuring that all communication with our patients and health plan members is in their preferred language. Sentara provides its patients and their families with qualified interpreters for a variety of languages, including American Sign Language (ASL). In 2024, SRMH had 38,839 requests for interpreter services. The highest percentage of interpreter services (79.3%) was for Spanish-speaking individuals, with the second highest percentage being Russian (3.5%), Arabic (3.1%), and Swahili (1.9%).

Language utilization, 2024



Spanish Russian, Arabic, Swahili, other

Figure 10 Source: SRMH Language Line Usage Report

Social determinants of health

Meaningful improvements in health outcomes require strategies reaching beyond clinical settings to address the root causes of health inequities.

Sentara works to:

- Meet the unprecedented need for behavioral health practitioners and ensure greater access to 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 care and human services in traditionally underserved populations.

Social determinants of health



Figure 11 Source: U.S. Department of Health and Human Services. Healthy People 2030.

To understand the population better, SRMH looked at socioeconomic status, including poverty rates, educational attainment, employment, unemployment, and insurance.

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.

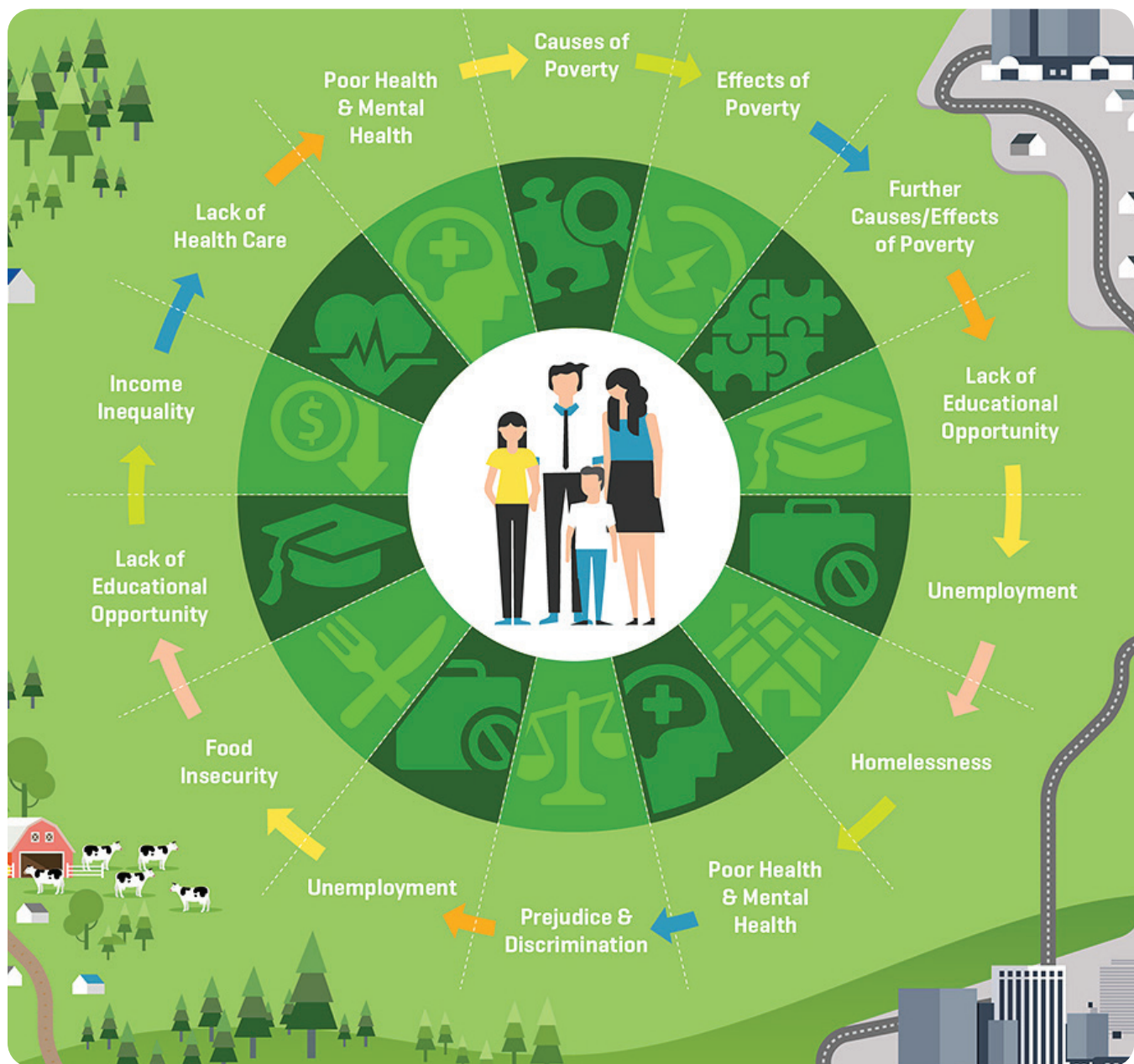


Figure 12 Source: Aurora University

Poverty

An examination of poverty rates and racial demographics underscores the racial disparities that impact economic and health outcomes for residents and their families. Black and Hispanic residents in the service area are more likely to live in poverty compared to White residents. At 12.0%, the service area* has a higher percentage of residents living in poverty compared to the Commonwealth of Virginia (10.2%).³

Education

Education is the basis for stable employment and financial stability, which in turn supports access to quality health care and positive health outcomes. The service area* has a lower percentage of residents (88.0%) who are high school graduates than the statewide percentage (91.3%). The service area also has a lower percentage of college graduates (27.0%) compared to the state overall (41.5%).³

Employment

Per the 2023 U.S. Census, the service area has a slightly lower percentage of unemployed residents (2.0%) compared to Virginia overall (2.7%). The labor force represents 50.8% of total residents. Within the labor force, 58.0% of female residents in the service area are employed, lower than the state (61.0%).³

Medicaid and FAMIS, Medicare, Medicare and Medicaid

Public health insurance programs play an important role in providing coverage for individuals who qualify based on income, age, or disability. According to the 2023 U.S. Census, 9.2% of residents living in the service area do not have health insurance. A total of 1,994,822 Virginians had health coverage through Medicaid and Family Access to Medical Insurance Security (FAMIS) as of February 11, 2025. This included 70,883 residents living in the service area* served by SRMH.⁷ Medicaid and FAMIS members

Estimated poverty status by race, 2023

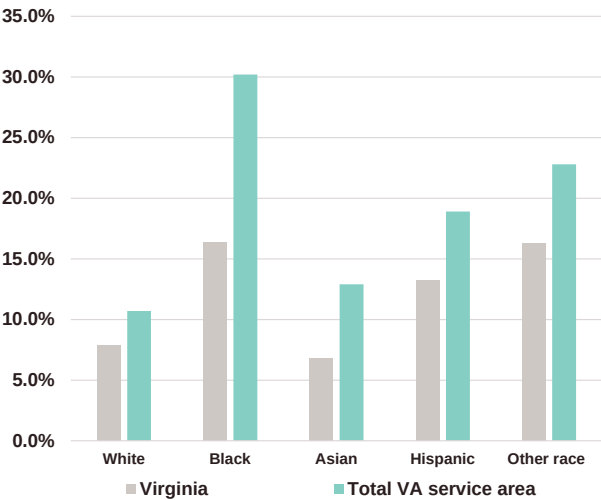


Figure 13 Source: U.S. Census Bureau

Education attainment, age 25+, 2019-2023

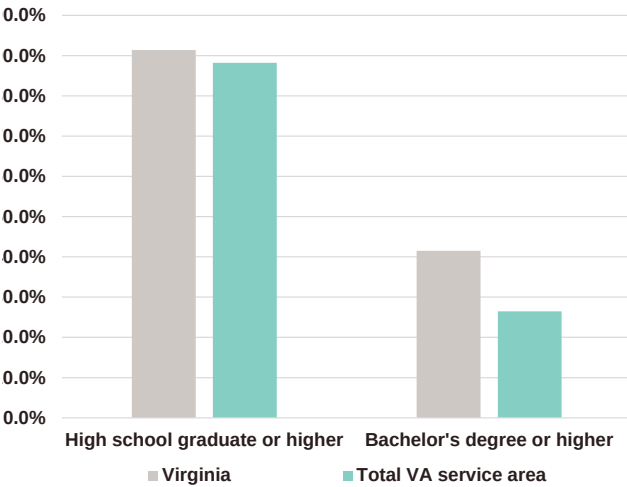


Figure 14 Source: U.S. Census Bureau

Civilian labor force, 2023

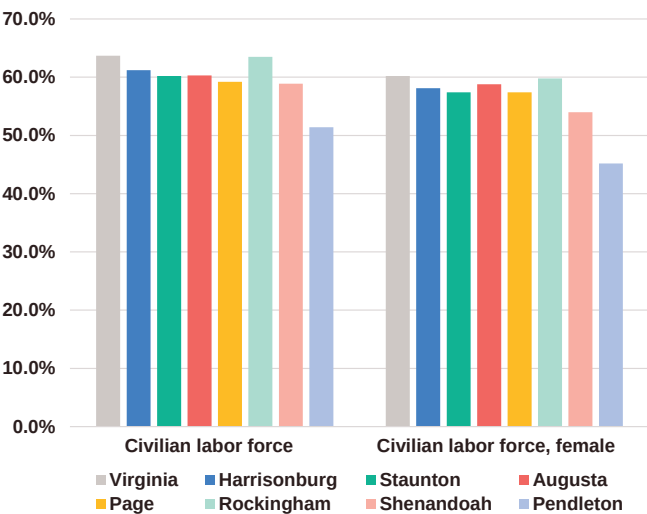


Figure 15 Source: U.S. Census Bureau

*Service area totals exclude Pendleton County, WV, due to differences in and access to state databases.

represent 22.8% of the total population in the service area, similar to the 22.9% of all Virginians who have Medicaid or FAMIS health coverage.⁶ Community health workers and enrollment specialists are available to provide guidance and assistance for qualifying individuals and families with enrollment in these government programs.

Population with insurance by provider type, 2022

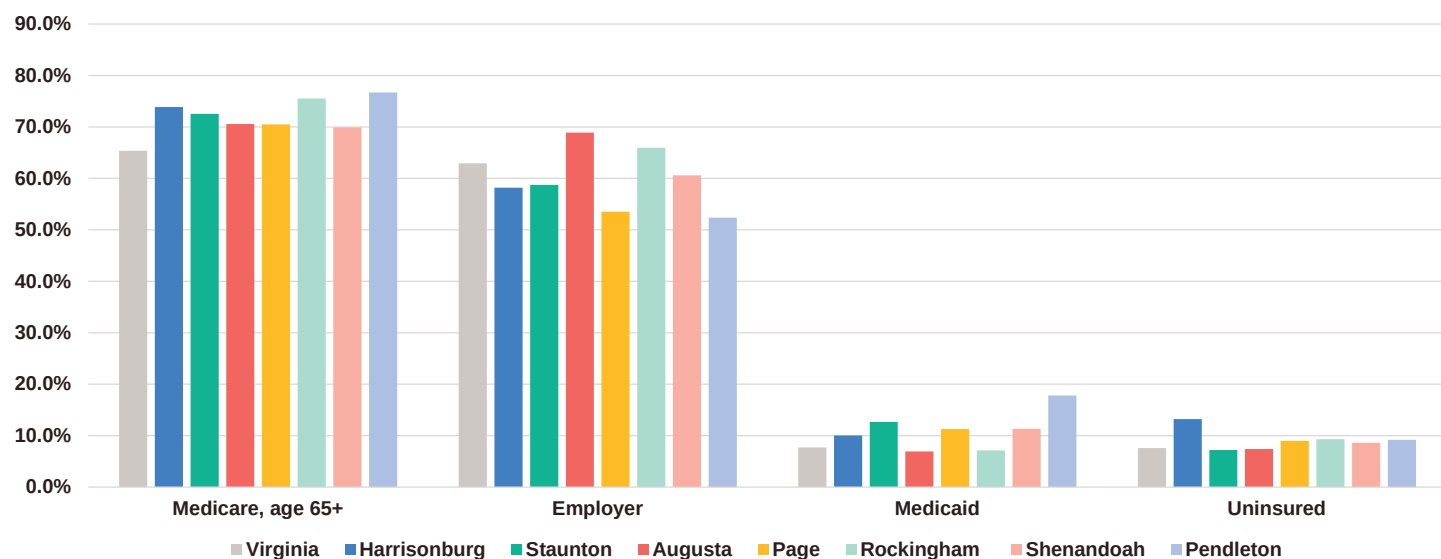


Figure 16 Source: Centers for Medicare & Medicaid Services data⁷

Endnotes

¹ United States Census Bureau. American Community Survey 5-Year Estimates, 2019-2023. Demographic and Housing Estimates. Accessed March 2, 2025. https://data.census.gov/table?q=United%20States&t=Age%20and%20Sex&g=040XX00US51_050XX00US51550,51710,51740,51800,51810.

² Weldon Cooper Center for Public Service. Virginia Population Projections. Accessed October 10, 2024. <https://www.coopercenter.org/virginia-population-projections#map-01>.

³ United States Census Bureau. QuickFacts. www.census.gov. Accessed March 3, 2025. <https://www.census.gov/quickfacts/fact/table/VA,chesapeakecityvirginia,norfolkcityvirginia,portsmouthcityvirginia,suffolkcityvirginia,virginiabeachcityvirginia/HSG445222#HSG445222>.

⁴ U.S. Department of Health and Human Services. Healthy People 2030. Accessed May 2, 2023. <https://health.gov/healthypeople/priorityareas/social-determinants-health>.

⁵ Aurora University. Social Work and Poverty: Rural vs. Urban Poverty. Access May 2, 2023. <https://online.aurora.edu/infographics/rural-poverty-vs-urban-poverty/>.

⁶ Department of Medical Assistance Services (DMAS) Data. Accessed February 10, 2025. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>.

⁷ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 10, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

⁸ Harrisonburg City Public Schools. HCPS Student Birth County and Home Language 2024. Fall 2024. Accessed November 27, 2024. <https://www.harrisonburg.k12.va.us/files/user/1/file/HCPS-Student-Birth-Country-Home-Language-2024.pdf>.

⁹ Barriers to Integration of Virginia's Immigrants. VCU. July 2022. Accessed January 9, 2025. https://www.dss.virginia.gov/files/division/cvs/ona/immigrant_services/2022-vcu_ona-study/ONA-Barriers_to_Integration_final_report_Sept_2022.pdf.

Community input

Having an active, supportive, and engaged community is essential to creating conditions that lead to improved health. The community insight component of this CHNA consisted of two methodologies: community surveys and a series of more in-depth focus groups.

Description

We gathered input from a wide range of community members through focus groups and surveys. This included individuals with direct knowledge of local health needs, such as representatives from health departments, schools, non-profits, and public and private organizations. We also heard from community leaders, service users, and individuals from underserved groups, including low-income populations, people in rural areas, racial/ethnic minorities, and those facing homelessness or other barriers.

Methodology

To include a wide range of perspectives and ensure broad representation across the community, several methods were used to identify groups and collect qualitative data for the CHNA.

Working with the Central Shenandoah Health District and CWS Harrisonburg, our team reviewed prior assessments in the same community to engage individuals and organizations who had previously participated. Importantly, the inclusion of service providers and community members (through surveys and focus groups) allowed us to identify health needs from the perspectives of diverse populations.

Community survey

Sentara RMH, the Central Shenandoah Health District, and CWS Harrisonburg worked together to develop a community survey, using surveys and best practices from other CHNA collaboratives across the Commonwealth. The survey was shared with a wide range of stakeholders, including those in public health, education, social services, business, local government, and civic organizations.

Our team worked with key community groups and organizations to distribute the survey, including a notable partnership with the Promotores de Salud, who went door-to-door in several neighborhoods to help residents complete surveys. We also identified community events where our teams could distribute paper surveys or digital codes to attendees. Electronic surveys in English and Spanish, and paper surveys in English, Spanish, Russian, and Arabic, were available to the public from September through November 2024. By the end of the survey period, we received 532 survey responses from the SRMH community.

After the initial survey period, the collaborative recognized that the majority of respondents were White. Most cities did not have an equally distributed response to surveys to represent the entire population. As a result, survey responses should be considered as only one component of information utilized to select health priorities. Feedback from the most underserved populations is not adequately reflected in most of the surveys. For the full list of questions and responses, see Appendix C.

Demographics of survey respondents

To encourage more responses to the health-related questions, we placed demographic questions at the end of the survey. As a result, many respondents skipped these questions. Out of the 532 completed surveys, 219 were paper surveys, with the majority in Spanish. While entering data from paper surveys took extra time, it was well worth the effort to receive valuable responses from residents whose preferred language is Spanish.



Survey responses

For the 2025 CHNA, we asked community members about their top health concerns, barriers to accessing services and resources, and social issues affecting health. Survey respondents were asked to review a list of common community health issues and select all that applied to their community. The tables below show the top three answers for the questions among community member respondents.

Top three most important health concerns in your community.

Rank	Youth	Adults
1	Mental health and stress	Mental health and stress
2	Dental and oral health	Chronic conditions: High blood pressure, obesity, and diabetes
3	Asthma and allergies	Dental and oral health

Top three barriers to accessing health care resources and services in your community.

Rank	All
1	Out-of-pocket costs
2	Could not get an appointment/wait for an appointment was too long
3	Insurance challenges: Did not cover what was needed, provider did not accept, or no health insurance

Top three social concerns impacting health in your community.

Rank	All
1	Access to affordable housing
2	Aging problems (e.g., arthritis, hearing/vision loss, etc.)
3	Affordable utilities

Community focus groups

In partnership with the Central Shenandoah Health District and CWS Harrisonburg, we conducted a series of in-depth community focus groups to gather valuable insights from a diverse range of stakeholders and community members. These focus groups were promoted through community partners or held during scheduled meetings of community groups. We made a concerted effort to include voices from underserved populations and those using services

in the community. Between November 2024 and March 2025, we held 10 focus group sessions, with participation ranging from four to 21 individuals, for a total of 103 participants. Refer to Appendix C for notes on these focus groups.

Demographics

The 103 focus group participants ranged in age from 20 to 65 and older. Altogether, participants were 61% White, 11% Middle Eastern, 6% Black, and 20% Hispanic.

Results

Topic	Key findings	
What are the most serious health problems in your community for children (0-17) and for adults (18+)? Who is most affected?	Greatest needs in the community (health and wellness)	
	1. Mental and behavioral health 2. Dental health 3. Nutrition (as it relates to childhood obesity)	1. Mental health 2. Chronic diseases and conditions 3. Dental health
What are some of the environmental and social conditions that affect quality of life for children and adults living in your community?	Key causes identified	
	1. Screen time and social media as it relates to mental health and sociability 2. Lack of support systems and community programming 3. Lack of parental education on topics like nutrition and pediatric mental health	1. Lack of transportation 2. Difficulty with interpretation services 3. Financial burden: Having to make choices on what care is received due to limited income
What do you think about the health-related services that are available in your community, including medical care, dental care, and mental health care for children and adults?	Key gaps identified	
	1. Lack of pediatric specialties 2. Lack of pediatric dentists 3. Lack of pediatric mental and behavioral health providers	1. Challenges with obtaining timely appointments 2. Quality of care: Short appointments that don't address all problems, provider turnover and lack of relationship building, lack of providers in general, lack of same day appointment options, difficulties with contacting providers (un-returned messages), challenges with phone trees and interpreter services, wait times for specialists, etc. 3. Lack of providers who accept Medicaid (insurance challenges in general)

Results (cont.)

Topic	Key findings
What is working in your community that can help residents live healthier lives?	Key community services identified for both adults and children 1. City services: Parks and recreation, police outreach, Rockingham Fire and Rescue 2. Social services: Community Services Board, VPAS/VIA 3. Low-barrier health care programs: Sentara Mobile Care, Suitcase Clinic, Bluebridge Free Clinic, HCHC, Community Paramedics Program 4. Community programs: Strength In Peers, Open Doors, food banks, Sentara's FREE program
	Broader community health solutions (how to build a healthier community) 1. Increased collaboration and communication for existing programs, including: ▪ Provider knowledge on existing programs that may help their patients ▪ Working together with other health care systems to provide more diverse care 2. Increased low-barrier or free health care options 3. A focus on patient-centered care: Decreasing provider turnover, increasing length of time with patient, increasing availability of appointments, improving interpretation services, increasing the number of providers, and listening to patient and caregiver concerns 4. More free educational opportunities to address health and wellness
	Challenges and opportunities ▪ Sentara RMH's service area is very diverse, and it is important to keep cultural differences in mind. It is not abnormal for residents originating from other countries to utilize the emergency department for common illnesses, as they may not have a primary care option. While health literacy challenges were identified in multiple focus groups, they are more likely to occur within this population as they may not understand the differences in care here. ▪ The challenges identified varied greatly depending on whether participants lived within the city versus the county. For example, those living in Harrisonburg reported no challenges with accessing food, whereas those living in the county reported more struggles with accessing food pantries.

Health status and prioritization

Health indicators

To gain a deeper understanding of our community, we looked at the 2024 County Health Rankings data to view length of life, quality of life, health behaviors, clinical care, social and economic factors, and physical environment. Per the County Health Rankings, “many of the leading causes of death and disease are attributed to unhealthy behaviors.” Below are key health status indicators for the counties representing this community.

Access to health services

Access to quality and affordable health care is important to an individual's health. Health insurance and local care resources can help 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 more primary care providers have lower rates of hospitalizations for preventable health issues.

The service area has fewer doctors to community members compared to the state (1341:1), with the following locality ratios: Staunton (2138:1), Augusta (1838:1), Page (3968:1), Rockingham (4019:1), and Shenandoah (2983:1). Though, Harrisonburg has better access (745:1) compared to the state. Increasing access to primary care is a key solution to reducing unnecessary and costly hospital stays and improving the health of the community. It is important to note

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

- Access to health services
- Life expectancy
- Diabetes
- Behavioral health
- Substance use
- Community violence
- Cancer
- Leading causes of death
- Women and infant health
- Older and aging adults

Preventable hospital stays by race/ethnicity, 2021

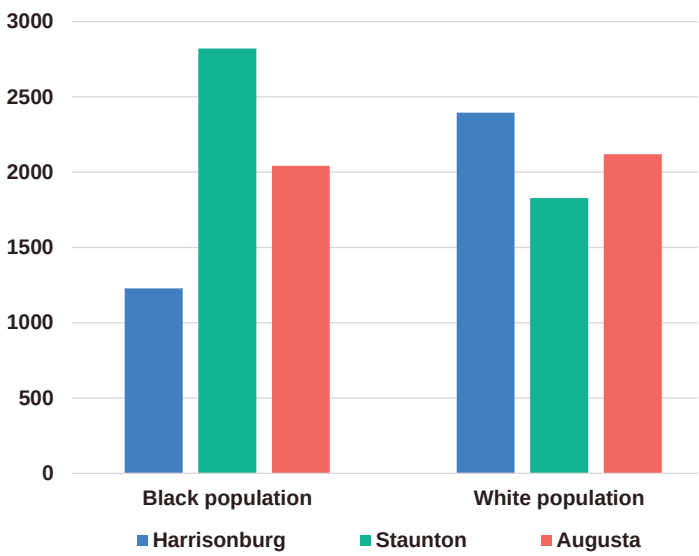


Figure 1 Source: County Health Rankings

that Black populations living in Virginia, particularly in Staunton, have higher rates of preventable hospital stays compared to White residents.¹

Life expectancy

Per the Virginia Department of Health, the life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. At 78.6 years, residents in this community have a lower life expectancy than Virginians overall. It is important to note that there is a racial disparity related to life expectancy specific to Black populations. Per the 2024 County Health Rankings, the life expectancy for Black individuals is up to six years shorter than White individuals in this service area.

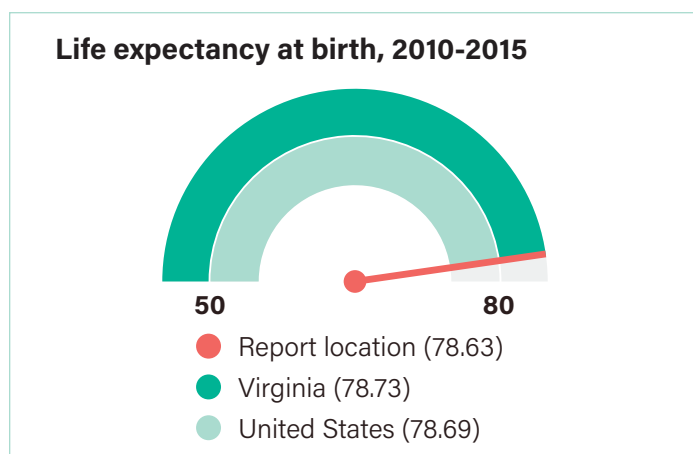


Figure 2 Sources: Virginia's Plan for Well-Being, Virginia Community Health

Leading causes of death

The Virginia Department of Health examined leading causes of death in localities of this community. Between 2021 and 2023, heart disease, cancer, stroke, accidents, and COVID-19 were the top five causes of death in this community.²

Medicare primary chronic conditions, 2023

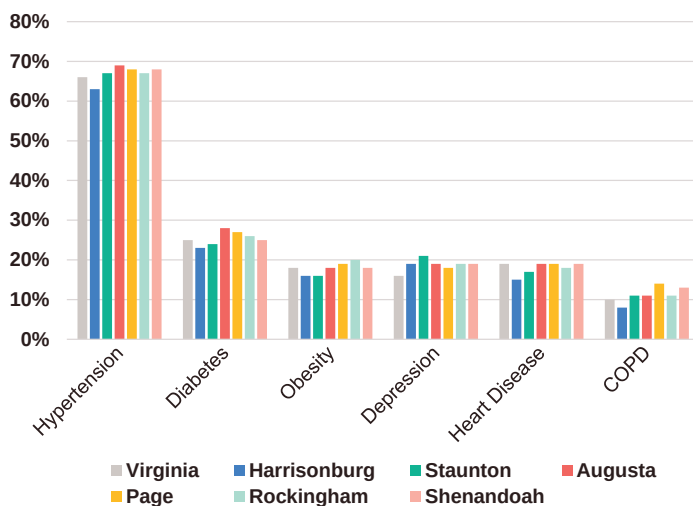


Figure 3 Source: Centers for Medicare & Medicaid

Chronic disease death rate, per 100,000

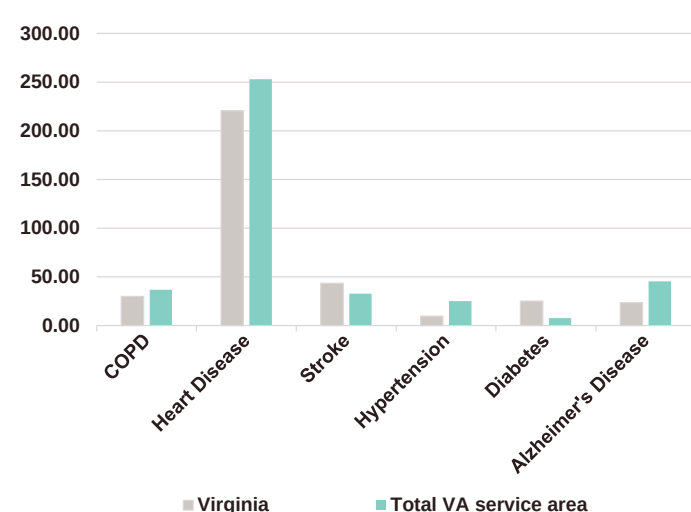


Figure 4 Source: Virginia Department of Health

Behavioral health, mental health, and substance use

Hospitalization rates due to substance use, drug overdose, mental health, suicide, and self-inflicted injury were examined. In the service area, there were higher hospitalization rates (per 100,000 population) due to drug overdose compared to Virginia rates.² This community also has a higher rate of alcohol-impaired driving deaths, liver disease, and cirrhosis compared to Virginia overall.

Mental health has been consistently identified as a top concern for both adolescents and adults. Sentara RMH examined emergency department visits for 2024 to gain a better understanding of the mental health crisis communities have been facing since the COVID-19

Substance use and mental health, age 18+

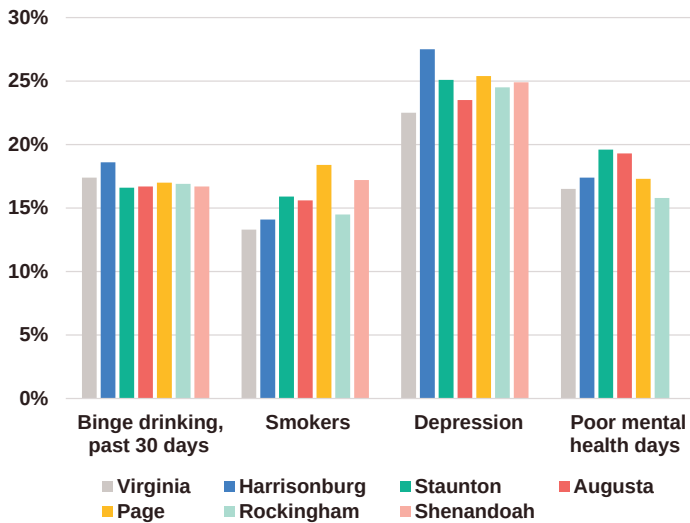


Figure 6 Source: Virginia’s Plan for Well-Being

pandemic. In 2024, the SRMH emergency department treated 1,962 adults (age 19+) with behavioral diagnoses. Of these visits, 19.52% of the patients presented with suicidal ideation, 5.20% with bipolar disorder, 3.72% with anxiety disorder, and 3.98% with generalized anxiety disorder. Additionally, SRMH saw 125 youth (age 0-18) present with a behavioral

Hospitalization rate, per 100,000, 2020

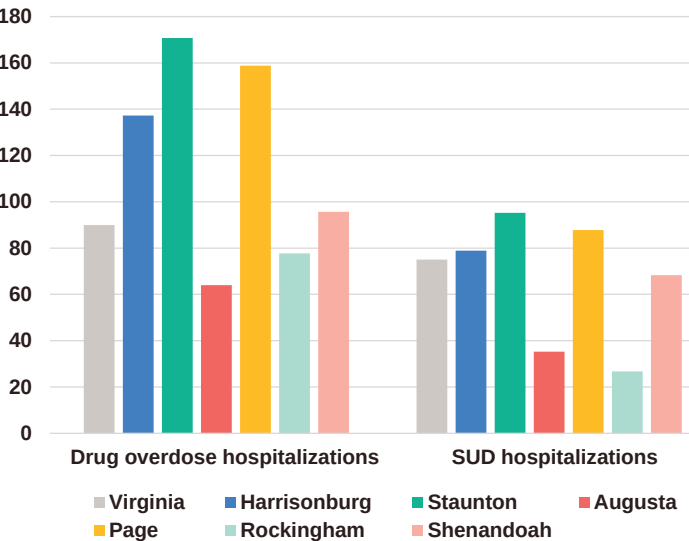


Figure 5 Source: Virginia’s Plan for Well-Being

Diagnosed depression among adults, 2022

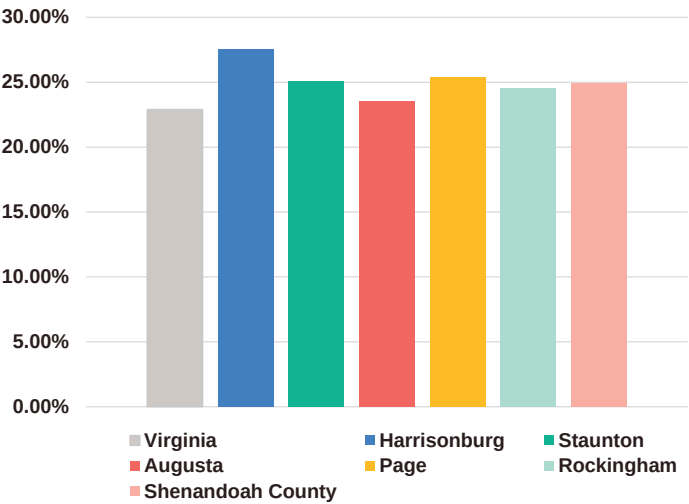


Figure 7 Source: Virginia’s Plan for Well-Being

health diagnosis. Of these visits, 35.20% presented with suicidal ideation and 2.40% with generalized anxiety disorder. It is important to note that the mental health workforce is nearing retirement age, which will negatively impact provider capacity. There is also a need for greater racial and ethnic representation in the mental health workforce.³

Cancer

Since cancer is a leading cause of death in this community, death and incidence rates for a variety of cancer types were examined. Compared to the previous three-year rates, 2017-2021, the number of cases and deaths from the most common types of cancer are decreasing in the Commonwealth of Virginia, as well as in this community.⁶ It is important to note that the incidence rate of breast cancer is rising for the White and Asian populations living in Virginia. Mortality rates were highest among lung and breast cancers, though declining in this community. Prostate and lung cancers are the leading causes of cancer death for Black populations living in Virginia. Staunton had the greatest incidence rates for all cancers (487.8 per 100,000 population).⁴ Medical advancements and community outreach programs providing cancer screenings and education are making strides but, to have the greatest impact, we will need to focus efforts on the populations at highest risk for various cancers.

Virginia cancer incidence rate, race/ethnicity

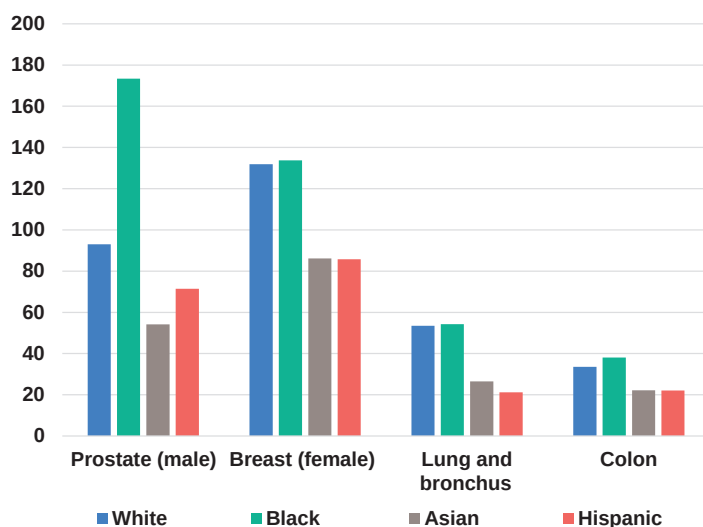


Figure 8 Source: Virginia's Plan for Well-Being

All sites cancer mortality rate, by sex, 2017-2021

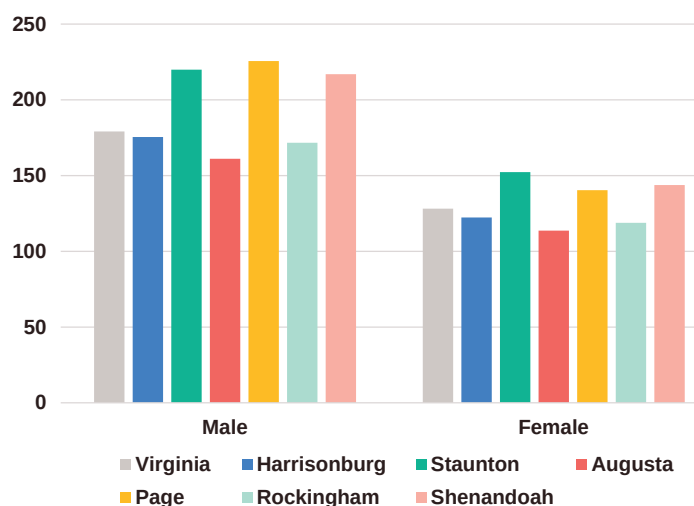


Figure 9 Source: Virginia Department of Health. Incidence rate per 100,000

All sites cancer incidence rate, 2017-2021

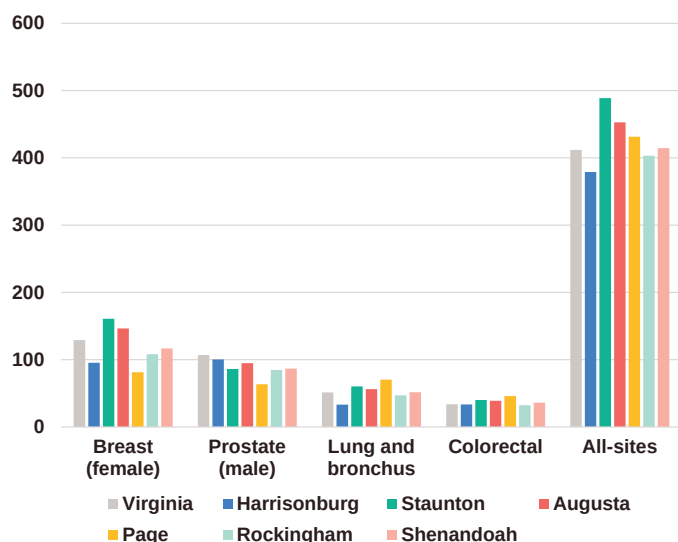


Figure 10 Source: Virginia Department of Health. Incidence rate per 100,000

Virginia cancer early stage detection rate, 2017-2021

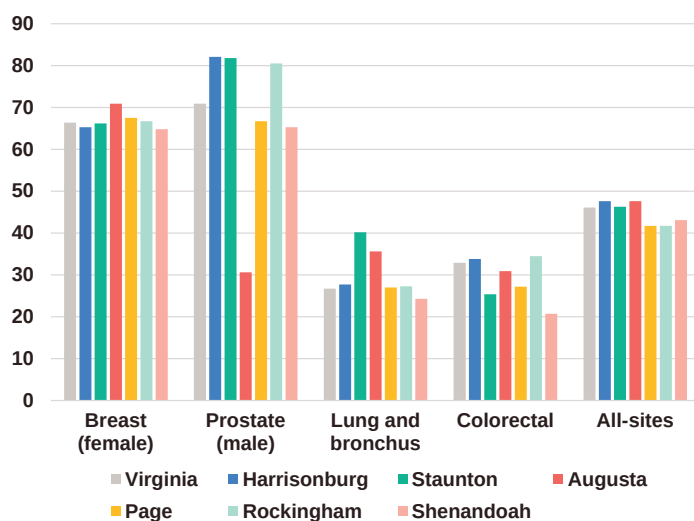


Figure 11 Virginia Department of Health. Incidence rate per 100,000

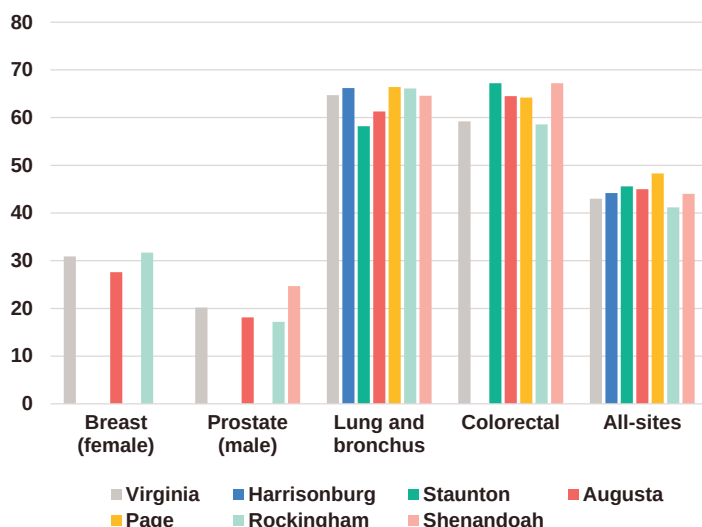
Virginia cancer late stage detection rate, 2017-2021

Figure 12 Source: Virginia Department of Health. Incidence rate per 100,000

Diabetes

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the U.S. and is the seventh leading cause of death in the United States. Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity are also key risk factors. The percentage of adults living with diabetes in this community is higher than the state percentage of 10%. The SRMH service area* hospitalization rate, 2,470.49 (per 100,000), for diabetes was above the state rate of 2,114.24.²

Women's health

Prioritizing women's health through early intervention and continuous care is essential for fostering healthier communities. In the SRMH service region, the rate of mothers with late or no access to prenatal care is higher compared to other localities in Virginia. This can lead to higher rates of preterm births and/or low birthweight infants. Late access to prenatal care can also indicate challenges with access to healthcare services and preventive care in general in the community. Mortality rates for breast cancer

in several localities in the service region are higher than average for Virginia, so it is important to continue working to increase access to screenings.

Older and aging adults

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 percentage of Medicare recipients being seen for hypertension and diabetes, the top conditions for which patients received hospital treatment in this community, was higher in this service area than in the state overall. The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia in this community (7%)⁷ is slightly higher than Virginia overall (6%).⁷ These conditions are important to note, as they will impact the aging population's health, quality of life, health care demand, and costs.

Sentara RMH is also working with the community to complete advance care plans. These plans are designed for adults to specify their medical wishes and/or designate someone as their medical decision-maker in the event they cannot communicate or advocate for themselves. While many team members working within the health care industry understand the importance

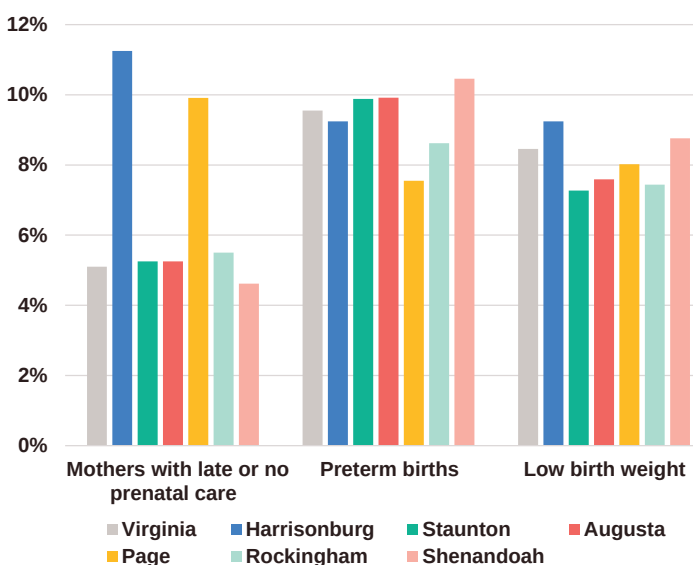
Maternal and infant health, 2020-2022

Figure 13 Source: Virginia's Plan for Well-Being

*Service area totals exclude Pendleton County, WV, due to differences in and access to state databases.

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 Virginia, there are approximately 48,271 active registrants with advance care plans filed within the U.S. Advance Care Planning Registry (formerly U.S. Living Will Registry).⁸

SRMH prioritization

The Forces of Change Assessment (FOCA) focuses on identifying all driving factors that can affect the public health system in a community. The assessment folds into the Mobilizing for Action through Planning and Partnerships model of community health improvement and was used to inform our new CHNA improvement strategy. Extensive secondary quantitative data from publicly available data, as well as primary qualitative data collected from surveys and focus groups, were synthesized and analyzed to identify the community health needs.

Conclusion

The findings in this CHNA highlight a community facing a number of health challenges, as reflected in the health data, focus groups, and survey responses. These challenges are shared in many communities across the country. Addressing them will require more than just the efforts of SRMH – it will take strong, ongoing partnerships with community organizations, health care providers, and community members to create lasting impact. We are committed to finding innovative, responsive, and effective strategies that will help overcome these challenges and advance our mission to improve health every day.

Recommendations

With the completion of the 2025 CHNA, SRMH has developed goals aimed at addressing the community’s key health concerns and social needs. By combining the expertise and resources of our community partners with our own, we will work together to identify effective solutions and set clear, actionable objectives for our implementation strategy. For 2026-2028, SRMH will focus on the following:



Improve mental well-being



Improve chronic conditions and avoidable health outcomes



Address and invest in social determinants of health

Endnotes

¹County Health Rankings & Roadmaps: Rankings Data & Documentation. Accessed October 10, 2024. <https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>.

²Virginia’s Plan for Well-Being Community Health Improvement Data Portal. Accessed October 10, 2024. <https://virginiawellbeing.com/virginiacommunity-health-improvement-data-portal>.

³Virginia 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. <https://pubmed.ncbi.nlm.nih.gov/35224633/> on April 11, 2022.

⁴National Cancer Institute, State Cancer Profiles. Incidence Rates Table. Accessed November 25, 2024. <https://statecancerprofiles.cancer.gov/incidencerates/index.php>.

⁵National Cancer Institute, State Cancer Profiles. Death Rates Table. Accessed November 25, 2024. <https://statecancerprofiles.cancer.gov/deathrates/index.php>.

⁶Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed November 12, 2024. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

⁷The U.S. Will Registry. Accessed March 5, 2025. <https://www.theuswillregistry.org/>.

Supplemental resources

2023-2025 Implementation strategy progress summary

The previous CHNA identified key health issues in the SRMH service area. In response, SRMH created a progress report to track efforts to address the priorities outlined in the 2022 assessment, using both community feedback and quantitative data. This section highlights those activities and partnerships. We continue to monitor and evaluate the impact of our strategies to improve community health. Below is a list of the 2022 health priorities that SRMH focused on in the implementation strategy, adopted in 2023.

- Behavioral health
- Chronic diseases
- Social determinants of health

During the 2023-2025 implementation strategy period, SRMH prioritized launching high-impact projects aimed at improving access to critical services across our community. Thanks to the generous support of the RMH Foundation and fueled by the community's charitable giving, we were able to launch some transformative initiatives focused on expanding access to health care, enhancing behavioral health services, and addressing urgent needs such as housing and wrap-around support services.

Behavioral health

Improving mental and emotional well-being by expanding access to behavioral health services is a top priority for SRMH. With one in five adults experiencing a mental illness serious enough to need treatment – and many more struggling with emotional health – SRMH is committed to meeting these needs.

Sentara RMH offers a full range of behavioral health services, including inpatient, outpatient, and emergency services. Inpatient programs support adults in crisis due to mental illness or emotional distress. Outpatient programs include a partial hospitalization program, intensive outpatient program, recovery support, and counseling. We work closely with the Harrisonburg-Rockingham Community Services Board and local law enforcement to support patients in crisis. Together, we operate the Crisis Intervention Team Assessment Center in the SRMH emergency department, helping to de-escalate situations and connect individuals with care. Sentara RMH will continue to partner with community mental health programs to identify alternate placement options for behavioral health patients.

As part of the new Rocktown Health collaborative care hub, SRMH is expanding access to substance use and addiction treatment. We have partnered with the Masters Center for Addiction Treatment to provide medication-assisted treatment and individual and group counseling services. Strength in Peers is another critical Rocktown Health partner, providing peer support and case management for those seeking recovery. Together, these wrap-around services aim to care for the whole person and improve long-term outcomes.

To increase community awareness and reduce stigma, Sentara partnered with the Virginia Stage Company to support an inspirational play about mental health.

"Every Brilliant Thing" is an intimate, interactive performance which continues to be brought to communities throughout Virginia and North Carolina.

Chronic diseases

Sentara RMH is working to reduce the impact of chronic diseases on morbidity and mortality for the community living in the service area by increasing disease management support, resources, and education. We extend our reach into the community, where life happens. As we seek to improve transitions of care from our hospital to community settings, several teams play important roles in helping patients to manage their chronic conditions and access the community resources they need.

The SRMH Hahn Cancer Center remains committed to delivering high quality cancer care close to home. The team offers educational programs, support groups, yoga, and nutrition education, while also leading outreach efforts to promote cancer screening and early detection. We have organized community events that

offer free screenings for a range of cancers, including oral, head and neck cancers, colorectal cancer, breast cancer, skin cancer, and prostate cancer.

To better serve uninsured and underinsured women, SRMH has expanded access to breast cancer screenings through a multifaceted approach. Our mobile mammography van partners with employers, local businesses, churches, and community organizations to deliver more than 2,000 mammograms at over 50 locations across our rural service region each year – bringing care directly to women where they live and work. Through the support of the RMH Foundation, we provide free screening mammograms to those who face financial barriers. Sentara RMH also participates in Every Woman's Life, a program which further increases access to breast and cervical cancer screenings for uninsured women in Virginia.

Through the generous support of local donors, the RMH Foundation launched the Supportive Care Clinic in 2024 to make a greater impact on the lives of those affected by cancer. This integrative approach provides

“The Community Health Needs Assessment is not just a report – it’s a roadmap. It helps us understand where the greatest needs lie and how we can partner more effectively to address them. Listening to our community ensures that the care we provide is not only high quality, but also equitable, accessible, and responsive to what matters most.”

Katie Robinson, MPH
Community Health Manager, Sentara Health



“No single organization can solve the complex health challenges our community faces – but Sentara RMH plays a vital role in leading the way. That’s why we’re deeply committed to advancing our Community Health Improvement Plan – developed in partnership with local leaders and service providers. This plans provides a clear, collaborative roadmap to focus our efforts where they matter most and help us deliver on our mission to improve health every day.”

Doug Moyer
VP, Hospital President, Sentara Health



coordinated, holistic, team-based care that addresses the emotional, social, and practical needs of patients during their cancer journey.

Social determinants of health

In the SRMH service region, populations with the greatest health disparities include immigrants and refugees, older adults, low-income households, individuals experiencing homelessness, and residents of rural areas. A major factor contributing to these disparities is limited access to essential services. Barriers such as lack of health insurance, shortages of providers and services, lack of transportation, and other social determinants all play a critical role in preventing these populations from receiving the care they need. Addressing these challenges is essential to advancing health equity across the region.

In 2024, the RMH Foundation and Strength in Peers opened a respite home on the SRMH campus to support homeless patients after hospital discharge. Staffed by Strength in Peers, the home offers peer support, counseling, home health care, and case management to help patients recover, stabilize their

health, and connect to housing, jobs, and ongoing medical and behavioral health care.

Through the RMH Foundation, SRMH supports the Suitcase Clinic that takes health care to local homeless shelters and coordinates care within the community’s safety net. We were also able to provide space for our community’s low barrier emergency shelter to provide 10 additional beds during inclement weather in 2023 and 2024. Sentara Cares provided support to the City of Harrisonburg and Open Doors as they opened the new Navigation Center in 2024, which provides emergency shelter and coordinated services to individuals experiencing homelessness. Sentara Cares also supported job training opportunities through the Harrisonburg Redevelopment and Housing Authority for residents of their housing programs.

To promote health care workforce development and increase economic growth and educational opportunities, SRMH continues to collaborate with local colleges and universities, including Blue Ridge Community College, James Madison University, Eastern Mennonite University, and Bridgewater College to provide residencies, internships, preceptorships,

and other experiential student learning opportunities for health care professionals and students. The RMH Foundation expanded the Institute for Nursing Excellence, which provides scholarships for SRMH employees seeking to increase their education.

Sentara hospitals have implemented the use of Unite Us, a cross-sector collaboration software establishing a new standard of care that identifies social needs in communities, manages enrollment of individuals in services, and leverages meaningful outcomes data and analytics to further drive community investment.

Grantmaking and community benefit

As part of the implementation strategy process, Sentara and its hospital facilities used a wide range of resources and strategies – like grants, in-kind support, and community partnerships – to support vulnerable populations.

Sentara recognizes our important role in strengthening the local economy and improving well-being in the communities we serve. We remain committed to investing in local organizations and projects that address key social factors affecting health, such as housing, food access, and employment. Our goal is to break down barriers to care and expand access to essential health and human services.

Sentara RMH continues to expand its partnership with the Foundation for Rehabilitative Equipment and Endowment (FREE) through Sentara Cares funding and operational support from SRMH. The foundation provides refurbished mobility-related rehabilitative equipment to low-income adults, helping 262 individuals with 358 pieces of equipment last year.

In 2023, Sentara invested more than \$294 million in the communities we serve — \$47 million in community giving, \$13 million in health and prevention programs, \$70 million in teaching and training of health care professionals, and \$164 million in uncompensated patient care. In 2024, Sentara invested more than \$329 million in the communities we serve — \$40 million in community giving, \$19 million in health and prevention programs, \$96 million in teaching and training of health care professionals, and \$174 million in uncompensated patient care.

Clearly, the definition of community health is broader than medical care. As we continue to understand the powerful role that social determinants play in overall health, new opportunities emerge to improve population health through community-based approaches. Creating lasting impact will require strong, active partnerships with local organizations and residents – collaborating beyond the walls of SRMH to address the root causes of health challenges and drive meaningful change.



Notes

[illegible]

Notes

[illegible]

Serving the cities of Harrisonburg and Staunton, and the counties of Augusta, Page, Rockingham, and Shenandoah

Sentara RMH Medical Center

2010 Health Campus Drive
Harrisonburg, VA 22801

sentara.com

