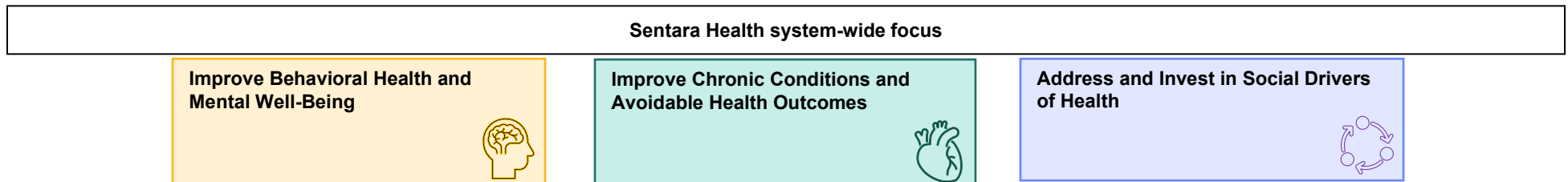
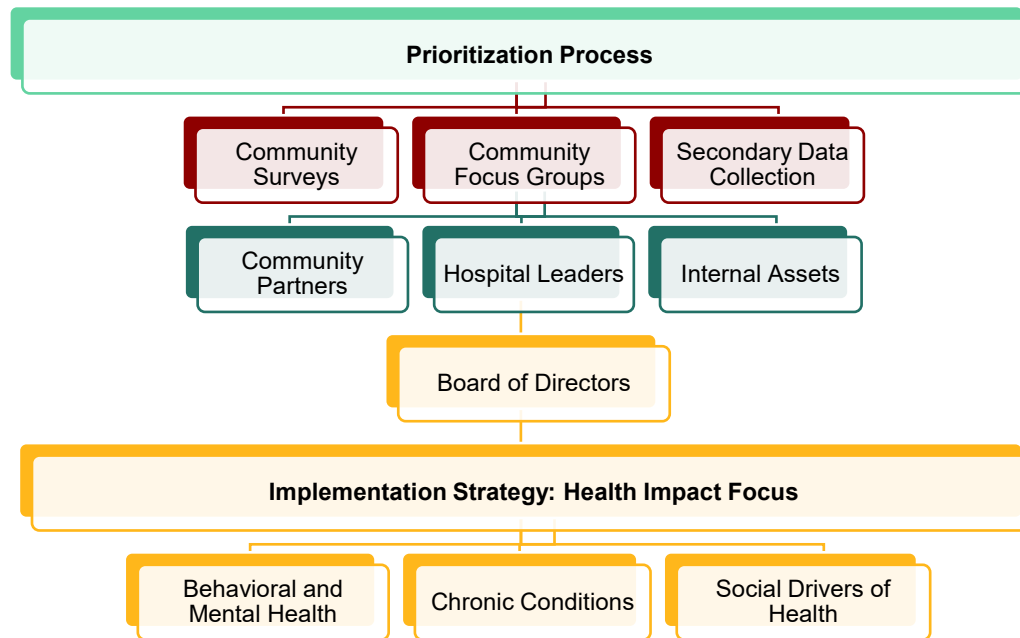


**Joint Community Health Needs Assessment Implementation Strategy for:
Sentara Rockingham Memorial Hospital
Adoption Date: October 14, 2025 | Start Date: January 1, 2026**

This implementation strategy identifies the actions that the hospital is undertaking to address the health problems identified in the community health needs assessment, consistent with the requirements described in section 501(r)(3) of the Internal Revenue Code per the Patient Protection and Affordable Care Act. The actions within this Implementation Strategy are guided by the hospital's mission and goals. The hospital reserves the right to amend this Implementation Strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the Community Health Needs Assessment process, Social Determinants of Health were determined to be a priority area. In this Community Health Implementation Plan, it will be referred to as Social Drivers of Health.



Implementation Plan	From CHNA Research: Survey results, collected data, focus groups.	
	Population at Risk	Community Assets and Potential Partners
Priority Area: Improve Behavioral Health and Mental Well-Being		
Goal: Increase access to behavioral health services for children and adults to ensure timely, effective support for those in need.	Youth, adults 19-44, low-income, minority populations	Master Center, HRCSB, Collins Center, Strength in Peers, Brightview, JMU/EMU graduate programs, CHW program, Promotores de Salud, BRFC behavioral health expansion, HCHC integrated model
Strategy: Strengthen coordination among service providers and make behavioral health services easier to navigate.		
Objectives: 1. Equip staff to connect individuals to appropriate behavioral health services using updated tools and referral pathways. 2. Assess community behavioral health services gaps and identify opportunities to expand treatment and recovery services.		
Priority Area: Improve Chronic Conditions and Avoidable Health Outcomes		
Goal: Reduce the impact of chronic conditions by improving early detection, care access, and long-term disease management to lower morbidity and mortality.	Children, adults, minority populations, low income populations	HCHC, CSHD, Suitcase Clinic, BRFC, SRMHMG, JMU
Strategy: Expand access to chronic disease prevention and management by enhancing education, improving resource availability, and promoting evidence-based care practices.		
Objectives: 1. Reduce barriers to care by leveraging both primary care settings and mobile health services to reach more individuals in the community. 2. Improve access to cancer care by expanding supportive services and promoting routine screening and early detection. 3. Increase access to chronic disease management education and availability of health education resources.		
Priority Area: Address and Invest in the Social Drivers of Health		
Goal: Advance strategic, collaborative efforts to address the social and economic factors that influence health outcomes.	Low-income, unhoused, individuals with mental health conditions, older adults, no/limited transportation, food insecure, low health literacy, language/communication needs	HCHC, CSHD, Suitcase Clinic, BRFC, HRHA, VPAS, Strength in Peers, BRAFB/local pantries, BRCC/MTC/local universities, FREE, CVHfH, HCC, Sentara Community Care
Strategy: Embed social drivers of health (SDOH) into hospital operations by building partnerships, improving staff awareness, and aligning workflows with community support systems.		
Objectives: 1. Improve how clinical teams identify and respond to patients' social needs through enhanced SDOH screening, referral tracking, and follow-up support. 2. Support strategic partnerships with community organizations to address health and social challenges of individuals and families.		