2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Staunton, Waynesboro & Augusta County, Virginia

Sponsored by

Augusta Health

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Prepared by
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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment — a follow-up to similar studies conducted in 2016, 2019 and 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Augusta Health. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Augusta Health by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

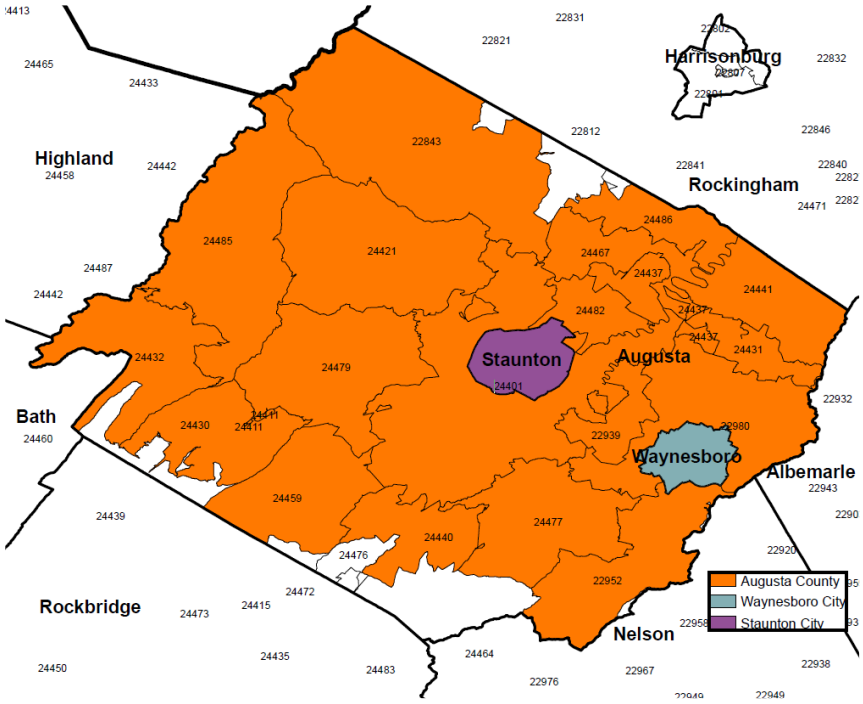
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Augusta Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Total Area" in this report) is defined as each of the residential ZIP Codes comprising Augusta County and the independent cities of Staunton and Waynesboro in Virginia. This community definition, determined based on the ZIP Codes of residence of recent patients of Augusta Health, is illustrated in the following map.



Sample Approach & Design

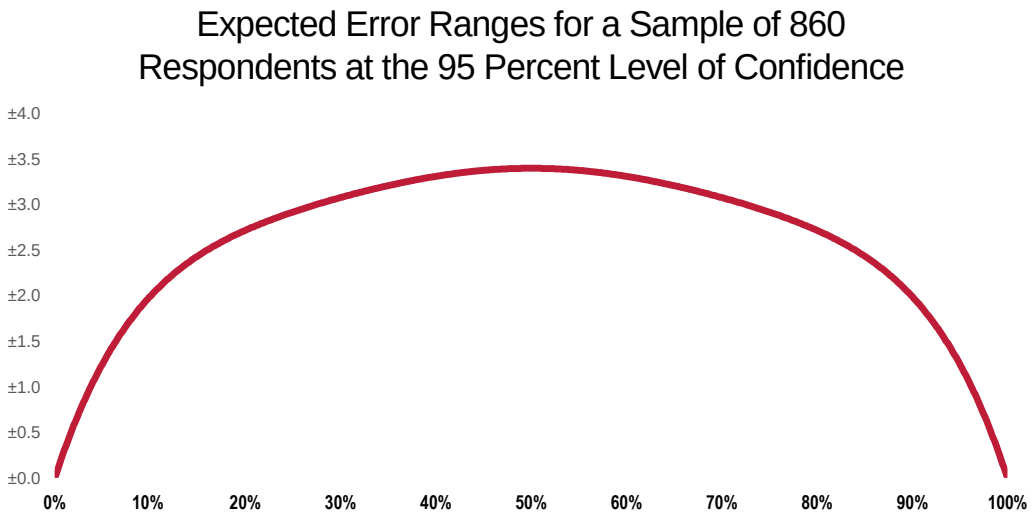
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (cell phone and landline) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 605 surveys throughout the study area.

COMMUNITY OUTREACH SURVEYS (Augusta Health) ► PRC also created a link to an online version of the survey, and Augusta Health promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 255 surveys to the overall sample.

In all, 860 surveys were completed through these mechanisms, including 227 in Staunton, 177 in Waynesboro, and 456 in Augusta County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 860 respondents is ±3.4% at the 95 percent confidence level.



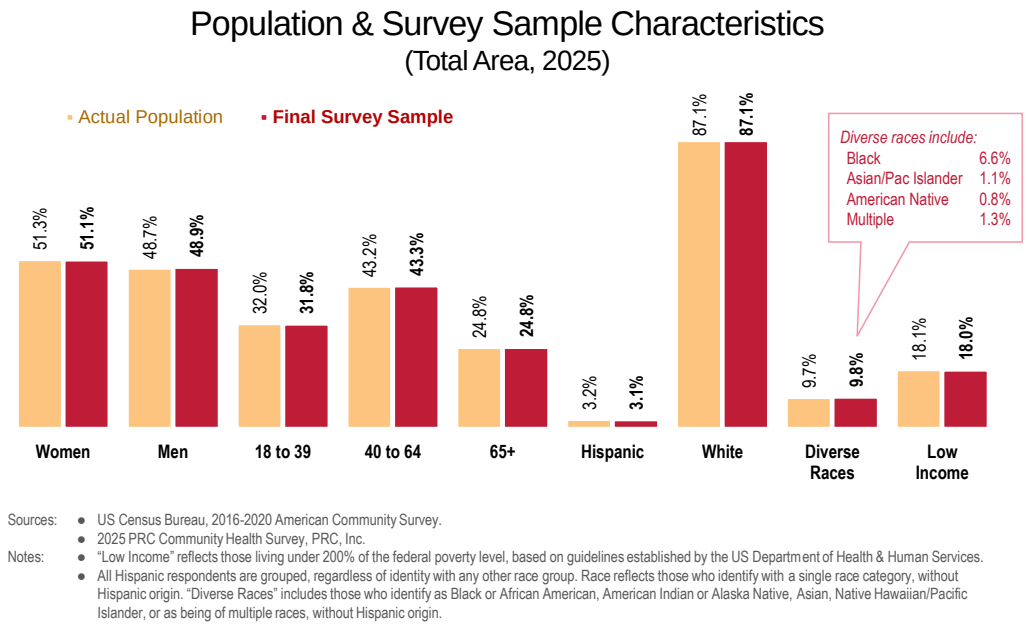
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 860 respondents answered a certain question with a "yes," it can be asserted that between 8.0% and 12.0% (10% ± 2.0%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.6% and 53.4% (50% ± 3.4%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses might contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics might have been slightly oversampled, might contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Total Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Augusta Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 141 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	13
Public Health Representatives	4
Other Health Providers	44
Social Services Providers	38
Other Community Leaders	42

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined on the following page.

- Allen Chapel
- Alliance for the Shenandoah Valley
- Amazon-Fishersville
- Augusta Care Partners
- Augusta County
- Augusta County Schools
- Augusta Health
- Augusta Health Boards and Committees
- Augusta Health Foundation
- Augusta Health Home Health
- Augusta Health Hospice
- Augusta Medical Group
- Augusta Regional Dental Clinic
- August Resources for Resilience, Opportunity and Wellness Project
- Blue Ridge Area Food Bank
- Blue Ridge Community College Educational Foundation
- Blue Ridge Court Appointed Special Advocate
- Boys & Girls Club
- Brain Injury Connections
- Central Shenandoah Planning District
- Community Action Partnership of Staunton, Augusta, and Waynesboro
- Community Foundation Central Blue Ridge
- Converge
- Cool Breeze Farms
- Covenant Presbyterian
- Creative Works Farm
- Disciple's Kitchen
- Dixie Gas and Oil/Quarles
- Ebenezer Baptist Church, Staunton
- Greater Augusta Regional Chamber of Commerce
- Isaiah 61 Ministries
- Love INC.
- Murphy Deming College of Health Sciences
- Plaza Apartments
- Project Grows
- Renewing Homes
- Ride with Pride
- Savida
- Shenandoah LGBTQ Center
- Shenandoah Valley Airport
- Shenandoah Valley Partnership
- Staunton
- Staunton Augusta Rescue Squad
- Staunton Augusta YMCA
- Staunton Fire and Rescue
- Staunton Housing Authority
- Strength in Peers
- Stuart Hall
- The Central Shenandoah Valley Office on Youth
- The Village Prenatal Clinic
- Valley Association of Independent Living
- Valley Community Services Board
- Valley Hope Counseling Center
- Valley Mission
- Valley Program for Aging Services
- Valley Supportive Housing
- Virginia Department of Health
- Waynesboro
- Waynesboro Area Refuge Mission Shelter
- Waynesboro Library
- Waynesboro Schools

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Total Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Comparisons

Trending

Similar surveys were administered in the Total Area in 2016, 2019, and 2022 by PRC on behalf of Augusta Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Virginia Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After receiving feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Augusta Health made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Augusta Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Augusta Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	33
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	188
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	14
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	15
Part V Section B Line 3h The process for consulting with persons representing the community's interests	9
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	196

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access ○ Cost of Prescriptions ○ Cost of Physician Visits ○ Appointment Availability ○ Difficulty Finding a Physician ○ Culture/Language ▪ Skipping/Stretching Prescriptions ▪ Difficulty Accessing Children's Health Care ▪ Primary Care Physician Ratio ▪ Routine Medical Care (Adults) ▪ Emergency Room Utilization ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths ○ Including Lung Cancer, Prostate Cancer, Female Breast Cancer, Colorectal Cancer ▪ Cancer Prevalence ▪ Cervical Cancer Screening
DIABETES	▪ Diabetes Deaths ▪ Prevalence of Borderline/Pre-Diabetes ▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Activity Limitations ▪ Alzheimer's Disease ○ Deaths ○ Family Members Diagnosed with Alzheimer's/Dementia ▪ Caregiving

— continued on the following page —

AREAS OF OPPORTUNITY (continued)	
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Heart Disease Prevalence ▪ Stroke Deaths ▪ High Blood Pressure Prevalence ▪ Overall Cardiovascular Risk
HOUSING	▪ Housing Conditions ▪ Housing Instability & Homelessness ▪ Key Informants: Social Determinants of Health (including Housing) ranked as a top concern.
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths ▪ Violent Crime Experience ▪ Intimate Partner Violence
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ 5+ Servings of Fruits/Vegetables per Day ▪ Meeting Physical Activity Guidelines ▪ Children's Physical Activity ▪ Overweight & Obesity [Adults] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths ▪ Asthma Prevalence [Adults]
SUBSTANCE USE	▪ Excessive Drinking ▪ Cirrhosis/Liver Disease Deaths ▪ Unintentional Drug-Induced Deaths ▪ Illicit Drug Use ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products ▪ Use of Smokeless Tobacco

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Nutrition, Physical Activity & Weight
3. Housing (Social Determinants of Health)
4. Diabetes
5. Substance Use
6. Access to Health Care Services
7. Heart Disease & Stroke
8. Tobacco Use
9. Disabling Conditions
10. Cancer
11. Infant Health & Family Planning
12. Injury & Violence
13. Respiratory Disease

Hospital Implementation Strategy

Augusta Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, Total Area results are shown in the larger, gray column.
- The columns to the left of the Total Area column provide comparisons among the county and independent cities, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the combined opposing areas.
- The columns to the right of the Total Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Total Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2016 (or earliest available data). Note that survey data reflect the ZIP Code-defined Total Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect county-level data.

SOCIAL DETERMINANTS	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	0.5	2.0	0.6	**0.8**	2.8	3.9		
Population in Poverty (Percent)	12.6	11.7	7.3	**9.2**	9.9	12.4	8.0	
Children in Poverty (Percent)	14.3	14.8	12.5	**13.3**	12.7	16.3	8.0	
No High School Diploma (Age 25+, Percent)	6.3	11.0	9.2	**8.9**	8.7	10.6		
Unemployment Rate (Age 16+, Percent)	2.4	2.6	2.2	**2.3**	2.5	3.9		3.8
% Unable to Pay Cash for a $400 Emergency Expense	25.8	26.9	18.6	**21.9**		34.0		21.3
% Worry/Stress Over Rent/Mortgage in Past Year	32.1	32.3	27.8	**29.7**		45.8		26.7
% Displaced From Housing in Past 2 Years	12.3	12.0	8.8	**10.2**		11.4		5.0
% Homeless in Past 2 Years	9.9	10.6	4.3	**6.8**		6.9		
% Unhealthy/Unsafe Housing Conditions	11.2	14.4	14.9	**14.0**		16.4		9.9

SOCIAL DETERMINANTS (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)	2.2	16.6	29.3	21.7	20.4	22.2		
% Food Insecure	26.0	24.3	23.2	24.1		43.3		9.3

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	17.1	15.9	18.1	17.4	18.1	15.7		18.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	7.6	9.0	9.0	**8.7**	10.1	8.1	7.6	11.2
% Difficulty Accessing Health Care in Past Year (Composite)	55.5	48.9	47.4	**49.5**		52.5		36.9
% Cost Prevented Physician Visit in Past Year	15.2	15.4	15.7	**15.5**	9.2	21.6		8.1
% Cost Prevented Getting Prescription in Past Year	16.4	16.7	15.9	**16.2**		20.2		7.6
% Difficulty Getting Appointment in Past Year	36.2	35.0	31.9	**33.5**		33.4		14.4
% Inconvenient Hrs Prevented Dr Visit in Past Year	11.1	15.4	13.4	**13.3**		22.9		9.9
% Difficulty Finding Physician in Past Year	26.5	21.9	19.7	**21.7**		22.0		3.4
% Transportation Hindered Dr Visit in Past Year	11.8	13.2	10.3	**11.2**		18.3		9.6
% Language/Culture Prevented Care in Past Year	3.5	0.4	3.0	**2.6**		5.0		0.1
% Stretched Prescription to Save Cost in Past Year	16.8	18.0	16.2	**16.7**		19.4		11.4
% Difficulty Getting Child's Health Care in Past Year	10.8		8.2	**8.2**		11.1		2.3

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Primary Care Doctors per 100,000	132.0	90.1	85.2	**95.7**	113.4	116.5		
% Have a Specific Source of Ongoing Care	74.7	73.7	73.3	**73.7**		69.9	84.0	77.7
% Routine Checkup in Past Year	71.7	72.6	71.1	**71.6**	80.2	65.3		79.5
% [Child 0-17] Routine Checkup in Past Year	87.5		87.3	**88.5**		77.5		87.2
% Two or More ER Visits in Past Year	17.6	17.6	13.1	**15.0**		15.6		4.3
% Rate Local Health Care "Fair/Poor"	12.6	16.3	14.7	**14.6**		11.5		7.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

CANCER	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	278.8	271.4	240.7	**254.0**	182.3	182.5	122.7	252.2
Lung Cancer Deaths per 100,000				**58.2**	40.5	39.8	25.1	36.5
Female Breast Cancer Deaths per 100,000				**32.3**	26.0	25.1	15.3	19.6
Prostate Cancer Deaths per 100,000				**22.9**	20.6	20.1	16.9	14.8
Colorectal Cancer Deaths per 100,000				**25.3**	16.2	16.3	8.9	16.0
Cancer Incidence per 100,000	626.1	650.1	393.1	**482.1**	409.4	442.3		
Lung Cancer Incidence per 100,000	74.4	98.0	47.5	**60.9**	53.6	54.0		
Female Breast Cancer Incidence per 100,000	183.1	183.6	111.5	**138.7**	126.1	127.0		
Prostate Cancer Incidence per 100,000	133.4	134.1	79.2	**97.5**	100.3	110.5		
Colorectal Cancer Incidence per 100,000	46.4	51.5	35.3	**40.3**	34.5	36.5		
% Cancer	14.4	11.5	13.0	**13.0**	11.9	7.4		12.7

CANCER (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% [Women 50-74] Breast Cancer Screening	76.3		79.8	**79.2**		64.0	80.5	75.0
% [Women 21-65] Cervical Cancer Screening	61.7	68.5	71.3	**68.6**		75.4	84.3	67.6
% [Age 45-75] Colorectal Cancer Screening	65.9	68.7	74.8	**71.8**		71.5	74.4	77.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

DIABETES	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	49.0	39.4	32.9	**37.3**	31.8	30.5		32.4
% Diabetes/High Blood Sugar	17.0	9.0	15.3	**14.4**	11.8	12.8		13.9
% Borderline/Pre-Diabetes	11.0	15.6	18.7	**16.4**		15.0		5.7
Kidney Disease Deaths per 100,000	41.3	19.0	20.1	**24.2**	19.1	16.9		24.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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DISABLING CONDITIONS	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	47.5	38.4	41.5	**42.2**		38.0		48.5
% Activity Limitations	38.3	27.3	32.4	**32.7**		27.5		25.6
% High-Impact Chronic Pain	24.0	17.8	19.2	**20.0**		19.6	6.4	18.4
Alzheimer's Disease Deaths per 100,000	77.4	48.1	40.6	**49.5**	29.0	35.8		48.7
% Family Member Diagnosed with Alzheimer's/Dementia	35.3	38.6	37.9	**37.5**				28.2
% Caregiver to a Friend/Family Member	30.9	32.5	29.3	**30.3**		22.8		20.0

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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HEART DISEASE & STROKE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	333.0	339.9	278.8	**300.9**	193.2	209.5	127.4	254.4
% Heart Disease	11.2	11.1	12.6	**12.0**	7.0	10.3		6.7
Stroke Deaths per 100,000	78.7	56.9	51.7	**58.2**	48.9	49.3	33.4	59.8
% Stroke	3.5	3.7	5.3	**4.6**	3.7	5.4		3.0
% High Blood Pressure	46.7	43.1	48.6	**47.1**	35.6	40.4	42.6	42.7
% High Cholesterol	36.6	34.3	37.6	**36.7**		32.4		36.0
% 1+ Cardiovascular Risk Factor	90.9	89.1	89.0	**89.4**		87.8		84.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

	DISPARITY AMONG SUBAREAS				TOTAL AREA vs. BENCHMARKS			
INFANT HEALTH & FAMILY PLANNING	**Staunton City**	**Waynesboro City**	**Augusta County**	**Total Area**	**vs. VA**	**vs. US**	**vs. HP2030**	**TREND**
Teen Births per 1,000 Females 15-19	20.6	29.4	11.4	**16.7**	12.8	15.5		
Low Birthweight (Percent of Births)	8.4	8.9	7.3	**8.1**	8.3	8.4		7.6
Infant Deaths per 1,000 Births			6.8	**6.1**	5.8	5.6	5.0	4.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

	DISPARITY AMONG SUBAREAS				TOTAL AREA vs. BENCHMARKS			
INJURY & VIOLENCE	**Staunton City**	**Waynesboro City**	**Augusta County**	**Total Area**	**vs. VA**	**vs. US**	**vs. HP2030**	**TREND**
Unintentional Injury Deaths per 100,000	59.4	77.3	55.6	**60.3**	61.1	67.8	43.2	45.9
Motor Vehicle Crash Deaths per 100,000		14.6	19.7	**16.3**	11.5	13.3	10.1	13.3
Homicide Deaths per 100,000				**2.9**	5.7	7.4	5.5	3.1
% Victim of Violent Crime in Past 5 Years	4.1	5.8	3.3	**4.0**		7.0		0.3
% Victim of Intimate Partner Violence	19.0	20.5	19.0	**19.3**		20.3		9.7

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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MENTAL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	27.8	25.8	18.2	**21.9**		24.4		8.7
% Diagnosed Depression	47.1	35.7	30.9	**35.5**	20.4	30.8		14.9
% Symptoms of Chronic Depression	50.4	48.0	36.1	**41.7**		46.7		21.8
% Typical Day Is "Extremely/Very" Stressful	22.1	15.4	16.0	**17.2**		21.1		10.5
Suicide Deaths per 100,000	15.5	21.9	18.8	**18.7**	13.9	14.7	12.8	19.6
Mental Health Providers per 100,000	485.4	139.7	219.4	**259.9**	268.6	315.8		
% Receiving Mental Health Treatment	41.4	24.2	23.1	**27.4**		21.9		14.9
% Unable to Get Mental Health Services in Past Year	13.5	11.9	8.2	**10.1**		13.2		2.5
% Child [Age 5-17] "Fair/Poor" Mental Health				**6.1**		14.4		5.8
% Child [Age 5-17] Needed Mental Health Svcs in the Past Year				**14.5**				14.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	23.9	20.6	22.3	**22.3**		30.0		19.1
% Child [Age 2-17] 5+ Servings of Fruits/Vegetables per Day				**46.8**				50.8
% 5+ Servings of Fruits/Vegetables per Day	21.4	24.6	25.8	**24.6**		29.1		
% No Leisure-Time Physical Activity	33.1	32.4	33.5	**33.2**	22.3	30.2	21.8	27.8
% Meet Physical Activity Guidelines	20.6	27.5	22.4	**23.0**	31.8	30.3	29.7	15.6
% [Child 2-17] Physically Active 1+ Hours per Day			38.6	**42.0**		27.4		66.8
% Overweight (BMI 25+)	71.1	71.0	74.1	**72.8**	68.6	63.3		61.9
% Obese (BMI 30+)	41.0	38.9	41.7	**41.0**	34.3	33.9	36.0	32.4
% [Child 5-17] Overweight (85th Percentile)			34.1	**35.3**		31.8		58.0
% [Child 5-17] Obese (95th Percentile)			27.4	**23.1**		19.5	15.5	37.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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ORAL HEALTH	DISPARITY AMONG SUBAREAS: Staunton City	Waynesboro City	Augusta County	Total Area	TOTAL AREA vs. BENCHMARKS: vs. VA	vs. US	vs. HP2030	TREND
% Have Dental Insurance	72.7	73.7	73.9	**73.6**		72.7	75.0	51.1
% Dental Visit in Past Year	63.5	68.1	68.9	**67.6**	68.4	56.5	45.0	69.9
% [Child 2-17] Dental Visit in Past Year			78.6	**81.0**		77.8	45.0	88.0

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS: Staunton City	Waynesboro City	Augusta County	Total Area	TOTAL AREA vs. BENCHMARKS: vs. VA	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	78.7	40.9	50.0	**54.2**	37.4	43.5		74.4
Pneumonia/Influenza Deaths per 100,000	12.9	21.9	18.0	**17.7**	11.6	13.4		21.6
% Asthma	13.4	15.6	16.4	**15.6**	10.2	17.9		9.1
% [Child 0-17] Asthma	17.9		13.9	**15.4**		16.7		9.3
% COPD (Lung Disease)	10.7	4.2	6.3	**6.9**	6.9	11.0		10.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SEXUAL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	206.4	230.8	113.9	**153.0**	337.8	386.6		
Chlamydia Incidence per 100,000	324.1	496.1	288.8	**333.7**	472.8	492.2		
Gonorrhea Incidence per 100,000	142.8	194.1	70.3	**107.6**	158.3	179.0		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SUBSTANCE USE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	23.2	19.0	13.3	**16.3**	11.3	15.7		16.9
Cirrhosis/Liver Disease Deaths per 100,000	23.1	29.2	22.2	**23.7**	13.7	16.4	10.9	12.4
% Excessive Drinking	19.8	15.8	16.9	**17.3**	14.9	34.3		9.2
Unintentional Drug-Induced Deaths per 100,000	18.1	30.6	11.1	**16.1**	27.8	29.7		8.3
% Used an Illicit Drug in Past Month	9.3	5.2	5.1	**6.1**		8.4		0.5

SUBSTANCE USE (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Used a Prescription Opioid in Past Year	16.1	11.7	15.5	**14.8**		15.1		17.7
% Ever Sought Help for Alcohol or Drug Problem	10.3	8.2	6.9	**7.9**		6.8		8.0
% Personally Impacted by Substance Use	44.0	41.1	37.7	**39.9**		45.4		36.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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TOBACCO USE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton City	Waynesboro City	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	22.2	15.5	13.7	**16.0**	10.9	23.9	6.1	17.2
% Someone Smokes at Home	21.4	15.0	12.3	**14.8**		17.7		17.2
% Use Vaping Products	14.5	12.6	10.2	**11.7**	7.0	18.5		0.3
% Use Smokeless Tobacco	5.9	5.4	10.2	**8.3**				3.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The Total Area (Staunton, Waynesboro, and Augusta County), the focus of this Community Health Needs Assessment, encompasses 1,001.96 square miles and houses a total population of 126,052 residents, according to latest census estimates.

Total Population
(Estimated Population, 2019-2023)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Staunton City	25,765	19.92	1,293
Waynesboro City	22,574	14.97	1,508
Augusta County	77,713	967.07	80
Total Area	**126,052**	**1,001.96**	**126**
VA	8,657,499	39,482.10	219
United States	332,387,540	3,533,298.58	94

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Population Change 2010-2020

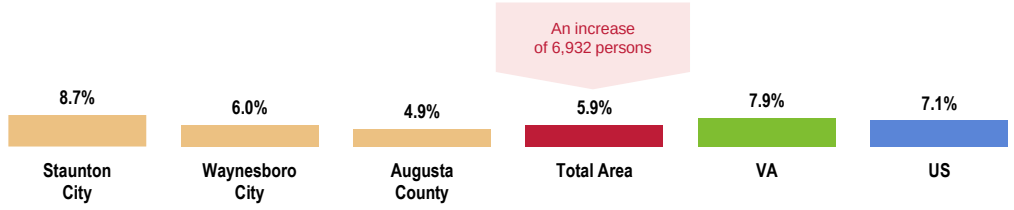
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2010 and 2020 US Censuses, the population of the Total Area increased by 6,932 persons, or 5.9%.

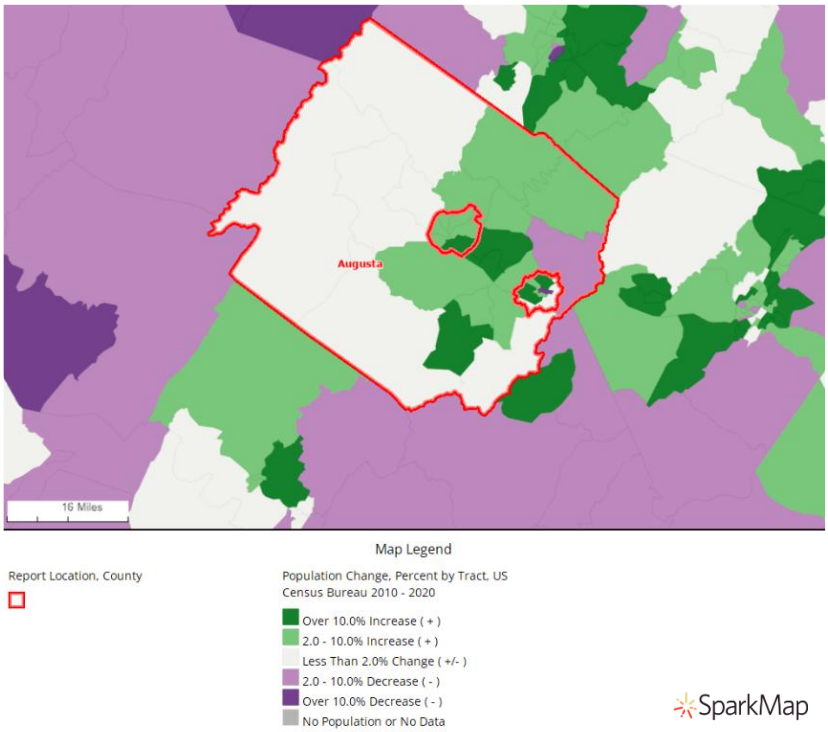
BENCHMARK ► A lower population change than both the state and US.

DISPARITY ► The highest increase in population was in Staunton.

Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

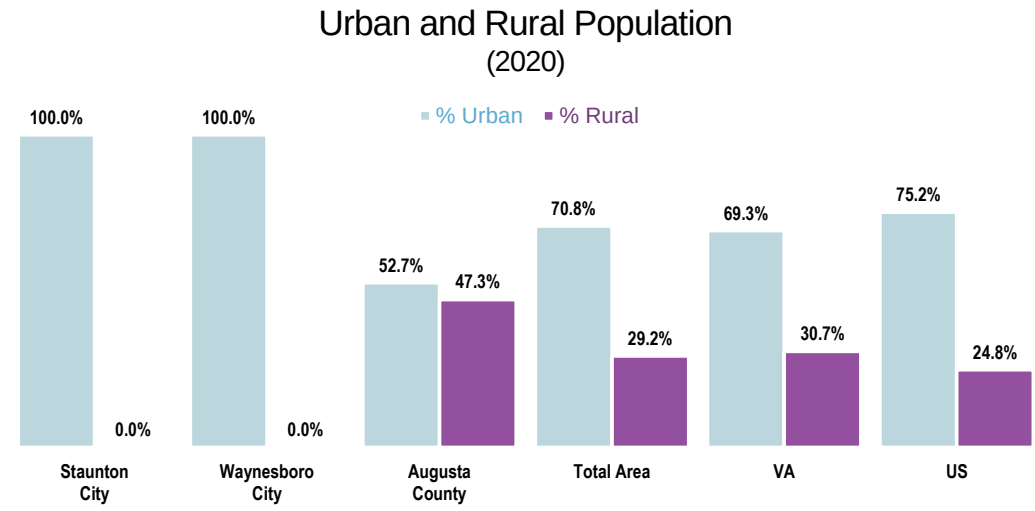


Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The Total Area is predominantly urban, with 70.8% of the population living in areas designated as urban.

DISPARITY ► While Staunton and Waynesboro are both completely urban, over half of the Augusta County population is designated as rural.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

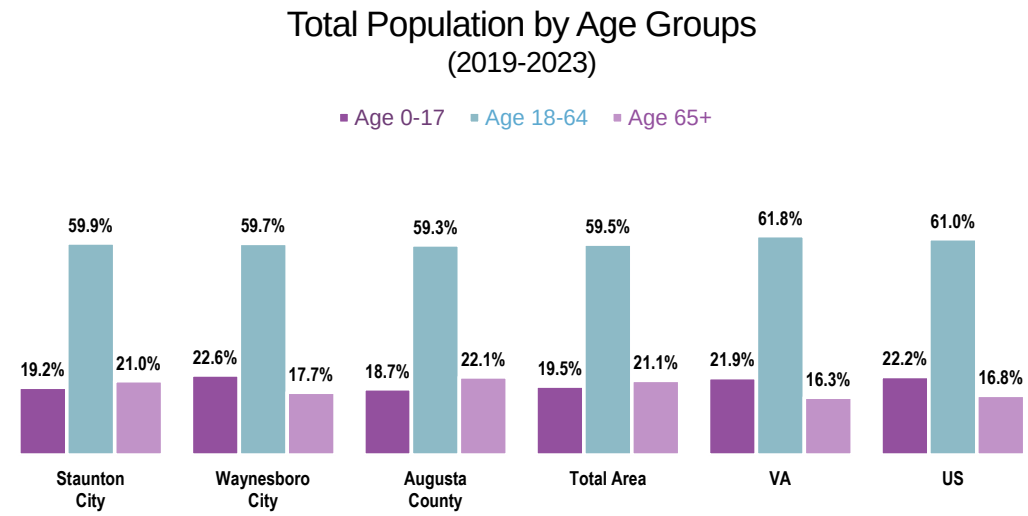
Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In the Total Area, 19.5% of the population are children age 0-17; another 59.5% are age 18 to 64, while 21.1% are age 65 and older.

BENCHMARK ► The Total Area has an older population than both statewide and national proportions.

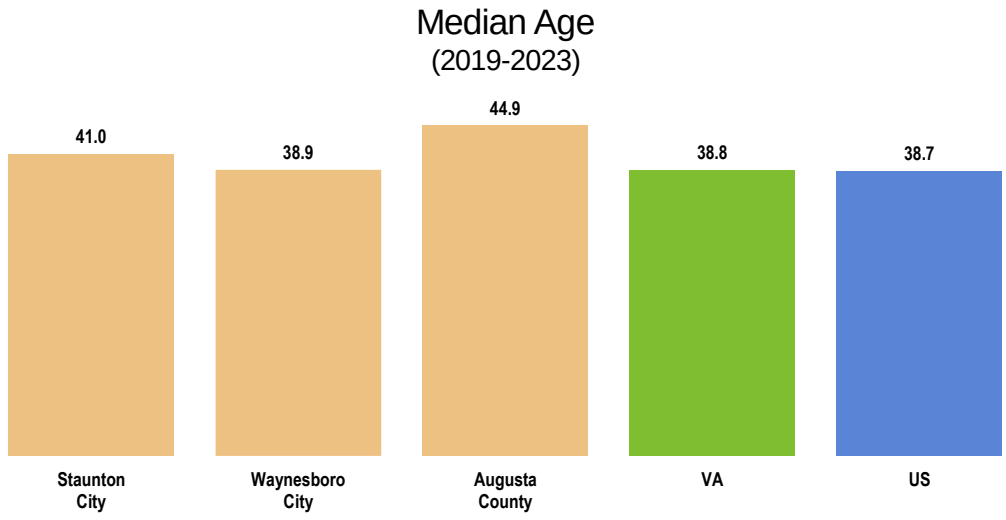
DISPARITY ► Waynesboro has a slightly higher proportion of children.



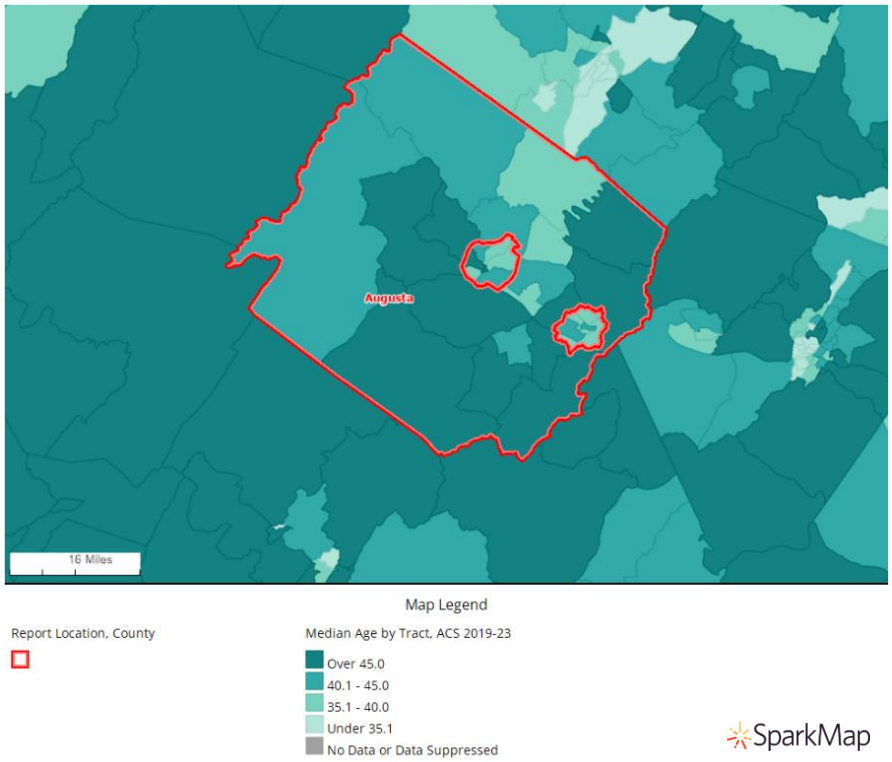
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Median Age

Staunton, Waynesboro, and Augusta County are slightly "older" than the state and the nation in that their median ages are higher. (A composite median is not available for the Total Area as a whole.)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).



Race & Ethnicity

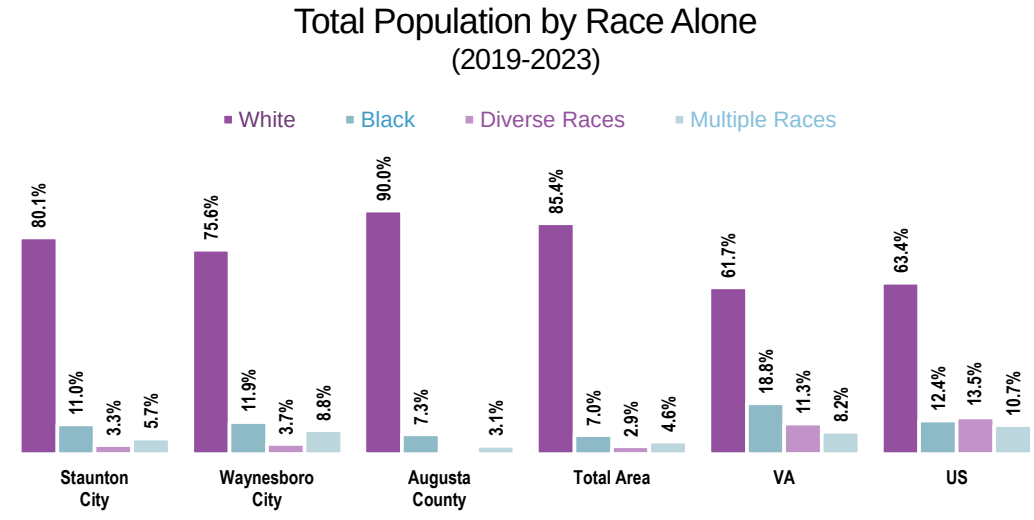
Race

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

In looking at race independent of ethnicity (Hispanic or Latino origin), 85.4% of residents of the Total Area are White and 7.0% are Black.

BENCHMARK ► The Total Area is less diverse than both the state and the nation.

DISPARITY ► Augusta County is less diverse than the cities of Staunton and Waynesboro.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

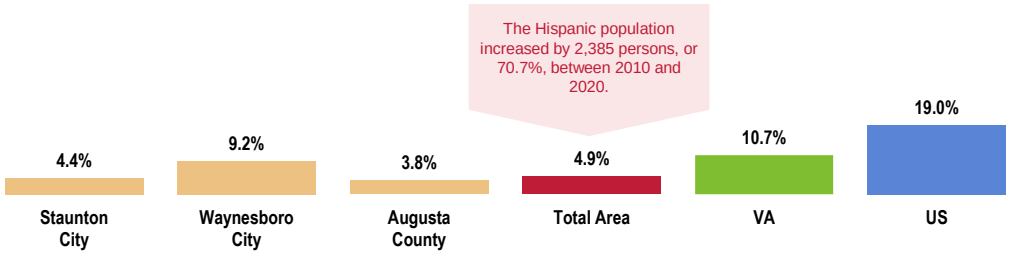
Ethnicity

A total of 4.9% of the Total Area residents are Hispanic or Latino.

BENCHMARK ► Much lower than both Virginia and (especially) US proportions.

DISPARITY ► The population percentage is notably higher in Waynesboro.

Hispanic Population
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

A total of 0.8% of the Total Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► A much lower percentage than both Virginia and the US.

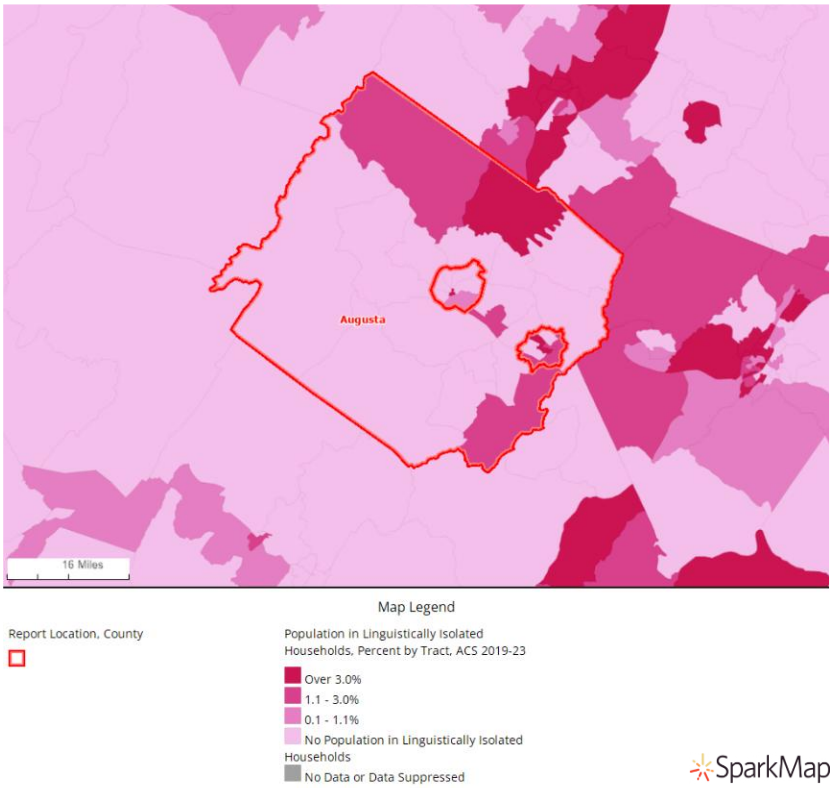
DISPARITY ► Significantly higher in Waynesboro.

Linguistically Isolated Population
(2019-2023)

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speaks a non-English language and speak English "very well."

Note the following map illustrating linguistic isolation throughout the Total Area.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health.

The latest census estimate shows 9.2% of the Total Area population living below the federal poverty level.

BENCHMARK ► Lower than the US percentage.

DISPARITY ► Lowest in Augusta County.

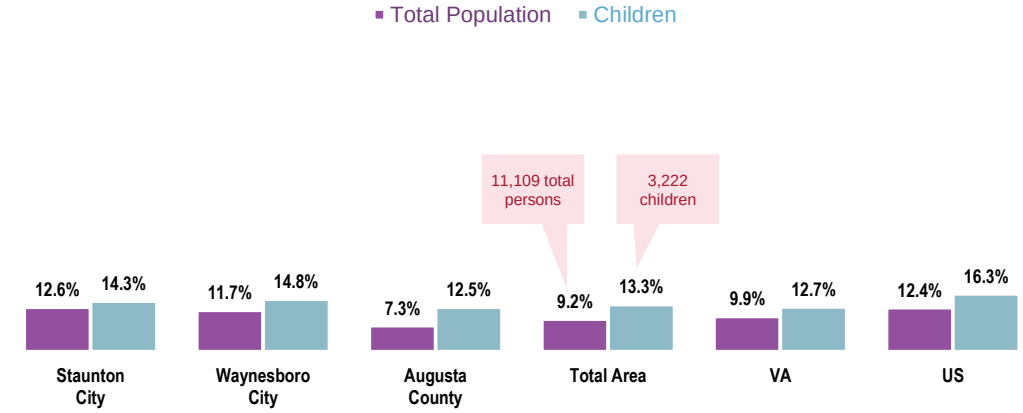
Among just children (ages 0 to 17), this percentage in the Total Area is 13.3% (representing an estimated 3,222 children).

BENCHMARK ► Lower than the US percentage. Fails to satisfy the Healthy People 2030 objective.

Percent of Population in Poverty

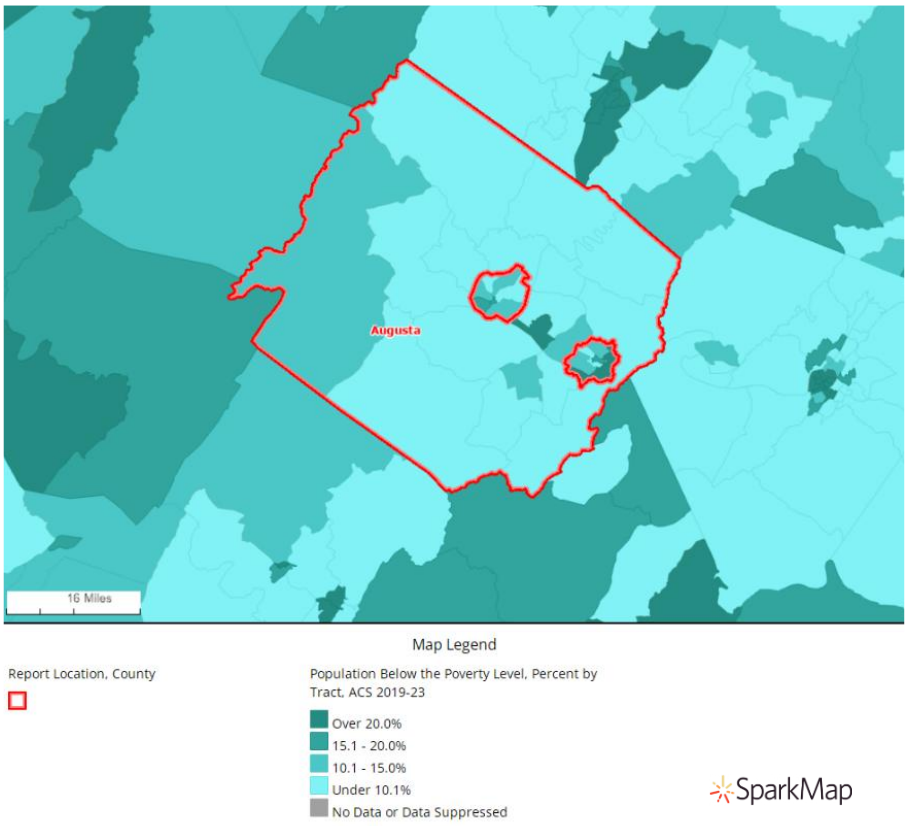
(2019-2023)

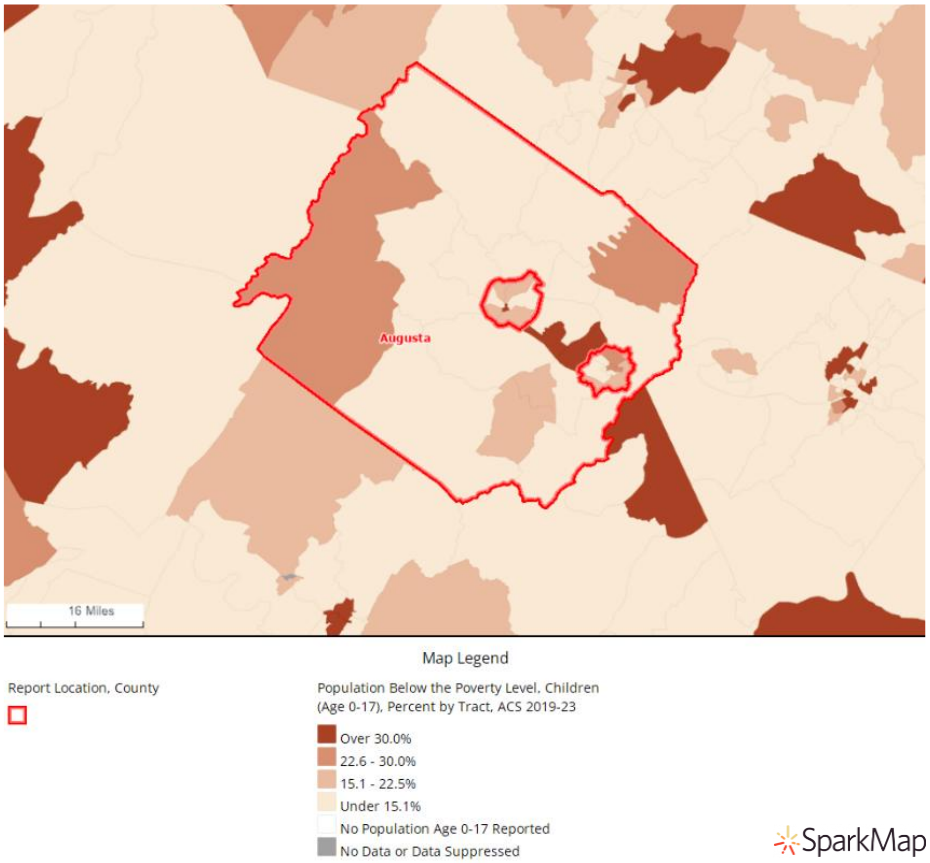
Healthy People 2030 = 8.0% or Lower



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

The following maps highlight concentrations of persons living below the federal poverty level.





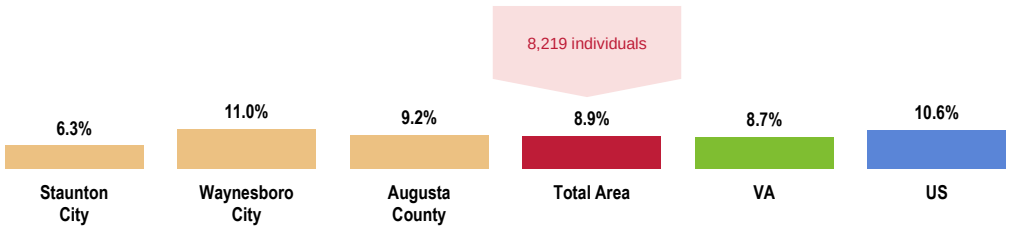
Education

Among the Total Area population age 25 and older, an estimated 8.9% (over 8,219 people) do not have a high school education.

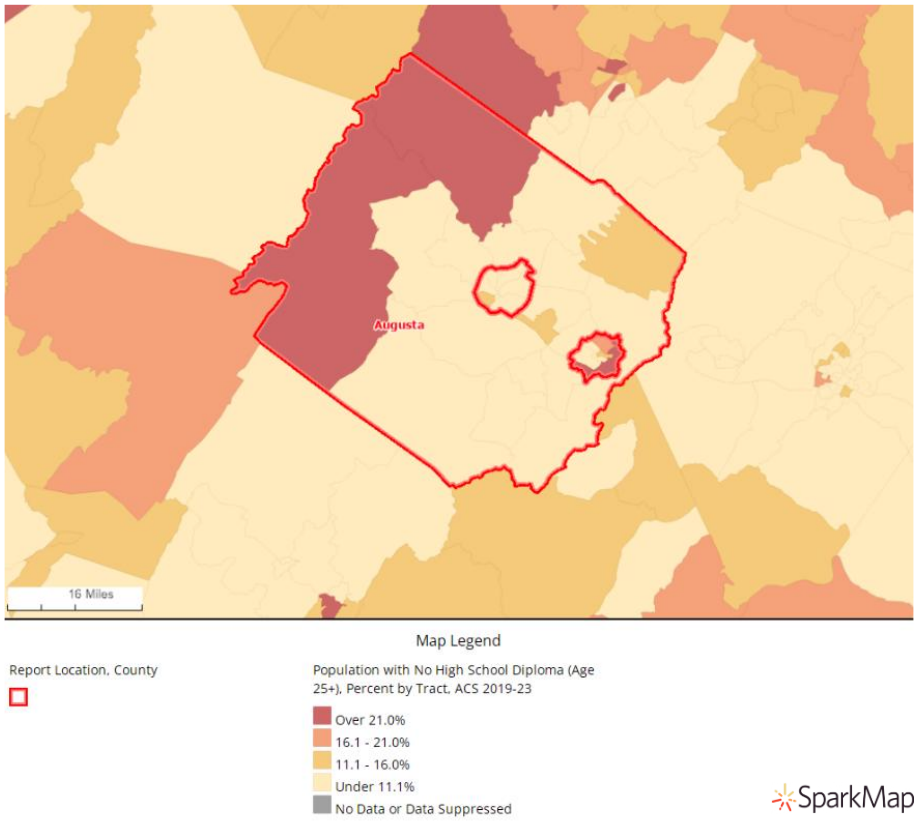
BENCHMARK ► Lower than the national proportion.

DISPARITY ► A higher percentage of Waynesboro residents are without a high school education.

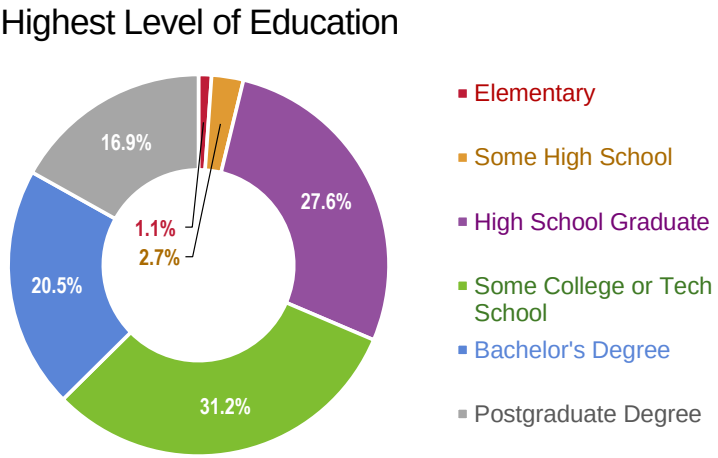
Population With No High School Diploma
(Adults Age 25 and Older; 2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).



A total of 58.8% of Total Area survey respondents are college graduates (with a college or postsecondary degree); another 37.4% are high school graduates (including those with some college or technical schooling). Note that 3.8% of residents do not have a high school diploma.



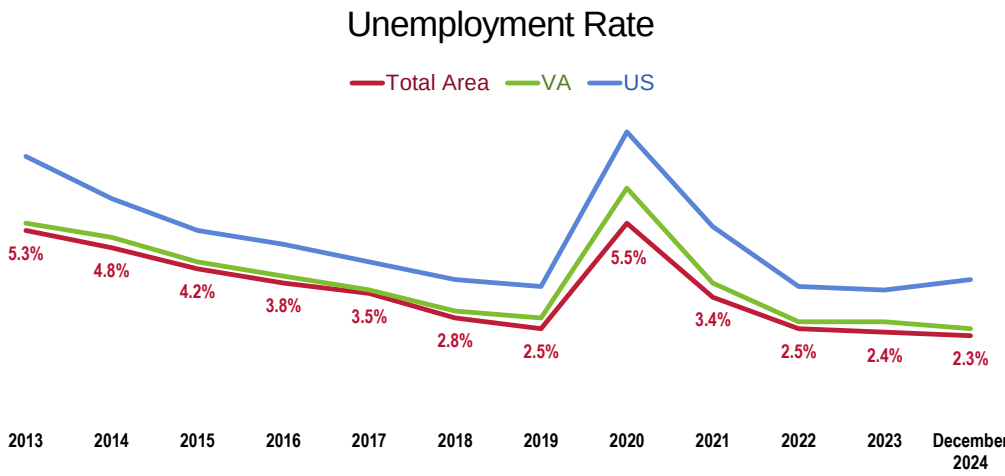
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: • Asked of all respondents.

Employment

According to data derived from the US Department of Labor, the unemployment rate in the Total Area as of December 2024 was 2.3%.

BENCHMARK ► Lower than the national rate.

TREND ► Following significant increases in 2020 (attributed to the COVID-19 pandemic), unemployment has dropped below pre-pandemic levels, and is much lower than found a decade ago.



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

Respondents were asked: "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

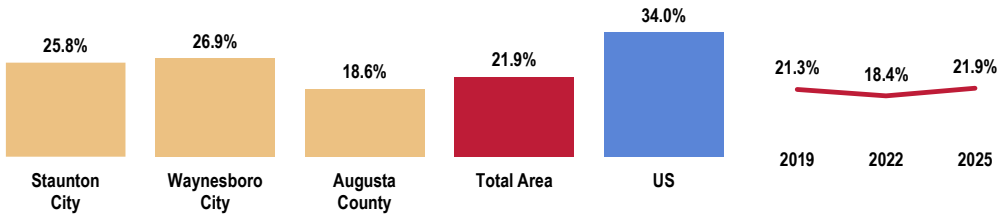
A total of 21.9% of the Total Area residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► Lower than the national percentage.

DISPARITY ► Reported more often among women, adults under the age of 65, those with lower incomes (especially), and LGBTQ+ respondents.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

Total Area



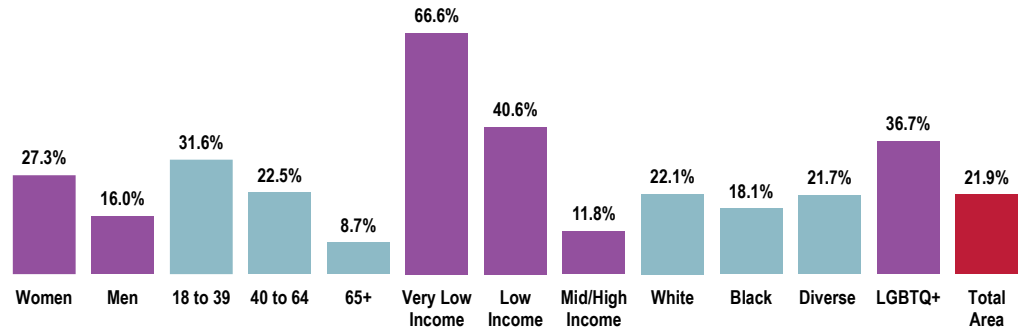
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

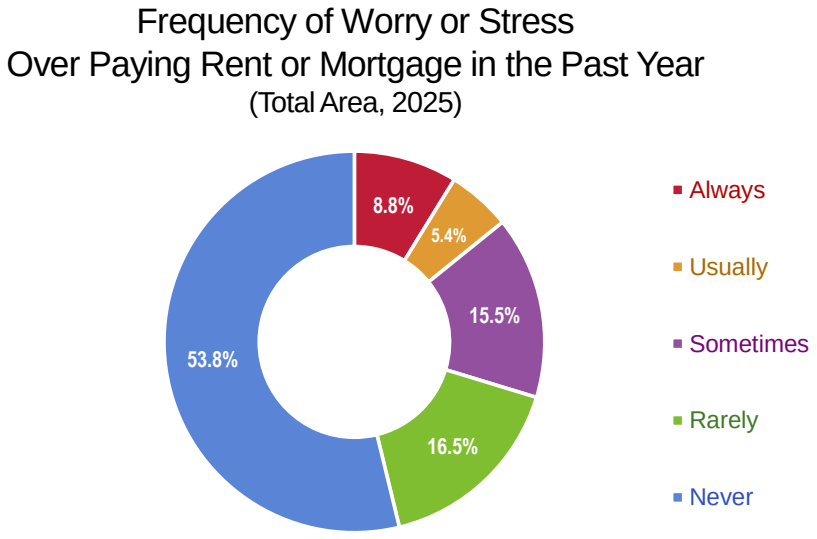
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2023 guidelines place the poverty threshold for a family of four at $30,000 annual household income or lower). In sample segmentation: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. Data are also detailed for individuals identifying with a race category, without Hispanic origin. “White” reflects those who identify as White alone, without Hispanic origin. “Black” or African American reflects those who identify as Black alone, without Hispanic origin. “Diverse” includes those who identify as Hispanic, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races.

Housing

Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.



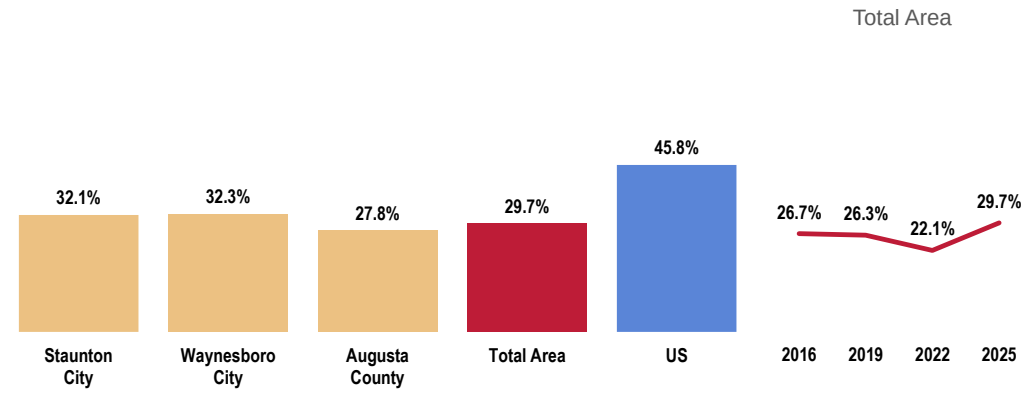
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

However, a considerable share (29.7%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Notably lower than the US prevalence.

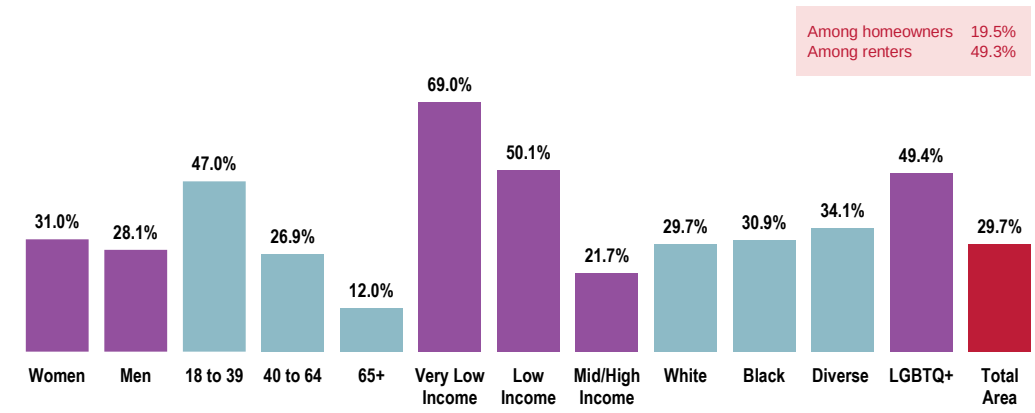
DISPARITY ► Reported more often among adults under the age of 65, those with lower incomes (especially), LGBTQ+ respondents, and renters.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

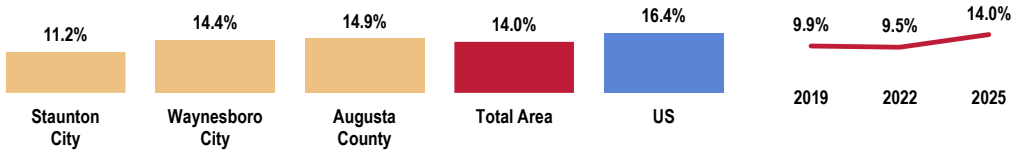
Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

A total of 14.0% of the Total Area residents report living in unhealthy or unsafe housing conditions during the past year.

TREND ► Significantly higher than 2019 findings.

DISPARITY ► Reported more often among adults under the age of 65, lower income residents, and renters.

Unhealthy or Unsafe Housing Conditions in the Past Year

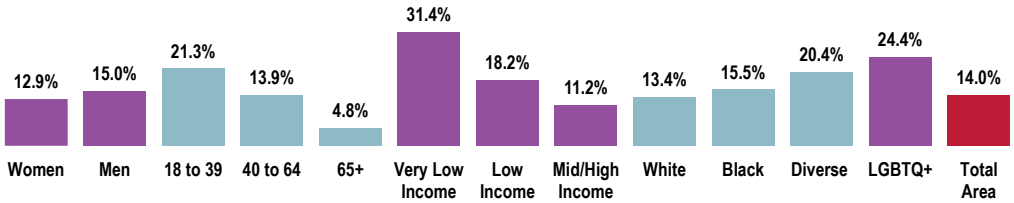


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Total Area, 2025)

Among homeowners	10.5%
Among renters	19.5%



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Housing Instability

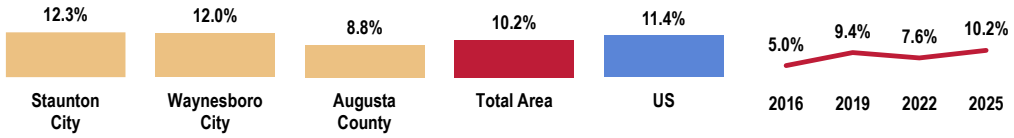
A total of 10.2% of survey respondents report that they have had to go live with a friend or relative at some point in the past two years due to an emergency, even if only temporarily.

TREND ► Doubling since 2016.

DISPARITY ► Reported more often among younger adults, those with lower incomes (especially), LGBTQ+ respondents, and people who rent their homes.

Had to Live With a Friend/Relative in the Past Two Years Due to an Emergency (Even if Only Temporarily)

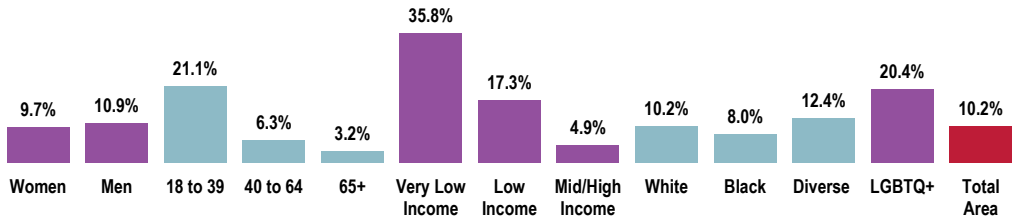
Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 303]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Had to Live With a Friend/Relative in the Past Two Years Due to an Emergency (Even if Only Temporarily) (Total Area, 2025)

Among homeowners	4.8%
Among renters	17.8%



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.

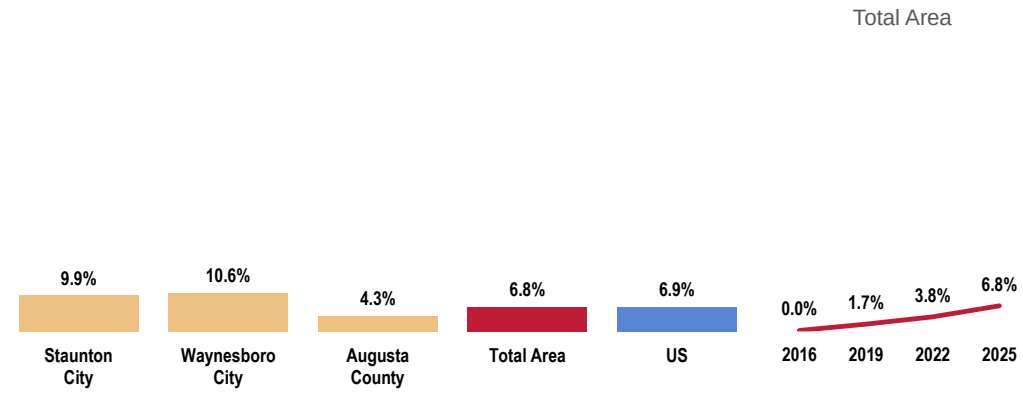
Homelessness

A total of 6.8% of Total Area adults reported there was a time in the past two years when they lived on the street, in a car, or in a temporary shelter.

TREND ► Increasing significantly since 2016.

DISPARITY ► Lower among Augusta County residents.

Homeless At Some Point in the Past 2 Years

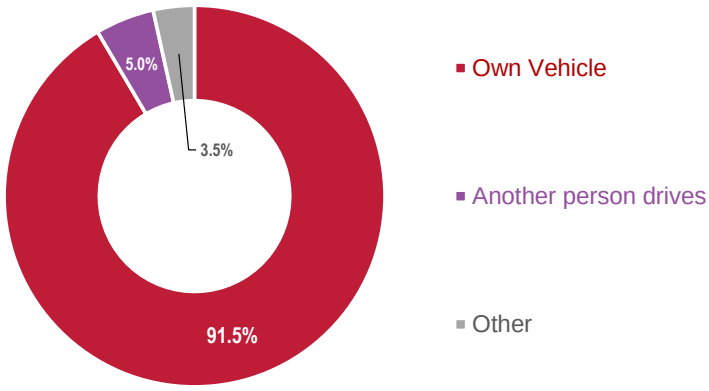


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 304]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Transportation

While most area residents own their own vehicle, 8.5% do not and must get rides from someone else, use public transport, walk, or find other means of transportation.

Primary Means of Transportation (Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: ● Asked of all respondents.

Food Access

Low Food Access

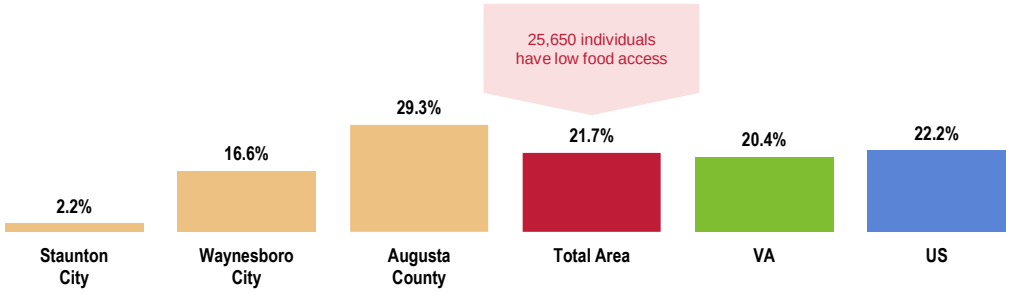
Low food access is defined as living more than 1 mile (in urban areas, or 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also Difficulty Accessing Fresh Produce in the *Nutrition, Physical Activity & Weight* section of this report.

US Department of Agriculture data show that 21.7% of the Total Area population (representing about 25,650 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

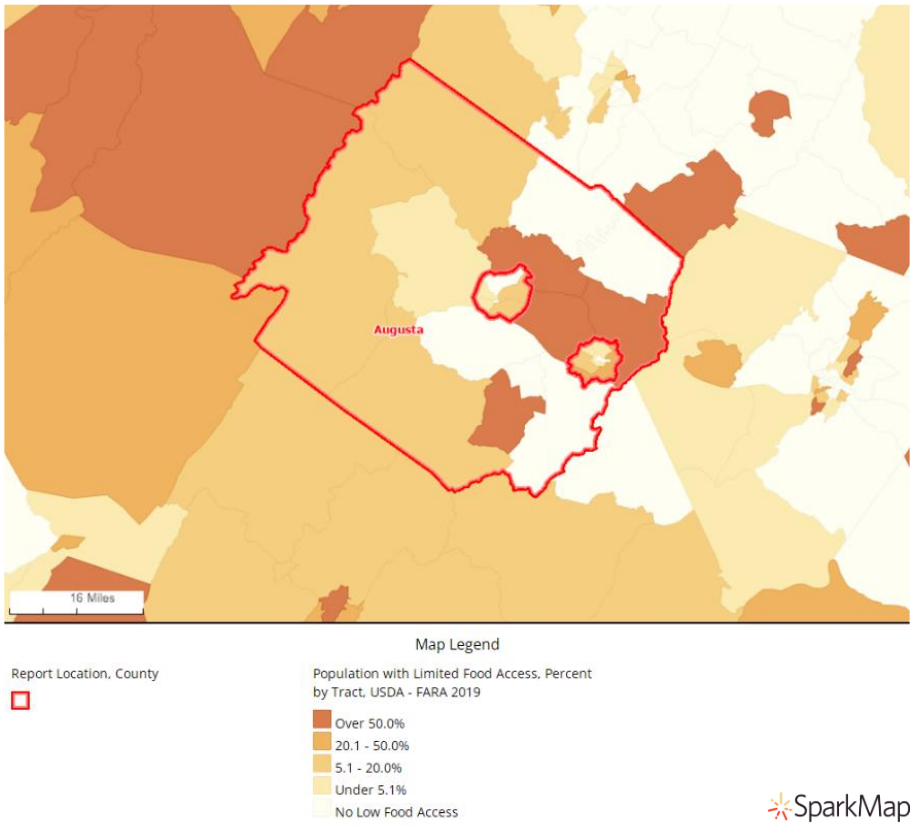
DISPARITY ► Considerably higher in Augusta County.

Population With Low Food Access
(2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.



Food Insecurity

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "often true," "sometimes true," or "never true" for you in the past 12 months:

I worried about whether our food would run out before we got money to buy more.

The food that we bought just did not last, and we did not have money to get more."

Those answering "often" or "sometimes" true for either statement are considered to be food insecure.

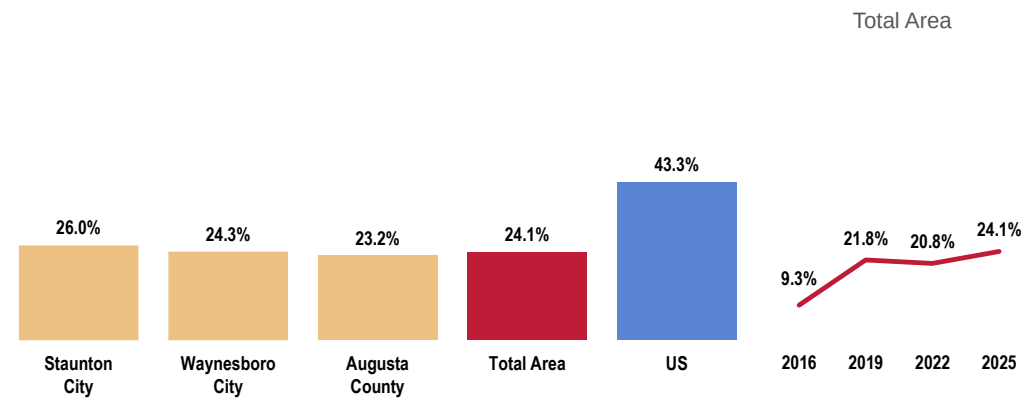
Overall, 24.1% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

BENCHMARK ► Much lower than the national rate.

TREND ► Significantly higher than baseline 2016 findings.

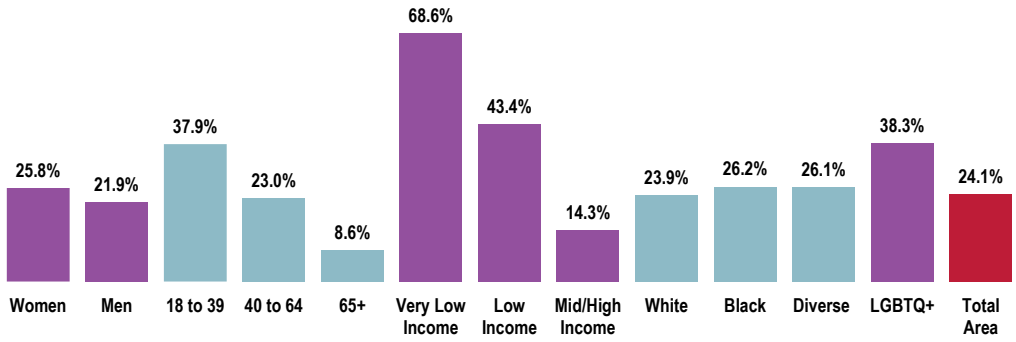
DISPARITY ► Reported more often among adults under the age of 65, those with lower incomes (especially), and LGBTQ+ respondents.

Food Insecurity



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

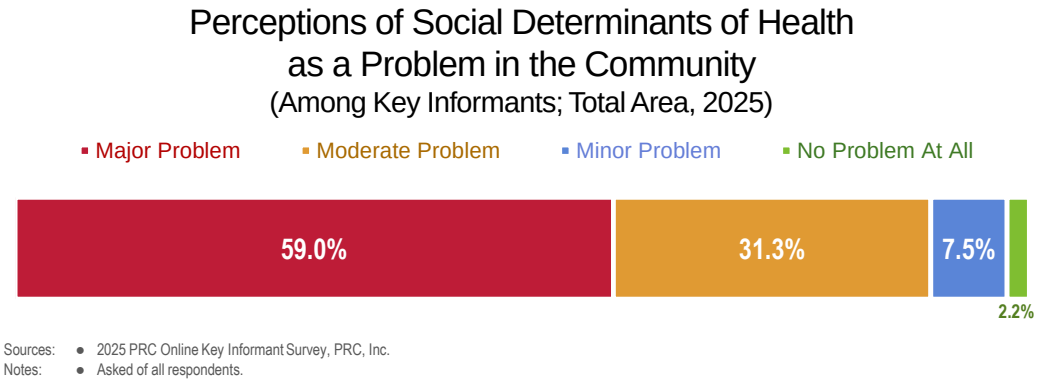
Food Insecurity
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Key Informant Input: Social Determinants of Health

The greatest share of key informants taking part in an online survey characterized *Social Determinants of Health* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Affordable Housing

> Housing costs are too high for working families. $1,500 per month rent is not reasonable for single parent families. We have many of those in this area. – Health Care Provider
>
> Again... why social determinants? I tell this story often about a 35-year-old husband/father working 2 jobs so the family can stay in a 1 room motel because they have bad credit but make enough money. It was stated that Housing is Health, this man died at 35 in front of his 2 teenage girls from a massive heart attack due to stress. That's one of thousands of stories. Hotel or motel living to accommodate real housing due to lack of housing stock, low wages in comparison to inflation, lack of education as to what is available to those in need as well as the community awareness that there is a true problem. It's systemic, never-ending and currently uncontrollable. – Social Services Provider
>
> Our community, particularly Staunton and Waynesboro, have an aging housing stock that requires personal investments that many of our community members cannot afford. The substandard living conditions are certainly a threat to the health of the occupants of those homes. Our community does not have a high percentage of job opportunities that provide higher incomes. This limits the choices of lower income residents for everything from medical care and prescriptions, food, and living conditions. – Social Services Provider
>
> Due to low housing stock housing costs are high and difficult to find. Most families are spending a higher percentage for housing. Food costs are high as well, so families have less for healthcare in some cases they choose food, rent, and transportation over healthcare. We need optional pre-k for all. This will help the children and the working parents reduce childcare costs. – Community Leader
>
> Because we don't have enough housing for our neighbors. Our school nurses need a 2nd job to support their family. Education is too expensive. And so our community resists science and reason in favor of religion and feelings because that's what we're left with when those other "luxuries" are taken out of our equation. – Community Leader
>
> Housing continues to rise in this area. The real estate on my Staunton home increased 20.57% this year after increasing 22.23% in 2023. I also hear anecdotally how expensive it is to rent in this area. The central Shenandoah Valley has lower educational attainment rates than other areas of the state - meaning that we have fewer people with a college degree or even some college than in other areas of Virginia. – Community Leader
>
> Lack of affordable housing. Lack of affordable childcare options. Transportation is a major issue in our community. Rising costs of food, utilities, rent, medical insurance etc. – Social Services Provider
>
> There is not an appropriate amount of affordable housing in SAW. The powers that continue to build expensive homes, that even our residents cannot afford. – Social Services Provider
>
> Because without this, how can you be healthy...how can you think of yourself? -Housing: don't have housing, then you don't have a place to store or cook food regularly. You don't have the security of a roof and a place to stay cool/warm and dry. -Food Insecurity: then you buy the cheapest food. Ramen noodles and hot dogs are not a balanced meal, but when you can get an entire meal for less than a bag of apples...you choose the noodles. – Health Care Provider
>
> Housing is health. We have very little affordable housing available, or non-affordable. Incomes in the top growth industries are not high enough for workers to purchase homes nor afford rent in the area. These are systemic issues and I am not sure we have a community "thought leader" in each area listed. – Social Services Provider

Housing prices and instability as well as food prices and lack of transportation services such as uber, bus, etc. – Health Care Provider

Good health begins with the environment you live in. Where there are deficits in housing, access to health food, income, and education, health concerns will follow. – Health Care Provider

Continue to receive many housing referrals to help find people housing throughout the AH community. – Health Care Provider

Housing is very limited. We are seeing a lot of homeless. Follow Staunton, VA on Facebook and see all the people seeking housing. There needs to be a facility that offers a one room studio. Old hotel, hospital, etc. made into facility that could serve single people even mentally challenged people that can maybe offer guidance or case management on site. I see mentally challenged patients struggle with paperwork, medication management, etc. – Health Care Provider

Housing stock is limited for those on reduced incomes and many houses are older and need repair. Rural areas do not have adequate transportation resources, expensive groceries. – Health Care Provider

We continue to see many of these factors that impact community members' overall health, and lack of affordable housing is a major problem. If people do not have these basic needs met, it ultimately impacts their health in a negative way. They are not going to prioritize their health if they do not have the means to do so financially, do not have stable and safe housing, etc. The stress this causes also takes a toll. – Health Care Provider

Housing cost. – Health Care Provider

Lack of access to affordable or temporary housing. Mental & physical health issues contribute to individual's ability to seek, gain, or maintain housing needs. – Community Leader

When a person does not have the financial resources to acquire adequate housing or food, this impacts health. The lower the education, the more likely the possibility of lower income, fewer resources, and greater tendency to eat junk food (cheaper), drink or do drugs (manage stress), and not have adequate access to health care (little or no insurance). Add to that the notion of discrimination, whether based upon education, skin color, or whatever a person is/does that is different from others, and you have even more stress to attempt to overcome to live a productive, happy life. – Social Services Provider

There are many people living in substandard housing (or homeless), rental rates are increasing so many people can't afford a decent home/apartment. People who are struggling to make ends meet financially choose food based on price rather than nutrition. And they have limited time and energy to develop good connections to the community and spend time on physical activity. – Social Services Provider

Social Determinants of Health are major challenges in Staunton, Fishersville, and Augusta County, impacting housing stability, income, education, healthcare access, and overall well-being. Limited affordable housing, job shortages, and rural healthcare gaps make it difficult for residents to meet basic needs. Transportation barriers, food insecurity, and environmental concerns further contribute to health disparities. Additionally, stigma around mental health and systemic discrimination create barriers to essential services. – Community Leader

The wages are not keeping up with the cost of housing or education. Most of what is being built in our community - even middle class, is being squeezed out. – Social Services Provider

Affordable, accessible housing is hard to find, low wage jobs make it difficult to make ends meet, many people living in the ALICE population and are unable to manage the costs of a crisis such as a car breakdown or the cost of a health episode. People are living in undesirable housing situations because it is all they can afford. Addiction issues. Lack of education beyond high school. There is still a great deal of discrimination of persons of color. – Social Services Provider

Not enough housing to meet the demand at a reasonable price. – Social Services Provider

Housing has been a big issue- I've seen this be a problem for patients. – Health Care Provider

Lack of income and high cost are the primary determinants of health. Many are struggling to provide housing for themselves and their families which makes health a lower priority and, for some, an impossibility. – Community Leader

Lack of affordable housing. Homelessness, mental health crisis to include substance abuse and lack of adequate community resources. – Community Leader

A lot of our clients at Ride with Pride struggle with housing because they are low income. – Social Services Provider

Socioeconomic Factors

The lower socioeconomic tiers in society are impacted by all of the above-mentioned determinants for obvious reasons. – Community Leader

Poor health outcomes are disproportionately concentrated in low-income neighborhoods, where residents face systemic barriers to health and well-being. The racial and economic makeup of these communities often correlates with higher disease prevalence, highlighting the deep-rooted inequities in our health system. To achieve equitable health outcomes, we must address disparities in income, education, and access to resources. Supporting programs and organizations that work to remove these barriers is critical to reducing social disparities and improving community health. – Social Services Provider

Where we live, and how we live impacts our quality of life. When one or more of the social determinants of health is failing or falling behind, health issues will follow such as unemployment, homelessness, food insecurity etc. – Community Leader

Augusta County has a lower socioeconomic status than its neighbors in Charlottesville and Harrisonburg. Many areas that score high on the area of deprivation index. Inflation is causing fuel, food, and housing costs to continue to rise meanwhile incomes are staying flat making it hard for people to survive. – Health Care Provider

Social Determinants of Health (SDoH) generally showcase the overall health of a community from a high level. Typically, if SDoH is low, then the community is healthy. The SAW area has elevated levels of poverty, likewise, there is an increasing trend of homelessness in the community (generally harder to see in rural areas). Staunton & Waynesboro have high levels of cost burden relative to the rest of Virginia. (Staunton- 25%, Waynesboro – 30%, Augusta- 20%, VA- 27%). Overall children in poverty rates - (Augusta- 13%, Staunton- 15%, Waynesboro- 15%). – Public Health Representative

Poverty. Mental health. Housing. Jobs. – Community Leader

Economic stability: poverty rates: approximately 10.7% of the population lives below the federal poverty level, with Waynesboro experiencing particularly high rates. Among children aged 0 to 17, 14.9% are affected by poverty. Education: health literacy: understanding health information is crucial for accessing services. Low health literacy rates are higher in Waynesboro (21.8%) and Staunton (18.2%) compared to Augusta County (12.9%). Healthcare access and quality: demand for services: facilities like the Augusta Regional Dental Clinic have seen a 46% increase in uninsured dental patients, leading to longer waitlists and highlighting challenges in accessing affordable care. Neighborhood and built environment: housing and transportation: affordable housing and transportation have been identified as significant needs, affecting residents' ability to access employment, education, and healthcare services. – Community Leader

Social factors have up to an 80% effect on health outcomes. – Health Care Provider

Any one social determinant can significantly impact the life of an individual, as well as the lives of their families. We currently see in the community significant issues around housing stability, income stability, and a lack of inclusivity. – Community Leader

Baseline low socioeconomic level of the area. Low educational attainment. – Physician

Access to Care/Services

There's a lack of resources to support folks who need help in these areas - lack of affordable housing; general and financial support for folks facing hard times in any of the areas listed. – Community Leader

In this very large county, there are many residents living far from any sort of city conveniences, including health care. – Community Leader

Our community's ability to achieve their desired level of health is too often limited by the choices they have, their environment, their resources, and their opportunities (or lack therefore). Too often, limitations in education, housing, employment, nutrition, childcare etc. cause or contribute to a vicious cycle of chronic disease and poverty. 80% of health happens outside the doctor's office. When we address SDOH, we address the factors that may be limiting a person's ability to be healthy or follow a doctor's recommendations. – Social Services Provider

Lack of resources... housing, transportation, financial, etc. have a huge impact in our community. – Health Care Provider

Unhoused Populations

Large homeless population in our area as evidenced by the number at Valley Mission, WARM Shelter. Increase number of elderly, disabled homeless patients who have difficulty access these services due to not being handicapped accessible. – Health Care Provider

Moderate unhoused population, aging population that can't afford to move or care for their homes. – Social Services Provider

If folks don't have a home that provides physical security and food security, everything suffers- health, mental health, lack of ability to find and keep a job. Then, if one is a minority or can't speak the language very well, the problems are multiplied. – Community Leader

Lack of housing and income directly impact on the community's ability to be proactive and reactive for their health. If they do not have housing, they are already at a disadvantage for basic self-care necessities. Without income, they are unable to purchase what is needed to manage self-care. Getting accustomed to less self-care leads to less awareness of when they should be seeking health care, because they are used to not even having the basics. – Community Leader

Food Insecurity

Too much economic inequality. Too many have too tough a time making ends meet to include eating healthy and decent housing. – Community Leader

With inflation, more individuals are experiencing food insecurities and the inability to afford good food and medication. – Health Care Provider

> Living in food deserts, lack of income for food or medications, elimination of resources, current political shenanigans will further ruin attempts to care for those in need. – Community Leader

Affordable Care/Services

> Poor access to medical care due to finances. – Community Leader
>
> We have a significant number of people who are under insured, financially struggling and have health issues as a result. – Physician
>
> The number of people reaching out to me for general information about financial assistance and general resources has increased considerably in the past 6 months. I personally see a lot more people getting food assistance at the Embrace Clinic and other local places. Also, many community members have asked me about housing, employment and legal services. All these concerns have a direct impact on individual health/wellbeing. – Community Leader

Cost of Living

> We seem to be finally understanding that everything affects everything else but are unable to make a large enough dent or fast enough progress in addressing the needs. Our community is struggling with increased food, housing, and utility costs with minimally increasing wages. Folks are trying to survive day to day which does not allow for a focus on prevention or treatment of major health conditions. It is a vicious cycle. – Social Services Provider
>
> Many of the patients we see struggle with affording basic necessities e.g. food, housing, transportation, and they lack support from others. When you then add in the stress/costs of a chronic disease, this can be a very difficult situation. We spend more of our time now helping our patients w/ access issues, etc. vs. education as we did in the past. – Health Care Provider

Incidence/Prevalence

> Large poor, health illiteracy, housing instability, tobacco using community. Also have a large amount of mental health and substance abuse issues. – Physician

Discrimination

> There are many communities within our area who do not feel welcomed into the larger healthcare community, I feel. We have a significant amount of poverty and hunger in our area. – Physician
>
> Discrimination and lack of knowledge about LBGTQ+ citizens. – Community Leader

Isolation

> People are isolated. – Social Services Provider
>
> Social isolation. There are a lot of people out there who don't feel connection to anything outside their cellphones. – Social Services Provider

Employment

> The majority of jobs in our city are retail, service, and other hourly, low paid jobs that do not generally provide health insurance. Medical treatment is unattainable at that point. I am grateful that there are neighborhood clinics in the SAW region providing this free access. Our unhoused neighbors and ALICE population are growing. Housing and grocery prices continue to rise out of step with wages. Even as a middle-class person, this is a difficult financial environment. I volunteer at our church and see the number of people coming in for a free meal increasing, I have heard from the Blue Ridge Food Bank that the demand for food there has increased, and I understand that requests at our local agencies such as SACRA and VCSB have tremendous difficulty meeting the needs. The stress of trying to meet basic needs is in itself a major health concern born out of economic constraints. – Community Leader

Impact on Quality of Life

> It can reduce overall quality of life due to limited access to healthy foods, resources like transportation and safe housing, health care, education, and more. People who struggle with having basic needs met tend to have higher stress levels which can cause health issues, bad life choices like dependence on drugs, cigarettes, or alcohol, and unstable job history. – Social Services Provider

Lifestyle

> Most of the major health issues in our community are lifestyle based- heart disease, diabetes, mental health, etc. When patients have limited access to some of these categories (food, housing, transportation, medication, clothing, community), their whole health can be affected. Access to affordable housing and food are two of the biggest SDH's that are affecting Augusta County. – Health Care Provider

Transportation

> Factors that impact health are sometimes overlooked as contributing to the state of one's health. Transportation, for example, is a problem for many. If one does not have access to transportation to health care appointments, their health is negatively impacted. If they can't afford medications or healthy food, their health is negatively impacted. The community should invest more resources to ensure that residents have the basic resources they need. – Social Services Provider

Healthcare System

> The systems in all aspects of health in the area are disrupted by each other. Many take physical but not mental health seriously or vice versa. The key is to find a balance. – Social Services Provider

Alcohol/Drug Use

> Meth use is prevalent and a growing problem in the community. – Community Leader

Lack of Providers

> Need more case workers to assist patients within the community. More outside fairs to assist these patients. – Health Care Provider

Impact on Quality of Life

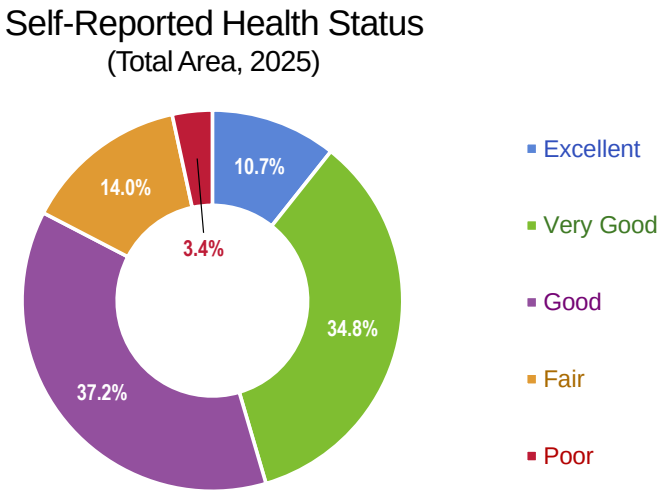
> When one area of SDOH poses challenges, other areas are affected. – Health Care Provider

HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is excellent, very good, good, fair, or poor?"

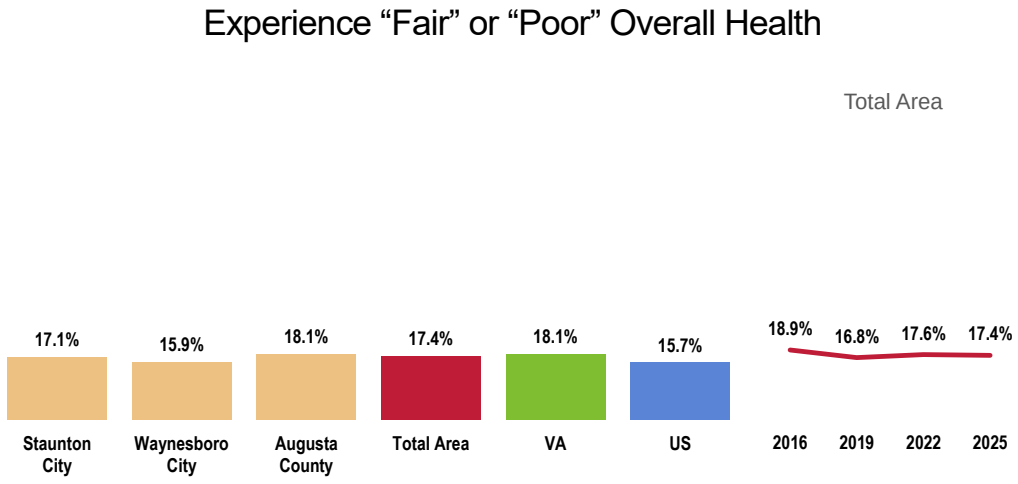
Most Total Area residents rate their overall health favorably (responding "excellent," "very good," or "good").



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

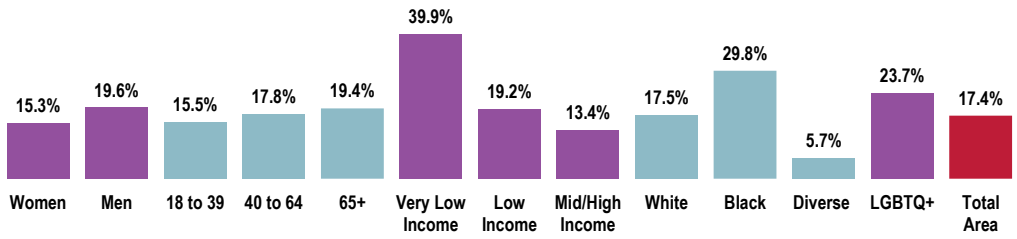
However, 17.4% of Total Area adults believe that their overall health is "fair" or "poor."

DISPARITY ► Reported more often among those with very low-incomes and among Black respondents.



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

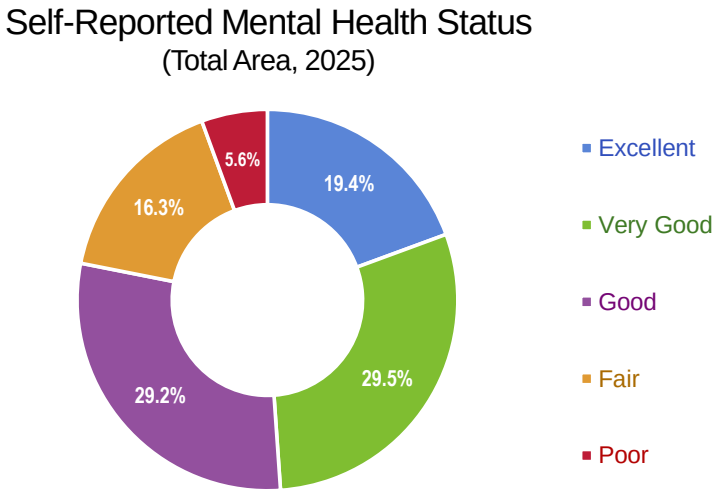
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

Adults

"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is excellent, very good, good, fair, or poor?"

Most Total Area adults rate their overall mental health favorably ("excellent," "very good," or "good").



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

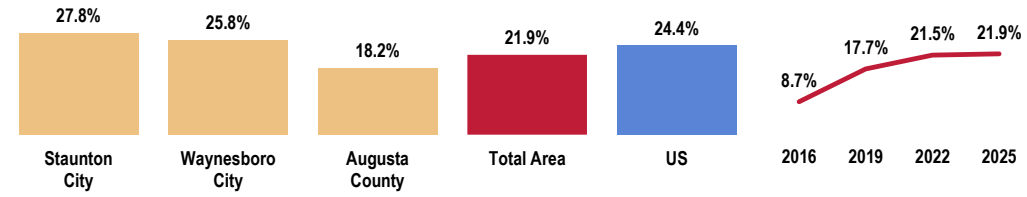
However, 21.9% believe that their overall mental health is "fair" or "poor."

TREND ► Increasing significantly since 2016.

DISPARITY ► Highest among Staunton residents.

Experience "Fair" or "Poor" Mental Health

Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Children

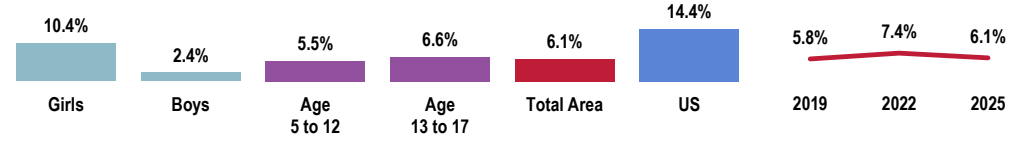
While most Total Area parents of children age 5 to 17 consider their child's mental health status to be "excellent," "very good," "or "good," a total of 6.1% rate it as "fair" or "poor."

BENCHMARK ► Much lower than the national rate.

DISPARITY ► Notably higher among girls than among boys.

Child Experiences "Fair" or "Poor" Mental Health

Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 310]
● 2024 PRC Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a child age 5 to 17 at home.

Depression

Diagnosed Depression

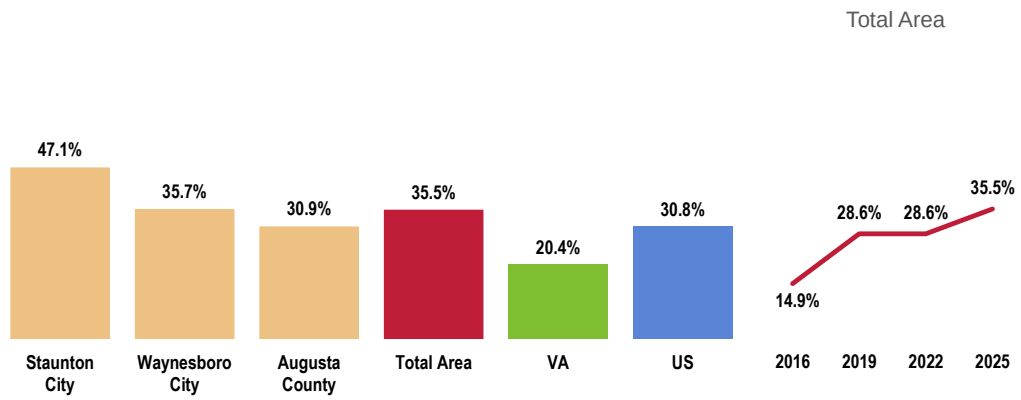
A total of 35.5% of Total Area adults have been diagnosed by a physician or other health professional as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

BENCHMARK ► Higher than both statewide and national findings.

TREND ► Significantly higher than baseline 2016 findings.

DISPARITY ► Highest among Staunton residents.

Have Been Diagnosed With a Depressive Disorder



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

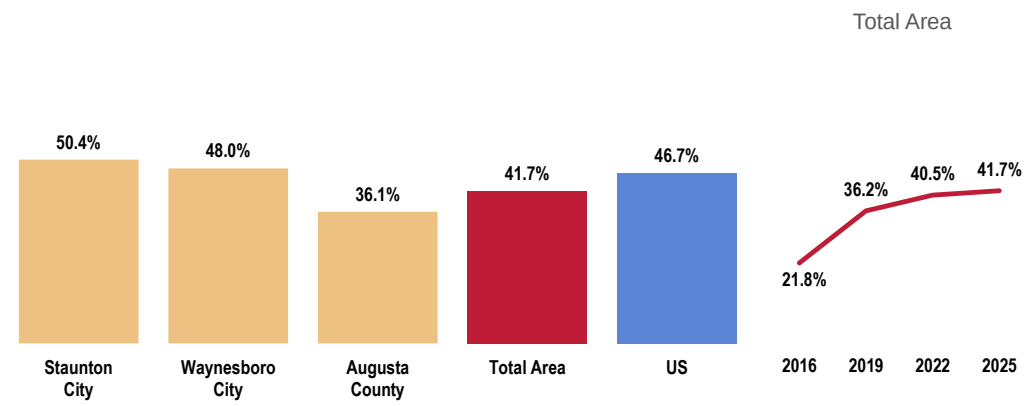
A total of 41.7% of Total Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

BENCHMARK ► Lower than the national prevalence.

TREND ► Nearly double 2016 findings.

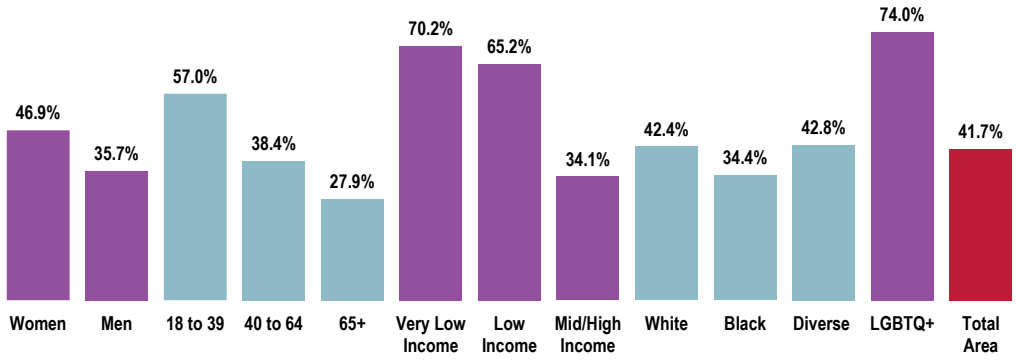
DISPARITY ► Reported more often among women, adults under the age of 65, lower income respondents, and LGBTQ+ respondents.

Have Experienced Symptoms of Chronic Depression



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

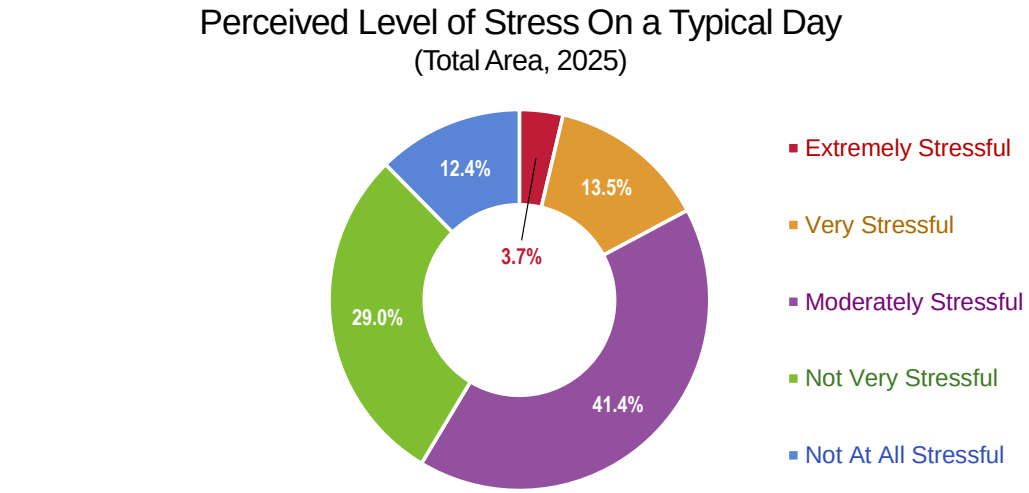
Have Experienced Symptoms of Chronic Depression
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
Notes: ● Asked of all respondents.
● Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Stress

A majority of surveyed adults characterize most days as no more than "moderately" stressful.



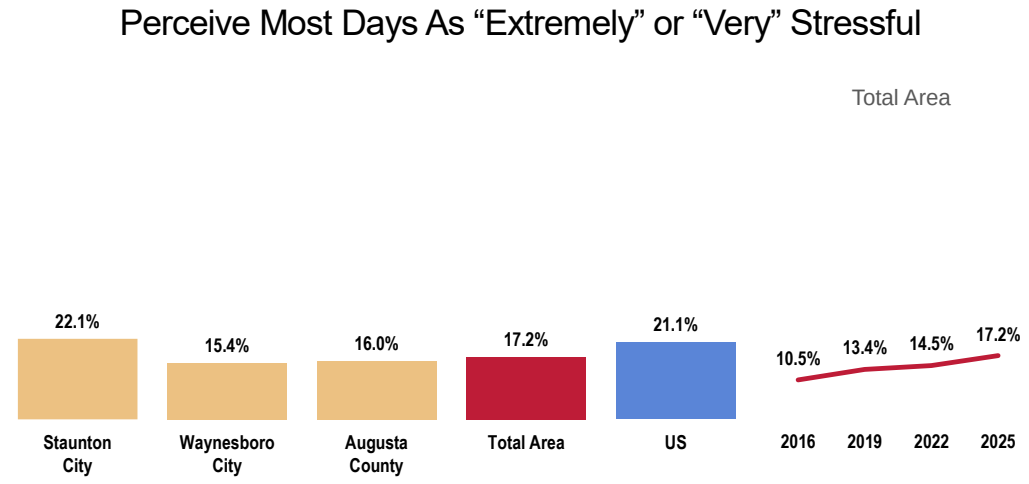
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

In contrast, 17.2% of Total Area adults feel that most days for them are "very" or "extremely" stressful.

BENCHMARK ► A lower percentage than found nationally.

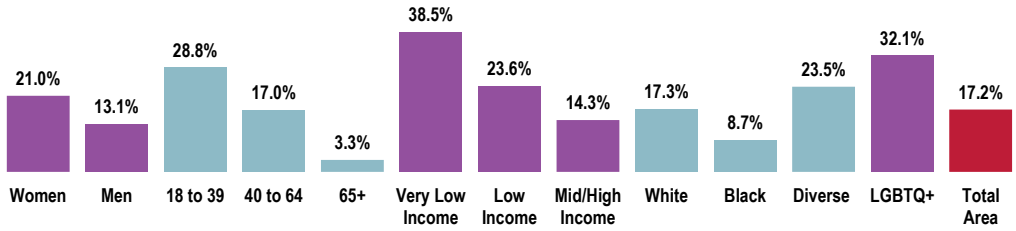
TREND ► Increasing over time.

DISPARITY ► Reported more often among women, adults under the age of 65, lower income residents, White respondents, residents of diverse races/ethnicities ("Diverse"), and LGBTQ+ respondents.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: • Asked of all respondents.

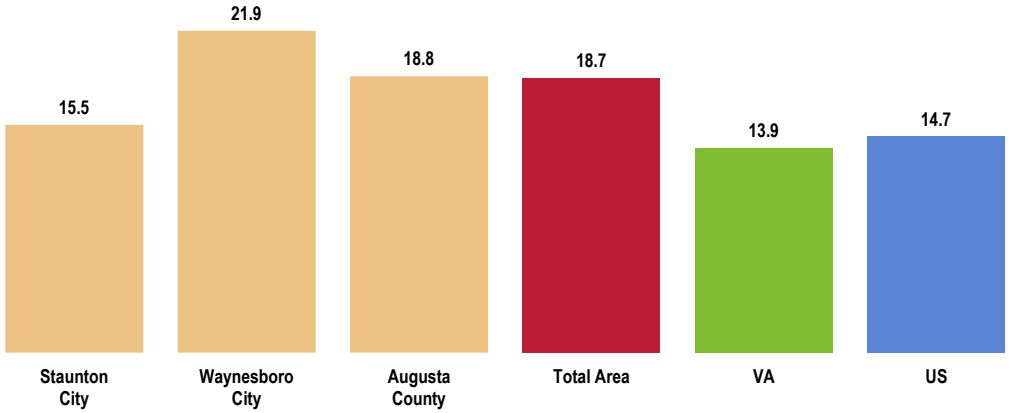
Suicide

In the Total Area, there were 18.7 suicides per 100,000 population (2021-2023 annual average rate).

BENCHMARK ► Higher than both Virginia and US rates. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lowest in Staunton.

Suicide Mortality
(2021-2023 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

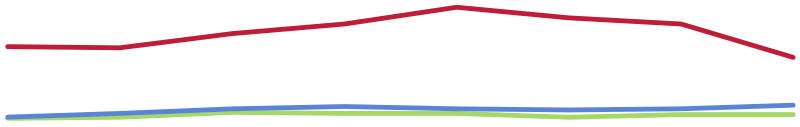


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population.

Suicide Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	19.6	19.5	20.7	21.5	22.9	22.0	21.5	18.7
VA	13.6	13.7	14.1	14.0	14.0	13.7	13.9	13.9
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Mental Health Treatment

Mental Health Providers

Note that this indicator only reflects providers practicing in the Total Area and residents in the Total Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

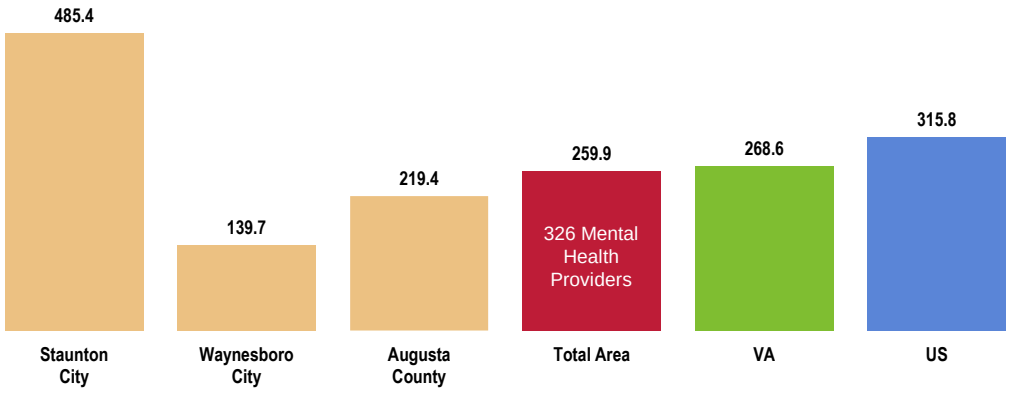
In 2025, there were 259.9 mental health providers (including psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) for every 100,000 population in the Total Area.

BENCHMARK ► Lower than the national ratio.

DISPARITY ► Particularly low in Waynesboro.

Number of Mental Health Providers per 100,000 Population

(2025)



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

Currently Receiving Treatment

Adults

A total of 27.4% of Total Area adults are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

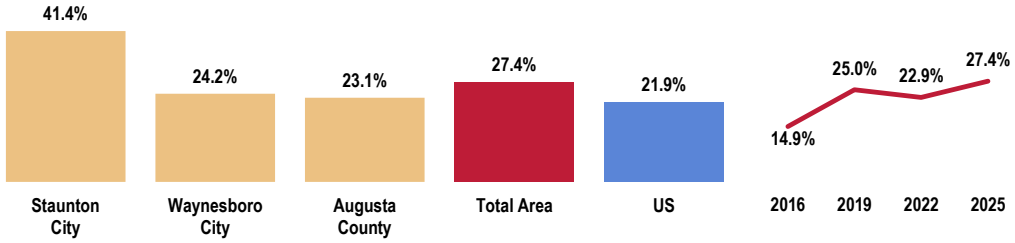
BENCHMARK ► Higher than the national rate.

TREND ► Significantly higher than 2016 findings.

DISPARITY ► Reported more often among Staunton residents.

Currently Receiving Mental Health Treatment

Total Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

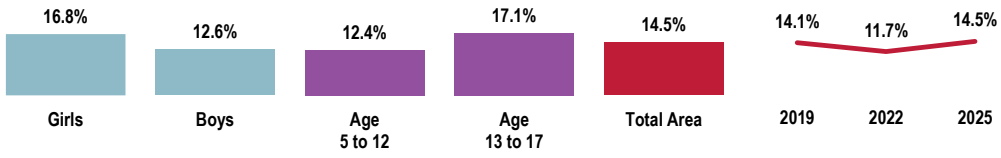
Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

Children

14.5% of surveyed parents with children age 5 to 17 were asked if their child needed mental health services at some point in the past year.

Child Needed Mental Health Services in the Past Year
(Total Area Parents of Children Age 5-17)

Total Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 311]

Notes:
- Asked of all respondents about a child age 5 to 17 at home.

Difficulty Accessing Mental Health Services

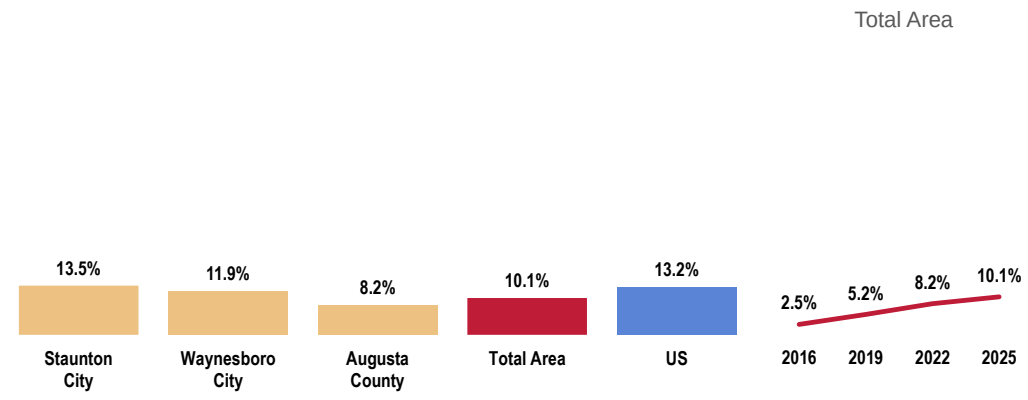
A total of 10.1% of Total Area adults report a time in the past year when they needed mental health services but were not able to get them.

BENCHMARK ► Lower than the national prevalence.

TREND ► Rising significantly since 2016.

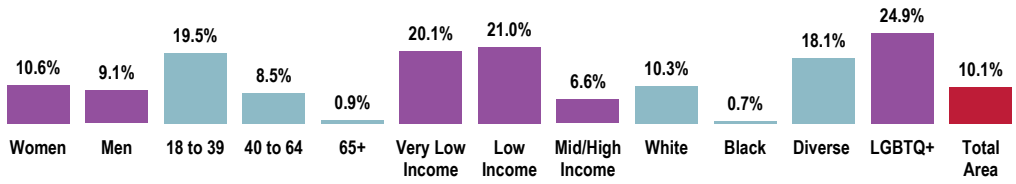
DISPARITY ► Reported more often among adults under the age of 65, those in lower income households, White respondents, Diverse race/ethnicity respondents, and LGBTQ+ respondents.

Unable to Get Mental Health Services When Needed in the Past Year



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 82]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

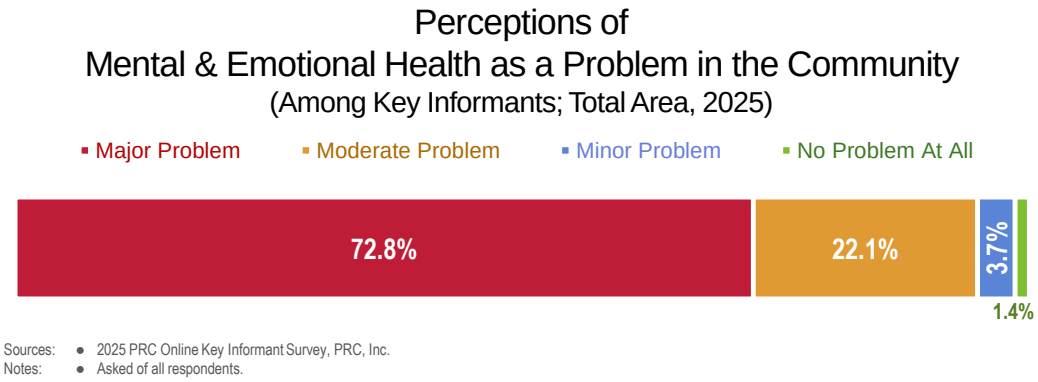
Unable to Get Mental Health Services When Needed in the Past Year
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 82]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

An overwhelming majority of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access and very poor family and social situation. – Physician
>
> People with mental health issues tend not to be able to find the help they need just maybe due to it being overwhelming, or there are not enough providers or there is a long wait list until the patient is able to be seen. – Health Care Provider
>
> Access to health care. Insured and uninsured members struggle to find mental health services. It is very challenging to get an appointment with a psychologist/psychiatrist, especially when financial resources are limited. Scheduling - lack of after-hours appointments. – Community Leader
>
> Scheduling in a timely fashion and high cost of services. Knowledge of where to go for specific services. Providers/facilities lack of awareness of available services in our area. Assistance for families of those dealing with mental health of loved ones. – Community Leader
>
> Access to services. VCSB is overwhelmed. – Community Leader
>
> Access to help, proper diagnosis and treatment, available resources and support. – Social Services Provider
>
> General support for the range of mental health issues. – Health Care Provider
>
> Finding appropriate counseling and therapy services that fit their needs. Second, crisis counseling should be more available to the public. – Health Care Provider
>
> Access to crisis intervention and rehabilitation, and very little child/adolescent care. – Health Care Provider
>
> Access to care. Waits take a while. Transportation to be seen is so hard. – Physician
>
> Access to resources and admissions to mental health clinics or hospitals. – Health Care Provider
>
> Access to mental health care remains a significant challenge for many individuals, despite growing awareness of its importance. For countless people, finding affordable, quality mental health services is a barrier, whether due to limited availability of providers, long wait times, or lack of insurance coverage. Rural areas, like ours, often face a shortage of mental health professionals, leaving residents with few options for care. Even when services are available, the cost can be prohibitive for those without adequate insurance or financial means. Compounding this issue is the stigma surrounding mental health, which continues to deter many individuals from seeking help. Cultural attitudes that view mental health struggles as a sign of weakness or failure often prevent people from reaching out for the support they need. This stigma is especially pronounced in rural communities. – Health Care Provider
>
> Lack of access, particularly for adolescents. – Health Care Provider
>
> Limited access to mental health services - the availability of mental health professionals, particularly psychiatrists and therapists, is limited. Long wait times and a shortage of providers. Rural barriers to care - Many areas in Augusta County are rural, making transportation to mental health services difficult. Individuals without reliable transportation may struggle to access in-person therapy, psychiatric care, or crisis intervention services. Crisis intervention and emergency care gaps - Individuals experiencing a mental health crisis may have limited options for immediate intervention. While local hospitals and law enforcement provide some crisis response, dedicated mental health crisis teams and inpatient psychiatric beds are often scarce. – Community Leader
>
> Access to services like no insurance or not enough. – Social Services Provider

Access to care, transportation, challenges in accessing support in making recommended changes to behavior/thinking patterns. – Social Services Provider

Limited access to mental health services: provider shortages: The region experiences a shortage of mental health professionals, making it difficult for residents to access timely care. This scarcity affects both outpatient and inpatient services, leading to extended wait times and unmet needs. Financial barriers: affordability of care: the cost of mental health services can be prohibitive, especially for those without adequate insurance coverage. High expenses deter individuals from seeking necessary treatment. Stigma surrounding mental health: Cultural Perceptions: Persistent stigma associated with mental health issues discourages many from seeking help. Misunderstandings and societal judgments contribute to reluctance in addressing mental health concerns. – Community Leader

Few programs available. Access is limited. Many homeless in the area do not have access. Substance abuse plays into this as well. – Health Care Provider

Lack of accessibility to counseling. Many places are booked out and do not take insurance. The self-pay is very expensive. To my knowledge not many support groups available. Many programs did not restart after COVID-19. I have seen caregiver fatigue due to lack of day programs for adult children with mental disabilities. – Public Health Representative

Lack of access to mental health services and substance abuse treatment. Honestly the system is broken and needs a lot of help. – Health Care Provider

The biggest challenge for people with mental health services is to have access to and be able to afford the appropriate level of service. Otherwise, mental health conditions go untreated causing problems in other areas of a person's life. – Community Leader

Not enough accessibility to Outpatient services and Telehealth. – Health Care Provider

Lack of available services to address issues. – Community Leader

No short term stay facility for a mental patient to stay before a true diagnosis is made. Need more acute psychiatrists on staff. – Health Care Provider

Lack of services and especially access to mental health professionals. – Health Care Provider

Access to mental health providers in a timely fashion. Need more counselors. Need more providers that take Medicaid. – Health Care Provider

Availability of and access to care. The sigma associated with mental health that oftentimes causes people not to seek care. The homeless population and access to community care for those individuals. The lack of community based crisis centers to take to burden off of emergency departments, EMS, and law enforcement. – Community Leader

Access to MH services. Demonstrated need for crisis receiving center. Need to move the ECO/TDO triage out of the emergency room aside from a medical clearance. – Community Leader

Access to counselors and other supportive services. It is difficult to get appointments with counselors and if you do get an appointment you have to wait a long time for the first visit. – Social Services Provider

Difficulty getting seen by a mental health provider in a timely fashion, lack of information on life skills and strategies that can help a person manage their difficult situations, our culture tends to emphasize technology, speed, and efficiency, which can lead to few opportunities for personal connection with other people. – Social Services Provider

Thinking more in the lines of mental health with our youth. – Community Leader

Lack of access to appropriate care. Lack of 24-hour receiving center for crisis and lack of crisis stabilization-detox unit for stabilizing crisis (the only option at this point in hospitalization, the emergency department, or incarceration. Stigma, lack of enough resources to provide care to the indigent. Transportation. – Social Services Provider

Access to behavioral health services at the right time and the right place. – Health Care Provider

Access to care. – Physician

Access to care. – Health Care Provider

There are no resources. There are long waitlists. It is difficult to find clinicians that take your insurance. – Social Services Provider

Finding the proper counseling services. Affordability of the services. Stigma associated with Mental health issues, sometimes maintaining employment. – Community Leader

Lack of access to resources. – Social Services Provider

Limited access to services in the CSB. Intake process is challenging for those with mental health disease with limited support and resources such as transportation barriers. It is a walk in service, no appt and may not have a slot to be seen and evaluated when they arrive. – Health Care Provider

Access to care is huge because there are either no face to face local practitioners or there are long wait lists. Transportation is also limited for low income people who need to get to their doctor or the CSB for mental health treatment. – Social Services Provider

Lack of resources. – Social Services Provider

Lack of crisis stabilization center and long wait times for counseling appointments, not enough counselors, substance use. – Health Care Provider

Access to mental health resources and clinicians. – Health Care Provider

Having some personal experience with this, the biggest problem is just the availability of therapists and counselors. – Community Leader

Access to proper care and drug addiction. – Health Care Provider

Lack of Providers

Not enough providers; no adequate location for them to go to in order to seek treatment (such as Crisis Stabilization and Detox Center); Many patients access the ER when experiencing mental health issues, but this is only a temporary solution and treatment there can only go but so far. – Health Care Provider

Tremendous unmet clinical need due to lack of clinicians at all professional levels who can provide mental health services. Low reimbursements by insurers for mental health services. – Physician

Lack of mental health providers and limited beds/facilities. – Health Care Provider

Access to counselors, substance abuse programs and adolescence counselors are very limited. Need case management in OBHS. – Health Care Provider

It's hard to find providers that can continually serve patients. Valley Board is our main resource but referrals to get patients in can take a long time. – Health Care Provider

Limited clinicians in the area that treat mental health problems. Stigma and access to appropriate medications. – Health Care Provider

Limited quantity of counselors, resulting in limited availability, as well as limited number of qualified counselors. Affordability of mental health services. Stigma of seeking mental health services. – Community Leader

Limited number of providers, limited providers in areas of specialty, and limited providers from diverse backgrounds. Limitation to health insurance, or lack of health insurance. – Community Leader

Lack of providers. Unaffordability. Lack of acute crisis intervention resources. – Social Services Provider

There are not enough providers. Individuals seeking help who need to wait to be seen are less likely to return to or follow through on services. Individuals self-medicating with illegal substances rather than seeking services. Individuals unaware of their need for services or family stigma around receiving services. – Social Services Provider

Lack of practitioners, difficulty with health insurance coverage. – Social Services Provider

Very limited access to help. Current providers are overwhelmed. – Community Leader

Access to providers and an understanding of mental health needs by those who work outside the mental health world. – Social Services Provider

Not enough doctors to follow patients and how the medicines they are being given affect them. More suicide awareness and prevention/intervention are needed. – Social Services Provider

Lack of accessible mental health providers in this area coupled with substance abuse co-dependency. – Public Health Representative

Affordable Care/Services

Affordable access to care which does not promote humiliation or financial impediment; lengthy wait times for care. – Community Leader

Poverty. Access to resources. Access to treatment. Access to case management. – Community Leader

Lack of access due to cost or insurance coverage; lack of providers and availability. – Social Services Provider

Affordable and quality mental health counseling is hard to find, especially for those with low income. Even with therapeutic interventions, it is incredibly stressful to be poor. Financial insecurity contributes to chronic stress which in turn exacerbates both mental and physical health decline. Many people with mental health issues also struggle with social isolation and loneliness making it hard to develop and access support systems through family, friends, and various forms of community. Finally, there's a tremendous lack of awareness among the public of what to do when someone you know is in crisis. The stigma around mental health has contributed to this, but it makes it really hard to know how to help someone when you see they're not well. When do you call CSB and what can they do? The police? Friends and family? Many people want to help but don't know how. – Social Services Provider

Crisis mental healthcare and access to affordable care. Too often police and sheriff deputies are the frontline for crisis mental healthcare and prison guards are too often the long-term care givers. We need a fourth leg of emergency responders who are crisis care givers that are not part of law enforcement but would work with law enforcement and EMTs. We also need the VCSB Crisis Receiving Center built and operational. – Community Leader

Access to affordable providers/access to providers in general for kids. There do not seem to be enough providers to fill open positions, again with a noted lack in kids. – Social Services Provider

Denial/Stigma

> Generally, it personally feels that stigma and lack of providers continue to be the largest barriers present within the community. Lack of physical providers does seem to have been alleviated with the increased access to virtual options, that said this is only an option for those who have consistent access to internet. – Public Health Representative
>
> Wanting help. – Health Care Provider
>
> Poor experiences/judgement from others, stigma around mental health. I see one of these issues almost daily. – Community Leader
>
> Stigma, isolation, potential discrimination for some part of their belief system, current situation, or identity (LGBTQIA+, person of color, substance use, homeless). Cooccurring factors – mental health, lack of stable housing, poverty, limited education, lack of job readiness, substance use. – Social Services Provider
>
> Although we have seen improvement, the stigma that has surrounded mental health and individuals seeking mental health case persist. Additionally, we still need more early intervention, particularly with school-age youth. – Social Services Provider
>
> By the time you get past the stigmas and things get bad enough where you decide to look for help you are put on a waiting list that can stretch into dangerous territory. I'm particularly concerned about our middle and high school kids. – Community Leader
>
> Unfortunately, I think there is still a stigma surrounding mental health. There have been strides to bridge the gap between treating mental health with the same openness as physical health, but I don't think we're quite there yet. I also think that mental health services, while they exist, can often be hard to access in terms of wait times, having beds available, etc. – Community Leader

Diagnosis/Treatment

> Transactional nature of living with mental health. Continuing regular use of medications. – Social Services Provider
>
> I see people w/o mental health issues being treated with mental health medications to treat their symptoms such as depression from their frustration for not receiving the right treatment for their ailments. I see this often for people with hormone imbalances (women suffering from high or low estrogen, girls and women with PCOS, men who are depleted of their testosterone levels, etc.). Also, people getting treated for heart disease and the medications having terrible effects on them, causing major depression and w/o being pushed to get answers, the result could have been detrimental. Those with mental health issues we often see them being treated with medications, then told to come back in six months if it's not working, with no monitoring, or communication portals, or journaling to track how the medication is impacting them. Also, have witnessed people being treated for the symptoms, but not the root of the problem and have a personal story about a friend directly related to this. – Community Leader
>
> How to recognize if one needs help, and then getting help and have the ability to have the help provided at very minimal cost if at all. – Community Leader
>
> Recognition. – Community Leader
>
> Advocating for themselves, especially in dealing with healthcare. – Health Care Provider

Awareness/Education

> Limited resources. Community citizens are unaware of resources that are available. Agencies are limited in personnel to be able to help. – Health Care Provider
>
> The biggest challenges are to identify mental health, true mental health, teaching and equipping the community resources to work with mental health. Make mental health an affordable issue when it comes to medication and treatment. Reengage schools into proper IEPS, and better educate the educators to work with children that are effected with mental health. Better trained staff in places like Commonwealth Center or Western State. Don't just medicate and warehouse, create community effective programs that are better than stuffing envelopes. Don't let a school shooting or stabbing of a political figure always be the precursor to a mental health discussion. – Social Services Provider

Incidence/Prevalence

> Large proportion of patients with mental health and substance abuse in our area. Lack of access to programs for substance abuse (ETOH) and mixed depression/SA disorders. Valley Community does a decent job of access but not with a prescriber which is what most people want. – Physician
>
> Many people in the area face MH struggles and are unready to face them. Men's mental health is an issue in the area and lack of providers and specifically at time lack of Male providers can make some men uncomfortable. Lacking in providers and long waitlists are negative impacts as well. – Social Services Provider

Cost of Living

> Cost of living. Lack of access to counselors. Cost of medications. Insurance coverage. Provider access. Lack of facilities to accommodate mental health care. – Health Care Provider
>
> Many with MH issues have increased risk of housing and food insecurity. – Social Services Provider

Vulnerable Populations

> Anxiety. Our Latinx community is having very challenging times with the recent changes in policies. There is an increasing fear at simple things like going out to work or grocery shopping. Many families are not going to the doctor, not attending church or not sending children to school. Many people will lose their jobs and housing. This is having a huge impact on the mental health of the community and will raise more social problems. – Community Leader

Unhoused Populations

> Homelessness as stated in an earlier question. Mental health and substance abuse issues are contributing to an increasing number of homeless in the community. – Social Services Provider

Alcohol/Drug Use

> This is often wrapped up in the problems associated with substance abuse. Access to timely intervention is crucial. – Physician

Language Barriers

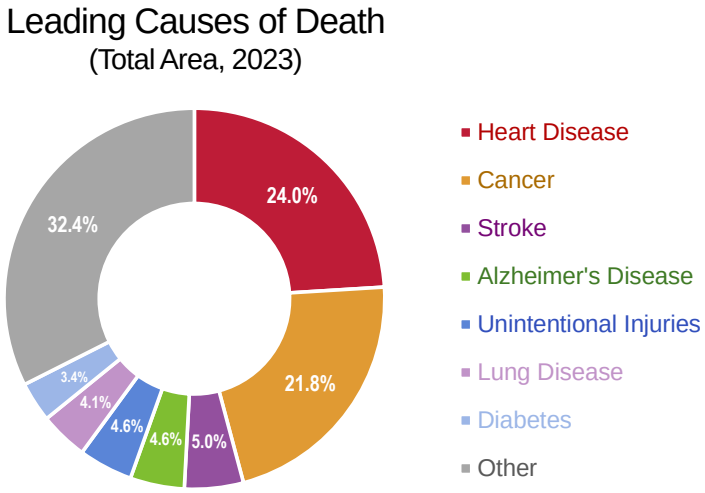
> No service in Spanish, no resources. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, cancers and heart disease accounted for nearly one-half of all 2023 deaths in the Total Area.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Lung disease includes deaths classified as chronic lower respiratory disease.

Death Rates for Selected Causes

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

The following chart outlines 2021-2023 annual average death rates per 100,000 population for selected causes of death in the Total Area.

Leading causes of death are discussed in greater detail in subsequent sections of this report.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	Total Area	VA	US	Healthy People 2030
Heart Disease	300.9	193.2	209.5	127.4*
Cancers (Malignant Neoplasms)	254.0	182.3	182.5	122.7
Unintentional Injuries	60.3	61.1	67.8	43.2
Stroke (Cerebrovascular Disease)	58.2	48.9	49.3	33.4
Lung Disease (Chronic Lower Respiratory Disease)	54.2	37.4	43.5	—
Alzheimer's Disease	49.5	29.0	35.8	—
Diabetes	37.3	31.8	30.5	—
Kidney Disease	24.2	19.1	16.9	—
Cirrhosis/Liver Disease	23.7	13.7	16.4	10.9
Suicide	18.7	13.9	14.7	12.8
Pneumonia/Influenza	17.7	11.6	13.4	—
Alcohol-Induced Deaths	16.3	11.3	15.7	—
Motor Vehicle Deaths	16.3	11.5	13.3	10.1
Unintentional Drug-Induced Deaths	16.1	27.8	29.7	—
Homicide [2014-2023]	2.9	5.7	7.4	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Heart Disease & Stroke Deaths

Heart Disease Deaths

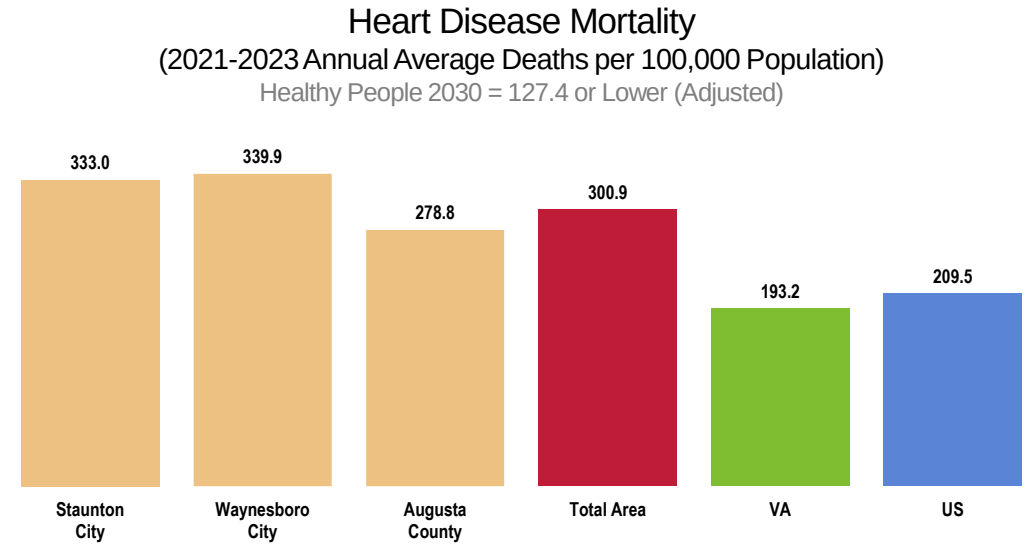
The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2021 and 2023, there was an annual average heart disease mortality rate of 300.9 deaths per 100,000 population in the Total Area.

BENCHMARK ► Considerably higher than both the state and US rates. Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing over the past decade (whereas state and national trends are more stable).

DISPARITY ► Lowest in Augusta County.



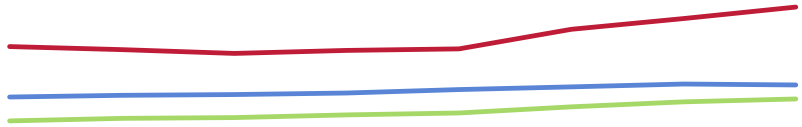
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Heart Disease Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	254.4	251.2	246.6	250.1	252.0	274.7	287.6	300.9
VA	167.5	170.4	171.6	174.5	176.8	183.9	189.9	193.2
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Stroke Deaths

Between 2021 and 2023, there was an annual average stroke mortality rate of 58.2 deaths per 100,000 population in the Total Area.

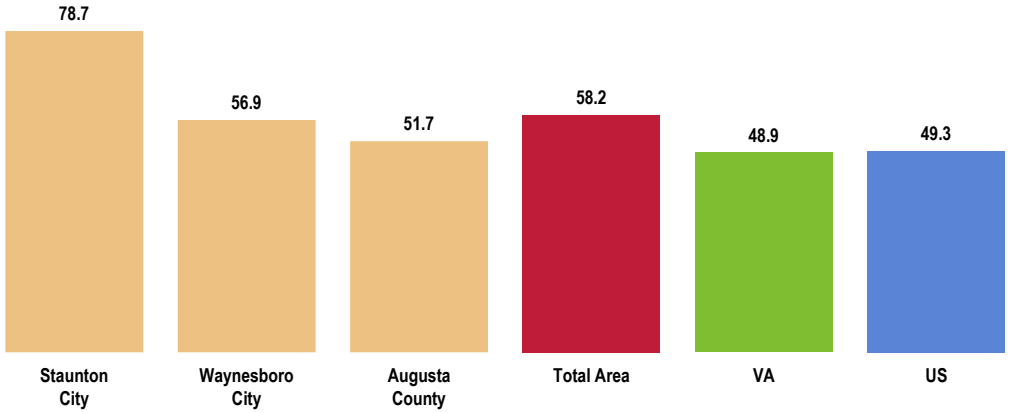
BENCHMARK ► Higher than both statewide and national rates. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Particularly high in Staunton.

Stroke Mortality

(2021-2023 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	59.8	54.8	53.8	52.9	55.1	53.1	52.5	58.2
VA	40.3	41.4	42.7	43.7	45.6	46.7	48.3	48.9
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

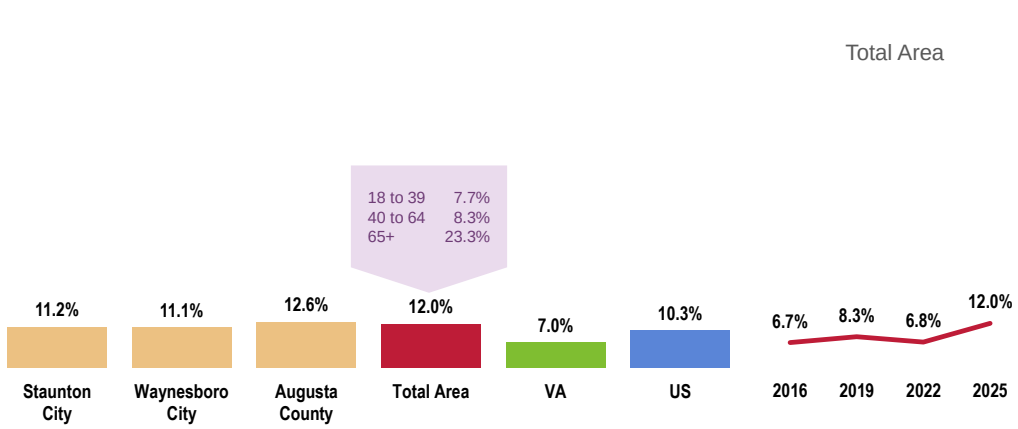
A total of 12.0% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

BENCHMARK ► A higher prevalence than Virginia.

TREND ► Significantly higher than baseline 2016 findings.

DISPARITY ► Increasing significantly with age.

Prevalence of Heart Disease



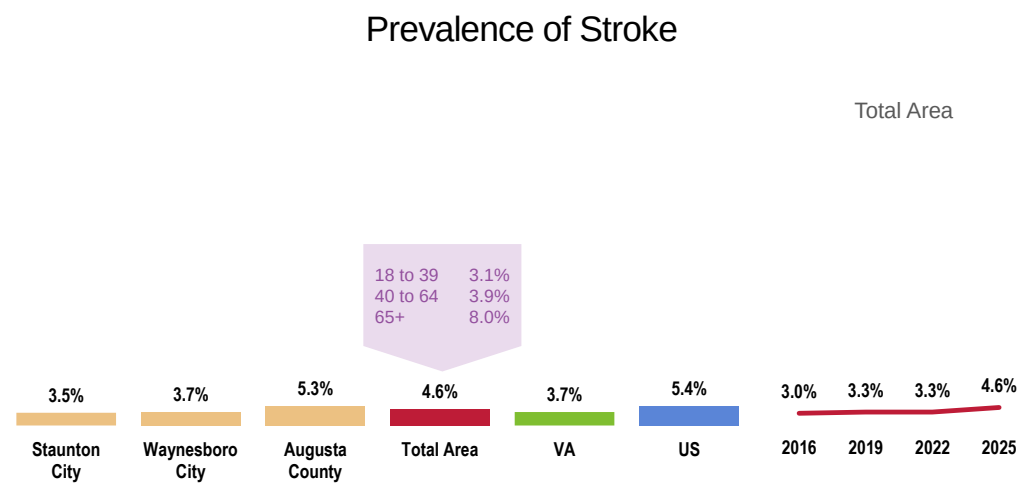
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

A total of 4.6% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

DISPARITY ► Increasing significantly with age.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

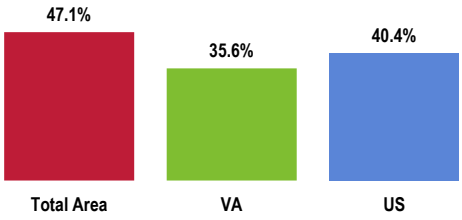
Blood Pressure & Cholesterol

A total of 47.1% of Total Area adults have been told by a health professional at some point that their blood pressure was high.

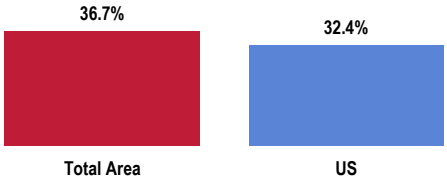
BENCHMARK ► Higher than both the state and national rates. Fails to satisfy the Health People 2030 objective.

A total of 36.7% of adults have been told by a health professional that their cholesterol level was high.

Prevalence of
High Blood Pressure
Healthy People 2030 = 42.6% or Lower



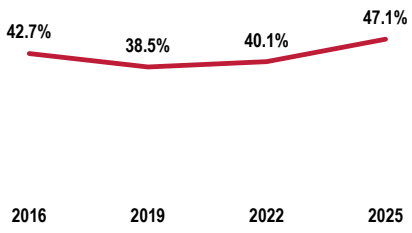
Prevalence of
High Blood Cholesterol



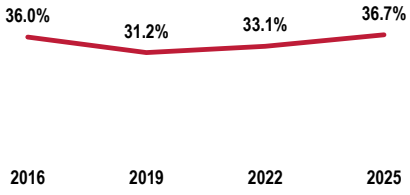
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(Total Area)
Healthy People 2030 = 42.6% or Lower



Prevalence of
High Blood Cholesterol
(Total Area)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

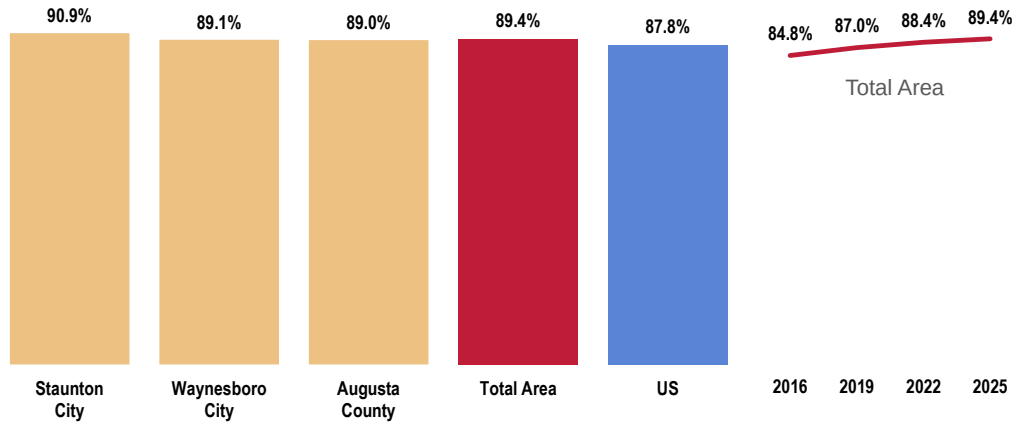
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

A total of 89.4% of Total Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

TREND ► Significantly higher than found in 2016.

DISPARITY ► Reported more often among adults over the age of 40 and among Black respondents.

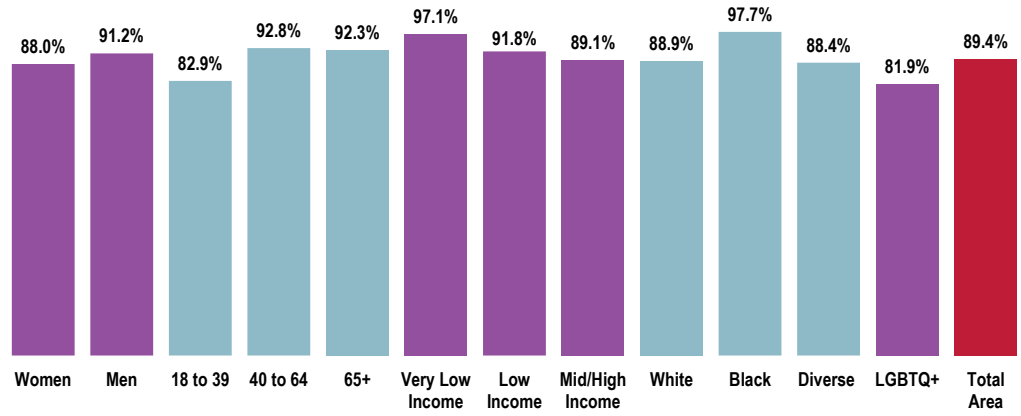
Exhibit One or More Cardiovascular Risks or Behaviors



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Exhibit One or More Cardiovascular Risks or Behaviors
(Total Area, 2025)

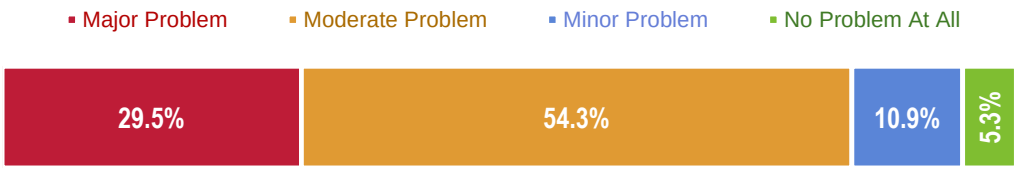


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
Notes: • Reflects all respondents.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Among Key Informants; Total Area, 2025)



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

> Poor and unhealthy diet and lack of exercising. Addictions. Untreated dental diseases. – Social Services Provider
>
> Outcomes of being overweight, smoking, sedentary lifestyles. – Social Services Provider
>
> Some contributing factors include: - Poor nutrition (due to lack of access) - Lack of access to quality care - Overabundance of highly processed foods high in sugar and sodium - High levels of stress, particularly among those facing financial difficulties can exacerbate heart conditions - Lack of time and resources for physical activity - High tobacco usages, most concernedly among youth. – Social Services Provider
>
> Poor nutrition and lifestyle. – Community Leader
>
> Lack of preventative lifestyle behaviors, healthy eating habits, physical activity, stress management, and unmanaged chronic conditions lead to a greater prevalence of heart disease and stroke issues. – Health Care Provider
>
> They are pervasive diseases in all communities. Considering the SDOH and lifestyle choices of residents in the area, I believe heart disease and stroke are significant problems. – Social Services Provider

Lifestyle choices, lack of exercise, alcohol and tobacco use contribute to heart disease and stroke. Our health system doesn't do enough preventative care to avoid heart disease and stroke but only provides access to these services AFTER a health episode has occurred. – Social Services Provider

Chick-Fil-A, Kentucky Fried. – Social Services Provider

Poor diet, lack of exercise, and lack of education on appropriate prevention. – Health Care Provider

Incidence/Prevalence

There are many people in the community who have heart diseases or other heart related issues, and we continue to see an increase in our stroke cases. This is often debilitating for patients. – Health Care Provider

Recently seen uptick in issue with 60-65 year old. How is this being missed in annual exams? – Community Leader

High incidence of type II DM in our community which increases risks for having heart disease and/or stroke in this population. – Health Care Provider

Cardiovascular disease. Large numbers of patients that present with a CV complaint. – Physician

Cardiovascular disease. – Social Services Provider

People seem to have a lot of heart disease and strokes. – Social Services Provider

All conditions. – Health Care Provider

Due to the number of stroke alerts that are transported to the hospital by ambulance. Heart disease due the medications that our patients are taking with health issues such as shortness of breath and hypertension. – Health Care Provider

Number of people in my church with these conditions, number of clients served in current work, work in AH Neighborhood Primary clinic. – Community Leader

It seems to be a prevalent issue within the population that I work with. – Social Services Provider

Seeing more people needing stents or dying of heart attacks or strokes. – Social Services Provider

Increase risk factors for heart disease and stroke are prevalent in our community. – Health Care Provider

Obesity

Obesity, way of life. – Health Care Provider

You can see first-hand in our community that on average residents are carrying more weight than is healthy for their hearts. However, obesity rates in Virginia are right on average for all States and the longstanding growth in obesity rates in Virginia appear to be leveling off. – Social Services Provider

I think we have an issue with obesity in our community which can lead to heart disease and stroke. I think people are more aware of the causes and symptoms of heart disease, but less aware about the causes and symptoms of stroke. – Community Leader

Obesity and DM heighten risk of heart disease and stroke. – Public Health Representative

Large volume of obese residents, leading to heart disease and stroke. – Health Care Provider

Awareness/Education

People not educated to control risk factors. – Physician

I think there is a lack of nutrition education in our community, paired with a lack of healthy local options. Again, particularly in the county. – Community Leader

Unknown high blood pressure. Lack of education of both as some do not know the difference between the two. Obesity. Access to providers. Poor diet. Noncompliance with medication preventative measures. – Health Care Provider

Be more evolving and bring information and education. – Community Leader

Aging Population

Aging population, obesity, and poor eating habits. Lack of nutritional diet. – Health Care Provider

Overall population in the Augusta County, Staunton, Waynesboro area is trending older. These are issues that are exacerbated by lack of access to areas for exercise and fresh food. It would be wise to begin to think of ways to curb these chronic conditions before the majority population is older adults who will be at higher risk to these conditions. – Public Health Representative

Leading Cause of Death

> A large percentage of the population will suffer from these conditions, and they are a leading cause of death. – Community Leader
>
> They are a major killer for patients and are life altering, if not fatal. – Physician

Access to Specialty Care

> Access to cardiology care is a concern due to recent loss of multiple cardiologists. – Physician
>
> Access to cardiovascular services. Stroke I believe is accessible. – Health Care Provider

Impact on Quality of Life

> This is part of the spectrum of atherosclerotic disease and we are typical of multiple communities across the nation in this. Acute MI, chronic heart failure, acute stroke with the multiple complications that then ensue all have a great impact on the community's ability to improve and maintain our residents' quality of life. – Physician

CANCER

ABOUT CANCER

The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

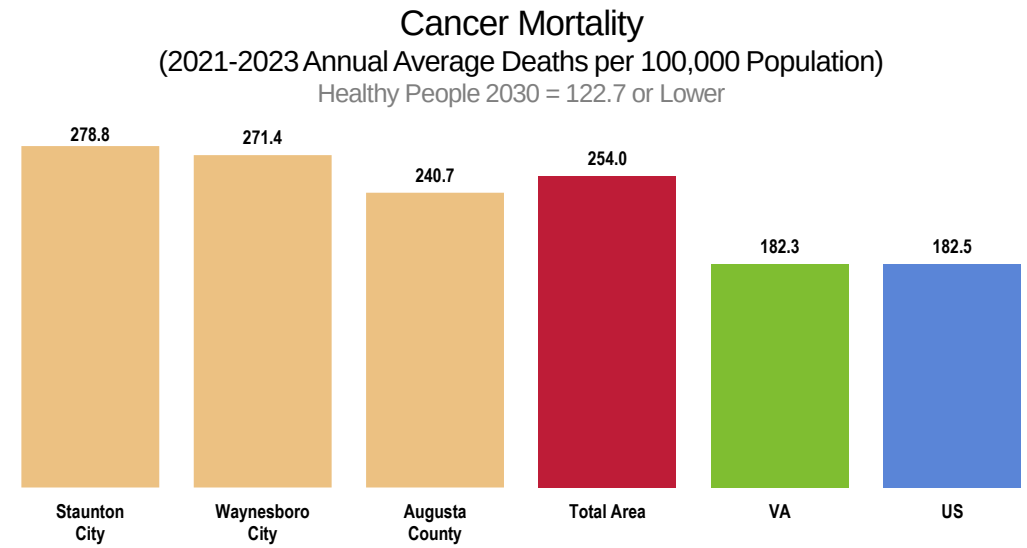
– Healthy People 2030 (https://health.gov/healthypeople)

Cancer Deaths

All Cancer Deaths

Between 2021-2023, there was an annual average cancer mortality rate of 254.0 deaths per 100,000 population in the Total Area.

BENCHMARK ► Significantly higher than both Virginia and US rates. Fails to satisfy the Healthy People 2030 objective.



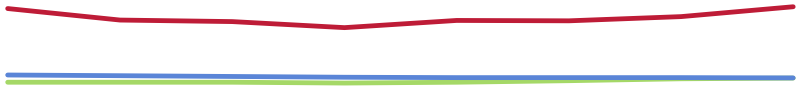
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cancer Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	252.2	240.6	238.9	233.0	240.2	239.7	244.0	254.0
VA	178.0	178.3	178.1	177.3	178.2	179.5	181.6	182.3
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cancer Deaths by Site

Lung cancer is the leading cause of cancer deaths in the Total Area.

Other leading sites include prostate cancer, female breast cancer, and colorectal cancer (both sexes).

BENCHMARK

Lung Cancer ► Higher than both state and national rates. Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Higher than both state and national rates. Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Higher than both state and national rates. Fails to satisfy the Healthy People 2030 objective.

Prostate Cancer ► Fails to satisfy the Healthy People 2030 objective.

Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

	Total Area	VA	US	Healthy People 2030
ALL CANCERS	254.0	182.3	182.5	122.7
Lung Cancer	58.2	40.5	39.8	25.1
Female Breast Cancer	32.3	26.0	25.1	15.3
Colorectal Cancer	25.3	16.2	16.3	8.9
Prostate Cancer	22.9	20.6	20.1	16.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

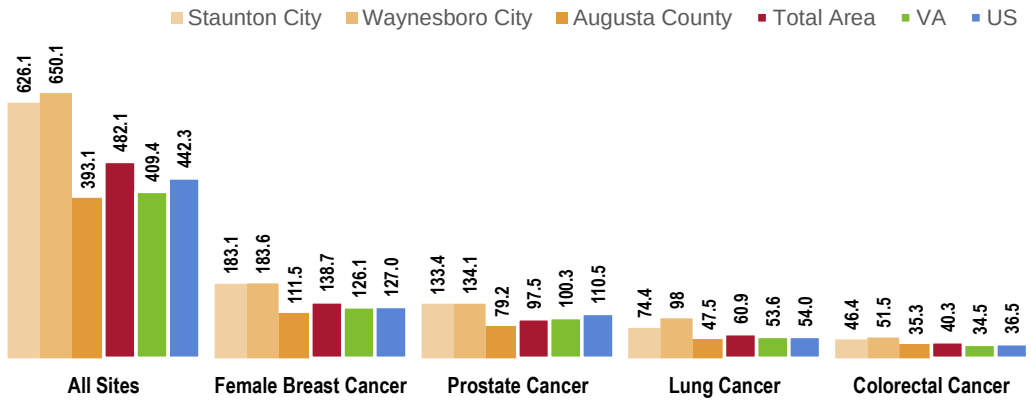
Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. It is usually expressed as cases per 100,000 population per year.

The highest cancer incidence rates are for female breast cancer and prostate cancer.

DISPARITY ► For each, rates are higher in the cities and lower in Augusta County.

Cancer Incidence Rates by Site
(2016-2020)



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

A total of 13.0% of surveyed Total Area adults report having ever been diagnosed with cancer.

BENCHMARK ► A higher rate than was found nationally.

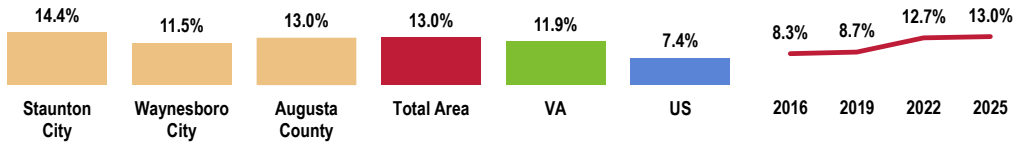
DISPARITY ► Reported more often among older adults and White respondents.

Prevalence of Cancer

Total Area

The most common types of cancers cited locally include:

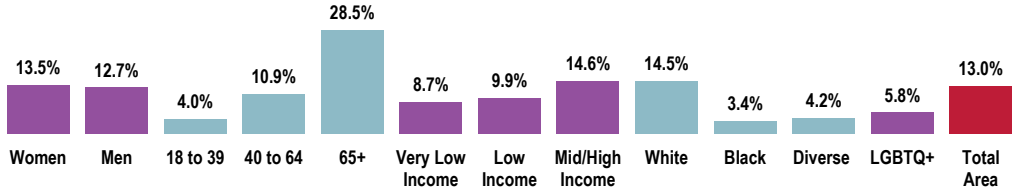
1) Melanoma 23.4%
2) Breast Cancer 19.5%
3) Prostate Cancer 10.9%



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Cancer
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 24]

Notes:
- Asked of all respondents.

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures. Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every 3 years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Among women age 50 to 74, 79.2% have had a mammogram within the past 2 years.

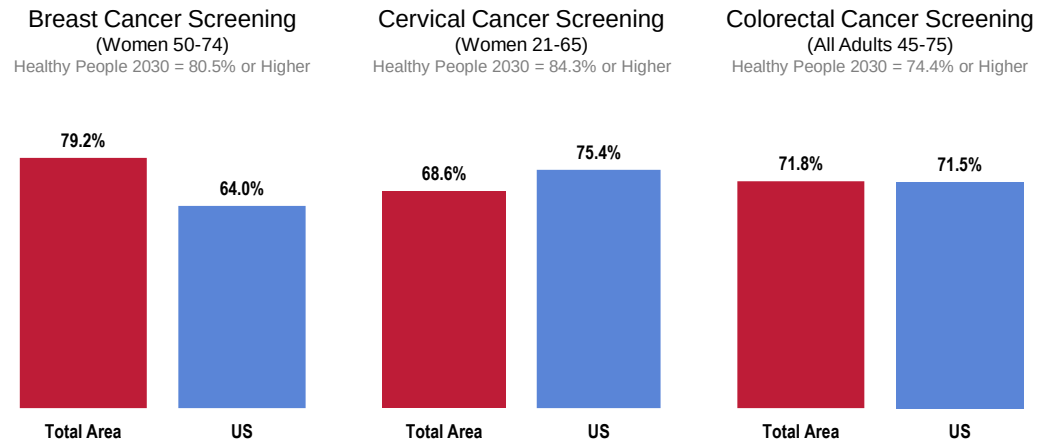
BENCHMARK ► Higher than the national percentage.

Among Total Area women age 21 to 65, 68.6% have had appropriate cervical cancer screening.

BENCHMARK ► Lower than the national percentage. Fails to satisfy the Healthy People 2030 objective.

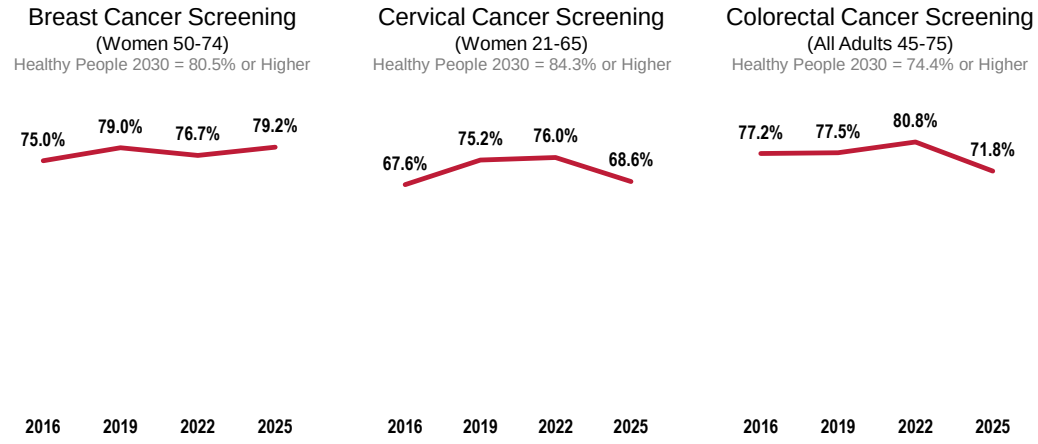
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

Among all adults age 45 to 75, 71.8% have had appropriate colorectal cancer screening.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that national data for colorectal cancer screening reflect adults ages 50 to 75.

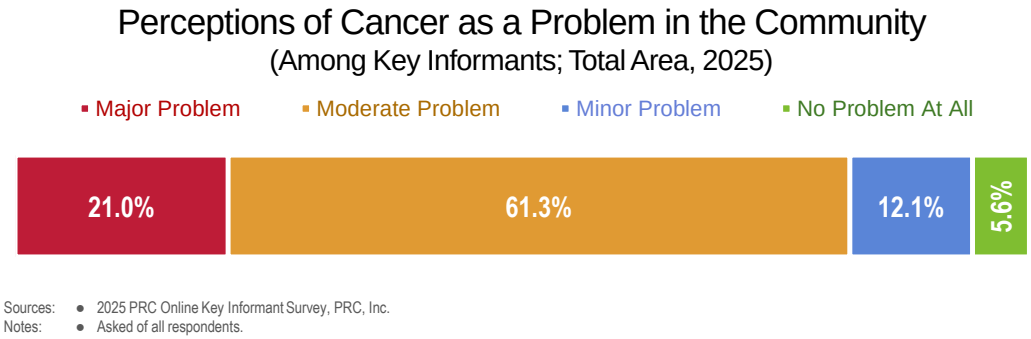


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> High incidence of cancer. – Community Leader
>
> I'm aware of several individuals in my community that are battling cancer or have passed from cancer. – Community Leader
>
> UVA Augusta UVA ECCC and AH Cancer Center along with Sentara RMH serve this area along with referral made outside the area. Multiple new diagnosis of childhood cancer in our area as well. – Health Care Provider
>
> Just seeing more cases. – Health Care Provider
>
> SAW has a higher prevalence of certain cancer modalities than other areas in our state. – Health Care Provider
>
> You either have had it yourself or you know someone who is currently battling it. – Health Care Provider
>
> Statistically this region has a very high number of cancer cases. – Community Leader
>
> Simply put, there appear to be a great deal of people suffering from malignancy. Cancer needs to be detected as early as possible and then evaluated and treated promptly. Our healthcare community currently does not provide enough resources for this both in terms of practitioners and logistical support. – Physician
>
> This is purely anecdotal, but it seems like it's not if you'll develop cancer in SAW, but when you'll develop it. – Social Services Provider
>
> I know so many people with cancer of all different kinds. It seems like every day someone else has gotten a cancer diagnosis. – Community Leader
>
> Because I know of a number of people diagnosed with cancers of varying severity. – Community Leader
>
> The number of new cancer diagnosis is high in my area. – Health Care Provider
>
> There are several middle-aged people and elderly who are battling cancer at present. Specifically, I see people who retire from our local factories (particularly DuPont / Koch) who then succumb to cancer within a few years of retirement. I feel this is related to the chemicals used in the factories. I also see alcohol and tobacco use as a major contributing factor to cancer here in the SAW region. – Social Services Provider
>
> Cancers of all types are prevalent in our community and greatly impact individual and family health and wellbeing, as well as being expensive to treat. – Community Leader

Awareness/Education

> I don't believe there is enough education or resources to educate the community on cancer causing agents. I also feel there are no cancer clinics that are convenient. I believe there to be lots of people walking around undiagnosed and by the time they feel sick enough to go to someone other than urgent care, the cancer has spread or become terminal. – Social Services Provider
>
> We don't have information. – Community Leader

Diagnosis/Treatment

> Without success in preventative care, many cancers are detected late, ensuring that the treatment costs and impacts are much greater for patients and families. – Physician

> Lack of screening for many easily detectable cancers, especially colon cancer. Use of tobacco products. – Community Leader

Impact on Caregivers/Families

> It seems that weekly I hear from a different person their families struggle with a loved one who has cancer. Anecdotally, it seems cancer frequently affects many families. – Social Services Provider

Leading Cause of Death

> It is the second largest cause of death in the USA, and I believe it is likely to be very much the same in the SAW area. – Social Services Provider

Impact on Quality of Life

> Divesting consequences of cancer. – Health Care Provider

Lack of Providers

> Need more loyal providers that stay long term. – Health Care Provider

Tobacco Use

> High volumes of smokers, exposure factors for farmers and factory workers. – Health Care Provider

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Respiratory Disease Deaths

Lung Disease Deaths

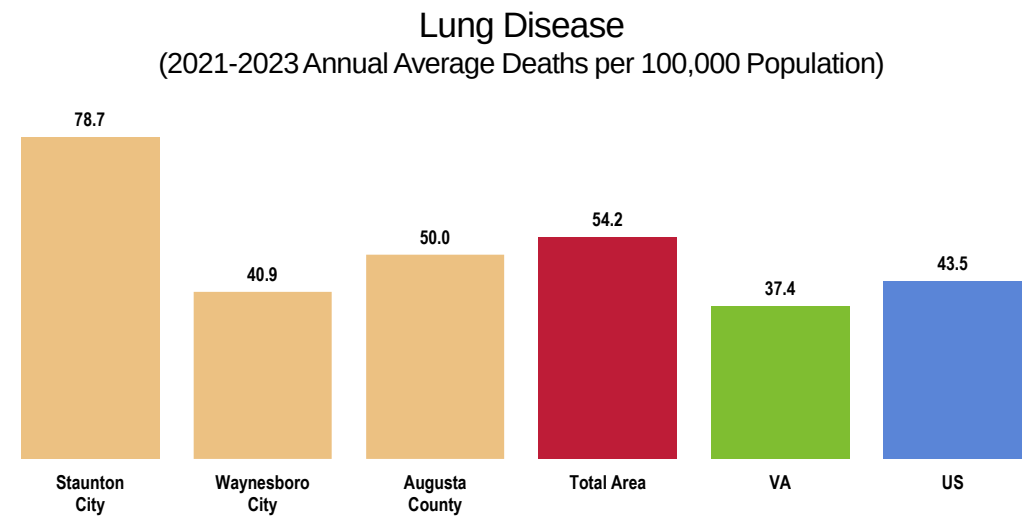
Note: Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

Between 2021 and 2023, the Total Area reported an annual average lung disease mortality rate of 54.2 deaths per 100,000 population.

BENCHMARK ► A higher rate than the state and nation.

TREND ► Decreasing in recent years.

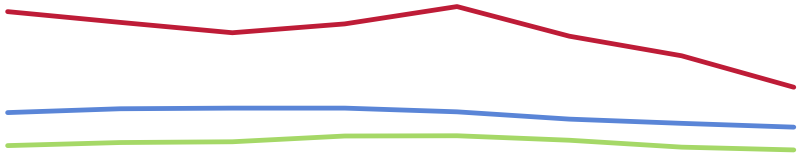
DISPARITY ► Particularly high in Staunton.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes: ● Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Lung Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	74.4	71.6	68.8	71.2	75.8	67.9	62.6	54.2
VA	38.6	39.4	39.6	41.1	41.2	40.0	38.1	37.4
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Deaths

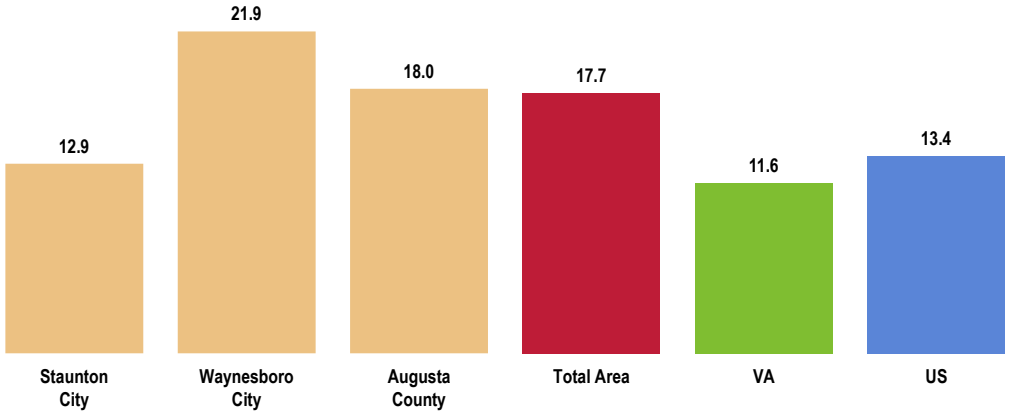
Between 2021 and 2023, the Total Area reported an annual average pneumonia/influenza mortality rate of 17.7 deaths per 100,000 population.

BENCHMARK ► Higher than both state and national rates.

TREND ► Decreasing significantly over the past decade.

DISPARITY ► Notably higher in Waynesboro.

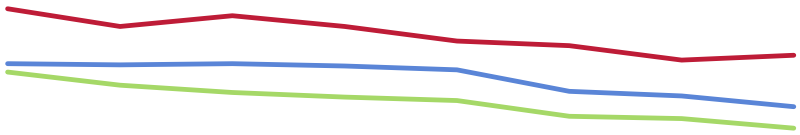
Pneumonia/Influenza Mortality
(2021-2023 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	21.6	20.1	21.0	20.1	18.9	18.5	17.3	17.7
VA	16.3	15.2	14.6	14.2	13.9	12.6	12.4	11.6
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	13.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Respiratory Disease

Asthma

Adults

A total of 15.6% of Total Area adults have asthma.

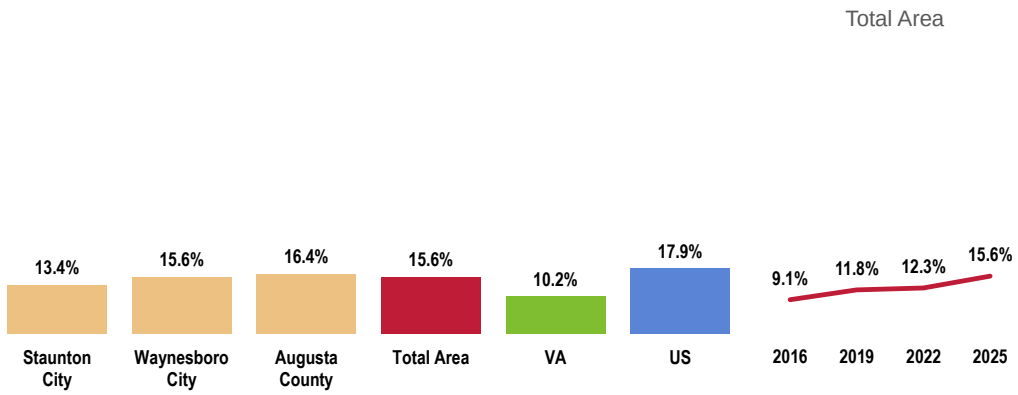
Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

BENCHMARK ► A higher percentage than was found statewide.

TREND ► Increasing significantly since 2016.

DISPARITY ► Reported more often among women, younger adults, and those with lower incomes.

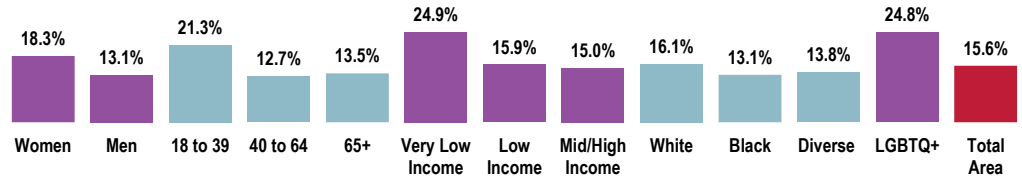
Prevalence of Asthma



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Asthma
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
Notes: • Asked of all respondents.

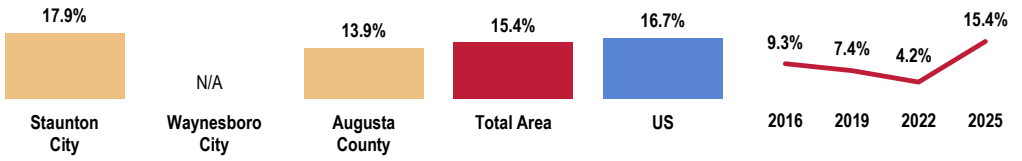
Children

Among Total Area children under age 18, 15.4% have been diagnosed with asthma.

DISPARITY ► Higher among children age 13 to 17 (not shown).

Prevalence of Asthma in Children
(Children 0-17)

Total Area



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 92]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

A total of 6.9% of Total Area adults suffer from chronic obstructive pulmonary disease (COPD).

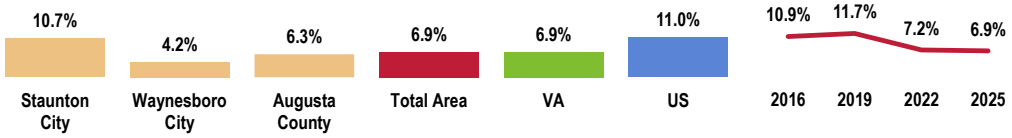
BENCHMARK ► Lower than the nationwide prevalence.

TREND ► Decreasing significantly since 2016.

DISPARITY ► Reported more often among Staunton residents.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Total Area



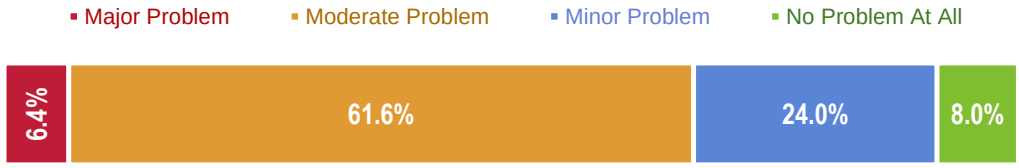
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a "moderate problem" in the community.

Perceptions of Respiratory Disease as a Problem in the Community
(Among Key Informants; Total Area, 2025)



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> High incidence of illness. – Community Leader
>
> Many people live with COPD and have to rely on O2 tanks. – Social Services Provider
>
> Much higher rate of respiratory diseases, especially in recent days. – Health Care Provider
>
> Many patients with poorly controlled asthma and COPD. – Physician

Awareness/Education

> Lack of education. – Community Leader

E-Cigarettes/Vaping

> Smoking/Vaping in the area along with COPD. – Health Care Provider

Tobacco Use

> Air quality is generally good to very good. Possibly we have a high percentage of smokers. And farmers who work fields on open tractors without masking. – Community Leader

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

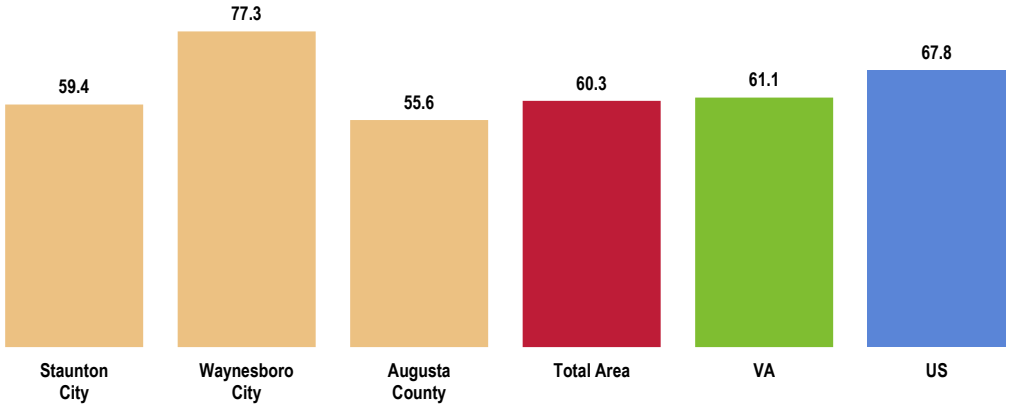
Between 2021 and 2023, there was an annual average unintentional injury mortality rate of 60.3 deaths per 100,000 population in the Total Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing significantly over the past decade.

DISPARITY ► Highest among Waynesboro residents.

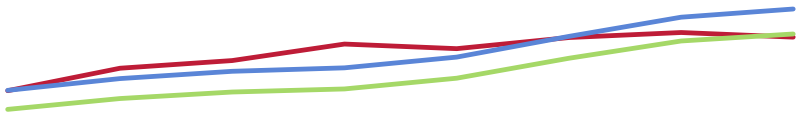
Unintentional Injury Mortality
(2021-2023 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Unintentional Injury Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	45.9	51.9	54.0	58.4	57.2	60.2	61.5	60.3
VA	40.9	43.8	45.5	46.4	49.3	54.6	59.2	61.1
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

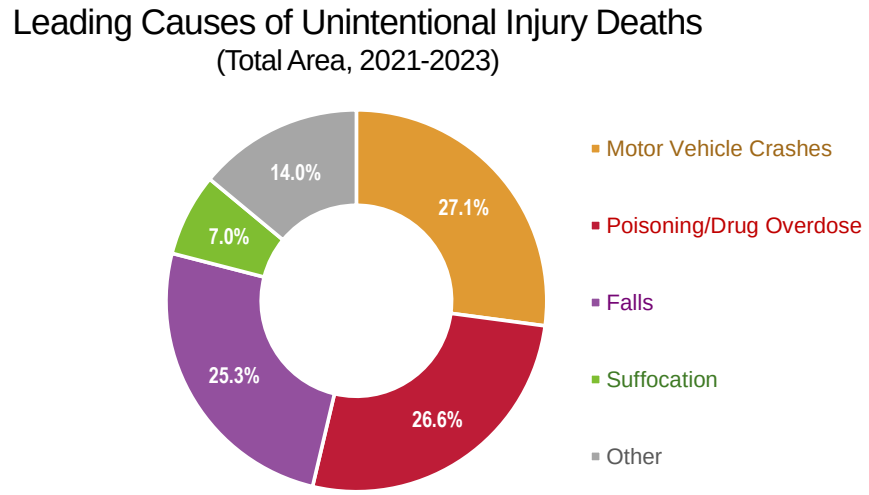
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

Motor vehicle crashes, poisoning (including unintentional drug overdose), and falls accounted for most unintentional injury deaths in the Total Area between 2021 and 2023.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

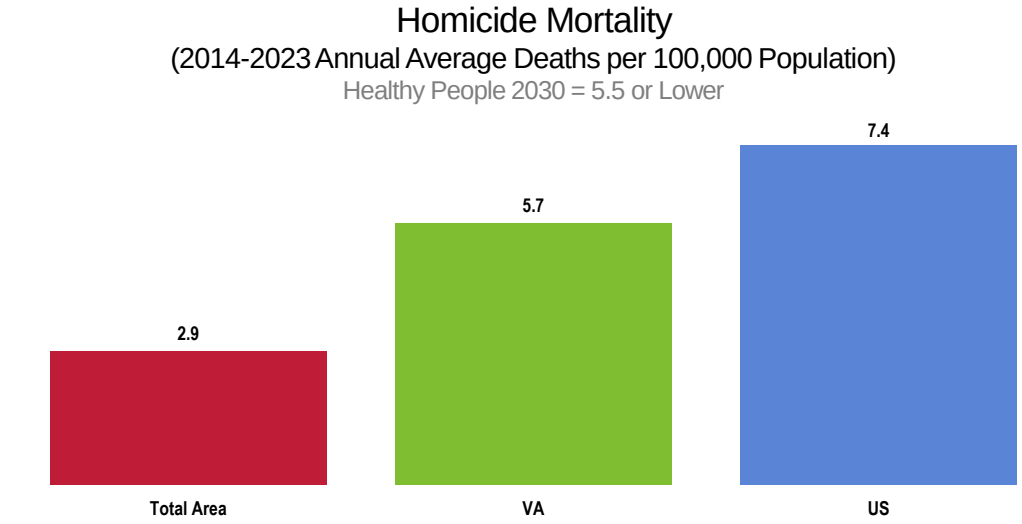
Intentional Injury (Violence)

Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

In the Total Area, there were 2.9 homicides per 100,000 population (2014-2023 annual average rate).

BENCHMARK ► Considerably lower than both state and national findings. Satisfies the Healthy People 2030 objective.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Community Violence

A total of 4.0% of surveyed adults acknowledge being the victim of a violent crime in the area in the past five years.

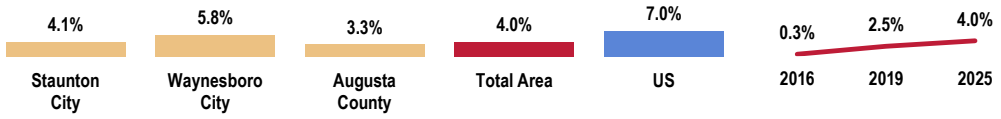
BENCHMARK ► Lower than the national prevalence.

TREND ► A significant increase since 2016.

DISPARITY ► Reported more often among young adults, and those in the Diverse race/ethnicity segment.

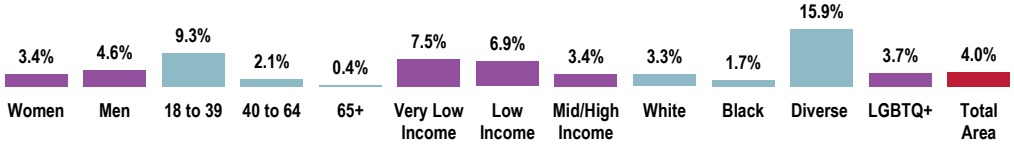
Victim of a Violent Crime in the Past Five Years

Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Victim of a Violent Crime in the Past Five Years
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
Notes: ● Asked of all respondents.

Intimate Partner Violence

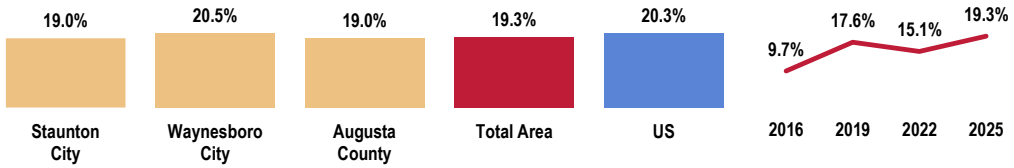
Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 19.3% of Total Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

TREND ► Significantly higher than baseline findings.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

Total Area



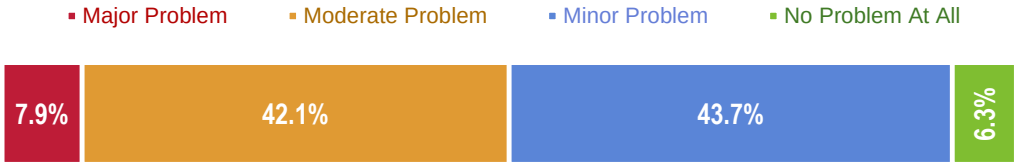
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

Key informants taking part in an online survey tended to characterize *Injury & Violence* as a "moderate problem" or as a "minor problem" in the community.

Perceptions of Injury & Violence as a Problem in the Community

(Among Key Informants; Total Area, 2025)



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Overall rates are minimal within SAW area. Some notable areas of interest include suicide, traumatic brain injury (mostly by motor vehicle accidents), firearms (includes suicide, homicide, and accidental). Other notable areas are drug overdose rates which have trended upward (2019- 16.6, 2020-17.4, 2021-12.1, 2022-17.6, 2023-16.9). – Public Health Representative
>
> Emergency Department cases. – Health Care Provider
>
> Violence in the US is a huge problem not just in Augusta County. We need better protection for the hospital staff, schools, churches, etc. – Health Care Provider
>
> Newspaper accounts, full domestic violence shelter. – Community Leader
>
> I feel like I hear and read on the news more incidents of violent crimes in our surrounding areas. More than I have in the past. – Health Care Provider

Domestic Violence

> Domestic violence is certainly an issue and is not always disclosed. – Physician

Unhoused Population

> Homelessness in Stuarts Draft and Waynesboro. Mental Health as evidenced by the event in Crozet. – Health Care Provider

Leading Cause of Death

> For younger populations these situations are the leading cause of death. – Community Leader

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

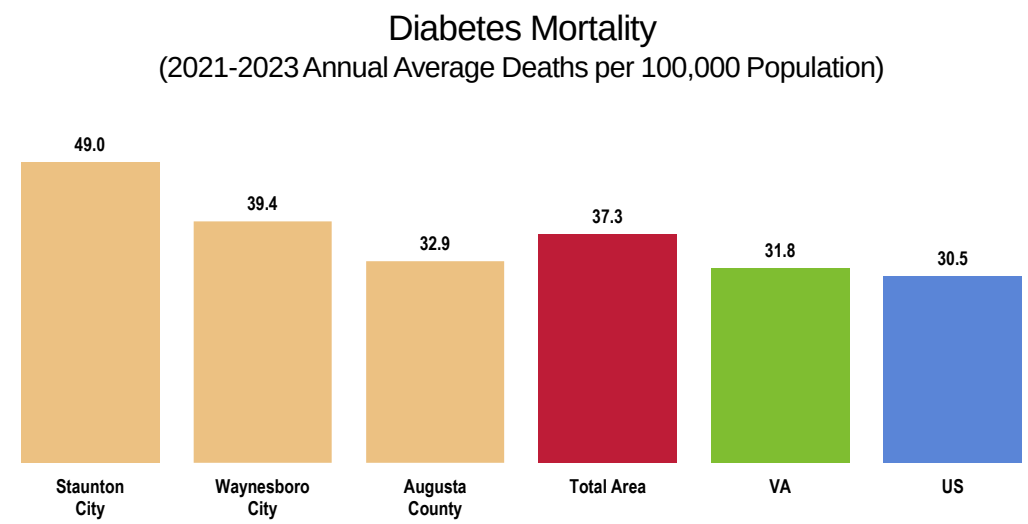
– Healthy People 2030 (https://health.gov/healthypeople)

Diabetes Deaths

Between 2021 and 2023, there was an annual average diabetes mortality rate of 37.3 deaths per 100,000 population in the Total Area.

BENCHMARK ► Higher than the US rate.

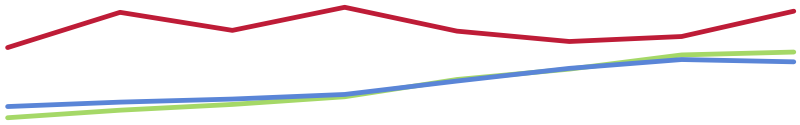
DISPARITY ► Particularly high in Staunton.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Diabetes Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	32.4	37.1	34.7	37.8	34.6	33.2	33.9	37.3
VA	23.0	24.0	24.8	25.8	28.1	29.5	31.4	31.8
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Diabetes

A total of 14.4% of Total Area adults report having been diagnosed with diabetes.

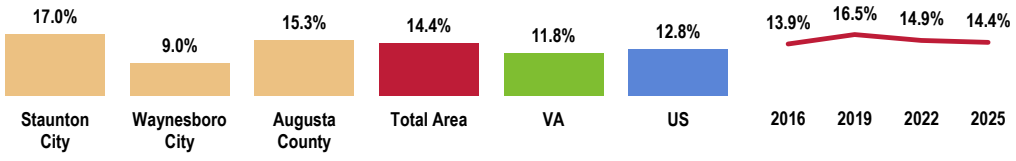
BENCHMARK ► Statistically higher than the statewide percentage.

DISPARITY ► Reported more often among adults over the age of 65 and Black respondents.

Prevalence of Diabetes

Another 16.4% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

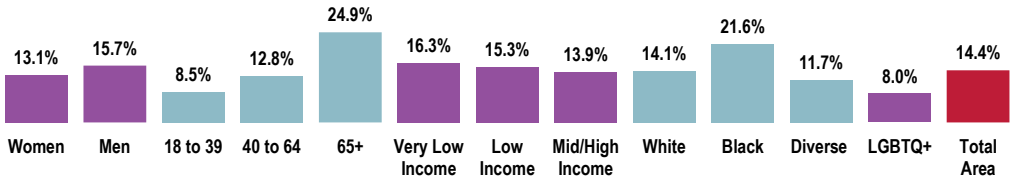
Total Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

Kidney Disease Deaths

ABOUT KIDNEY DISEASE & DIABETES

Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

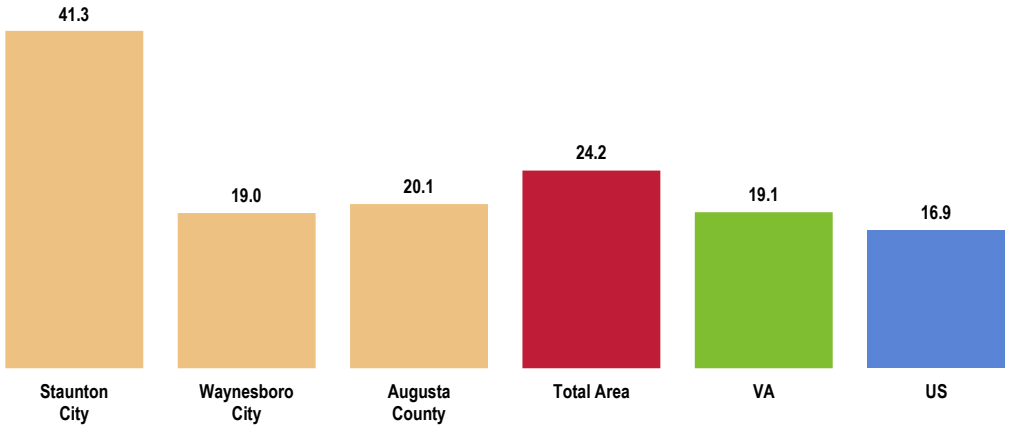
– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Between 2021 and 2023, there was an annual average kidney disease mortality rate of 24.2 deaths per 100,000 population in the Total Area.

BENCHMARK ► Higher than both the state and national findings.

DISPARITY ► Particularly high in Staunton.

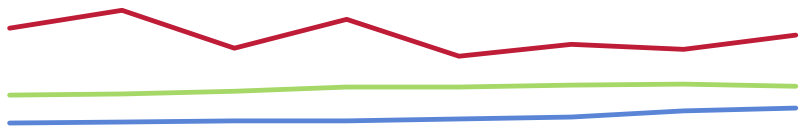
Kidney Disease Mortality
(2021-2023 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Kidney Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



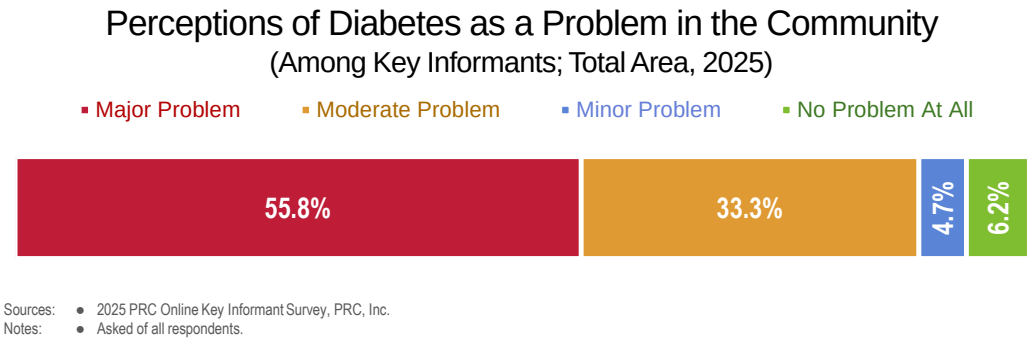
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	24.9	26.7	22.9	25.8	22.1	23.3	22.8	24.2
VA	18.2	18.3	18.6	19.0	19.0	19.2	19.3	19.1
US	15.4	15.5	15.6	15.6	15.8	16.0	16.6	16.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Key Informant Input: Diabetes

A high percentage of key informants taking part in an online survey characterized *Diabetes* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

Access to affordable and nutritious foods. Overabundance of cheap fast food. Overabundance of cheap highly processed foods high in sugar, sodium, and empty calories. Lack of preventative care for diabetes prevention and lack of access to healthcare. Lack of (and/or access to) incentives to support healthy eating (i.e. produce prescriptions programs). Lack of (and/or access to) nutrition and wellness knowledge and education. – Social Services Provider

Access to and affordability of nutritious food and understanding the importance of diet in disease management. Also access to medication and compliance with using. – Community Leader

The availability of nutritious food and how to prepare them. Having accountability to others about diet and exercise. – Social Services Provider

All the surrounding causes of being overweight. No money for healthy food, difficulty accessing the right food, cultural norms of foods eaten and inflammatory chemicals/pesticides. – Community Leader

Healthy eating habits. Access to affordable fresh foods. Public education on good and bad carbs and portion size. – Social Services Provider

The high cost of organic foods keeps people who have limited income at a disadvantage because they are choosing high carb and high sugar foods that are incredibly over processed. This leads to worsening diabetes and/or the onsite of type II diabetes. – Social Services Provider

Access to healthy food. – Social Services Provider

Affordability of healthy foods and lack of resources outside of health care settings on healthy food preparation and free exercise education. Easily accessible, time and location to where people reside. – Public Health Representative

Affordable food and cost of medicine. – Health Care Provider

Access to and understanding healthy food choices. – Social Services Provider

Lack of access to readily available nutritional foods for those in the county, nutritional education, and proximity to health services. – Community Leader

Financial strain to purchase healthy foods. – Health Care Provider

Lack of access to nutritious food and education about healthy eating/lifestyle, as well as a lack of affordable access to annual preventive care. – Physician

Access to healthy foods; education about diabetes management; obesity, cost of care and medications. – Social Services Provider

Awareness/Education

Education about diabetes prevention and access to affordable, diabetic friendly foods. With the popularity of GLP1 medications for weight loss in the media, glucose monitoring has less stigma, but a vast majority of type 2 diabetes is linked to lifestyle. Many patients do not have access to healthy food or spaces for physical activity, lack basic nutritional knowledge, or can't afford to manage their diabetes. – Health Care Provider

Education and food pantries do not have healthy food options for those that are food insecure. – Health Care Provider

Knowledge of balancing diet to control diabetes. – Health Care Provider

Education. – Community Leader

Education and self-management. – Health Care Provider

Understanding what to do and how to do it. – Health Care Provider

Many people recognize they have diabetes but do not understand the implications or severity. Many continue to live as they had until diagnosis caused further health issues and loss of limbs. – Social Services Provider

Education, medication management, affordable healthful options for food. – Social Services Provider

Access to nutritional guidance and access to food indicated for people with diabetes. – Social Services Provider

Understanding proper nutrition, access to the meds that are needed, cost of meds needed, utilization of the devices such as Dexcom coverage by insurance. – Community Leader

Education doing clinics periodically whit information and education about diabetes. – Community Leader

I think proper education on diabetes and accessibility to healthy nutritious food creates a real barrier for our community. I believe that diabetes is impacted in our area by the obesity rate in children and poorly educated them at a young age about how to eat healthily. – Social Services Provider

Obtaining self-management education to better understand how to manage the DM given their personal circumstances. Accessing DM supplies including CGMs etc. Accessing DM medications due to high cost. MAP assistance helps. – Health Care Provider

Food, serious food knowledge and education. Access to health counselling. – Community Leader

Lack of understanding and education regarding their disease. Even with proper coordination of care, over utilization of medications rather than lifestyle changes happen on a regular basis with this population. – Health Care Provider

Knowledge, insulin cost and access to healthy food and preparation. – Health Care Provider

Access to Care/Services

Wait time to see endocrinologist. Crucial lack of education when it comes to nutrition, exercise, diet etc. Medication affordability and insulin rationing. Healthy food is very expensive. – Social Services Provider

Residents often encounter difficulties accessing healthcare services, particularly in rural parts of Augusta County. This includes limited availability of healthcare providers and challenges in obtaining timely medical appointments. The cost of diabetes management, encompassing medications, testing supplies, and healthy food options, poses a significant burden, especially for underinsured or low-income individuals. Poor nutrition and physical inactivity contribute to the rising rates of diabetes. Factors such as limited access to affordable healthy foods and safe environments for physical activity exacerbate this issue. There is a need for enhanced education on diabetes management and prevention. Many individuals lack knowledge about maintaining a healthy lifestyle, the importance of regular monitoring, and effective disease management strategies. – Community Leader

1. Access to Endocrinology in a timely manner. 2. Obtaining diabetic testing supplies in a way that is affordable and convenient. 3. Affording insulin. 4. Obtaining CGM in a way that is affordable. Each insurance is different. 5. Access to Diabetic Educator during inpatient stay and OP setting. – Health Care Provider

Not enough healthy choices and zero awareness of the severity of the disease. – Social Services Provider

They need community-based solutions. – Social Services Provider

Primary care, access and education. – Physician

Adequate clinic follow-up for Type II diabetes. Patients are poorly educated regarding T2DM complications and seek care late. – Physician

We have issues with access to the hospital education and supplies. Patients do struggle to get the supplies they need, and we need a bigger team to deal with that. Inpatient is being served by the outpatient educator that has a full load of outpatients. A lot of those patients need in-depth care to try to figure out what their regimen at home is. They are only essentially available from 11am-3pm in the hospital during weekdays and with the acuity growing, we cannot continue to support the needs of the population we serve. Patients also need to have sustainable access to CGM that we cannot always accommodate or help with through MAP. – Health Care Provider

Lifestyle

Diet and exercise. – Physician

Poor nutrition and personal behaviors, lack of access to medical resources. – Community Leader

Overweight. Poor eating habits. Lack of exercise and lack of recreational facilities/programs in our area. – Community Leader

1.- Need for community-level programming to reduce obesity: access to nutritious affordable foods, green spaces, exercise spaces, school programming, tackling housing insecurity, reducing poverty levels. Obesity and diabetes have tremendous social dimensions... our medicines are not adequate treatment against these larger forces. 2- Cost of diabetes medications. – Physician

Obesity epidemic within the area, lack of access to healthy eating, lack of access to healthy lifestyles. – Health Care Provider

Healthy eating/diet. – Social Services Provider

Having a nutrition plan that enables a healthy diet. – Community Leader

Choosing better foods and monitoring of sugar levels. – Social Services Provider

Specifically for Type 2 Diabetes, there are many controllable factors that could prevent the disease from developing like good nutrition and exercise. While I think there is a general awareness of this, I don't think there's enough education about Type 2 Diabetes and the causes of it. For instance, how does the disease develop? What are the warning signs? What factors make you more susceptible? And what are you facing if you develop the disease? More in depth, I don't think there is enough education or enough resources to deal with the underlying issues of why people aren't choosing healthy foods and exercise. This could range from lack of access to healthy foods, unresolved trauma that's leading to overeating, a lack of support system to reach exercise goals, etc. – Community Leader

I don't think people in our community are as focused on healthy nutrition as they should be. Diabetes is often preventable, but I don't think people have the dedication to live in such a way that diabetes is prevented. It's almost like they'd rather eat and live like they want to and let medications "fix" the problem. – Community Leader

Access to proper diabetic nutrition. Making good lifestyle decisions about factors impacting their diabetic management, diet, activity. – Social Services Provider

Affordable Medication/Supplies

Cost of medication. Cost of food and availability. Education and access to providers. – Health Care Provider

Being able to afford a pump, medication, etc. – Health Care Provider

Unable to manage diabetes due to lack of financial resources for medications, health literacy, lack of diabetes educators/diabetic education, lack of access to healthy nutrition. – Health Care Provider

Being able to afford their medications and be able to afford appropriate food for themselves. – Health Care Provider

Cost of care- they often cannot afford testing supplies, medications. Also, with so many persons having this diagnoses, the demand for endocrinology services is great. Patients are coming from as far as West VA to see endocrinologists. Other issues include cost of healthy food and lack of access to fitness resources. – Health Care Provider

Affording medications. Motivation for self-care. – Health Care Provider

Affordable testing supplies. Lack of compliance with dietary guidelines. Possibly due to some food insecurity and also lack of education. – Public Health Representative

Cost of medications, access to medical oversight and information. – Community Leader

Resources to check glucose levels. Understanding of consequences of uncontrolled diabetes. Nutrition and lifestyle circle back in to it as well. Food insecurity plays into it too. – Physician

Having a primary care physician for regular checkups. Access to medications, medicine, needles are very expensive, fresh food and education. – Community Leader

Disease Management

Managing diabetes, managing health issues related to contributing to diabetes, understanding the role of nutrition and exercise in managing diabetes, accessing medications to manage diabetes. – Social Services Provider

Managing. – Social Services Provider

Lack of personal attention to preventative care, which is further complicated by limited healthy grocery choices for lower income residents. – Social Services Provider

There are good local resources for our diabetics. I feel the bigger issue is getting patients to seek care, get diagnosed, and then follow their providers management plans. There seems to be good community education and that needs to continue to reach as many as possible. Maybe spend more time with emphasis on long term consequences of failure to keep blood sugar under control. – Community Leader

Learning how to manage the disease and access to clinical support. – Health Care Provider

Incidence/Prevalence

> Prediabetes and diabetes are becoming increasingly prevalent across the United States, with projections indicating a significant rise in the coming decade. Many individuals struggle to afford essential medications, such as GLP-1s, which are used to manage both obesity and prediabetes/diabetes. The situation is made worse by the recent removal of GLP-1s from the FDA's shortage list, and the loss of access to more affordable compounded medications for those without insurance coverage. This makes it even more difficult for those who need these treatments to manage their conditions. – Health Care Provider

Built Environment

> Walkable and bikeable communities and affordable healthy food options. – Community Leader

Lack of Providers

> Lack of good access to providers. Lack of education. Cost of medications and supplies. – Community Leader

Transportation

> Transportation to healthcare appointments, affordability of care and medications, access to interventions. – Social Services Provider

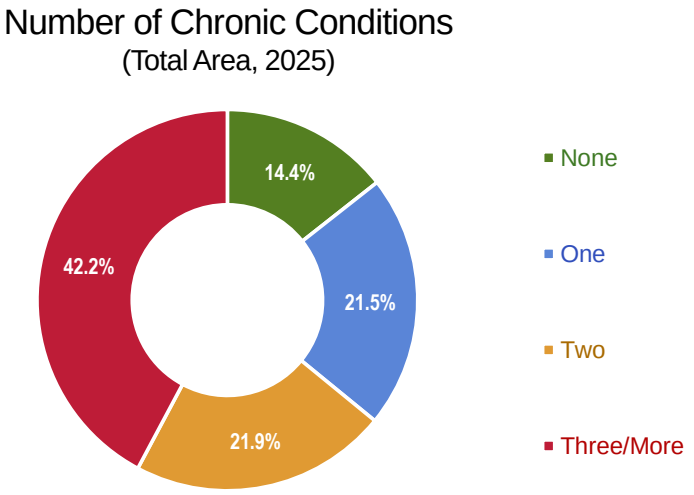
DISABLING CONDITIONS

Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

Among Total Area survey respondents, most report having at least one chronic health condition.



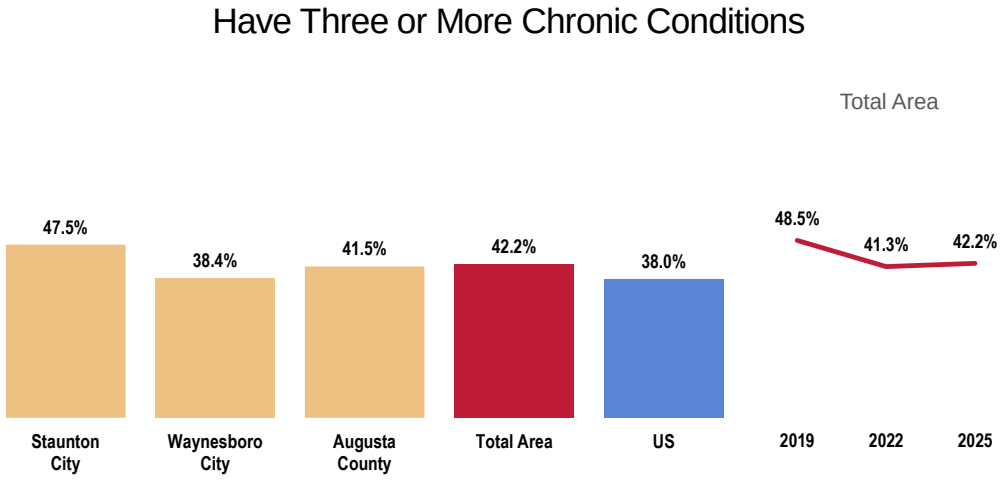
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

In fact, 42.2% of Total Area adults report having three or more chronic conditions.

TREND ► Significantly lower than 2019.

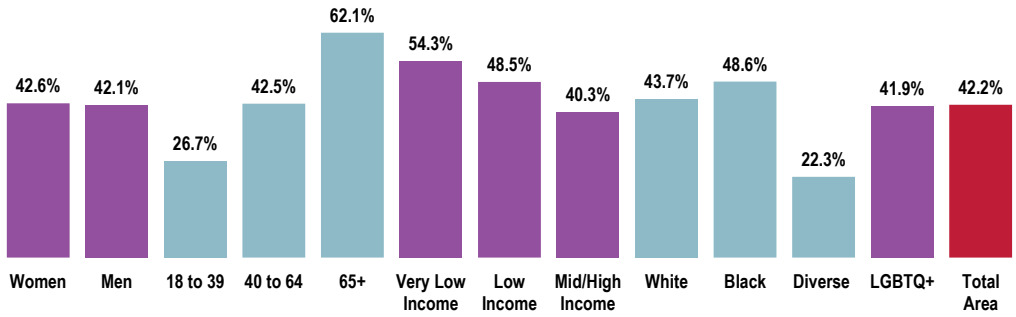
DISPARITY ► Reported more often among adults over the age of 40, lower income residents, White respondents, and Black respondents.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Have Three or More Chronic Conditions
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

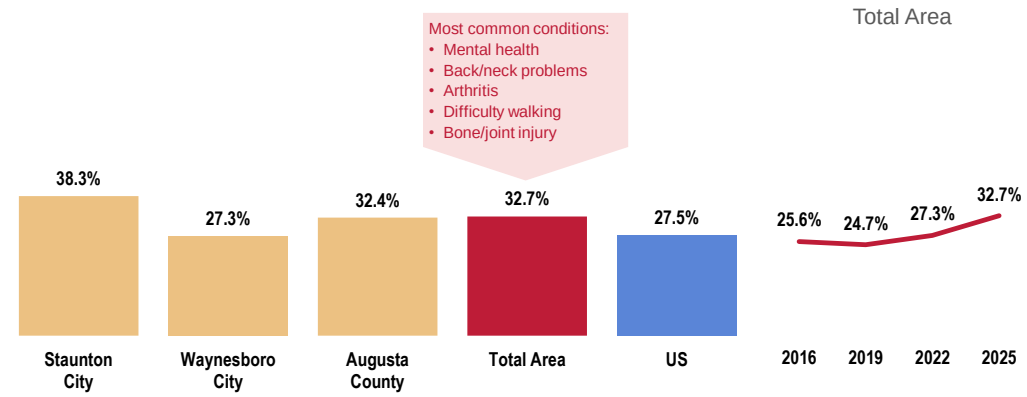
A total of 32.7% of Total Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

BENCHMARK ► Higher than the national prevalence.

TREND ► A significant increase over time.

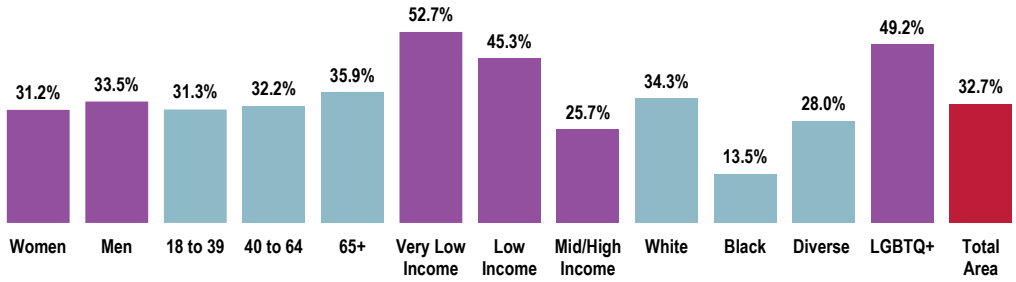
DISPARITY ► Reported more often among lower income residents and LGBTQ+ respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Items 83-84]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

Chronic Pain

A total of 20.0% of Total Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.

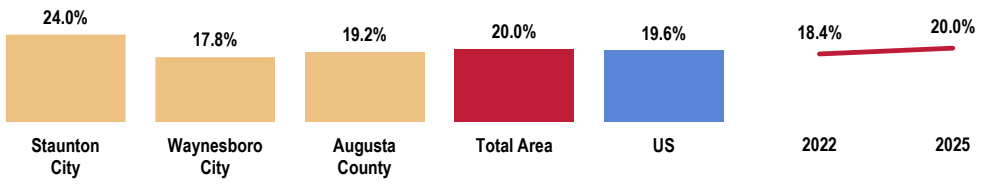
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Reported more often among lower income respondents.

Experience High-Impact Chronic Pain

Healthy People 2030 = 6.4% or Lower

Total Area



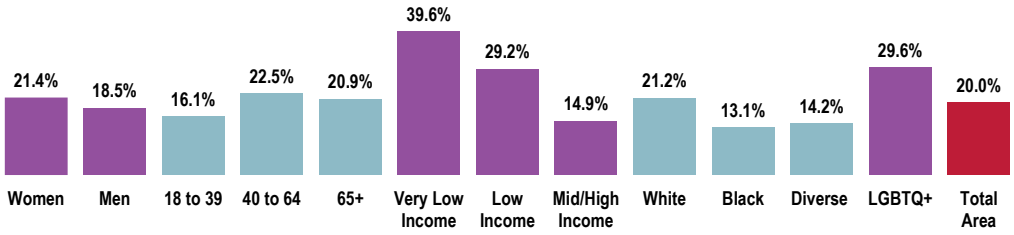
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain

(Total Area, 2025)

Healthy People 2030 = 6.4% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia. Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

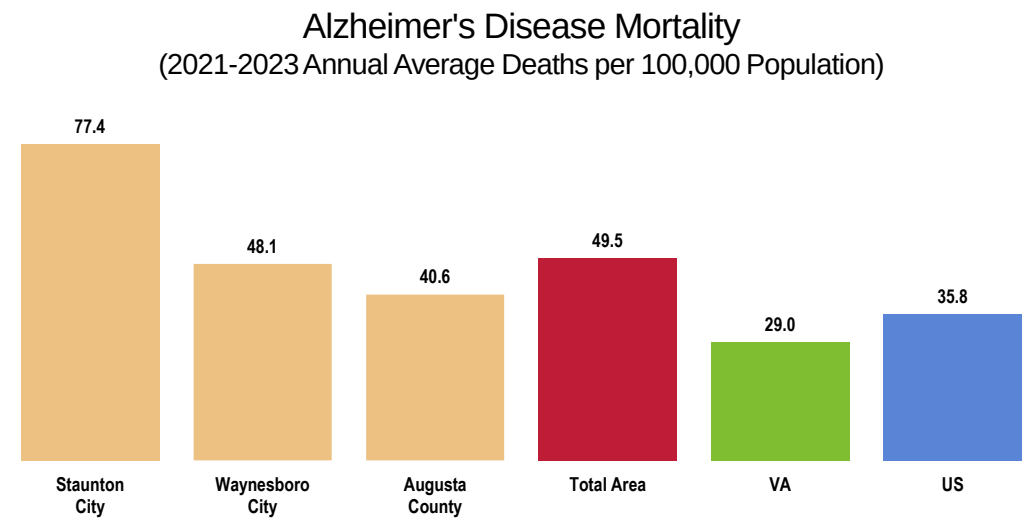
– Healthy People 2030 (https://health.gov/healthypeople)

Alzheimer's Disease Deaths

Between 2021 and 2023, there was an annual average Alzheimer's disease mortality rate of 49.5 deaths per 100,000 population in the Total Area.

BENCHMARK ► Notably higher than both Virgina and US rates.

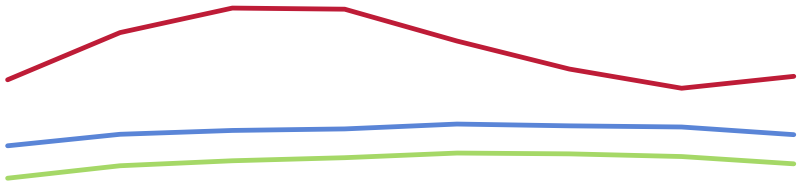
DISPARITY ► Particularly high in Staunton.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Alzheimer's Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	48.7	59.7	65.5	65.2	57.8	51.2	46.7	49.5
VA	25.6	28.5	29.7	30.4	31.5	31.3	30.7	29.0
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

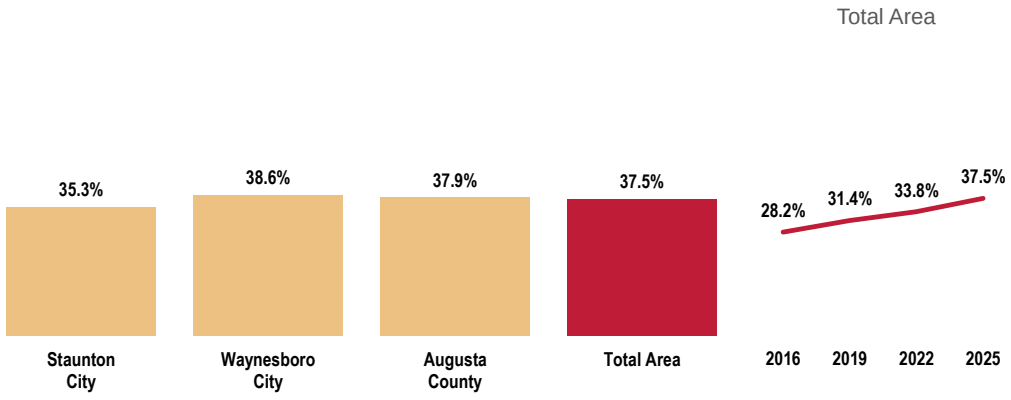
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Prevalence of Alzheimer's Disease

Over one-third (37.5%) of area adults reports that a member of their family ever has been diagnosed with Alzheimer's disease or dementia.

TREND ► A significant increase over time.

Family Member Has Been Diagnosed with Alzheimer's Disease



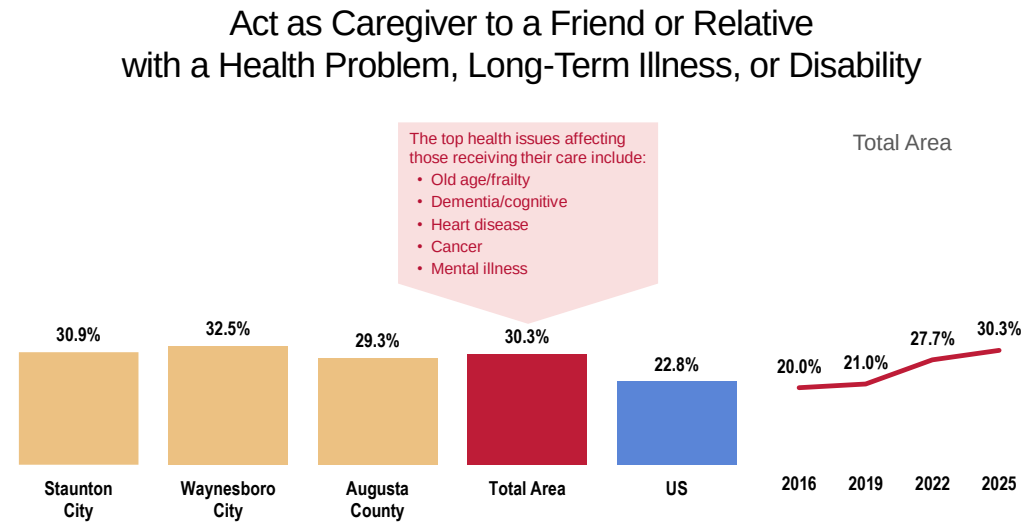
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.

Caregiving

A total of 30.3% of Total Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

BENCHMARK ► Higher than the national prevalence.

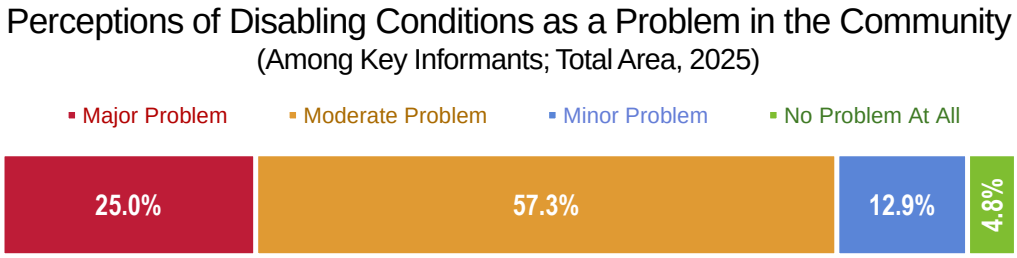
TREND ► Increasing over time.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

Key informants taking part in an online survey most often characterized *Disabling Conditions* as a "moderate problem" in the community.



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Aging Population

> Our aging and disabled populations and their caregivers don't always have the resources to manage these conditions properly. – Community Leader
>
> High level of older patients with limited access and resources. I see a lot of older patients with dementia who no longer can care for themselves who have had dementia for years without treatment. Would be nice to identify these patients early and initiate treatment and have a plan for when they can no longer live independently. – Physician
>
> Because we have an aging population in this area, particularly in Augusta County, who may have other limiting factors like lack of reliable access to necessary health services. – Community Leader
>
> With the aging population, many more community members are being diagnosed with dementia. – Health Care Provider
>
> I consider dementia, loss of vision and hearing as major health issue in Staunton, Fishersville, and Augusta County due to an aging population, limited specialized healthcare, and caregiver burden. Rural challenges, financial strain, and lack of awareness further complicate care. Social isolation and increased demand on emergency services add to the impact. – Community Leader
>
> Once you pass a certain age point in our community, especially those in poverty, these are inevitable. – Health Care Provider
>
> We have an aging population, considered the oldest in the state. These disabling conditions often begin in the middle years but then extend as one ages, presenting many challenges for ongoing management. Caring for these folks is a burden on their families as well as on state and local services. Our community needs more support to help with management. – Physician
>
> Increased issue in society in general due to aging. Lack of affordable resources, dementia care givers, lack of Medicaid and coverage. – Social Services Provider
>
> A major factor is our demographic of aging population. These are usually inevitable results of growing older. – Community Leader

Access to Care/Services

> There are not a lot of resources for people suffering with disabling conditions. – Health Care Provider
>
> Multiple factors including, inaccessible and/or difficult to access/understand medical information. Lack of social network/support. Lack of employment or underemployment/barriers to employment. – Health Care Provider
>
> Many of the homeowners that Renewing Homes of Greater Augusta serves have disabling conditions that prevent them from accessing community resources, maintaining a safe living environment, and remaining employed. – Social Services Provider
>
> Limited resources for ongoing care for dementia population, Memory Care Units. – Health Care Provider

Incidence/Prevalence

> The 2022 Needs Assessment noted that over 40% of total area adults reported 3 or more disabling conditions. This is unacceptable. It means that many people can contribute minimally to society as well as an impaired quality of life. There do not seem to be many resources in the community to help people maintain their independence and live their lives to the fullest. – Social Services Provider
>
> Dementia and Alzheimer's disease. Just feel that I am hearing more people who are dealing with this issue with family members. – Community Leader
>
> Dementia is at record highs. – Community Leader
>
> Have numerous family members, church members, and older friends struggling with many of these disabling conditions. – Health Care Provider

Awareness/Education

> It's difficult to convince older residents that they have an issue, and that they can be dealt with through trust, insurance, and nonprofits. – Community Leader
>
> There are many people living in rehab facilities and nursing homes, most of our client’s self-report chronic pain. I believe this all to be in hand in hand with the lack of resources and education to live healthier and make better choices. – Social Services Provider

Activity Limitations

> The population of people in this area within physical limitations in ambulation and functional mobility is high. In addition, there is limited resources and support available for patients with dementia and their families to assist them in caring for them. With our aging population combined with people working longer we need services to support our working adults who are caring for their aging patients. – Health Care Provider

> Lack of access to adaptive rec, lack of access to community playgrounds, lack of personal care attendants so people are not able to live independently. More resources needed to assist in teaching skills to people who need support. – Social Services Provider

Mental Health

> I have seen mental health, lack of knowledge about healthy lifestyle, or ability to implement it, and addictions really ruin the health of my patients. Some have trouble getting in to find doctors in many areas, especially mental health. – Physician

> Mental health. – Community Leader

Impact on Quality of Life

> Disability impacts not only our physical and mental health, but in general our quality of life. When people are unable to work and have limited resources, they may not be able to keep appointments and health issues keep escalating, affecting family members as well because they need to take time off from work to care for loved ones. People with disabilities and their families are more vulnerable and prone to suffer depression, isolation, discrimination, homelessness, etc. which impacts the whole community. – Community Leader

ADA Compliance

> This is not an especially ADA compliant community. Public buildings, including schools have many steps and few elevators. Part of the charm that make the area so attractive to tourists is its hilly terrain. – Community Leader

Chronic Conditions

> Management of chronic conditions. I see people every day who are oblivious to their blood pressure, cardiac health, and their potential of developing type II diabetes. It is simply not a priority, even if already diagnosed. – Social Services Provider

Nutrition

> Poor nutrition and lack of access to quality care contribute to many disabling conditions. In turn, disabling conditions make it difficult to access and consume nutritious foods, which exacerbates many disabling conditions like diabetes. – Social Services Provider

Obesity

> Look on the streets at the number of people having difficulty and obesity. – Community Leader

Specialty Care

> Rheumatology. – Health Care Provider

BIRTHS

BIRTH OUTCOMES & RISKS

Low-Weight Births

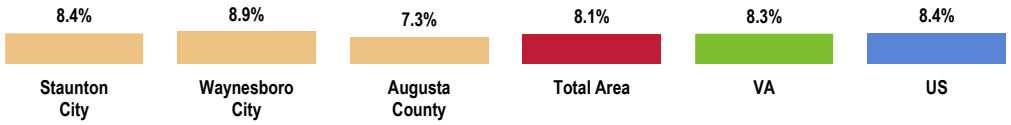
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 8.1% of 2017-2023 Total Area births were low-weight.

DISPARITY ► Lowest among Augusta County residents.

Low-Weight Births
(Percent of Live Births, 2017-2023)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2018 and 2020, there was an annual average of 6.1 infant deaths per 1,000 live births.

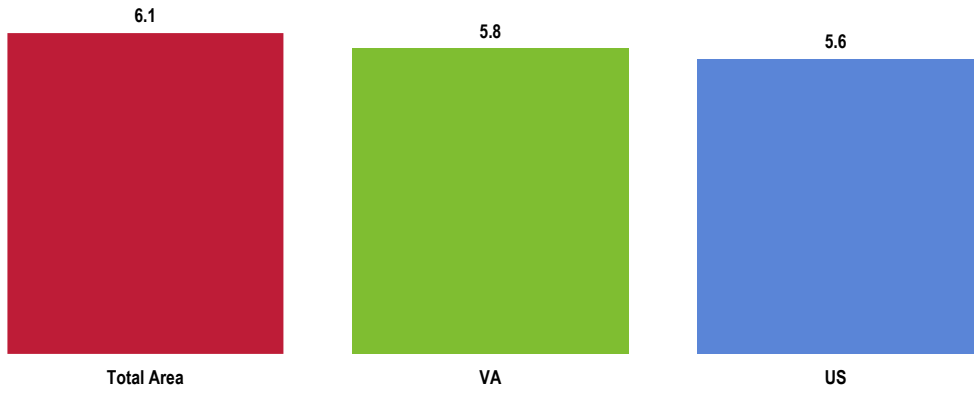
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing significantly since 2015.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2018-2020)

Healthy People 2030 = 5.0 or Lower



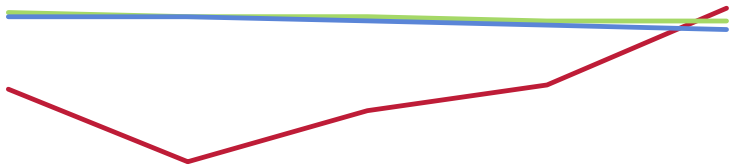
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Infant deaths include deaths of children under 1 year old.

Infant Mortality Trends

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2030 = 5.0 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	4.2	2.5	3.7	4.3	6.1
VA	6.0	5.9	5.9	5.8	5.8
US	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2025.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

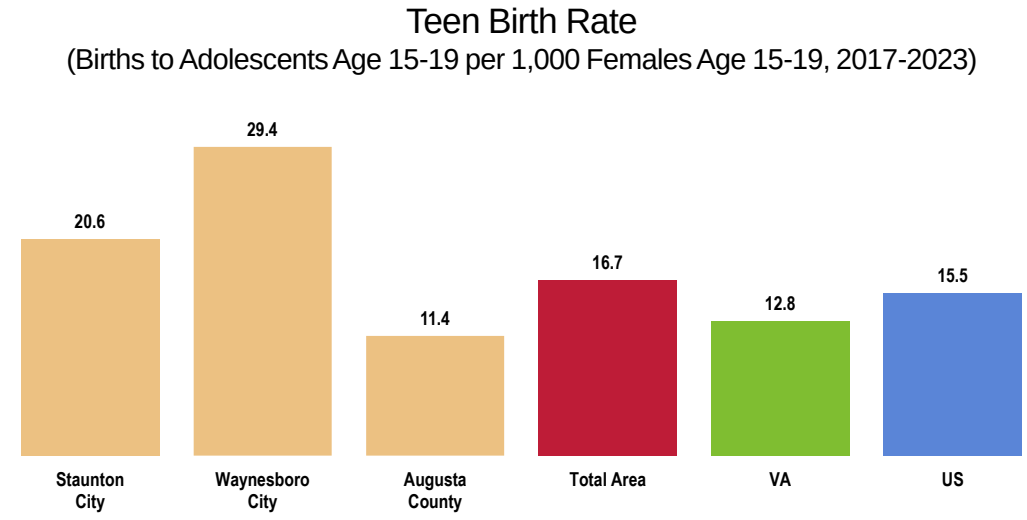
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2017 and 2023, there were 16.7 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Total Area.

BENCHMARK ► A higher incidence than was found statewide.

DISPARITY ► Significantly higher in Waynesboro and among Hispanic adolescent females.

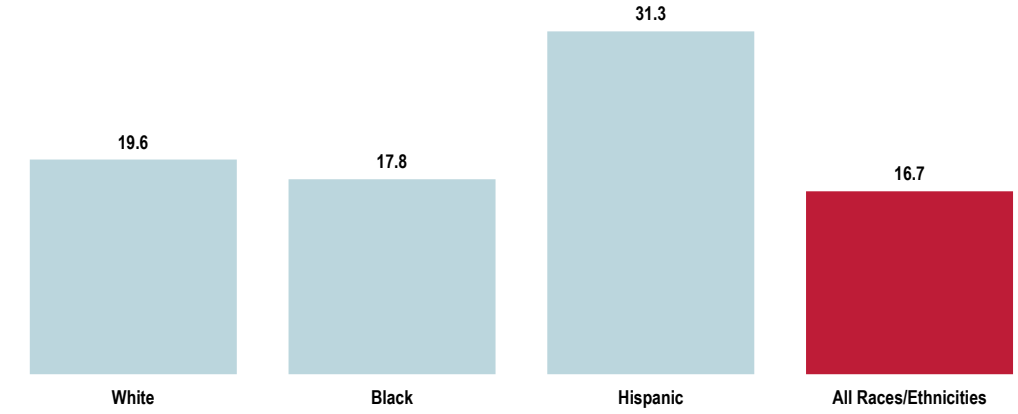


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Teen Birth Rate by Race/Ethnicity

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19; Total Area, 2017-2023)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

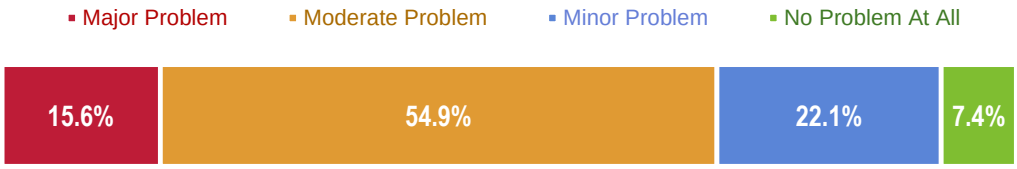
Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.
- Race categories reflect individuals without Hispanic origin.

Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a "moderate problem" in the community.

Perceptions of Infant Health & Family Planning as a Problem in the Community

(Among Key Informants; Total Area, 2025)



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> The upcoming 2025-2030 VDH Office of Family Health Services plan will be focusing on post-partum care. Our area has approximately 11% of births that receive no post-partum care. Likewise, it appears there are a lack of resources in the (SAW) Staunton/Augusta/Waynesboro area for care that does not require a long distance to travel for mothers. Augusta Health is also the only birthing hospital in our area. Currently, we are at approximately 45.5% of maternal deaths within 5 years of giving birth. – Public Health Representative
>
> Lack of access to care. The care resources are available but while public transportation is available, it is difficult to access. Remember, this is a rural area with long driveways. – Community Leader
>
> Pregnancy care. Resources are there, just patients don't access them. – Physician
>
> The rural nature of Augusta County makes access to this healthcare a challenge and the political climate adds to this. – Community Leader

> Lack of prenatal care. Lack of sex education. Lack of access to free prevention, condoms, birth control, etc. – Community Leader
>
> Access to health care. The Health Department is no longer offering free birth control. Now every woman needs to have a primary care physician to have access to birth control or at least, to be seen by a doctor. – Community Leader
>
> We see many pregnant women in the community who do not have the resources that they need, who may be incarcerated or dealing with substance use issues, etc. – Health Care Provider
>
> There are limited resources available in the community specifically for this population of community members. Often family suffer significant deficits as a lack of family planning services and in many instances children will end up in the social services system as a result. – Community Leader

Infant Mortality Rates

> Infant Health Challenges: Infant Mortality Rates: Virginia's average infant mortality rate between 2020 and 2022 was 5.5 per 1,000 live births. Notably, disparities exist among different racial and ethnic groups, with Black infants experiencing a higher mortality rate of 11.1 per 1,000 live births, compared to 4.5 for White infants. Health Literacy: Effective healthcare utilization is closely linked to health literacy. In Waynesboro, 21.8% of adults have low health literacy, while Staunton reports 18.2%, and Augusta County 12.9%. These rates can impact individuals' ability to access and comprehend essential health information, potentially affecting maternal and infant health outcomes. Family Planning Challenges: Access to Services: While family planning services are available through local health departments, awareness and utilization of these services may vary. Ensuring community members know about and can access these resources is crucial for effective family planning. – Community Leader

Impact on Caregivers/Families

> Babies are being born in this community and left in the care of grandparents that receive little to no support from other agencies, there is a mass drug abuse issue, mental health issues, there are babies born to families that are homeless. Health and wellbeing of the mother and the baby is of utmost importance. Minimal aids due to staffing or volunteers, or preconceived notions over religious beliefs, or families in the community that fear the relevance of being "legal". There are many who work hard and do their best but more is needed. Schools have become weak in the education of family planning and rely on The Office on Youth to step up, if they are even allowed to. – Social Services Provider

Vaccine Hesitancy

> Growing pockets of this area that are vaccine hesitant and increase in vaccine preventable illnesses. This is a major problem because it places our community at risk for outbreaks , which could place a significant burden on community and healthcare, place our most vulnerable at risk for infection and the sequelae, and place institutions (like schools) at risk for temporary closure. – Public Health Representative

Alcohol/Drug Use

> Substance abuse issues among individuals affect both infant health and family planning. Transportation issues for family planning and infant care. Family doctors not providing/ asking about family planning. – Social Services Provider

Awareness/Education

> Lack of understanding in rural areas, safe sex practices not taught or understood. People also assume smoking marijuana is safe for the baby. – Social Services Provider

Childcare

> Childcare options for lower class, required financial classes of those getting assistance, case management. – Health Care Provider

Teen Pregnancy

> Our community's teenage pregnancy rate and infant and maternal mortality rate continue to be above average. Like other rural communities, we also have a shortage of OB/GYN providers. – Health Care Provider

Unplanned Pregnancy

> So many unplanned pregnancies and people without resources to care for an infant. – Physician

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

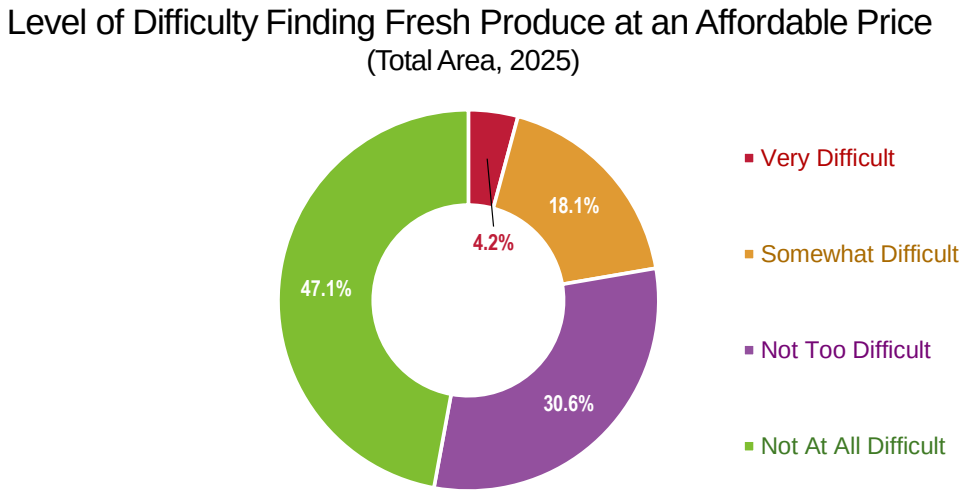
– Healthy People 2030 (https://health.gov/healthypeople)

Difficulty Accessing Fresh Produce

Most Total Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked, "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say very difficult, somewhat difficult, not too difficult, or not at all difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.



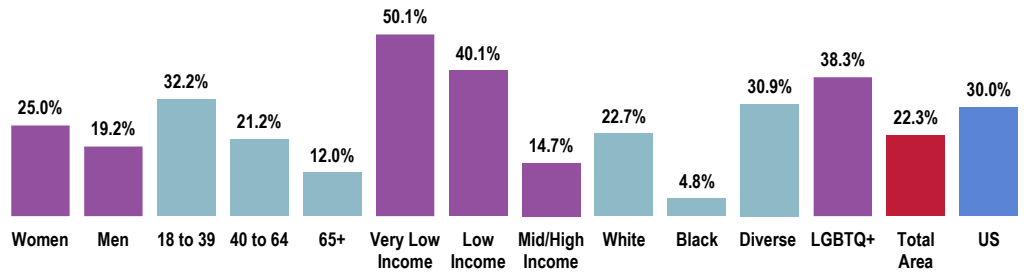
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

However, 22.3% of Total Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

BENCHMARK ► Lower than the national prevalence.

DISPARITY ► Reported more often among women, adults under the age of 65, lower income residents, White respondents, respondents in the Diverse race/ethnicity segment, and LGBTQ+ respondents.

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: • Asked of all respondents.

Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 24.6% of Total Area adults report eating five or more servings of fruits and/or vegetables per day.

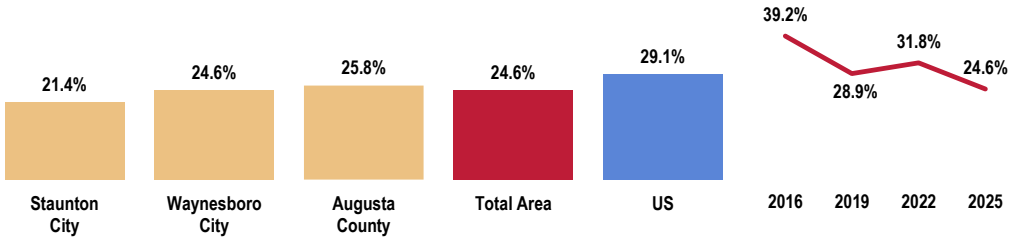
BENCHMARK ► Lower than the national prevalence.

TREND ► A significant decrease from 2016.

DISPARITY ► Reported less often among younger adults and those with lower incomes.

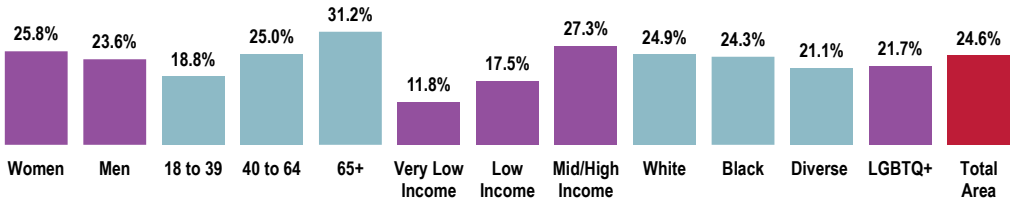
Consume Five or More Servings of Fruits/Vegetables Per Day

Total Area



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 109]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food intake on the previous day.

Consume Five or More Servings of Fruits/Vegetables Per Day (Total Area, 2025)



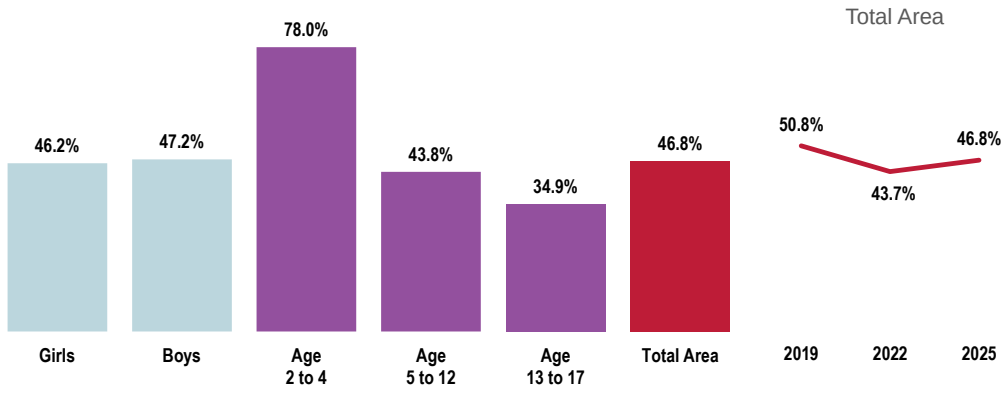
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 109]
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food intake on the previous day.

Children

Among area parents, 46.8% report that their child eats five or more servings of fruits and/or vegetables in a typical day.

DISPARITY ► Reported less often among parents with children age 5 and older.

Child Consumes Five or More Servings of Fruits/Vegetables Per Day



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: • Asked of all respondents with children age 2 through 17.
• For this issue, respondents were asked to estimate their child's intake on a typical day.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

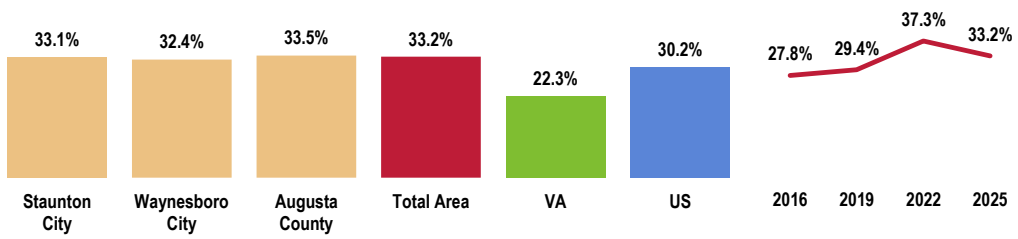
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 33.2% of Total Area adults report no leisure-time physical activity in the past month.

BENCHMARK ► Higher than the state prevalence. Fails to satisfy the Healthy People 2030 objective.

No Leisure - Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

For adults, “meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activities:

- **Aerobic activity** is one of the following: at least 150 minutes per week of light to moderate activity (such as walking), 75 minutes per week of vigorous activity (such as jogging), or an equivalent combination of both.
- **Strengthening activity** is at least two sessions per week of exercise designed to strengthen muscles (such as push-ups, sit-ups, or activities using resistance bands or weights).

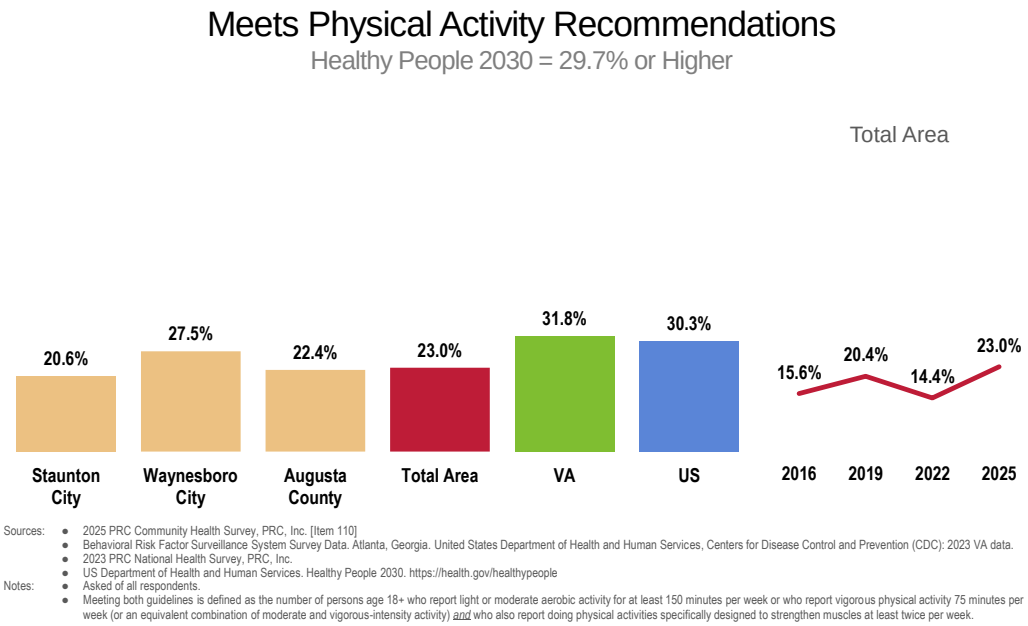
– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

A total of 23.0% of Total Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

BENCHMARK ► Lower than both state and US percentages. Fails to satisfy the Healthy People 2030 objective.

TREND ► Significantly higher than found in the 2016 baseline survey.

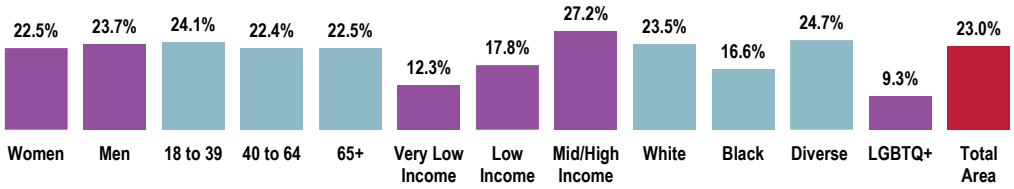
DISPARITY ► Reported less often among lower income residents and LGBTQ+ respondents.



Meets Physical Activity Recommendations

(Total Area, 2025)

Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 110]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

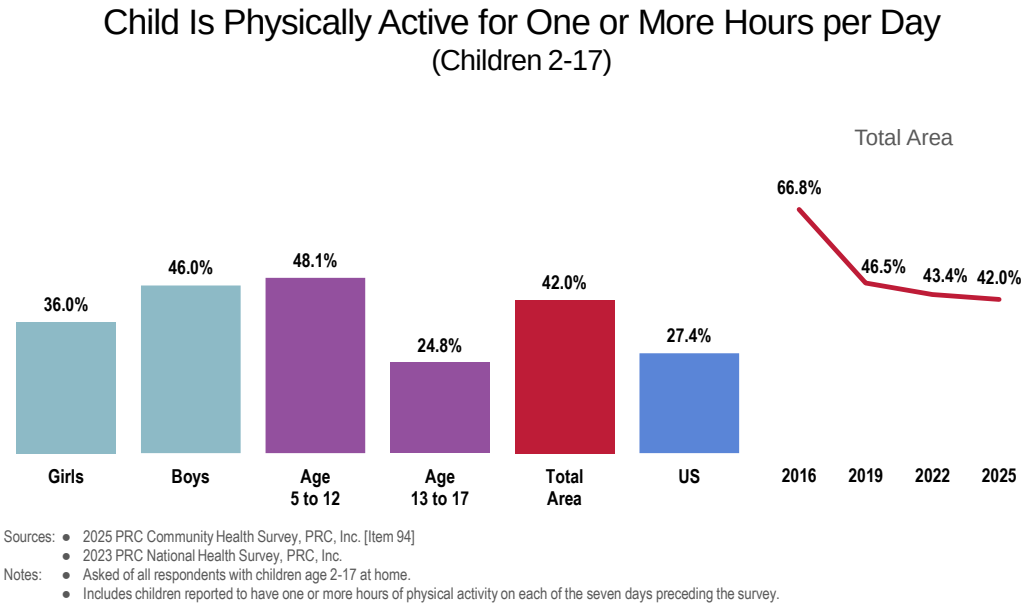
– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among Total Area children age 2 to 17, 42.0% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► Higher than the national prevalence.

TREND ► Significantly lower than 2016 findings (although similar to intervening years' findings).

DISPARITY ► Particularly low among children age 13 to 17.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Overweight Status

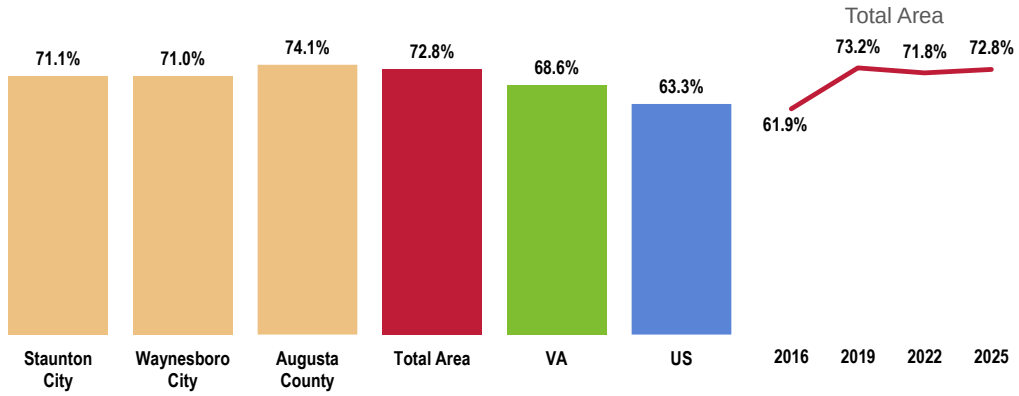
Here, "overweight" includes those respondents with a BMI value ≥25.

A total of 7 in 10 Total Area adults (72.8%) are overweight.

BENCHMARK ► Higher than both the state and US prevalence.

TREND ► Significantly higher than baseline 2016 findings.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0,. The definition for obesity is a BMI greater than or equal to 30.0.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

The overweight prevalence above includes 41.0% of Total Area adults who are obese.

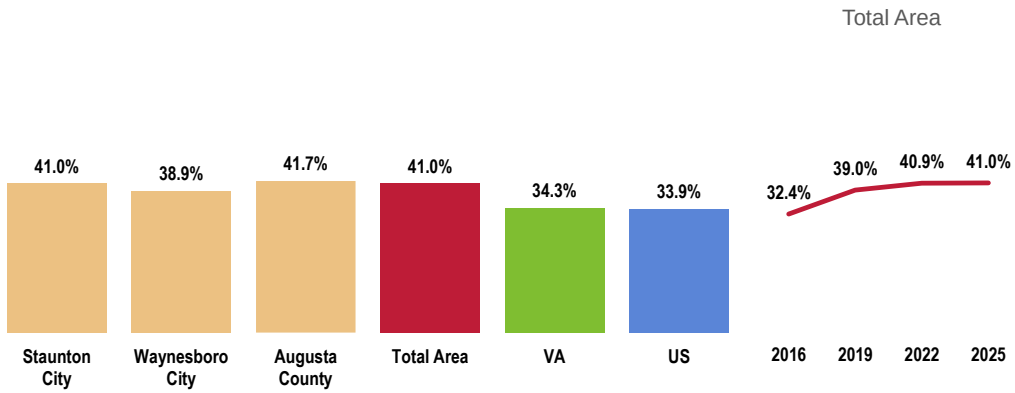
BENCHMARK ► Higher than both the state and US prevalence. Fails to satisfy the Healthy People 2030 objective.

TREND ► A significant increase since 2016.

DISPARITY ► Reported more often among adults age 40-64 and Black respondents.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower



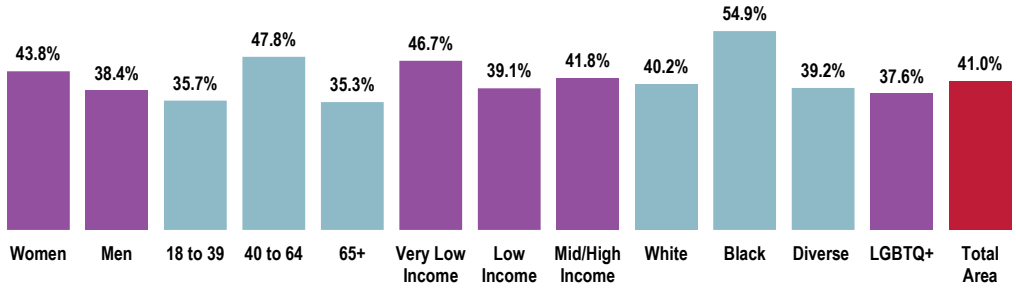
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Prevalence of Obesity

(Total Area, 2025)

Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

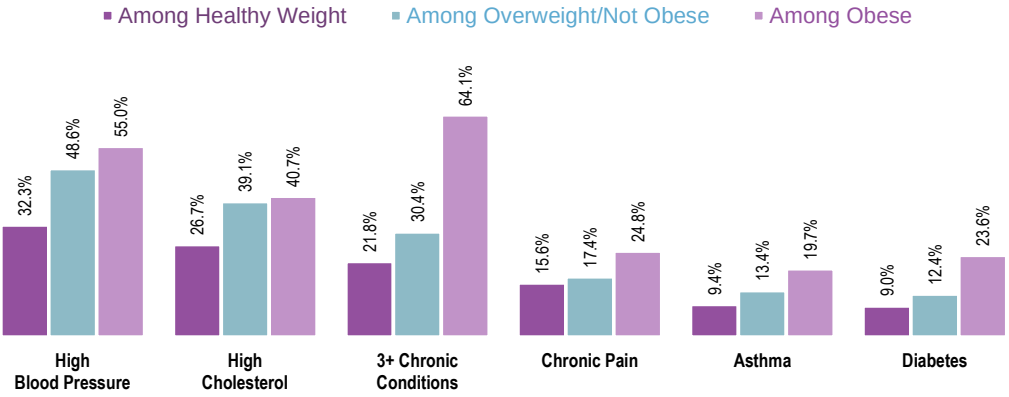
Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

The correlation between overweight and various health issues cannot be disputed.

Relationship of Overweight With Other Health Issues

(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]

Notes:
- Based on reported heights and weights, asked of all respondents.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

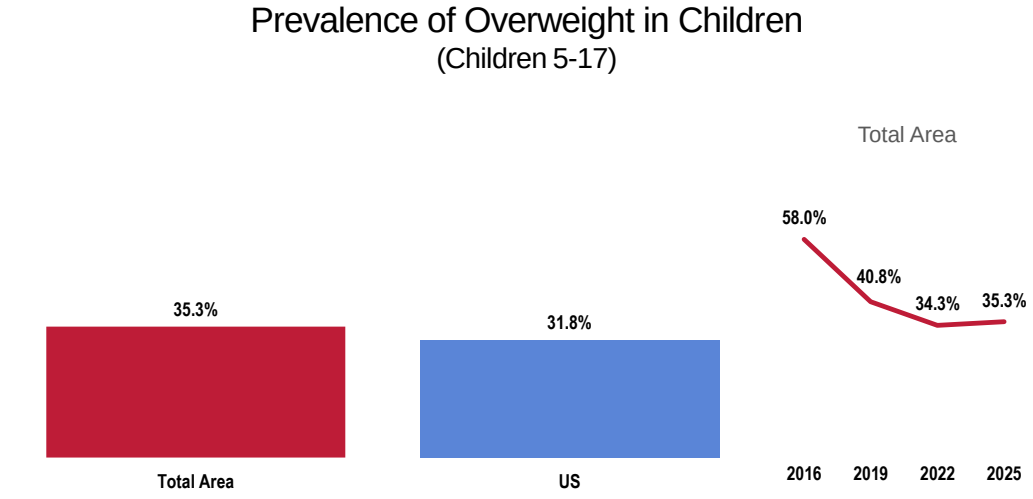
BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 35.3% of Total Area children age 5 to 17 are overweight or obese (≥85th percentile).

TREND ► Overall decreasing since 2016 (similar to 2019 and 2022 findings).



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

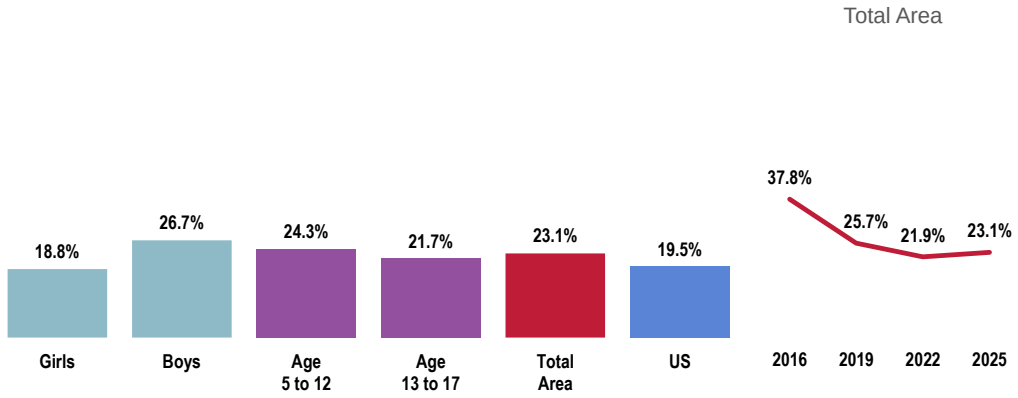
Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 23.1% of area children age 5 to 17 who are obese (≥95th percentile).

BENCHMARK ► Fails to satisfy the Healthy People 2023 objective.

TREND ► Overall decreasing since 2016 (similar to 2019 and 2022 findings).

Prevalence of Obesity in Children
(Children 5-17)
Healthy People 2030 = 15.5% or Lower



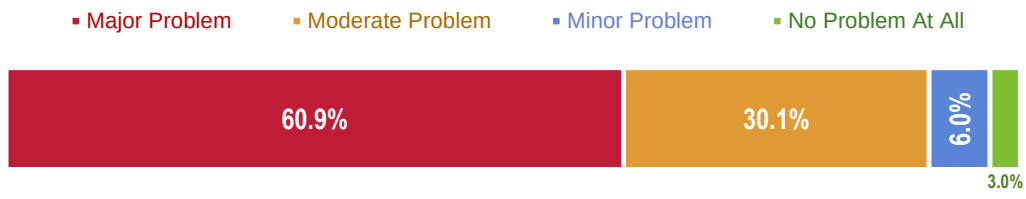
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input:
Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; Total Area, 2025)



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Affordable Healthy Food

> Those living in poverty will have low access to nutritious food, higher chronic stress impacts on the body, and higher rates of obesity and diabetes. Local efforts to raise the standard of living, to reduce housing insecurity, will lead to better health. Need for more walking spaces, bike paths, connected large green spaces. Nutrition insecurity remains high in multiple neighborhoods in our service area, in spite of growing programs to target food insecurity. – Physician
>
> The availability for under-resourced people to afford a healthier diet and how to prepare the food they receive from local food pantries. Community gardens and incentives to help at those that are available. – Social Services Provider
>
> The high cost of quality and organic foods pushes people to eat highly processed foods, which lead to obesity. Obesity leads to impairment in regard to physical activity level. Inflation has also impacted people who may choose to cancel gym memberships in order to pay other more pressing bills. Lastly, if people have to work three jobs to make ends meet, there's not much time for healthy eating and exercise. – Social Services Provider
>
> Food and nutrition insecurity are high because: high food prices, transportation challenges (getting to store/pantry), limited knowledge/equipment/kitchen to support cooking nutritious meals, the prevalence of processed foods in our culture (and our tastes shifting toward preferring these foods), and lack of time to shop and cook given working multiple jobs. – Social Services Provider
>
> In addition to a shortage of affordable, healthy food choices in our community, ours is not a very walkable or cycling-friendly community in terms of road design, sidewalks and driver behavior. Organized physical activity facilities are also expensive, limiting access for those with lower incomes. – Social Services Provider
>
> Cost of food, access to food. – Health Care Provider
>
> Access to healthy food. – Social Services Provider
>
> Being able to afford healthy foods. – Health Care Provider
>
> Unhealthy food choices tend to be less expensive and more convenient than healthy choices. – Social Services Provider
>
> Ready access to affordable healthy eating and the ability and know how to cook it. – Health Care Provider
>
> Food access and lack of knowledge. – Health Care Provider
>
> We have a lack of healthy options for eating (or maybe I should say an over-saturation of Unhealthy options) – Augusta and much of Staunton and Waynesboro are not walkable. Although there are recreation options in our downtowns, our area is not as conducive to a healthy lifestyle and culturally it's not emphasized in our region. – Community Leader
>
> Finding affordable fruits, vegetables, proteins and time to plan and prepare healthy meals, neighborhoods and apartment complexes not designed for pedestrians and play for children, limited time and opportunity for regular exercise and further distances for rural residents to travel to fitness centers and outdoor recreational parks. – Social Services Provider
>
> Cost of healthy foods. Cost of fitness programs. Time with several jobs. – Health Care Provider
>
> People do not have access to fresh, nutritious foods like fruits and vegetables and/or not being able to afford them due to increasing costs; lack of education; lack of infrastructure to support physical activity such as playgrounds, sidewalks, bike paths, etc. – Health Care Provider
>
> Access to affordable healthy foods. Access to affordable physical activity outlets. Motivation. – Health Care Provider
>
> The rise of cost of living has made access to organic, healthy foods something that is harder to access. Farmer's Markets are often at a high price point for the average citizen, even if they take SNAP. Food and nutrition literacy are also quite low, making new lifestyle changes seem intimidating. There is also a severe lack of walkability in Augusta County. Most parks have to be driven too, and unless you are in the downtown of Staunton or Waynesboro, sidewalks are nearly nonexistent. Even parks that are meant for pedestrians, like Gypsy Hill Park, are overridden with cars. – Health Care Provider
>
> Food cost, it seems like when the fast-food places can provide a "meal" that is lots of calories and not much nutrition, for a small cost, it creates a bigger problem. It seems to me that in low-income families, fruits and vegetables are not affordable and thus not pushed. If mom and dad are not familiar with good nutrition, it’s no surprise that their children are not introduced at early ages. Then, the other problem is exercise-lack of. With video games and TV commanding many hours of the day, exercise and sports get tossed aside. – Community Leader
>
> Ability to purchase nutritious food. Lack of education about nutrition, exercise, and diet. Fitness centers cost money, and people need to be motivated to exercise on their own. – Social Services Provider

Lifestyle

Lack of access to nutritional food, gym memberships are expensive, reduced physical activity in schools, reduced green spaces in Augusta County. – Health Care Provider

We have already spoken about nutrition, the availability of healthy food options, and the affordability of healthy food options. Physical activity is getting better but we need well-lit sidewalks in nice areas so people can walk and enjoy the mountain valley air that people travel here to experience. Coming from a fat guy, weight is an issue, and it revolves around several things. We can blame food, laziness, sediment life style and so many other factors but the truth is in the Valley I had to get referred to UVA to get help because Augusta Health lost their provider. I'm lucky but so many suffer and cannot afford the time or have the ability to drive over the mountain. We just need better. – Social Services Provider

Improving nutrition, increasing physical activity, and managing weight are key strategies in addressing many of the health issues highlighted in this survey. A stronger focus on obesity management is essential, whether through enhanced education, affordable access to GLP-1 medications, or more accessible weight loss clinics. By prioritizing these solutions, we can make a significant impact on the health and well-being of our community members, helping to prevent or mitigate a range of chronic conditions and improve overall quality of life. – Health Care Provider

Lack of motivation. – Social Services Provider

Poor choice of diet and lack of exercise. – Health Care Provider

In general, the standard American diet relies more heavily on sugar, salt, beef & processed foods than is nutritious and people in our area follow that type of meal plan. Low incomes can make it difficult to buy healthy foods regularly. While there are a good number of outdoor and active recreational options, I think most of our residents are still very sedentary. – Social Services Provider

Poor eating habits, sugar and fast food. – Community Leader

Fast food is easy. Making meals is more difficult and takes more time. It is difficult to maintain a healthy diet. – Social Services Provider

Sugar addiction. – Community Leader

Fast food. – Physician

I think the biggest challenges are a disconnect between the toll that poor nutrition and lack of physical exercise has on your health and quality of life and that there can be consequences like developing Type 2 Diabetes that may be permanent. I also think that there isn't enough done to address the underlying issues of why someone isn't making healthy choices. Is there a cofactor of a mental health issue like depression? Is there lack of a support system? Is it that someone may not have been exposed to meal planning or healthy recipes and simply doesn't know how to go about making healthy meals? I don't think we fully understand or address the other factors that are contributing to the outcome of poor nutrition and lack of physical activity. – Community Leader

Obesity

Obesity. – Community Leader

High rates of overweight and obesity: approximately 72% of adults in the area are classified as overweight or obese, surpassing both the national average of 61% and Virginia's average of 67%. Physical inactivity: low activity levels: only about 14% of residents meet current recommendations for physical activity, indicating a significant decline from previous assessments. Food insecurity: access to nutritious food: approximately 21% of individuals in the community have experienced concerns about running out of food or have actually run out, highlighting issues with food security. Socioeconomic barriers: financial constraints: economic limitations can hinder access to healthy foods and opportunities for physical activity, making it challenging for some residents to maintain a healthy lifestyle. Environmental factors: limited access to exercise facilities: some areas may lack adequate infrastructure, such as parks, reducing opportunities for physical activity. – Community Leader

Obesity is endemic, with resultant skyrocketing diabetes, heart disease, stroke, etc. – Physician

Obesity and diet-related diseases are on the rise in our community. Nutrition is the foundation of health, yet many people face barriers to accessing healthy foods, whether due to transportation challenges, financial constraints, or a lack of knowledge about how to use food to promote health. This is one of the most pressing concerns because of the high prevalence of diet-related diseases, which are largely driven by poor nutrition and inadequate physical activity. Addressing this issue is critical to improving overall community health and preventing chronic illness. – Social Services Provider

There are too many obese people. I'm afraid they are relying on mediation to lose the weight but not encouraged to exercise. I feel if they are given meds to lose weight to continue that prescription the patient should have to show a log of exercise or maybe be required to enter a program that shows attendance. – Health Care Provider

The people in our area have more issues with obesity and poor nutrition. – Health Care Provider

We live in an obese society. Need more focus on weight loss, healthy eating, exercise programs. – Physician

Awareness/Education

> School nutrition programs, inflation, access to healthy choices. – Health Care Provider
>
> Universal across the US, but knowledge doesn't fix the problem and judgement from providers is an issue. – Physician
>
> Education. – Community Leader
>
> Lack of education in schools, family. Healthy food is getting more and more expensive. – Social Services Provider
>
> Education. Higher cost to eat and live healthier lifestyles. At times, the mental health behind the weight issues need to be addressed for long-term success. – Community Leader
>
> Nutrition counseling. – Physician
>
> Poor education of dieticians and physicians who do not know what a healthy diet or lifestyle are (yes, I am saying that dieticians do not know what a healthy diet is because it is true). The cultural and peer pressure to eat junk and engage in unhealthy behavior is staggering even at our very own hospital that for every meeting and birthday and celebration serves junk food. It is just about impossible for a patient to lose weight in a healthy way and maintain it when everyone around them is misinformed and trying to get them to eat high calorie density food and addictive food or take a very expensive drug with potentially quite bad side effects that they then have to take the rest of their lives to maintain weight loss. Very sad and devastating situation. – Physician
>
> There is a lack of education in how nutrition and physical activity affect weight and how weight affects overall health and life expectancy. No Transportation to farmers' markets to obtain fresh foods. Lack of community gardens. Not enough walking- biking trails close to where people reside. No Transportation to activities and programs – cost of programs make them unattainable. – Social Services Provider
>
> Lack of education and lack of access. – Health Care Provider
>
> Education and access to be physical. – Health Care Provider
>
> Lack of care about weight and physical health. Nutrition and physical wellness is cast aside for laziness or disregard for long term implications of lack of exercise. – Social Services Provider
>
> Often, people feel like the changes they need to make are out of reach or too overwhelming. Education is needed to help people understand small changes can add up to better health. – Health Care Provider
>
> Lack of programs and facilities. Too much screen time with adults and children. – Community Leader

Access to Care/Services

> There are limited weight management access in the area. – Health Care Provider
>
> Lack of equality of access of resources for healthy living in those most vulnerable. – Public Health Representative
>
> Offering options for those who want to make a change. Clinic at our hospital with access issues. Cost of the medications to assist are costly and may not be covered. Continue to educate provider and patients on programs available to public to help address this issue. Also issue among our school age population as well. – Health Care Provider
>
> Access and cost. Despite the growing number of community gardens, good food tends to be very expensive. – Community Leader
>
> Lack of resources and education. – Social Services Provider
>
> Access to care, counselors and doctors for weight loss. – Physician

Built Environment

> Personally, the largest issue is there are no community areas for recreation within Augusta and Waynesboro. There are some beautiful parks in Staunton for recreation, but for most of the population, this requires you travel to the location. It would also be nice to increase the ability for individuals to walk in the more urban areas within Augusta and Waynesboro. Staunton has been able to develop sidewalks, but in areas where individuals spend the majority of time (grocery shopping centers) it is difficult to walk to them given how busy roads intersect. – Public Health Representative
>
> A lot is personal motivation but as a community we have to do something. Big proponent of primary prevention. – Health Care Provider
>
> Lack of places to be active safely. Healthy food can be expensive, federal cuts to school meal programs. – Social Services Provider
>
> We have terrific access to the outdoors, but infrastructure for everyday living is lacking. We need more micro communities built in sub-divisions that have shared use paths, greenways and sidewalks. Most subdivision do not have any human locomotion infrastructure, so you have to bike and walk in streets. Schools do not have safe passage for kids to ride or walk to school and not ride with a parent or a bus. In the 60's over 40 percent of students walked or biked to school, now in our area it is around 5 percent. – Community Leader

Lifestyle

> Lifestyle change, ready access and knowledge, higher cost of fresh/whole foods. – Community Leader
>
> Lifestyle choices. – Community Leader
>
> SDOH and difficulty of changing behaviors/life style changes. – Social Services Provider

Food Deserts

> People eat more than they should and they eat food that is not always the healthiest. Cities like Staunton have food deserts in that people may have a challenge getting to a grocery store if they don't have a vehicle. Overall, people are not as active as they should be - this is probably not just a SAW-area issue. – Community Leader
>
> We have several food deserts. Combined with a lack of transportation for our low and moderate income families this results in lack of access to fresh, affordable, nutritious foods. – Social Services Provider

Affordable Care/Services

> Lack of access to affordable programs, lack of access to healthy foods. – Health Care Provider
>
> Financial resources to participate in local fitness options. Transportation to those activity centers. Cost of weight loss medications for morbid obesity. – Social Services Provider

Lack of Providers

> Patients do not have adequate access to dietitians. Currently only two dietitians are serving the community. – Health Care Provider
>
> Very few nutritionists offering services. Very few holistic or medication assisted weight loss programs. – Health Care Provider

Adolescence

> In middle school, recess ends and all the introspection and insecurity begin. Too skinny. Not skinny enough. Nutrition? Who is there checking in with that. If I had concerns about my own nutrition I would google an answer. I don't know anyone I trust who is a go-to for nutrition. Well, maybe friends at the YMCA, but I really don't trust anyone in this field. Too many opinions and fads. Not enough science. And I think that is answer enough to the lack of general education around nutrition. – Community Leader

Affordable Medication/Supplies

> Weight loss medicines are expensive and financial assistance programs are difficult to navigate. Long instilled habits of poor eating. Many jobs reduce activity levels (sitting at a desk all day), life stress, the challenges of caring for children and parents or grandparents, job stress, financial stress leave little time for exercise. Availability of fast, processed food make it hard to take the time to cook healthy meals. Advertisers promote processed food as a healthy option when it really isn't. – Social Services Provider

GLP Medications

> The popularity of GLP-1 medications on the market, I believe is making it less desirable for people to try to lose weight through proper diet and nutrition. Once a person gets on the medication(s) I don't see them coming off. Or if they do, they want the medication again once the weight has returned. Our society wants quick fixes. People also do not want to cook and prepare meals making it challenging to eat healthy and consume less processed food. These poor habits and then "transferred" down to their children where good food choices are not made. Cost of groceries is a factor. – Public Health Representative

Diagnosis/Treatment

> Again, from a medical perspective, there is a consistency of people being treated for their symptoms and not the root of the problem. – Community Leader

Lack of Physical Activity

> Access to exercise. – Community Leader

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

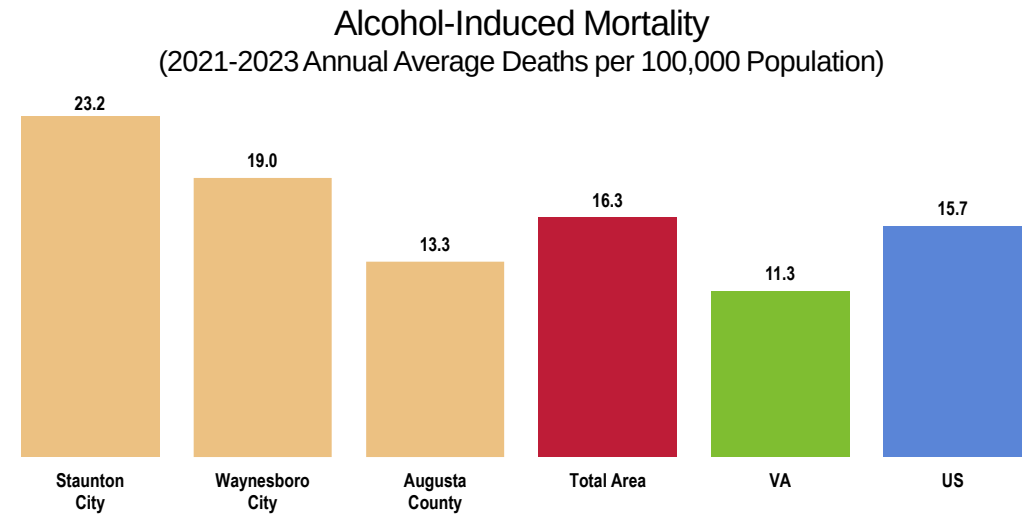
Alcohol Use

Alcohol-Induced Deaths

Between 2021 and 2023, the Total Area reported an annual average mortality rate of 16.3 alcohol-induced deaths per 100,000 population.

BENCHMARK ► Higher than the statewide rate.

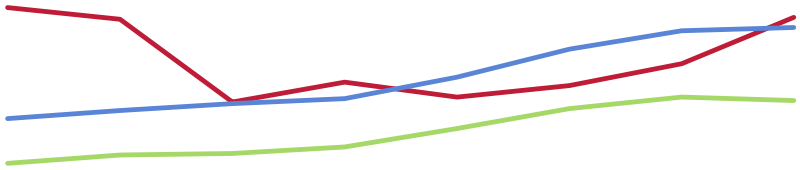
DISPARITY ► Particularly high in Staunton.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Alcohol-Induced Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	16.9	16.2	11.2	12.4	11.5	12.2	13.5	16.3
VA	7.5	8.0	8.1	8.5	9.6	10.8	11.5	11.3
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 17.3% of area adults engage in excessive drinking (heavy and/or binge drinking).

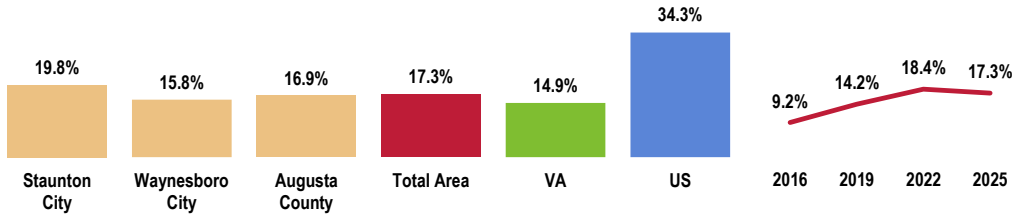
BENCHMARK ► Less than half the national prevalence.

TREND ► Significantly higher than baseline 2016 findings.

DISPARITY ► Reported more often among men and younger adults.

Engage in Excessive Drinking

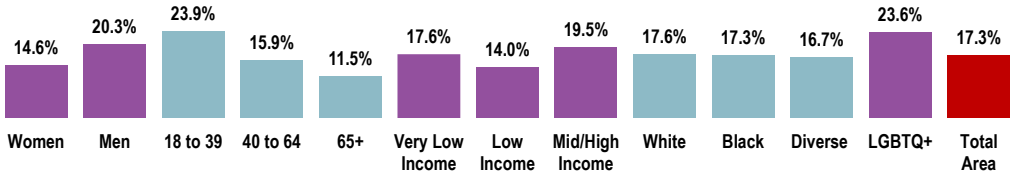
Total Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Engage in Excessive Drinking
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drug Use

Unintentional Drug-Induced Deaths

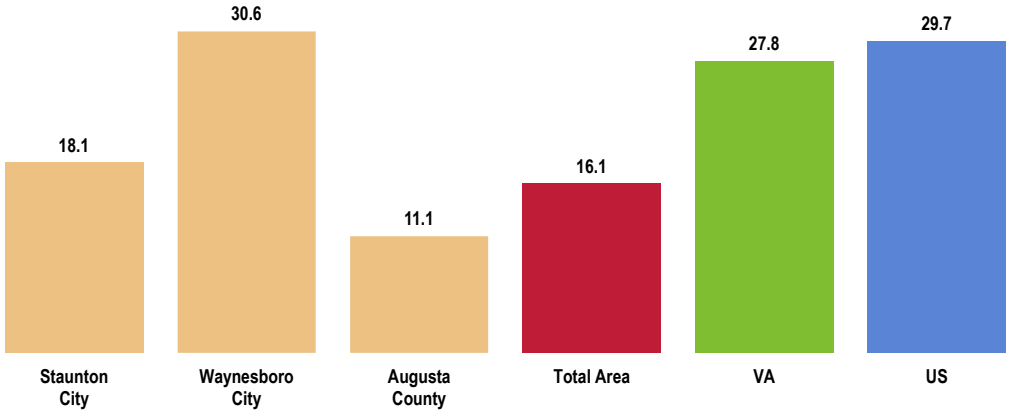
Between 2021 and 2023, there was an annual average mortality rate of 16.1 unintentional drug-induced deaths per 100,000 population in the Total Area.

BENCHMARK ► Considerably lower than both state and national rates.

TREND ► Increasing significantly over the past decade (although less sharply than found statewide and nationally).

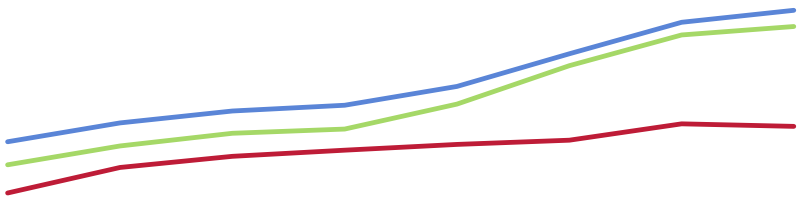
DISPARITY ► Particularly high in Waynesboro.

Unintentional Drug-Induced Mortality
(2021-2023 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Unintentional Drug-Induced Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Total Area	8.3	11.3	12.6	13.3	14.0	14.5	16.4	16.1
VA	11.6	13.8	15.3	15.8	18.7	23.2	26.8	27.8
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

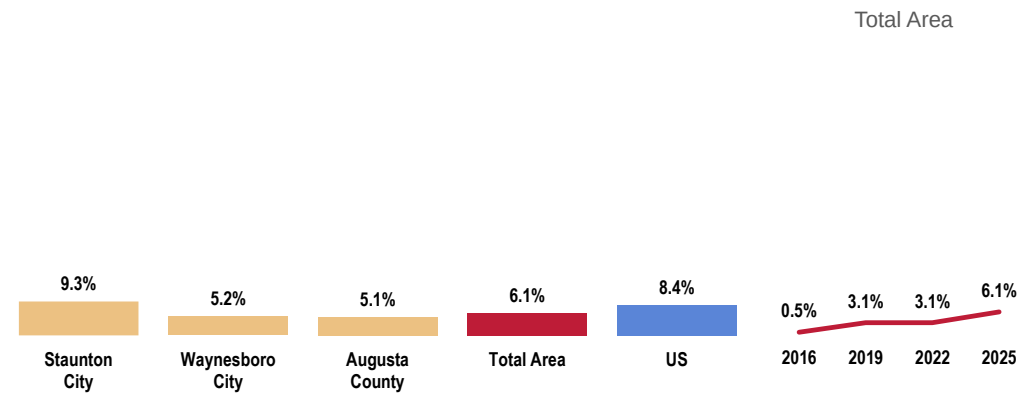
Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 6.1% of Total Area adults acknowledge using an illicit drug in the past month.

TREND ► A significant increase over time.

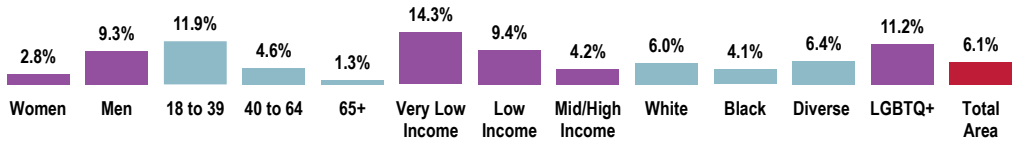
DISPARITY ► Reported more often among Staunton residents, men, adults under the age of 65, and lower income respondents.

Illicit Drug Use in the Past Month



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Illicit Drug Use in the Past Month
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

Use of Prescription Opioids

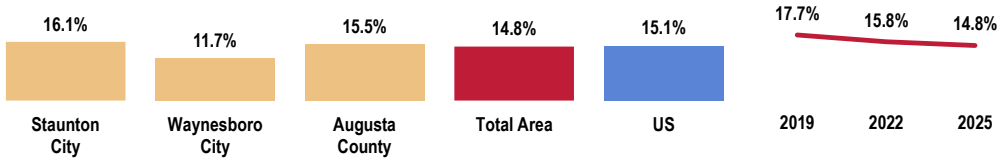
Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

A total of 14.8% of Total Area adults report using a prescription opioid drug in the past year.

DISPARITY ► Reported more often among low-income residents.

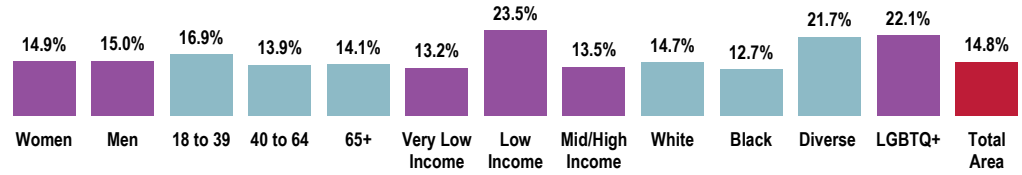
Used a Prescription Opioid in the Past Year

Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Used a Prescription Opioid in the Past Year
(Total Area, 2025)



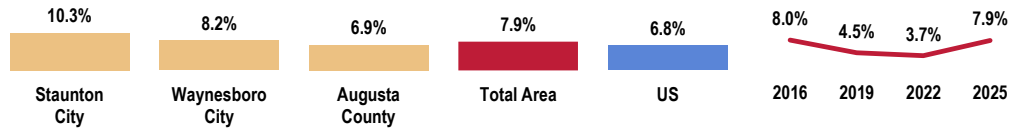
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
Notes: ● Asked of all respondents.

Alcohol & Drug Treatment

A total of 7.9% of Total Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 42]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

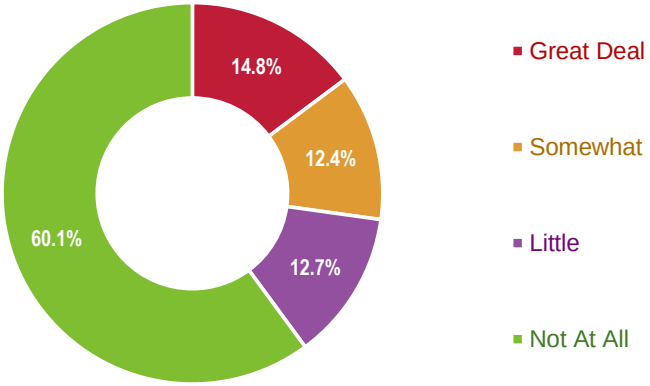
Personal Impact From Substance Use

Most Total Area residents' lives have <u>not</u> been negatively affected by substance use (either their own or someone else's).

Surveyed adults were also asked to what degree their lives have been impacted by substance use (whether their own use or that of another).

Degree to Which Life Has Been Negatively Affected by Substance Use (Self or Other's)

(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
Notes: ● Asked of all respondents.

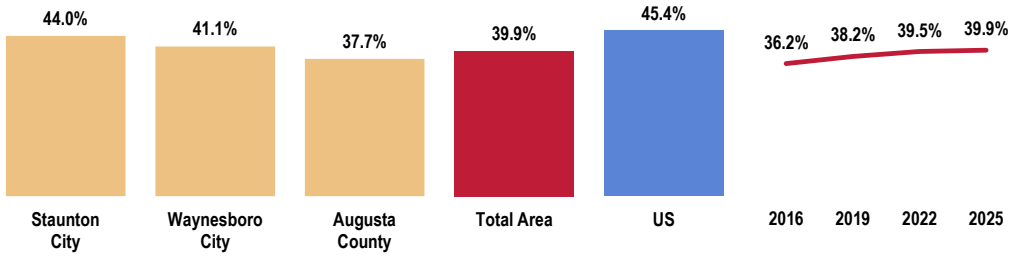
However, 39.9% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

BENCHMARK ► Lower than the national prevalence.

DISPARITY ► Reported more often among women, adults under 65, lower income residents, White respondents, and LGBTQ+ respondents.

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)

Total Area

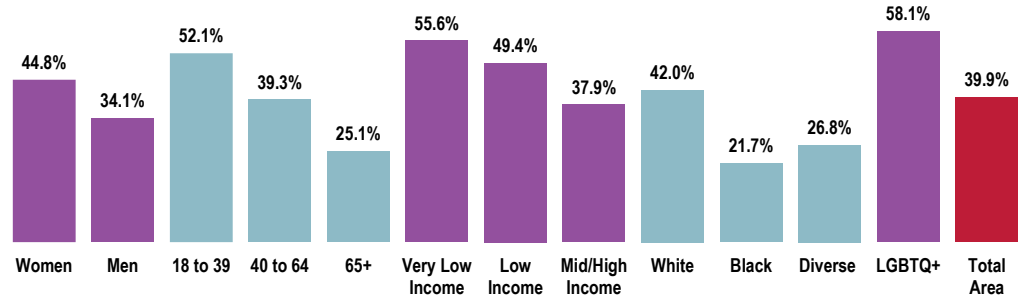


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those responding "a great deal," "somewhat," or "a little."

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)

(Total Area, 2025)

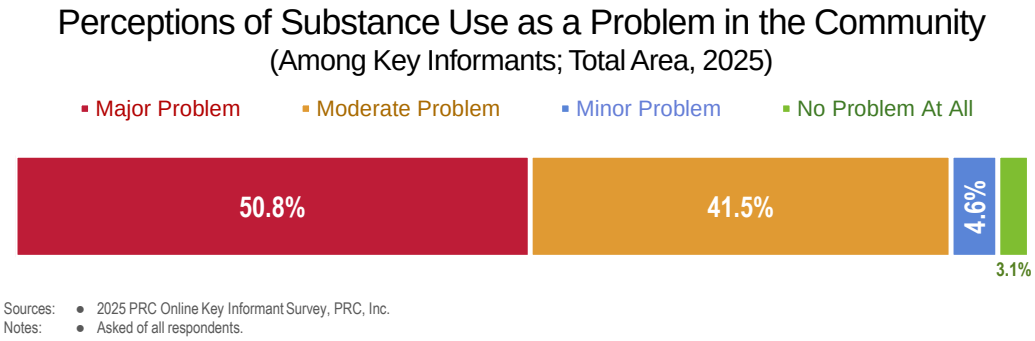


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]

Notes:
- Asked of all respondents.
- Includes those responding "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

The greatest share of key informants taking part in an online survey characterized *Substance Use* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Limited resources and providers who treat substance use disorders. Stigma. – Health Care Provider

Lack of resources. Training medical providers when to use opioids and when not to. Train them that they not only need a plan to prescribe them but provide care in getting patients off of them. When I had surgery on my jaw, I was offered opioids for pain. No real conversation about them. I had no intention of using them but used standard painkillers and ice. But someone else could have gotten hooked on them. – Community Leader

Limited access to treatment facilities: high-need classification: both Staunton and Waynesboro are designated by the Virginia Department of Health as high-need areas for targeted drug prevention and treatment support, indicating a scarcity of accessible treatment facilities. Stigma and societal perceptions: reluctance to seek help: The stigma associated with substance use disorders can deter individuals from pursuing treatment due to fear of judgment or discrimination. Financial constraints: treatment costs: the expense of substance use treatment can be prohibitive, especially for those without adequate insurance coverage, limiting access to necessary care. Co-occurring mental health disorders: dual diagnosis challenges: many individuals with substance use disorders also experience mental health conditions, complicated treatment and requiring integrated care approaches. Insufficient family intervention services: lack of support for affected families. – Community Leader

The lack of a substance abuse treatment facility. – Community Leader

Capacity. – Community Leader

No Outpatient services to support. – Health Care Provider

Limited facilities available to seek treatment. – Health Care Provider

Finding anything local is very difficult. – Social Services Provider

There is a limit to area resources and insurance is a barrier. – Health Care Provider

Access, access, access. – Physician

There are very few places to go. May patients must travel far. – Health Care Provider

Lack of treatment options locally. – Health Care Provider

Lack of access to VCSB. Lack of funding to pay for SA Treatment. No inpatient treatment options in our immediate SAW area. – Health Care Provider

There aren't enough programs/groups. Have groups offered to caregivers/spouse and children. – Health Care Provider

Not enough treatment facilities, stigmas to treatment, no local Inpatient rehab facilities. – Health Care Provider

Availability of programs to help with SA. – Health Care Provider

Lack of inpatient/residential programs. These people are present in crisis and outpatient follow-up is not very successful. Need to be captured during that crisis. – Physician

Access and awareness. – Health Care Provider

Proximity to detox and rehab facilities in the local area. – Community Leader

There simply is none other than the Emergency Department and this is for overdosing, not treatment. – Social Services Provider

Availability in the local area is nonexistent. – Community Leader

Nonavoidable. – Social Services Provider

Lack of a crisis stabilization-detoxification center. Lack of providers. Lack of funding. Stigma related to substance use diagnoses. – Social Services Provider

Lack of community-based programs and services. There simply are not enough resources available to meet the demand and it puts the burden back on law enforcement and criminal justice services to include the jails where often times these people end up. This also causes an increase in EMS responses and transport. – Community Leader

Lack of resources and lack of education. – Social Services Provider

Waiting lists. Availability of treatment right when someone wants it. Lack of support from friends and family. Stigma is associated with using substances that keep people from being honest about their use. Lack of a harm reduction approach in our community. – Social Services Provider

There are no facilities in the local area and there is a shortage of substance abuse counselors to deal with this problem. – Social Services Provider

Lack of insurance coverage or financial ability to access services, not enough providers available. – Social Services Provider

Lack of recovery options and clinics. – Health Care Provider

People in jail, inmates, particularly pregnant women need access to Suboxone treatment if they want it. – Health Care Provider

Lack of resources, transportation, cost and availability. – Social Services Provider

Denial/Stigma

Denial, not aware of programs/organizations to help, stigma and other issues besides substance abuse. – Health Care Provider

Not sure what the barriers are, aside from the person who is struggling that may not be willing to ask for help or feeling too trapped in their situation to want to change, or family members not getting involved to help. If we can decrease the accessibility of drugs and other substances, it could help alleviate the issue before it becomes a situation where treatment is needed. – Social Services Provider

Not wanting help. – Health Care Provider

Patients that are in danger. Patients that do not desire treatment. Community disinformation that supports patients that are in denial. Treatment impact on personal finances of patients. – Physician

Acknowledgment of need for treatment. – Community Leader

Desire for change, learned consequences, lack of awareness of Hep C seriousness, transportation. – Social Services Provider

First is a desire to stop. Then access and transportation and financing. – Physician

Stigma for seeking treatment (and fear of losing custody of your kids for seeking treatment). Lack of effective prevention efforts. Cost of care for seeking treatment (and loss of wages if working). Co-occurring issues between substance abuse and mental health. – Social Services Provider

Stigma. Lack of awareness about available resources. – Social Services Provider

Lack of Providers

Lack of providers. Wait time too long. Transportation. No Inpatient treatment. – Social Services Provider

Not enough providers in this area to address needs. – Health Care Provider

Inadequate number of providers and services. – Physician

I need more group therapy. Do not need to provide a safe patient to do their drugs provided by a mobile clinic. To me this is enabling these folks to do their drugs. They need more rehab facilities to help them clean. More law enforcement to help get drugs and drug dealers out of the community and off the streets. – Health Care Provider

Lack of providers and treatment facilities. – Health Care Provider

Lack of providers who are trained in addiction medicine and willing to devote practice resources to combatting addiction. These providers do not all need to be board certified in addiction medicine; they need education on core best practices and a desire to manage substance use disorders as we manage other chronic health conditions like diabetes. Stigma and isolation in our community against those who have addiction as a chronic health problem. Treating addiction is multi-disciplinary, longitudinal work... we lack a coordinated community program that organizes our professional expertise. – Physician

Awareness/Education

Finding information about treatment. Access to the facilities, getting to the place they need help. – Social Services Provider

Lack of awareness. – Community Leader

Dispelling myths and educating resources. We also need a treatment facility in this area that has beds and gives out needed medication assisted drugs, overdose prevention. – Health Care Provider

Treatment, knowledge and access to drugs. – Health Care Provider

Affordable Care/Services

> Income, cost of counseling/programs and the awareness and availability of programs. – Community Leader
>
> Lack of affordability and want to get clean. – Community Leader
>
> Affordability and outpatient programs. – Physician

Incidence/Prevalence

> Probably the overwhelming need for it. – Community Leader
>
> Substance use runs rampant in the community at all ages. I can't drive down the road without smelling skunk weed no matter how legal it is coming from a car next to me. Fentanyl is widely used in many drugs and although it might not be heavily reported here locally it's here and killing all ages. It's no longer a fried egg in a pan situation we are way past that. – Social Services Provider

Law Enforcement

> In speaking with community organizations who conduct this work it appears that working with law enforcement is a barrier. Rather than connecting individuals to services for recovery, some districts instead go to incarceration. That said, those individuals who do seek services prior to intersecting with law enforcement may have a difficult time getting to locations due to distance. Most of the resources in SAW are centered in Staunton, with one in Waynesboro and the rest in Harrisonburg. Thinking of accessibility, are these intervention programs accessible for individuals who lack health insurance or means to pay? – Public Health Representative

Self-Medicating

> I believe many people with substance abuse issues are using substances to treat mental health issues. Mental health support services are difficult to access as stated in the previous response. This often leads to homelessness which compounds the problem. – Social Services Provider

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as causing the most problems in the community, followed by **methamphetamines/other amphetamines**, **heroin/other opioids** and **prescription medications**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a "Major Problem")	
ALCOHOL	42.2%
METHAMPHETAMINE OR OTHER AMPHETAMINES	32.2%
HEROIN OR OTHER OPIOIDS	11.9%
PRESCRIPTION MEDICATIONS	5.1%
COCAINE OR CRACK	3.4%
HALLUCINOGENS OR DISSOCIATIVE DRUGS (e.g. Ketamine, PCP, LSD, DXM)	1.7%
MARIJUANA	1.7%
OVER-THE-COUNTER MEDICATIONS	1.7%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

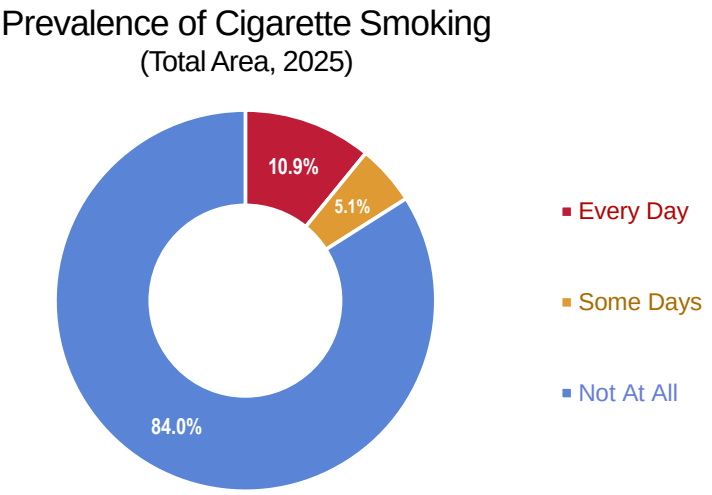
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Prevalence of Cigarette Smoking

A total of 16.0% of Total Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: • Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Total Area.

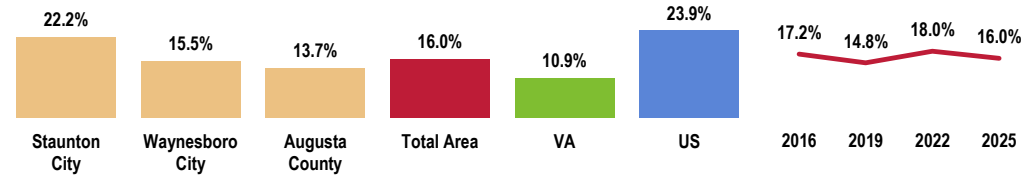
BENCHMARK ► Better than found nationally, but higher than found statewide. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Reported more often among Staunton residents, men, adults under 65, and lower income respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

Total Area



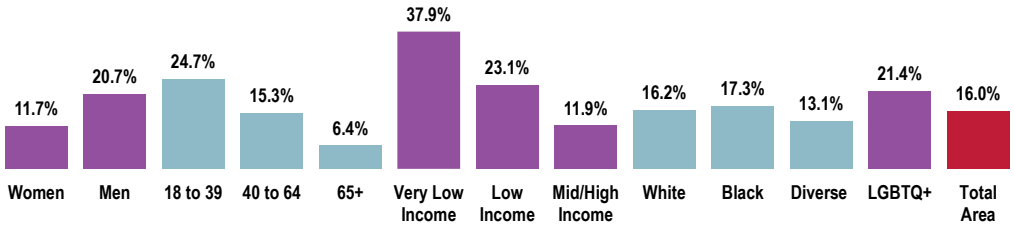
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Currently Smoke Cigarettes

(Total Area, 2025)

Healthy People 2030 = 6.1% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

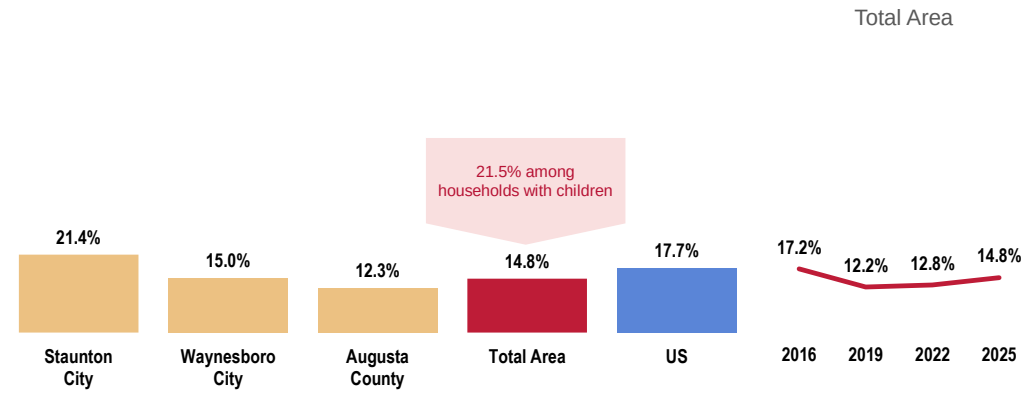
Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Environmental Tobacco Smoke

Among all surveyed households in the Total Area, 14.8% report that someone has smoked cigarettes, cigars, or pipes anywhere in their home an average of four or more times per week over the past month.

DISPARITY ► Reported more often among Staunton residents.

Member of Household Smokes at Home

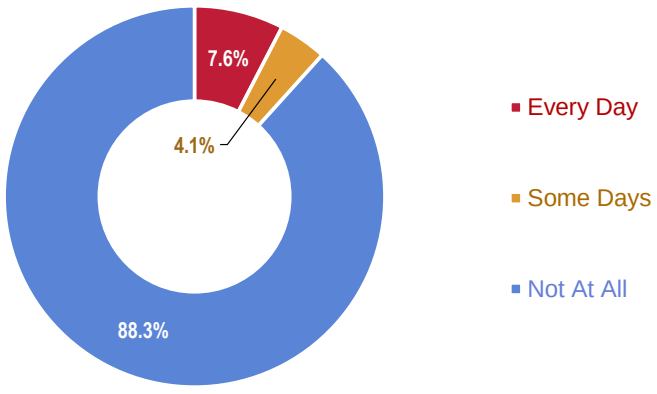


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

Most Total Area adults do not use electronic vaping products.

Use of Vaping Products
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
Notes: ● Asked of all respondents.

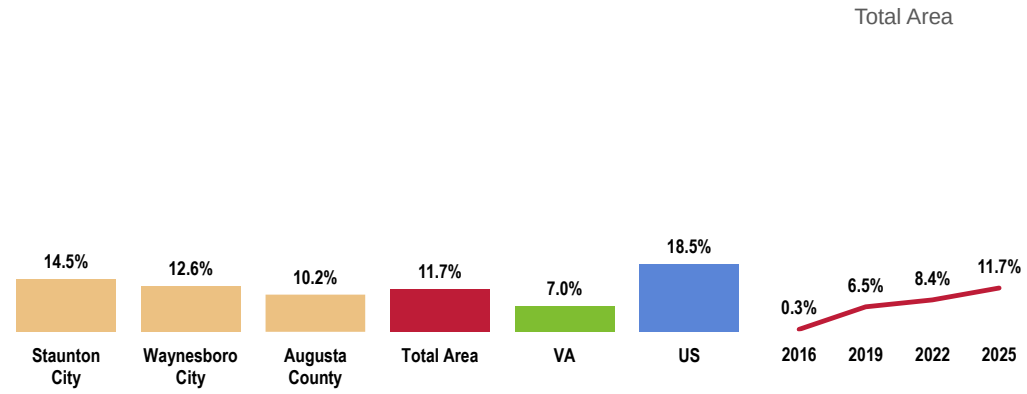
However, 11.7% currently use electronic vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ► A higher percentage than was found statewide. Better (lower) than found nationally.

TREND ► Significantly increasing over time.

DISPARITY ► Reported more often among adults under age 65, lower income residents, and LGBTQ+ respondents.

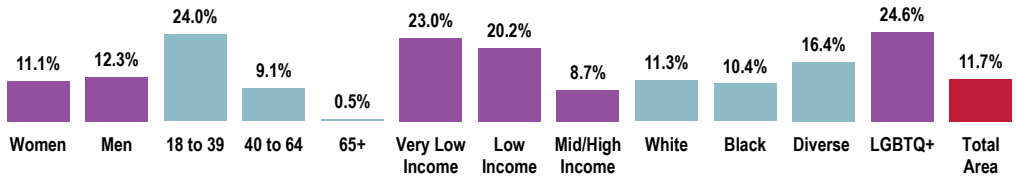
Currently Use Vaping Products
(Every Day or on Some Days)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Currently Use Vaping Products
(Total Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Smokeless Tobacco

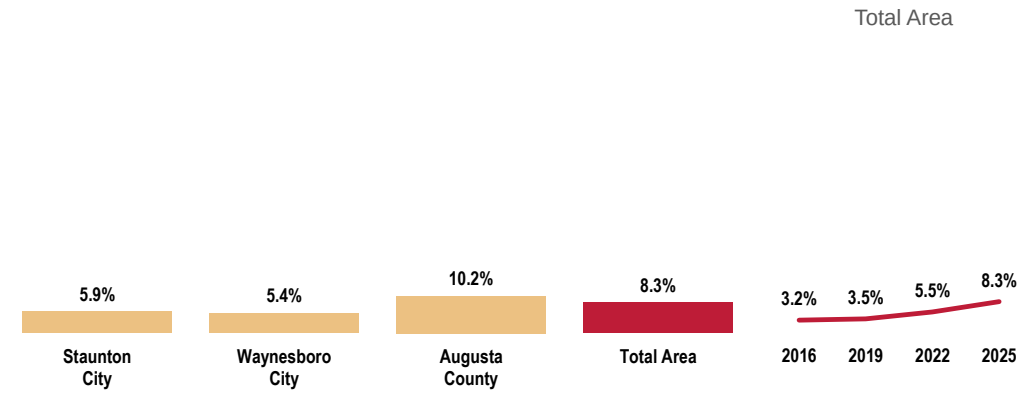
Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 8.3% of Total Area adults use some type of smokeless tobacco every day or on some days.

TREND ► A significant increase since 2016.

DISPARITY ► Reported more often among Augusta County residents.

Currently Use Smokeless Tobacco (Total Area, 2022)

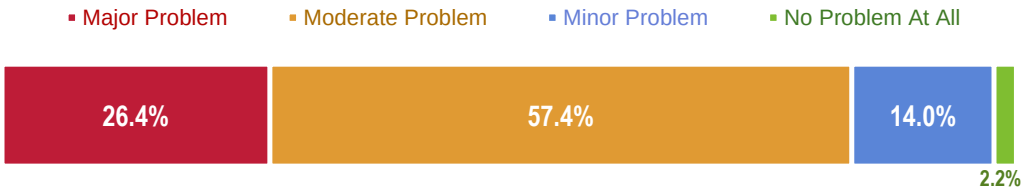


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.
● Includes use of chewing tobacco, snuff, or snus every day or on some days.

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "moderate problem" in the community.

Perceptions of Tobacco Use as a Problem in the Community (Among Key Informants; Total Area, 2025)



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Because stinky smoking people are everywhere. – Community Leader
>
> High number of smokers in rural areas. – Health Care Provider
>
> Many of my patient’s smoke. – Physician
>
> Still see a lot of smokers especially in rural locations. – Social Services Provider
>
> It is so commonly used among all users that it seems to be expected and not the first thing people want to quit. – Social Services Provider
>
> I witness daily with the population I work with a number of smokers. – Social Services Provider
>
> Tobacco particularly within vapes has been increasing. A recent study found that high school kids are more likely to use a vape than cigarettes. It is a rising trend that should be continued to be watched. – Public Health Representative
>
> Because many people in our community smoke. – Social Services Provider
>
> You're more likely to see someone smoking or dipping than anything else. Vape has also become a huge usage. – Community Leader
>
> The increase of teenagers is turning to tobacco. – Health Care Provider
>
> High number of smokers and COPD patients. – Physician
>
> High use of cigarettes. – Community Leader
>
> The severity of illnesses associated with tobacco use. – Health Care Provider
>
> We are a poor community, and we smoke. I smoke and I know it could cause cancer, and I take the risk because I am addicted. If we don't smoke, we vape or chew. So maybe we don't have a tobacco problem, but we definitely have a nicotine problem. – Social Services Provider

E-Cigarettes/Vaping

> Vaping. – Health Care Provider
>
> Vape, ZYN, all substances acceptable and readily available. – Health Care Provider
>
> For all that the vaping industry promised regarding the reduction of tobacco use, which has not caught on in our community. Tobacco use seems to be part of the culture, particularly in our more rural communities. It is also more prevalent in lower income households, and our community has a much lower area median income than the Virginia AMI. – Social Services Provider
>
> Vaping especially is a major problem for all ages, but especially among youth. It’s easy to conceal, easy to access, it’s very popular, and there’s a lack of understanding about the real dangers of e-cigarettes. Nicotine is a highly addictive substance and can contribute to so many other health problems and risk factors. Most people believe that vaping is safer than smoking traditional cigarettes, which is simply not true. – Social Services Provider

Ease of Access

> Tobacco is easily accessible to younger people and is likely the first drug they will experiment with. The addictive nature of tobacco perpetuates the problem. Kids are addicted before they realize what is happening. – Social Services Provider
>
> It's easily purchased, it’s everywhere, I find chew to be the most prevalent vs. traditional cigarettes. But this also contributes to oral health, and cancer. – Social Services Provider

Impact on Quality of Life

> Smoking may not have negative consequences immediately; also, nicotine is addictive. Difficult to stop even in the face of negative health consequences. – Health Care Provider

Awareness/Education

> No knowledge. – Community Leader

Generational

> Examples of family members. – Physician

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

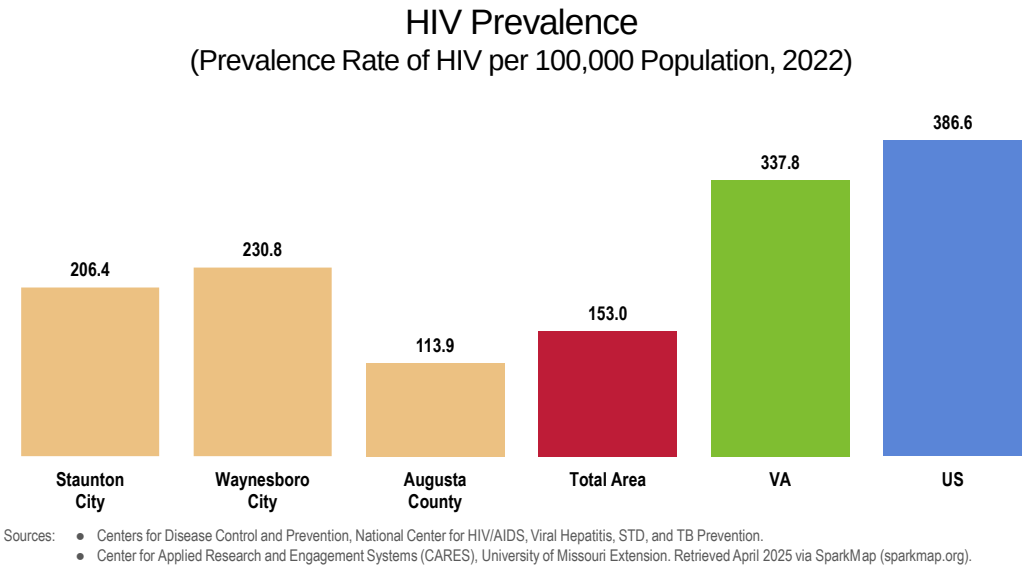
– Healthy People 2030 (https://health.gov/healthypeople)

HIV

In 2022, there was a prevalence of 153.0 HIV cases per 100,000 population in the Total Area.

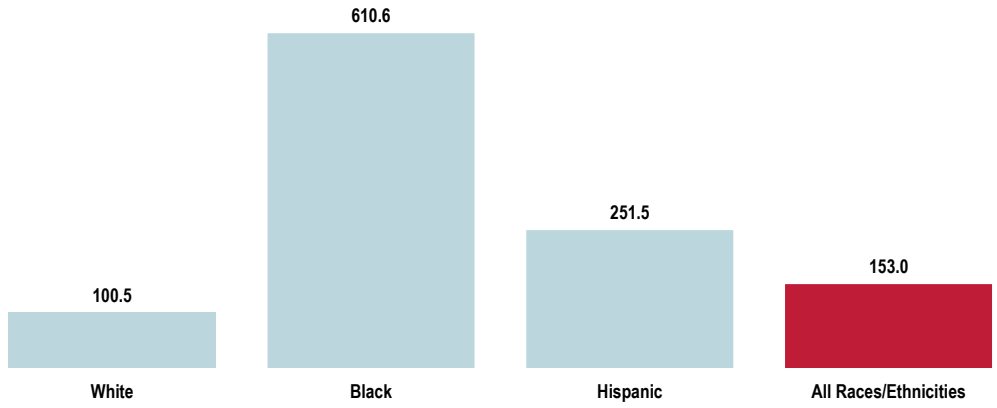
BENCHMARK ► Considerably lower than both statewide and national rates.

DISPARITY ► Higher in Staunton and Waynesboro than in Augusta County. Also higher among Black residents.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

HIV Prevalence by Race/Ethnicity
(Rate per 100,000 Population; Total Area, 2022)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- Race categories reflect individuals without Hispanic origin.

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

In 2023, the chlamydia incidence rate in the Total Area was 333.7 cases per 100,000 population.

BENCHMARK ► Notably lower than both Virgina and US rates.

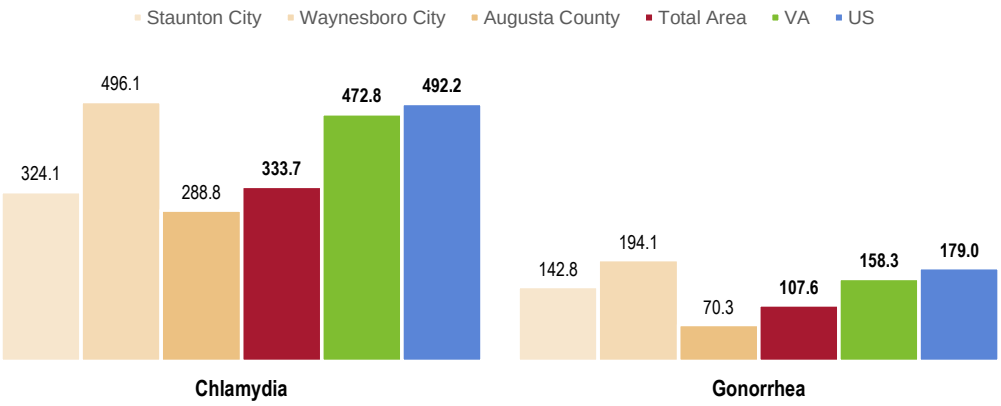
DISPARITY ► Highest among Waynesboro residents.

The Total Area gonorrhea incidence rate in 2023 was 107.6 cases per 100,000 population.

BENCHMARK ► Lower than both Virgina and US rates.

DISPARITY ► Highest among Waynesboro residents.

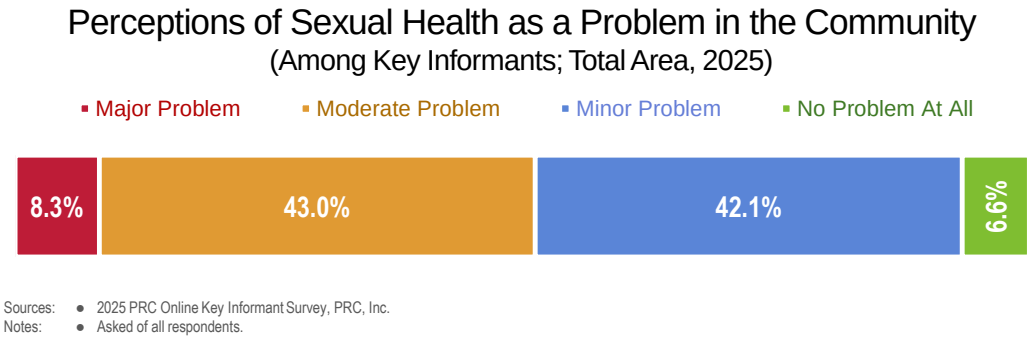
Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2023)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

Key informants taking part in an online survey generally characterized *Sexual Health* as a "moderate" or "minor problem" in the community.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

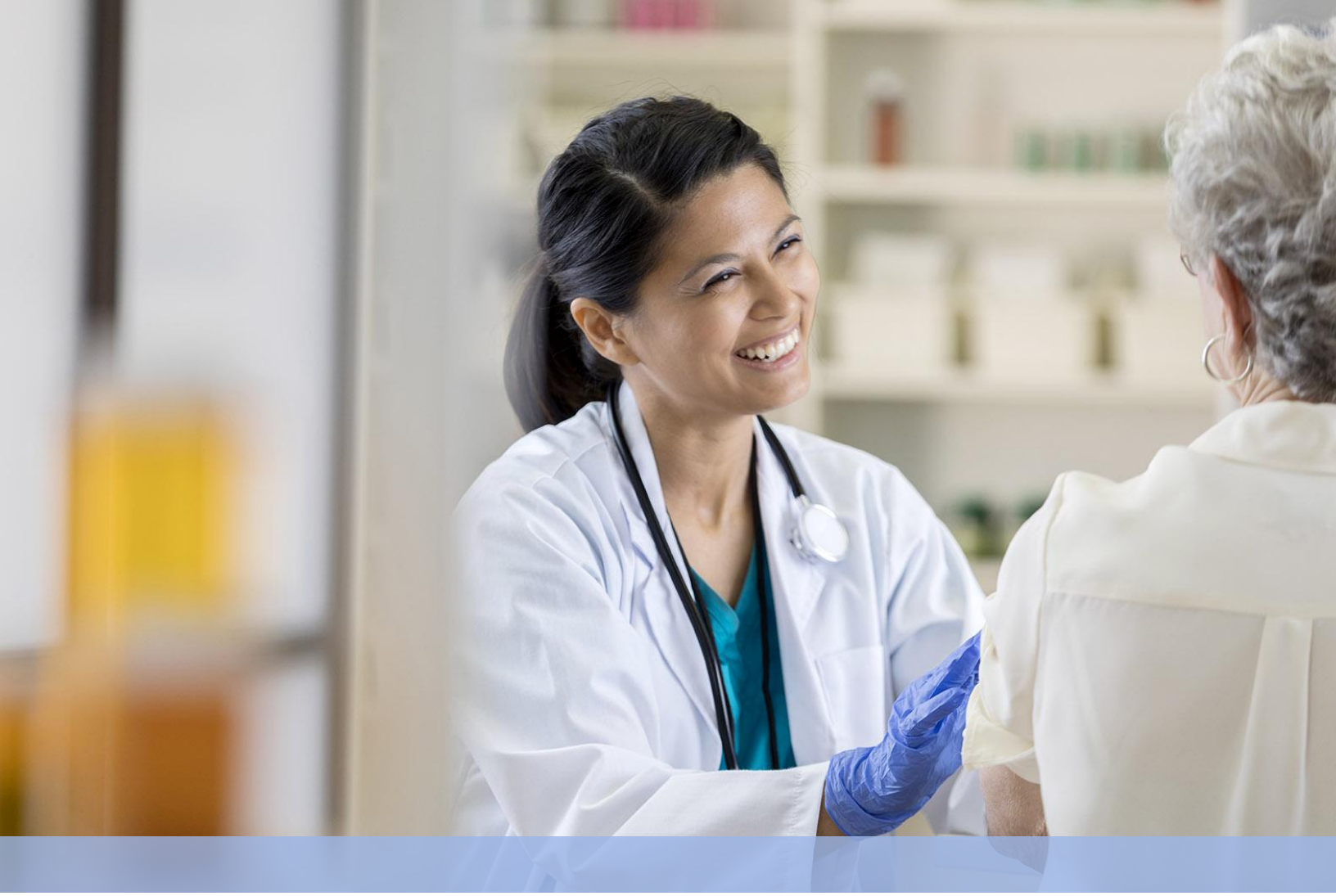
> Within SAW, Waynesboro is the one with the highest rates of STDs, HIV, etc. That said, STDs have high levels of stigma which may go unreported. – Public Health Representative
>
> The increase of STI's and the increase of IV drug use. – Health Care Provider
>
> Lots of STIs. – Physician

Awareness/Education

> Lack of information and access to preventative medication or prophylactics. – Social Services Provider
>
> Education. Lack of access to prevention methods, condoms and birth control. – Community Leader

Access to Care/Services

> The VDH is not accessible, and information is very limited on safe sex practices to Augusta County residents, specifically students. – Social Services Provider



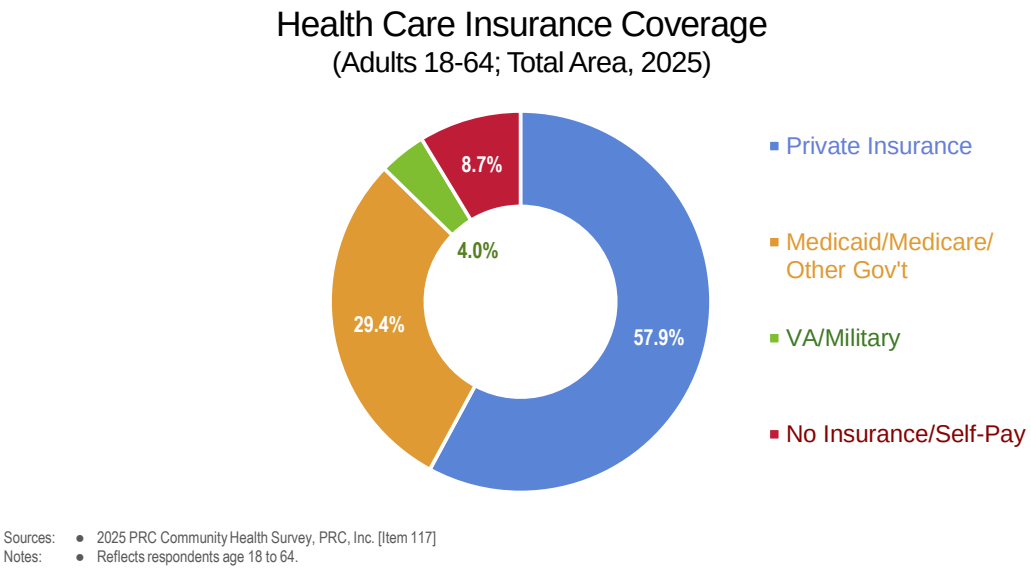
ACCESS TO HEALTH CARE

HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 57.9% of Total Area adults age 18 to 64 report having health care coverage through private insurance. Another 33.4% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

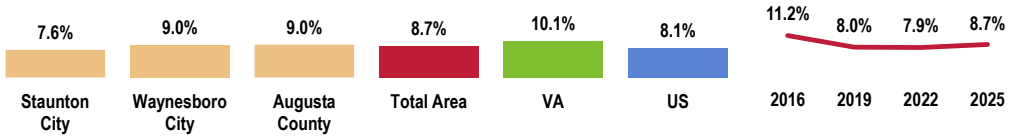
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 8.7% report having no insurance coverage for health care expenses.

DISPARITY ► Reported much more often among lower income residents.

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower

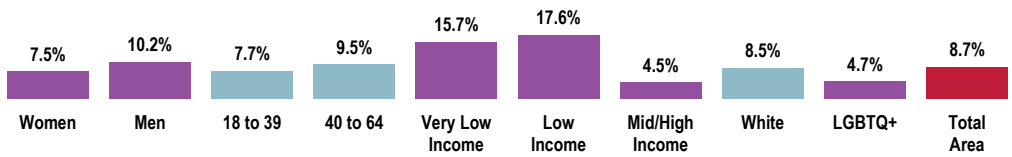
Total Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; Total Area, 2025)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

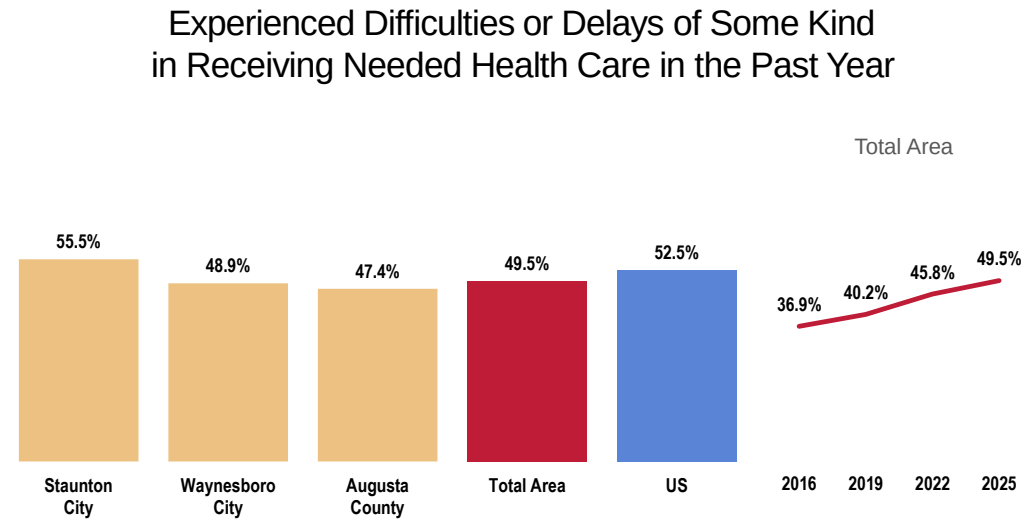
Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 49.5% of Total Area adults report some type of difficulty or delay in obtaining health care services in the past year.

TREND ► Steadily increasing since the baseline 2016 study.

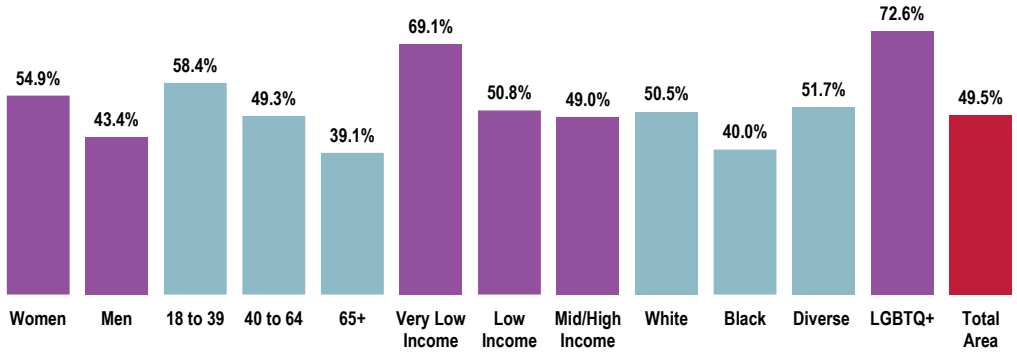
DISPARITY ► Reported more often among Staunton residents, women, adults under the age of 65, lower income residents, and LGBTQ+ respondents.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Total Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

Of the tested barriers, appointment availability and finding a physician impacted the greatest shares of Total Area adults.

BENCHMARK ► Lower (better) than found nationally for cost-related barriers, inconvenient office hours, transportation difficulties, and language/cultural barriers..

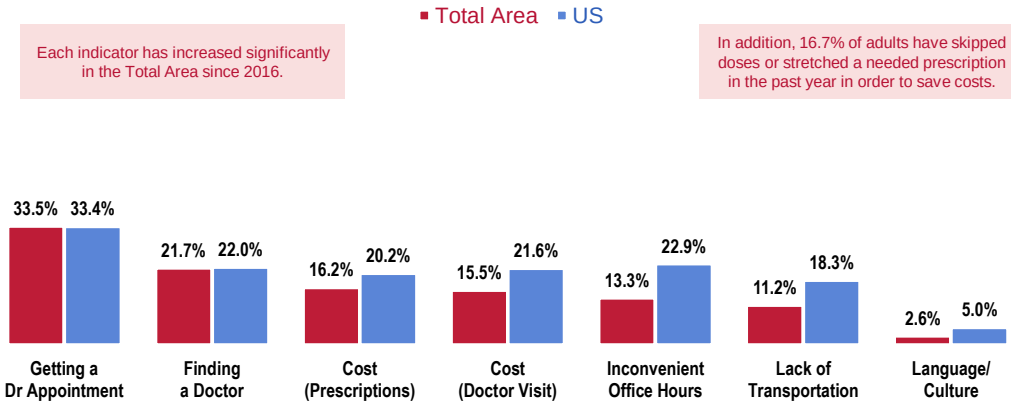
To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

Each indicator has increased significantly in the Total Area since 2016.

In addition, 16.7% of adults have skipped doses or stretched a needed prescription in the past year in order to save costs.



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

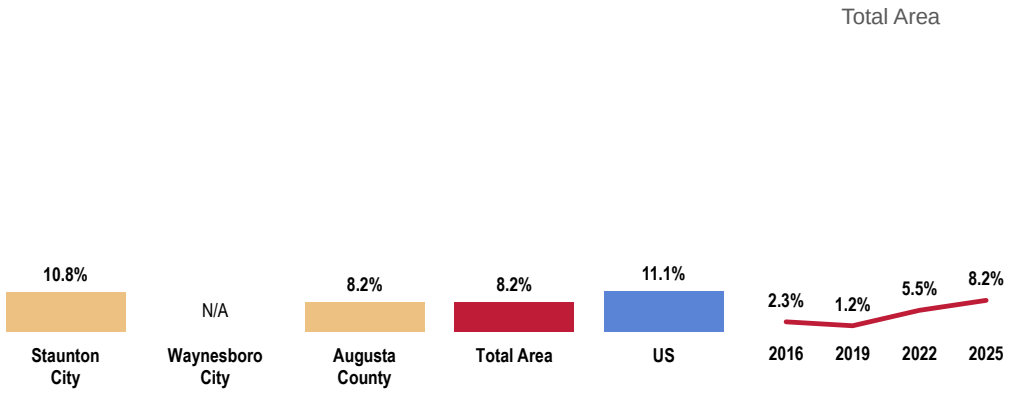
Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 8.2% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

TREND ► A significant increase from 2016.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

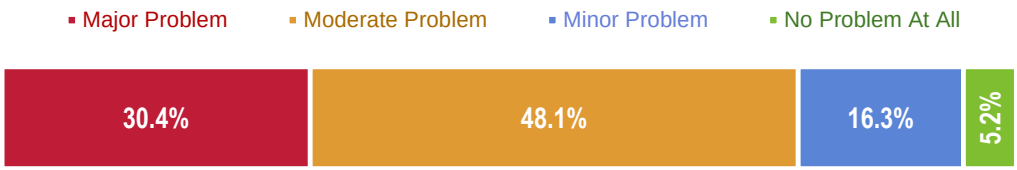


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.

Perceptions of Access to Health Care Services as a Problem in the Community
(Among Key Informants; Total Area, 2025)



Sources: ● 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

> Timely availability of general practitioners and timely availability of specialists. Limits on transportation continue to affect the ability for some citizens to get to appointments. Extreme limits on mental health services include excessive delays or poor-quality therapists. – Community Leader
>
> If you are sick and need to see a PCP in a timely manner, it is almost impossible to see someone on the same day or even the next day. This leads to people using the Urgent Cares and Emergency Department more frequently. – Health Care Provider
>
> Lack of access takes many forms, including limitations with the practice setting, waiting times, provider availability, etc., and barriers to care for those who are medically underserved transportation, financial, etc. – Health Care Provider
>
> Access to care and adherence to treatment plan. – Health Care Provider
>
> Primary care. – Health Care Provider
>
> Wait time to get an appointment. – Health Care Provider
>
> Access to primary care providers and specialists in a timely manner. Patients are waiting months to get in with a PCP or specialist and ultimately use ED to access care that could be provided at a lower level to address their needs. Access also in the form of transportation to get to their appts. SAW is a rural area and many live in rural areas that does not have access to transportation resources to get to their PCP or specialist. – Health Care Provider
>
> Getting an appointment at AH. – Health Care Provider
>
> There are several areas with limited ability for new patients in a timely manner. Primary Care, GI, to name a few. – Health Care Provider
>
> Long waits for providers, lack of financial ability to access services. – Social Services Provider
>
> There are many times during which our clients do not have access to counselors, psychiatrists, or other mental health providers. I also feel like access to adult dental services (specifically low cost or Medicaid) is severely lacking. Lastly, access to services for those dealing with substance use issues is either non-existent or extremely limited. We were very hopeful about the Crisis Intervention Center, and now that is off the table due to the "not in my backyard" issues in Fishersville. – Social Services Provider
>
> Appointment access to clinics and specialties long wait list. Also, transportation to and from appointments. – Health Care Provider
>
> Navigating the scheduling process whether by phone or in person or online. Transportation to and from appointments. Cost. – Physician
>
> Not enough providers with convenient and timely appointment availability. – Health Care Provider
>
> Not enough providers, which means a low amount of availability to appointments. – Health Care Provider
>
> Not having enough providers and facilities, especially for mental health services, financial barriers and transportation barriers. – Health Care Provider
>
> Extended waiting times for appointments for both primary and specialty care. If you have a sudden, non-emergent illness such as the flu or COVID it's often difficult to get an appointment with your PCP. This often causes someone to have to go to a UC or they use the ED. This is more costly and overburdens those services. Specialty care appointments are often booked a month or two out. This causes patients to sometimes seek care elsewhere in other health systems. – Community Leader
>
> We see a huge problem in affordability of healthcare, knowledge of resources, time/accessibility, i.e. needing to take off work to access healthcare, daycare for children, transportation. Mental health is also a piece, lots of people are under the assumption or have previously had a negative experience, leading them to believe they cannot be helped or will be judged for doing so. – Community Leader
>
> Fewer available providers, long wait times to be seen, barriers to insurance acceptance and barriers for under/uninsured patients, unaffordable co-pays, lack of reliable transportation, lack of comprehensive care for chronic conditions, limited choices for affordable holistic and integrative care. – Social Services Provider

Lack of Providers

> Not enough access to timely primary care due to physician shortages. – Physician
>
> Primary care, quick access. – Community Leader
>
> As a rural area, it is hard to attract providers to practice here. At the same time, many providers are leaving for various reasons (retirement, etc.) and this limits the number of providers accepting patients. Many people also have transportation barriers (e.g. no money for gas, distance) and hence, cannot get to the offices. – Health Care Provider
>
> Not enough providers, providers unable to keep up with demands, community members not receiving timely appointments, long waiting times for appointments. – Health Care Provider
>
> Limited number of providers, limited providers in areas of specialty, and limited providers from diverse backgrounds. Limitation to health insurance, or lack of health insurance. – Community Leader
>
> Not enough doctors to meet the need. – Social Services Provider
>
> Limited primary care MDs. Getting an appointment with a PCP is difficult and takes a long time. – Physician

Affordable Care/Services

> Access to affordable healthcare including transportation. – Health Care Provider
>
> Financial challenges. Community members are very concerned about not being able to pay for medical services (co-pays, high bills, etc.). The mobile clinics are a blessing, but when additional screening or procedures are needed, searching and applying for services can be challenging (Medicaid, financial assistance, etc.). Also, completing forms and gathering supporting documents can be difficult. Making copies of documents, asking employers to provide proof of income or having to pay fees to the banks to obtain copies of statements. For people with pending immigration processes (asylum, refugee, etc.) language & cultural barriers, transportation. Fear of being in public. – Community Leader
>
> Cost of care and access to specialty services. – Community Leader
>
> Lacking the ability to afford the care. Lack of awareness of resources. Lack of transportation. Difficultly getting off work for appointments. Support of social networks. – Physician
>
> Financial barriers and transportation barriers. – Health Care Provider

Transportation

> Transportation, although addressed, still is a massive stumbling block when it comes to accessing healthcare. Community knowledge as to what healthcare is provided where is also a huge issue, who qualifies for what, what's covered by who, frequent changes in primary care physicians. What happens when Augusta Health has a specialty doctor at the start of the year but then loses it, where does care pick up from there and if it's continued at UVA or Martha Jefferson, how does one get there? – Social Services Provider
>
> Biggest challenges are access to reliable transportation and quality health insurance. Not all local providers accept Medicaid, so receiving care for those on Medicaid sometimes requires traveling out of town, relying on public transportation which can take a full day of travel (even to Charlottesville) and an undue burden of coordination. This can result in a loss of income for those employed. In terms of health insurance, finding affordable health insurance for those just above the poverty line is nearly impossible unless their employer can provide it which many do not and it's not usually affordable. – Social Services Provider
>
> Consistent transportation issues to/from medical appointments/picking up prescriptions. Difficulty with finding and making PCP appointments. Patients' lack knowledge on how to identify and utilize healthcare services/programs. – Health Care Provider

Aging Population

> Augusta County is rural and includes an aging population, making it challenging for some residents to access healthcare given transportation limitations and/or isolation. Staunton and Waynesboro include significant immigrant and refugee populations who may not trust healthcare, may not have money/insurance to pay for medical bills, and may fear contact with formal entities due to immigrant-related fears. There are no free clinics or FQHCs in the area, further increasing limitations to affordable care for diverse groups who are low income. – Social Services Provider
>
> Healthcare navigation for elderly community. – Health Care Provider
>
> Elderly care and assistance. We often are called to home where there are elderly people and have difficulty caring for themselves and their spouse. We are usually unable to get them the care and assistance that they need. Adult Protective Services is contacted with little or no response. – Health Care Provider
>
> Assistance for the elderly getting medical care is needed. In home care and facility care are very costly. The elderly have difficulty with transportation, necessary medical paperwork, etc. – Community Leader
>
> 1- Growing mismatch between the aging population with chronic health problems and the national/local provider shortage. 2- Lack of same-day access for patients with acute needs, particularly those with chronic health problems. 3- Lack of adequate access to virtual appointments through Augusta Health. – Physician

Language Barriers

> Language and cultural barriers. Transportation. Awareness of health care services. – Community Leader
>
> The language, the services for their needs. – Community Leader

Culturally Competent Providers

> Culturally competent providers to meet the overall health care access and educational needs for Limited English Proficiency (LEP) and other language users, such as American Sign Language; providing language interpretation as required by law is only one part of addressing this problem and present disability and cultural awareness training is surface-level at best; health disparities continue to exist and leads to above-average health care service and emergency room utilization when information is inaccessible, symptoms unable to be adequately explained, and the same for at-home care; consider supporting the growth and training of Community Health Workers from these specific communities (one such pilot program in Virginia is developing a cohort of training Deaf CHWs who are ASL users). – Social Services Provider
>
> Lack/fewer culturally competent and affirming providers in the area. Stigma. Transportation barriers. Financial cost. – Social Services Provider

Mental Healthcare

> Access to mental health is especially difficult with long waiting times for appointments and the high cost of counseling services. There are not enough providers in network with Medicaid and even fewer accept Medicare. In-patient mental health services in our area are limited as well. Families of those with significant mental health issues often find it difficult to know where to go or how to navigate the process of getting quality services. Many feel helpless in helping their loved ones and often feel the mental health system has let them down. Finally, substance abuse is another significant issue in our area. I think awareness of what is available, flooding the area with information about the various providers and services, is much needed. Also, for providers/facilities to be made aware of the various services/programs in our area and even outside our area would also be helpful. – Community Leader

Medicaid

> Currently Medicaid, which covers many vulnerable communities, is being threatened by government cuts. This could have a significant impact on patient care. – Health Care Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

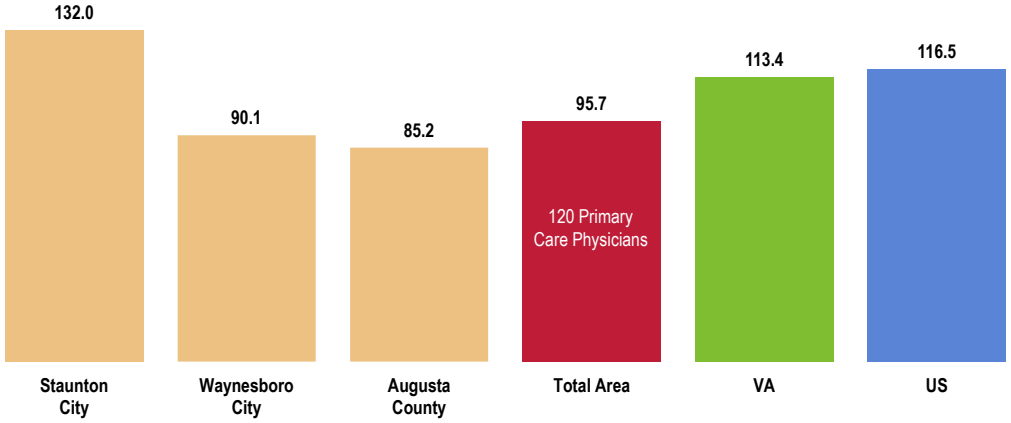
Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

In 2025, there were 120 primary care physicians in the Total Area, translating to a rate of 95.7 primary care physicians per 100,000 population.

BENCHMARK ► Lower than both state and US rates.

DISPARITY ► Significantly higher in Staunton.

Number of Primary Care Physicians per 100,000 Population
(2025)



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

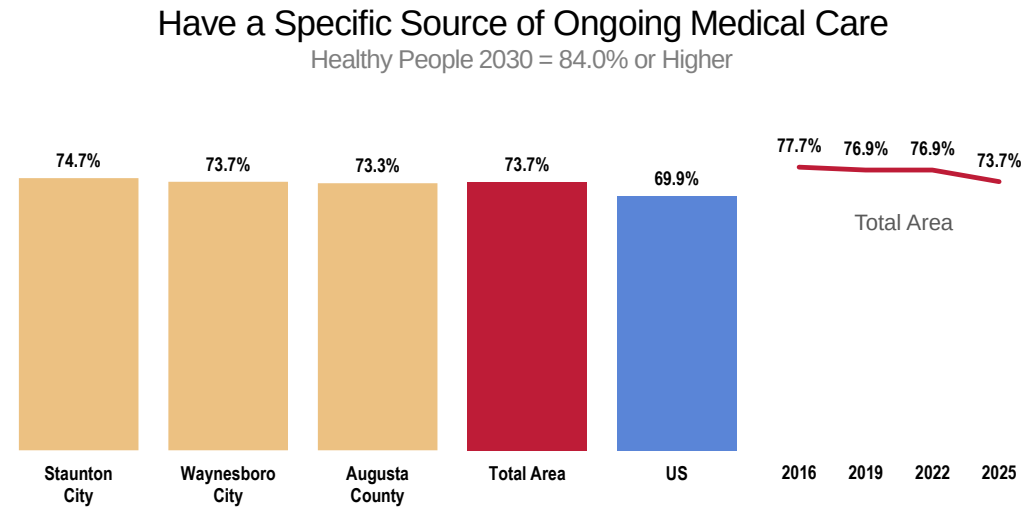
Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, public health clinic, community health center, urgent care or walk-in clinic, military/VA facility, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 73.7% of Total Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 118]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

Adults

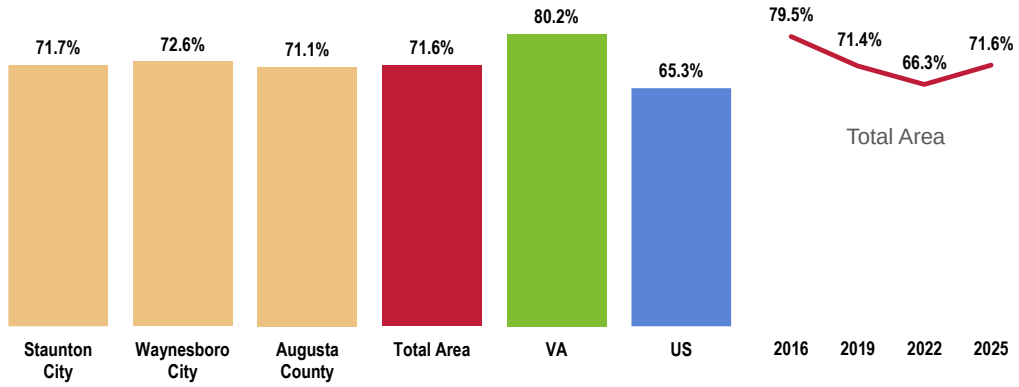
A total of 71.6% of adults visited a physician for a routine checkup in the past year.

BENCHMARK ► Lower than the statewide percentage.

TREND ► Significantly lower than first reported in 2016.

DISPARITY ► Reported less often among adults under the age of 65, lower income residents, and LGBTQ+ respondents.

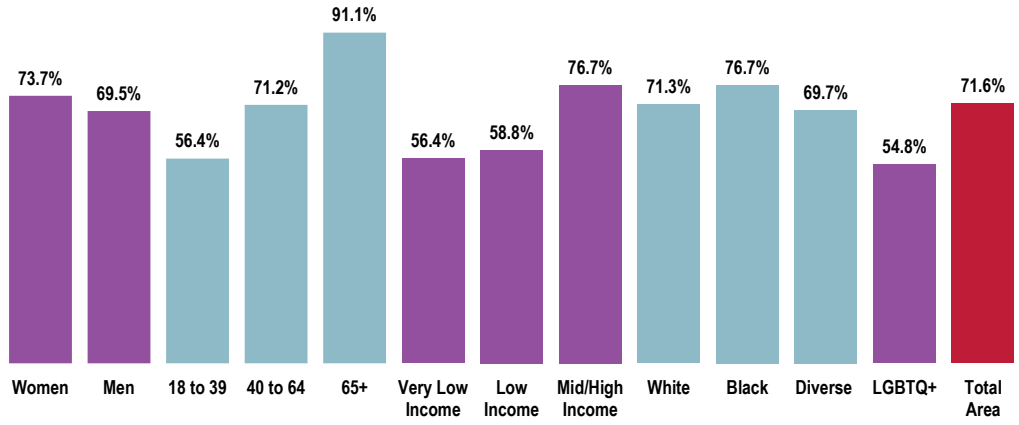
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Total Area, 2025)



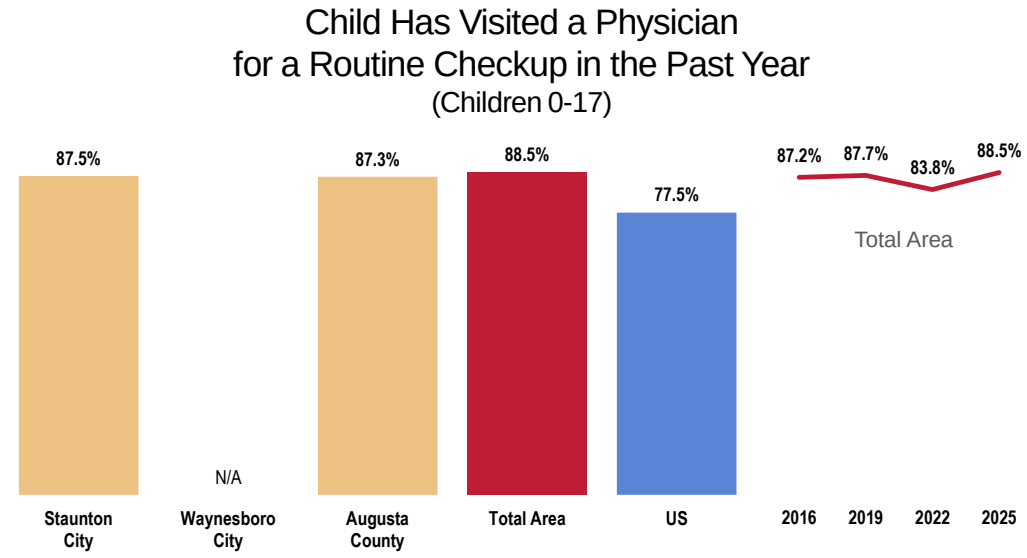
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 88.5% report that their child has had a routine checkup in the past year.

BENCHMARK ▶ Notably higher than the US prevalence.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

EMERGENCY ROOM UTILIZATION

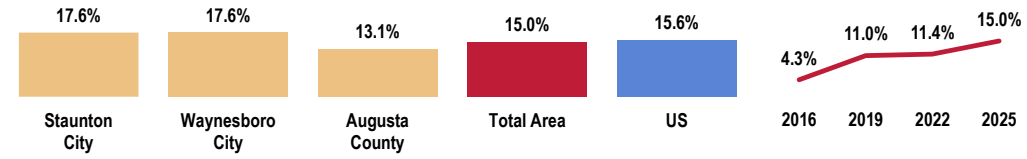
A total of 15.0% of Total Area adults have gone to a hospital emergency room more than once in the past year about their own health.

TREND ► Rising significantly since 2016.

DISPARITY ► Reported more often among adults under age 40 and lower income residents.

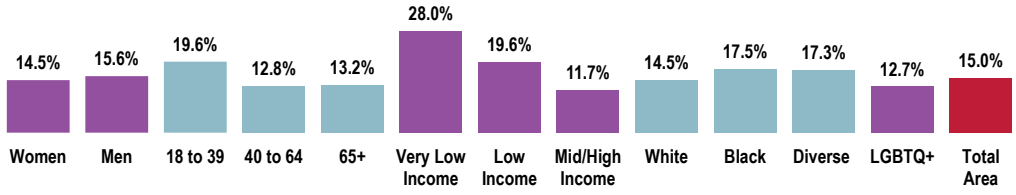
Have Used a Hospital Emergency Room More Than Once in the Past Year

Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 19]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 19]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

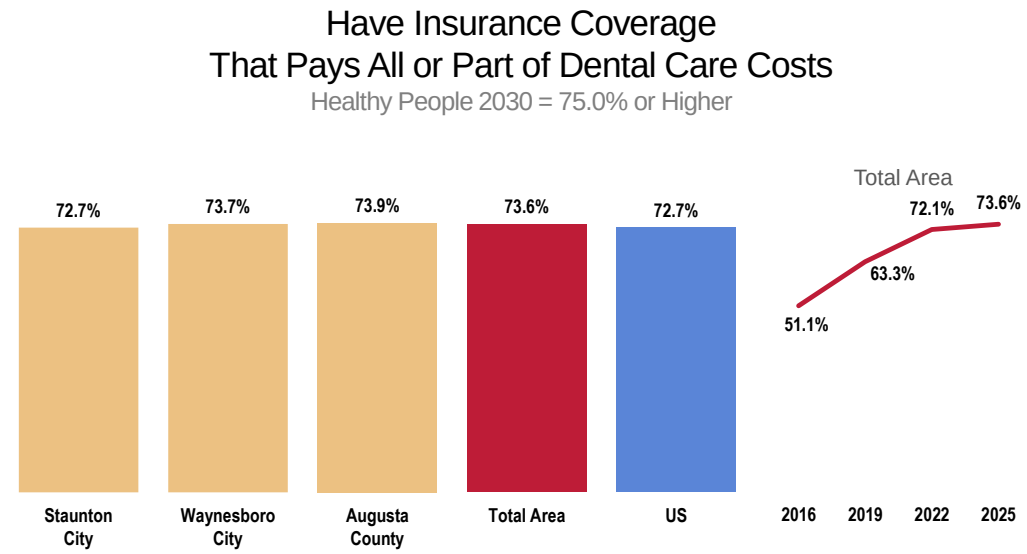
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Insurance

Nearly three quarters (73.6%) of Total Area adults have dental insurance that covers all or part of their dental care costs.

TREND ► A dramatic increase from baseline 2016 findings.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 18]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Dental Care

Adults

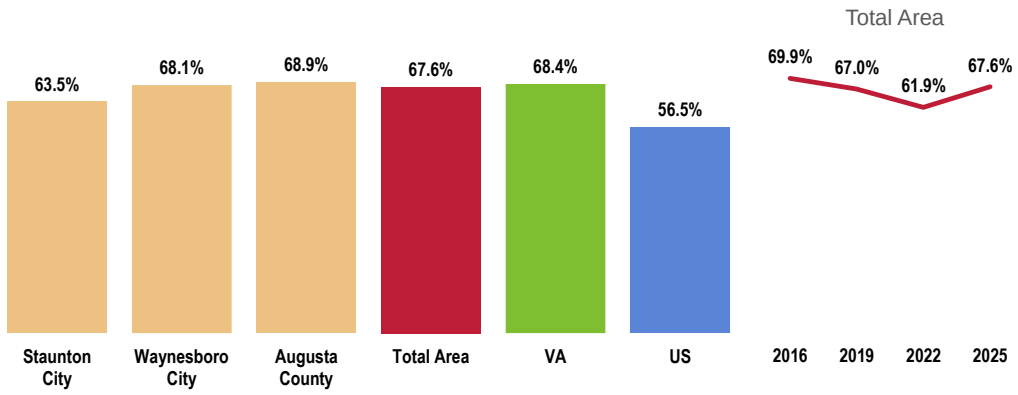
A total of 67.6% of Total Area adults have visited a dentist or dental clinic (for any reason) in the past year.

BENCHMARK ► Higher than the national rate. Satisfies the Health People 2030 objective.

DISPARITY ► Reported less often among adults under the age of 65, lower income residents (especially), LGBTQ+ respondents, and those without dental insurance (especially).

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



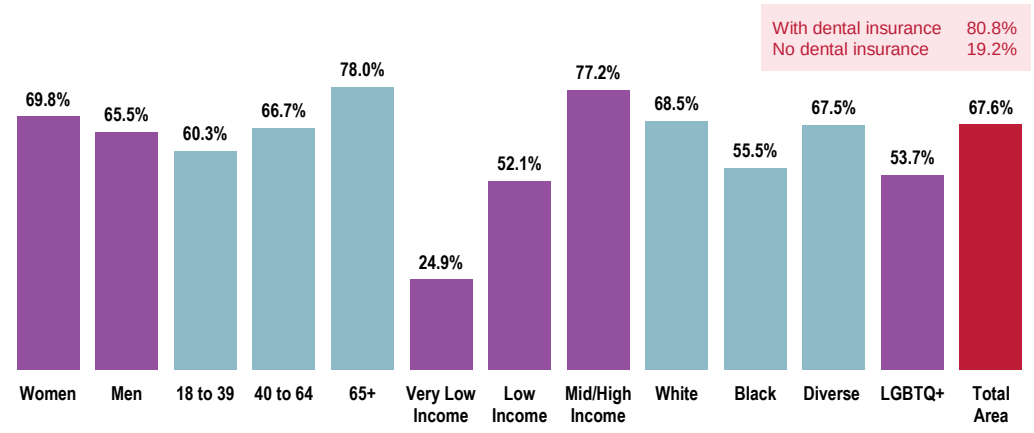
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 VA data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Total Area, 2025)

Healthy People 2030 = 45.0% or Higher



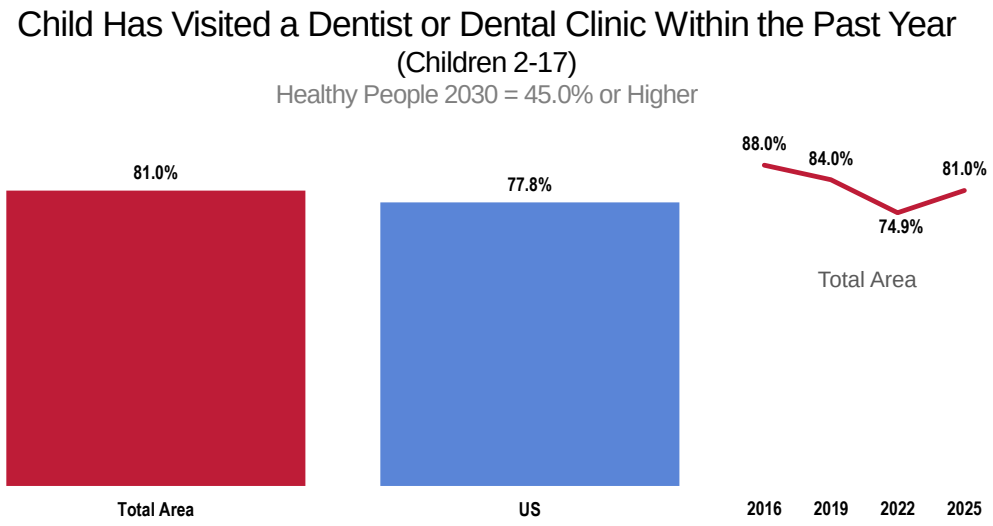
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 17-18]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Children

A total of 81.0% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Satisfies the Health People 2030 objective.

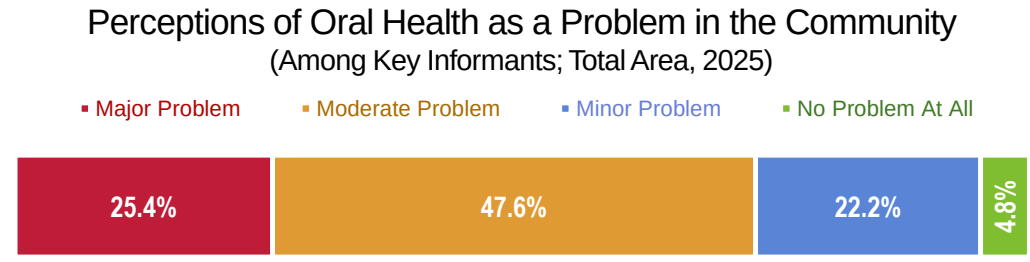


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 93]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Affordable Care/Services

> It's too expensive. Dental Insurance is a racket. – Community Leader
>
> Not enough access to affordable dentistry. – Physician
>
> It's expensive and people are sometimes scared to go as they haven't been in years. – Health Care Provider
>
> Expensive. Providers want payment up front. No good programs to help solve. – Health Care Provider
>
> It's too expensive going to the see a doctor. – Community Leader
>
> Cost and programs such as providing free dental care are so lacking. – Community Leader
>
> I hear people cannot afford dental services. – Community Leader
>
> Oral health is tricky. Insurance is tough to find and use. Many dentists only take one or two insurance plans. I was working with one dentist for a cyst on my jaw. In 2024 they took HealthKeepers, The cyst returned in early 2025 and they no longer took HealthKeepers so I had to pay out of pocket. – Community Leader
>
> Not sure if there is a dental program that go into the schools. That may help to instill the importance of dental hygiene. – Public Health Representative
>
> The lack of affordable dental insurance makes it difficult for many people to access necessary dental care. Because dental insurance is often separate from medical insurance, it is frequently one of the first expenses to be dropped. Many of the people we serve experience poor dental health, which can make it painful or challenging to eat fresh fruits and vegetables, further contributing to poor nutrition and overall health decline. – Social Services Provider
>
> Inaccessibility of dental care. – Health Care Provider
>
> Dentists are very expensive and most people do not have dental insurance. – Social Services Provider
>
> Because so many people in our community cannot afford dental work. Even those who have insurance are now not having work done because of the cost. – Social Services Provider
>
> Dental care that is affordable. – Physician

Access to Care for Underinsured and Uninsured

> Unable to help the Medicaid community as all Medicaid offers are full. – Health Care Provider
>
> There is a lack of dentists who take Medicaid. Those who do not have private insurance or Medicare are on wait lists that are 2-3 years long for clinics in Harrisonburg or Charlottesville. There isn't enough in Augusta County, in fact, currently there is nothing in Augusta County until the free clinic gets started up again to take low income families and that will also generate a long wait list. – Public Health Representative
>
> Expensive if you do not have insurance. Really not sure why, but doesn't seem to be a priority for people. Not having dental insurance. – Health Care Provider
>
> Access to dental care for those who are uninsured is the main driver for this issue. Few providers accept Medicaid payments for dental services. Those that do are limited. Likewise, the Augusta Regional Dental clinic is available, but may be out of reach for those with limited transportation. – Public Health Representative

Incidence/Prevalence

> VSH has 68 tenants, all with a diagnosed mental health issue, 80% need dental care on a continuing basis. – Social Services Provider
>
> Lots of people with no teeth. I've met 16-18 year olds with no top teeth because they rotted out, and I've met lots of older people with no teeth at all. – Social Services Provider
>
> We see many neighbors with poor oral health and education. Due to poor diets, financial issues to take care of (preventative) or surgical measures. Poor dental health leads to many other health issues and just needs to be better addressed at all ages, especially with the unhoused community. – Social Services Provider
>
> I see it in many of my patients. – Physician

Alcohol/Drug Use

> Drug usage and poor oral health are both large crisis in this area that seem to go hand in hand. Meth usage is one of the leading drug problems. Oral health contributes to every other system in the body, including heart and brain health. – Community Leader
>
> People consuming drugs often disregard their oral health and assume they will get dentures. – Social Services Provider

Diagnosis/Treatment

> People only seek care when they are in pain because they do not have a dental home. Private practices prices are unfordable for the uninsured. Lack of Medicaid providers. Lack of education in oral health vs. general health, and healthy diet. This issue will only get more crucial with the risk on Medicaid funding at the federal level. – Social Services Provider
>
> Adults often do not prioritize their oral health, especially when they are using illicit substances or experiencing mental health issues like depression. If people do want to focus on their dental health, there are very limited options for people with Medicaid or people who have limited income. – Social Services Provider

Lack of Providers

> Lack of access to providers accepting Medicaid or no insurance. Even though the free clinic has expanded access, the need outweighs the supply. – Public Health Representative
>
> Lack of dental providers. – Health Care Provider

Impact on Quality of Life

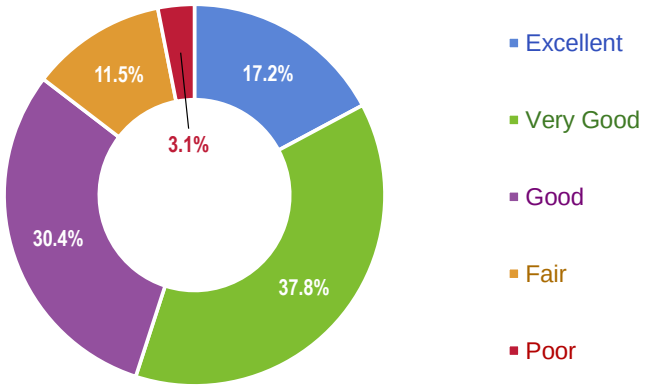
> Untreated oral health issues create health and social problems for persons of all ages. A person cannot be truly healthy without proper oral health treatment and management. This is especially true for children who need to have a good foundation of oral health to learn, thrive and grow. – Community Leader

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

Most Total Area adults rate the overall health care services available in their community as "excellent" or "very good."

Rating of Overall Health Care Services Available in the Community
(Total Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

However, 14.6% of residents characterize local health care services as "fair" or "poor."

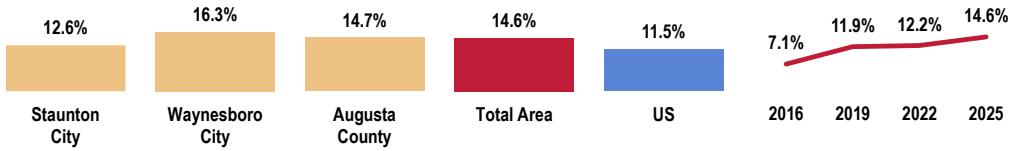
BENCHMARK ► Above the national percentage.

TREND ► Increasing over time.

DISPARITY ► Reported more often among lower income residents, LGBTQ+ respondents, and those with access difficulties in the past year.

Perceive Local Health Care Services as "Fair/Poor"

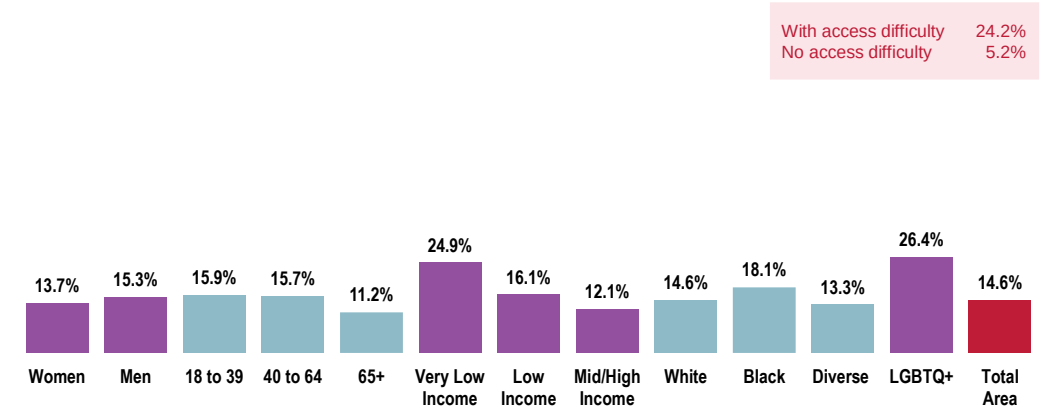
Total Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Local Health Care Services as “Fair/Poor”

(Total Area, 2025)

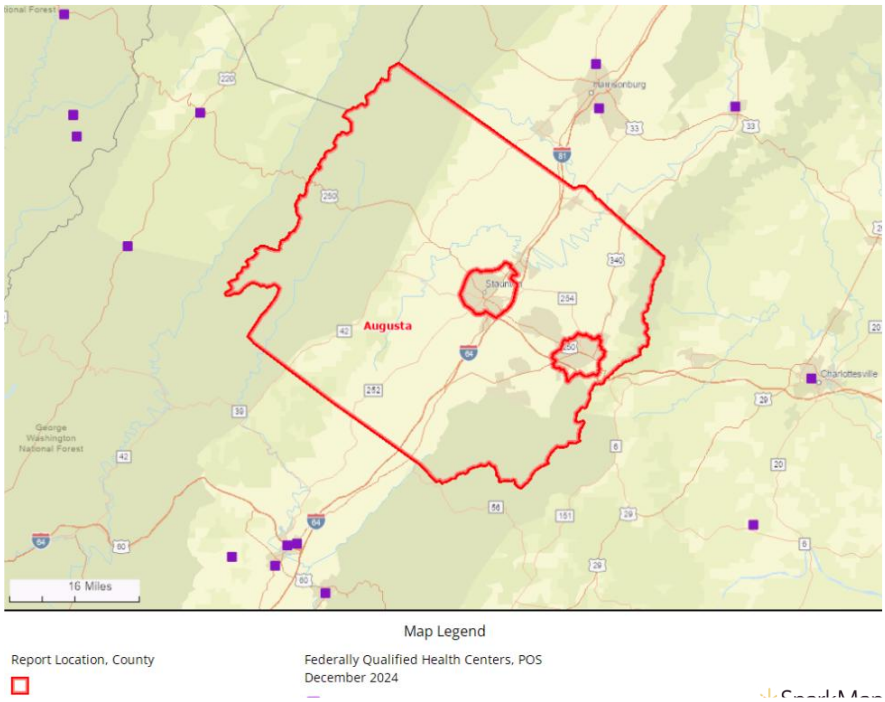


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Items 5, 119]
Notes: • Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

Note the lack of Federally Qualified Health Centers (FQHCs) within the Total Area as of December 2024.



Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- AMH Case Managers
- Arrow Project
- Augusta Health
- Augusta Health Behavioral Services
- Augusta Health Community Clinics
- Augusta Health Mobile Clinics
- Augusta Health Neighborhood Clinics
- Augusta Regional Dental Clinic
- Brite Bus
- Bus Services
- Carilion Primary Care Services
- Case Managers/Management
- Central Shenadoah Health District
- Churches
- Community Clinics/Nurses
- Community Foundation of Central Blue Ridge
- Community Health Organizations
- Comprehensive Behavioral Health
- Crisis Intervention/Prevention
- Crossroads
- Dental Clinics
- Department of Social Services
- Diabetes Education
- Doctor's Office
- Embrace Community Center
- Emergency Room
- Food Banks/Pantry
- Health Departments
- Health Fairs/Screenings
- Hospitals
- Isaiah 61 Ministries
- Kuley and Associates
- Libraries
- Love Inc.
- Medexpress
- Medicaid/Medicare
- Middlebrook Family Medicine
- Mobile Clinics
- Neighborhood Primary Care Clinics
- Nickles and Dimes
- Nutritionists
- Ram Clinic
- Savida Health
- Sentara Health
- Shenandoah LGBTQ Center
- State Services
- Telehealth
- University of Virginia
- Urgent Care
- UVA Health Services
- Valley Community Services Board
- Valley Hope Counseling Center
- Valley Mission
- Valley Program for Aging Services
- Virginia's Medicaid Expansion
- Youth Center

Cancer

- American Cancer Society
- Augusta Health
- Augusta Health Cancer Center
- Cancer Centers
- Doctor's Office
- Every Women's Life Program
- Health Departments
- Health Fairs/Screenings
- Hospice
- Hospitals
- Pharmacies
- Sentara Health
- Sentara Oncology
- Sentara RMH Hahn Cancer Center
- Smoking Cessation Classes
- Support Groups
- University of Virginia
- UVA Health Services
- Women's Breast Health Center

Diabetes

- American Diabetes Association
- Arrow Project
- Augusta County Board of Supervisors
- Augusta Health

- Augusta Health Community Clinics
- Augusta Health Diabetes & Endocrinology Clinic
- Augusta Health Farm
- Augusta Health Fitness Center
- Augusta Health Food Pantry
- Augusta Health Food Pharmacy
- Augusta Health Foundation Grant
- Augusta Health Medication Assistance Program
- Augusta Health Metabolic Weight Management Clinic
- Augusta Health Mobile Clinics
- Augusta Health Neighborhood Clinics
- Augusta Medical Group
- Blue Ridge Area Food Bank
- Carilion Primary Care Services
- Case Managers/Management
- Central Shenadoah Health District
- Churchville Health Equipment Loan Program
- Community Clinics/Nurses
- Community Services
- Community Services Board
- Department of Social Services
- Diabetes Education
- Doctor's Office
- Emergency Room
- Farmer's Markets
- Fitness Centers/Gym
- Food Banks/Pantry
- GME Community Clinic
- Health Departments
- Hospitals
- Jones Garden
- Libraries
- Lifeworks
- Meals on Wheels
- Medicaid/Medicare
- Medication Assistance Programs
- Mobile Clinics
- Neighbor Bridge
- Neighborhood Primary Care Clinics
- Nutritionists
- Online Resources
- Parks and Recreation
- Pharmacies
- Project Grows
- Project Mobile
- River City Bread Basket
- SAW Housing Committee
- School System
- Sentara Health
- Shenandoah Valley Social Services
- Staunton Augusta Health Department
- Staunton City Council
- University of Virginia
- Urgent Care
- UVA Health Services
- Valley Community Services Board
- Valley Program for Aging Services
- Virginia Cooperative Extension
- Virginia Correctional Enterprises Family Nutrition Programs
- Virginia Department of Health
- Waynesboro City Council
- Written Materials
- YMCA

Disabling Conditions

- Alzheimer's Association
- Amazon
- Arrow Project
- Assisted and Skilled Nursing Homes
- Assisted Living Facilities
- Augusta Health
- Augusta Health Behavioral Services
- Augusta Health Mobile Clinics
- Augusta Medical Group
- Churchville Health Equipment Loan Program
- Community Disability Board
- Community Foundation of Central Blue Ridge
- Department of Aging and Rehabilitative Services
- Department of Social Services
- Diabetes Education
- Doctor's Office
- Food Banks/Pantry
- Home Health Care
- Long Term Care Facilities
- Meals on Wheels
- Memory Care
- Mental Health America
- Non-Profits
- Physical Therapy/Rehabilitation
- Project Grows
- Renewing Homes of Greater Augusta
- School System
- Social Security
- Social Services
- Support Groups
- The ARC
- UVA Health Services
- Valley Association for Independent Living
- Valley Children's Advocacy
- Valley Community Services Board
- Valley Program for Aging Services

- Veterans Administration
- Virginia Department for the Blind and Vision Impaired
- Wilson Workforce and Rehabilitation Center

Heart Disease & Stroke

- American Heart Association
- Augusta County Board of Supervisors
- Augusta Health
- Augusta Health Fitness Center
- Augusta Health Heart and Vascular Center
- Augusta Health Heart Failure Clinic
- Augusta Health Neighborhood Clinics
- Augusta Medical Group
- Boys and Girls Club
- Cardiac Rehab
- Carilion Primary Care Services
- Churches
- Community Child Care
- Community Services
- Doctor's Office
- Emergency Room
- Fire Department
- Fitness Centers/Gym
- Food Banks/Pantry
- GME Community Clinic
- Grocery Stores
- Health Departments
- Health Fairs/Screenings
- Hospitals
- Mobile Clinics
- Non-Profits
- Online Resources
- Parks and Recreation
- Pharmacies
- Physical Therapy/Rehabilitation
- Project Grows
- Sentara Health
- Staunton City Council
- Stroke Smart Cities/Communities
- Urgent Care
- UVA Health Services
- Virginia Cooperative Extension
- Virginia Department of Health
- Waynesboro City Council
- YMCA

Infant Health & Family Planning

- Augusta Health
- Augusta Health Center for Women's Health
- Augusta Health Mobile Clinics
- Central Shenadoah Health District
- Churches
- Comfort Care Women's Health
- Doctor's Office
- EducationSafe Sleep Program
- Hand in Hand Resource Mothers
- Headstart
- Health Departments
- Healthy Families of Blue Ridge
- Hospitals
- Infant and Toddler Connection
- Maternal Health Navigator
- Middle River Jail for Incarcerated Mothers
- Mobile Clinics
- Mothering Together
- Office on Youth
- Public Health Facilities
- Social Services
- Staunton Augusta Health Department
- The Village Prenatal Clinic
- UVA Health Services
- Valley Community Services Board
- Valley Pediatrics
- Youth Center

Injury & Violence

- Addiction Counseling
- Arrow Project
- Augusta Health
- Crisis Intervention/Prevention
- Law Enforcement
- Mental Health Services
- New Directions Center
- Non-Profits
- Valley Community Services Board

Mental Health

- Amazing Grace Psychiatric Services
- Arrow Project
- Augusta Health
- Augusta Health Behavioral Services
- Augusta Regional Dental Clinic
- Behavioral Health Center
- Behavioral Health Group
- CAN
- Carilion Primary Care Services
- Churches
- Commonwealth Center for Children and Adolescents
- Community Services
- Community Services Board

Compass Behavioral Group
Comprehensive Behavioral Health
Crossroads
Department of Social Services
Doctor's Office
Emergency Room
For-Profits
Health Centers
Health Connect America
Hospitals
Hotlines
Isaiah 61 Ministries
Kuley and Associates
Lall Community Services
Law Enforcement
Mental Health America
National Alliance on Mental Illness
National Counseling Group
New Directions Center
Non-Profits
Online Resources
Optima EAP Services
Pride Services
Ride With Pride
Salvation Army
School System
Sentara Health
Shenandoah Psychiatric Medicine
Shenandoah Valley Social Services
Social Services
Sparrow Project
State Services
Staunton-Agusta Church Relief Association
Staunton City Schools
Strength In Peers
Support Groups
The Space
Trinity Episcopal Church
UVA Health Services
Valley Center for Family Relations
Valley Children's Advocacy
Valley Community Services Board
Valley Homeless Connection
Valley Hope Counseling Center
Valley Mental Health Services
Valley Mission
Valley Pastoral Counseling Services
Valley Supportive Housing
VCDB
Veterans Administration
Virginia Department of Health
Western State Hospital
YMCA

Nutrition, Physical Activity, & Weight

AH Community Benefit Initiatives
Allegheny Mountain Institute
Anytime Fitness
Augusta Health
Augusta Health Crops to Community
Augusta Health Diabetes & Endocrinology Clinic
Augusta Health Farm
Augusta Health Fitness Center
Augusta Health Food Pantry
Augusta Health Food Pharmacy
Augusta Health Metabolic Weight Management Clinic
Augusta Health Neighborhood Clinics
Augusta Medical Group
Blue Ridge Area Food Bank
Board of Supervisors and City Councils
Boys and Girls Club
Case Managers/Management
Churches
Community Services
Community Services Board
Comprehensive Behavioral Health
Diabetes Education
Doctor's Office
Farmer's Markets
Findhelp.org
Fitness Centers/Gym
Food Banks/Pantry
Fox Family
Government Programs
Grocery Stores
Gypsy Hill Park
Health Centers
Health Departments
Hospitals
Jewell's Naturals
Jones Garden
Libraries
Lifetime RXEX Program
Lifeworks
Meals on Wheels
Neighbor Bridge
Nutritionists
Parks and Recreation
Planet Earth
Planet Fitness
Project Grows
River City Bread Basket
School System
Sentara Health
Staunton Augusta Farmers' Market

Stauntonrha.org
Supplemental Nutrition Assistance Program
The Green Way
University of Virginia
Urban Farms
Valley Community Services Board
Valley Program for Aging Services
Virginia Department of Health
Walk to School Week
Waynesboro Educational Farm
Weight Management Services
Weight Watchers
Women, Infants and Children
YMCA
Youth Center

Oral Health

Augusta Health
Augusta Health Mobile Clinics
Augusta Medical Group
Augusta Regional Dental Clinic
Blue Ridge Maxillofacial
Dental Clinics
Doctor's Office
Harrisonburg Rockingham Community Health Center
Health Centers
Health Departments
Medicaid/Medicare
Mobile Clinics
Ram Clinic
Rockbridge Area Health Center
UVA Health Services
Veterans Administration
Virginia Department of Health

Respiratory Diseases

Augusta Health
Care Advantage
Christian Healthcare Ministries
Community Health Organizations
Doctor's Office
Health Departments
Pharmacies
Physical Therapy/Rehabilitation
Stay Well Community Wellness
Valley Community Services Board
Youth Center

Sexual Health

Augusta Health
Augusta Health Mobile Clinics
Central Shenadoah Health District
Hospitals
Libraries
Office on Youth
Strength In Peers
Valley Community Services Board
Virginia Department of Health
Women's Clinic
Youth Center

Social Determinants of Health

Affordable Housing Coalition
Artis Transitions
Augusta Health
Augusta Health Community Clinics
Augusta Health Diabetes & Endocrinology Clinic
Augusta Health Farm
Augusta Health Food Pantry
Augusta Health Mobile Clinics
Augusta Health Neighborhood Clinics
Blue Ridge Area Food Bank
Blue Ridge Community College
Blue Ridge Legal Services
Boys and Girls Club
BRCC
Brite Bus
Case Managers/Management
Central Shenadoah Health District
Christian Housing
Churches
Community Action Partnership of Staunton, Agusta, and Waynesboro
Community Foundation of Central Blue Ridge
Community Foundation of Greater Augusta
Community Services
DCCU Cares
Department of Social Services
Doctor's Office
Dominion Energy
Emergency Room
Food Banks/Pantry
For-Profits
Habitat for Humanity
Health Departments
HERO
Hospitals
Housing Authority
Housing Summitt

- HUD Housing
- Jones Garden
- Libraries
- Lifeworks
- Local Elected Officials
- Love Inc.
- Medication Assistance Programs
- Mobile Clinics
- Neighbor Bridge
- New Directions Center
- New Recovery High School
- Non-Profits
- Office on Youth
- Project Grows
- Renewing Homes of Greater Augusta
- Rugged Hands
- Salvation Army
- SAW Housing Committee
- School System
- Shenandoah LGBTQ Center
- Shenandoah Valley Social Services
- Social Services
- Staunton-Agusta Church Relief Association
- Staunton Redevelopment and Housing Authority
- Unemployment Agencies
- Unite Virginia
- United Way
- Valley Career and Technical Center
- Valley Children's Advocacy
- Valley Community Services Board
- Valley Homeless Connection
- Valley Mission
- Valley Program for Aging Services
- Valley Supportive Housing
- Valley Workforce Center
- Verona Community Center
- Veterans Administration
- Virginia Department of Health
- Virginia Organizing
- Waynesboro Area Refuge Mission Shelter
- YMCA

Substance Use

- 12 Steps Program
- AA/NA
- Arrow Project
- Attorneys/Lawyers
- Augusta Health
- Augusta Health Behavioral Services
- Brightview
- Celebrate Recovery Programs
- Community Services Board
- Comprehensive Behavioral Health
- Crossroads
- Doctor's Office
- Drug Courts
- Emergency Room
- Health Departments
- Hospitals
- Hotlines
- King's Daughters Community Health
- Law Enforcement
- Mid-Atlantic Recovery Center
- National Alliance on Mental Illness
- New Directions Center
- New Recovery High School
- Office on Youth
- Pathways Program
- Savida Health
- Sentara Health
- State Services
- Staunton Augusta Health Department
- Staunton Treatment Center
- Strength In Peers
- Support Groups
- Teen Challenge
- The Village Prenatal Clinic
- University of Virginia
- Valley Community Services Board (VCSB)
- Valley Hope Counseling Center
- Valley Mission
- Virginia Peninsula Community College
- Wilson Workforce and Rehabilitation Center
- Youth Center

Tobacco Use

- Augusta Health
- Doctor's Office
- Health Centers
- Health Departments
- Savida Health
- School System
- Smoking Cessation Classes
- UVA Health Services
- Valley Community Services Board

APPENDIX

EVALUATION OF PAST ACTIVITIES

Health Need:	**Access to Healthcare**					
Goals:	Improve access, navigation, and coordination of services to reduce health care barriers for vulnerable and underserved community members.					
Strategy or Program	**Tactics**	**Timeframe**	**Accountability**	**Budget**	**Outcome Measures**	**Status**
1. **Financial Assistance** Increase community awareness and provide navigation support to help community members access Augusta Health financial assistance resources.	1.1 Explore web design editing to make Financial Assistance more user friendly.	2023	Lori Sitzberger Katie Adams	Operational	a) Explore (Yes or No) b) Changes made to Web Site design (Yes or No)	**2023** a) Yes (achieved through partnership with Breez Health) b) Yes (July 2023) **2024** a) N/A b) N/A
	1.2 Financial Counselor collaboration w/ Neighborhood Clinic.	2023-2025	Lori Sitzberger Katie Adams		a) # clinics attended b) # patients assisted	**2023** a) 15 clinic dates b) 144 patients assisted **2024** a) 23 b) 210
	1.3 Create public awareness campaign through social media and other media channels.	2023-2025	Lori Sitzberger Katie Adams		a) # of campaigns designed and launched b) # of media impressions generated	**2023** a) 0 b) 0 **2024** a) 0 b) 0
2. **Homeless Healthcare Connection** Increase access to primary and specialized care and social support services through intentional navigation for those experiencing homelessness. Provide health screenings, health education, vaccinations, preventative care, and social resources to address social determinants of health.	2.1 Collaborate with local homeless shelters and Augusta Health Neighborhood Clinic sites to provide homeless outreach assistance and resources.	2023-2025	RN Health Educator	Community Benefit Endowment	a) # of resource events established b) # of individuals served	**2023** a) 30 b) 395 **2024** a) 0; RN Health Educator position vacant since Nov 2023 b) 0; RN Health Educator position vacant since Nov 2023

	2.2 Explore collaborations to provide foot care clinics and podiatry resources for people experiencing homelessness and living in shelters.	2023-2025	RN Health Educator Isaac Izzillo		a) Explore collaborations (Yes or No) b) # of podiatry clinics held c) # of individuals served	**2023** a) Yes b) 5 c) 28 **2024** a) Yes b) 1 c) 3
	2.3 Provide preventative vaccinations such as Flu and COVID.	2023-2025	RN Health Educator		a) # of vaccines administered	**2023** a) 44 **2024** a) 0; RN Health Educator position vacant since Nov 2023
	2.4 Provide awareness training/support and resources to local law enforcement, security teams, care teams, providers, and service providers as to the needs of those experiencing homelessness.	2023-2025	RN Health Educator		a) Create Training PowerPoint/Module (Yes or No) b) # of individuals receiving this training	**2023** a) Yes b) 50 **2024** a) No; RN Health Educator position vacant since Nov 2023 b) 0; RN Health Educator position vacant since Nov 2023
3. **Faith Community Nursing (FCN)** Engage faith communities through collaboration to provide health education, health screenings, vaccinations, preventative care, and social resources to address social determinants of health.	3.1 Provide preventative vaccinations and health education/screenings.	2023-2025	RN Health Educator	Community Benefit Endowment	a) # of vaccines provided b) # of health screening/education events	**2023** a) 22 b) 6 **2024** a) 0; RN Health Educator position vacant since Nov 2023 b) 0; RN Health Educator position vacant since Nov 2023
	3.2 Provide summation of volunteer hours/activities by FCN's engaged in providing connecting and resources to faith communities.	2023-2025	RN Health Educator		a) Total # of hours volunteered by FCN's	**2023** a) 957 hours **2024** a) 0 hours; RN Health Educator position vacant since Nov 2023

4. Hispanic/Latinx Healthcare Increase access to primary and specialized care and social support services through intentional navigation for members of the Spanish-speaking community. Provide health screenings, health education, vaccinations, preventative care, and social resources to address social determinants of health.	4.1 Collaborate with community partners to create Spanish health education programs in topics such as: Diabetes, Hypertension, Obesity, Heart Disease and Stroke Prevention.	2024-2025	RN Health Educator	Operational/Community Benefit Endowment	a) # of programs created and delivered b) # of individuals receiving this education	**2023** a) N/A b) N/A **2024** a) 2 b) 20
	4.2 Explore collaborations to facilitate and support ESL classes.	2023-2025	Krystal Moyers RN Health Educator		a) Explore collaborations (Yes or No) b) # of individuals served	**2023** a) Yes b) N/A **2024** a) No; RN Health Educator position vacant since Nov 2023 b) 0 hours; RN Health Educator position vacant since Nov 2023
	4.3 Collaborate with community partners to provide resource fairs to include outreach assistance, vaccines, and food assistance.	2023-2025	RN Health Educator		a) # of events/health fairs b) # of individuals receiving assistance c) # of vaccines administered	**2023** a) 22 (through end of October 30, 2023) b) 759 c) 90 **2024** a) 6 b) 134 c) 0
	4.4 Facilitate and organize preventative cancer screening events such as Mammograms and Cervical Screenings.	2023-2025	Isaac Izzillo RN Health Educator Roxanne Harris Catherine Hill		a) # of screening events b) # of individuals served	**2023** a) 6 b) 35 **2024** a) 2 b) 37
	4.5 Explore collaborations to provide trainings for certified medical translation certifications.	2024-2025	Krystal Moyers RN Health Educator		a) Explore collaborations (Yes or No) b) # of individuals served	**2023** a) N/A b) N/A **2024** a) No; RN Health Educator position vacant since Nov 2023 b) 0; RN Health Educator position vacant since Nov 2023

5. Sexual Health Education Provide age-appropriate sexual health education with a focus on prevention of teen pregnancy, sexually transmitted infection, and intimate partner violence. Collaborate with providers, Augusta Health Neighborhood Clinic, and school-based community health workers to provide a variety of points of access for birth control methods while emphasizing the concept of sexual integrity.	5.1 Create a sexual health box that can be taken to community outreach events to include a variety of feminine hygiene products for menstruation, bladder leakage products, condoms and educational material including but not limited to: menstrual hygiene, kegal exercises, sexually transmitted infection prevention and intimate partner violence.	2023-2025	Roxanne Harris	Community Benefit Endowment	a) # of products distributed b) # of events for accessibility of products for community members	**2023** a) 320 packs b) 27 events **2024** a) 2,773 items (pads, tampons, and condoms) b) 13 events (278 people served)
	5.2 Offer assistance to collaborate with SAW school superintendents and school nurses to offer educational session on sexual integrity including pregnancy prevention, STI and/or IPV.	2024-2025	Roxanne Harris		a) Assistance offered to each school district in SAW area (Yes or No) b) # of programs SAW superintendents/nurse asked assistance with	**2023** a) N/A b) N/A **2024** a) Yes b) 0
	5.3 Creation of a directory of community resources for Women's Health Resources.	2024-2025	Roxanne Harris		a) Explore the creation of a directory to be used within Augusta Health by RN Maternal Health Navigator, nurses, case managers, social workers, and providers (Yes or No) b) Implemented (Yes or No)	**2023** a) N/A b) N/A **2024** a) Yes b) Yes
	5.4 Explore a collaboration with the Office of Youth and their Teen Pregnancy Prevention Coordinator with programs for teen pregnancy prevention and teen pregnancies.	2023-2025	Roxanne Harris		a) Explore a future collaboration (Yes or No)	**2023** a) Yes **2024** a) Yes
	5.5 Explore opportunities to dispense birth control methods at mobile clinics.	2023-2025	Roxanne Harris		a) Explore prescription courier services through Augusta Health Outpatient pharmacy to the mobile clinics (Yes or No) b) Implemented (Yes or No) c) # of prescriptions dispensed at mobile clinic d) # of Depo-Provera distributed	**2023** a) Yes b) No c) 0 d) 0 **2024** a) Yes b) No c) 0 d) 0

6. Transportation Explore community collaborations and partnership opportunities to provide transportation support and education to reduce barriers.	6.1 To spread awareness of free Brite Bus transportation to all Augusta Health facilities.	a) 2024-2025 b) 2025	Krystal Moyers	Community Benefit Endowment	a) Increase signage at bus stops, on the buses and at low-income housing complexes (Yes or no) b) Educate about the availability of accessing paratransit services (Yes or no)	**2023** a) N/A b) N/A **2024** a) Yes b) N/A
	6.2 To provide/distribute Brite Bus fare cards to assist community members who are experiencing homelessness, for employment/school, or needing to gain access to essential living resources.	2023-2025	RN Health Educator Trisha Fillion		a) # Fare cards distributed b) # Rides provided c) # of individuals served	**2023** a) 1,722 (0.50 Fare cards) b) 20,664 c) 1, 543 **2024** a) 1,057 (0.50 Fare cards) b) 12,684 c) 1,057
	6.3 Provide grant funding to VPAS for Senior Transportation Program.	2023-2025	Krystal Moyers Trisha Fillion		a) Grant funded (Yes or No)	**2023** a) No **2024** a) No; VPAS did not apply
7. Housing Collaborate and convene with community partners to provide leadership education and explore housing solutions.	7.1 Raise community awareness on housing instability as an issue.	2023	Clint Merritt Krystal Moyers RN Health Educator	Community Benefit Endowment	a) Create Housing Awareness (Yes or No)	**2023** a) Yes **2024** a) N/A
	7.2 Provide housing education to community partners and hospital leadership teams.	2023	Clint Merritt Krystal Moyers RN Health Educator		a) # of individuals receiving housing education	**2023** a) 15 (CPC) **2024** a) N/A
	7.3 Capture data from SDOH screenings and other community partners.	2023	Clint Merritt Krystal Moyers RN Health Educator		a) % captured a Housing insecure	**2023** a) 1.7% **2024** a) N/A
	7.4 Convene community partners through a Housing Summit.	2023	Clint Merritt Krystal Moyers RN Health Educator		a) # of participating partners b) # of individuals attending Housing Summit	**2023** a) 5 b) 200 **2024** a) N/A b) N/A

8. Community grants and Strategic funding Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on access to health care services.	8.1 Call for funding applications to be completed on Smarter Select.	2023-2025	Krystal Moyers Trisha Fillion	Community Benefit Endowment 2023- $285,000 2024- $325,000	a) # of applications received	**2023** a) 37 **2024** a) 38
	8.2 Review funding applications and make funding recommendations through the Funding SubCommittee Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Access to Healthcare.	2023-2025	Krystal Moyers Trisha Fillion		a) # of grants awarded b) Total amount funded for Access to Healthcare	**2023** a) 19 b) 274,500 **2024** a) 7 b) $67,500

Health Need:	**Mental Health and Substance Use**
Goals:	Improve the health status of the community by increasing the availability of services, resources, and education surrounding mental health and substance use disorders.

Strategy or Program	Tactics	Timeframe	Accountability	Budget	Outcome Measures	Status
1. **Substance Use Screening** Support primary care physicians and advanced practitioners to screen patients for substance use during office and or clinic visits.	1.1 Identify community partners, local clinics, and agencies, to accept referrals for substance use disorder.	2023	Clint Merritt	Operational	a) Engaged community partners, local clinics, and agencies (Yes or No) b) Create map of a services map for local MAT providers (Yes or No)	**2023** a) Yes b) Yes **2024** N/A
	1.2 Create a standard screening and referral process for substance use disorder.	2023			a) Create a standard screening process (Yes or No)	**2023** a) Yes **2024** N/A
	1.3 Pilot and refine screening process within the AMG Neighborhood Clinic.	2023-2025			a) Pilot within mobile clinic (Yes or No) b) Percentage of patients receiving screening c) Number and percentage of patients who had a 'positive' substance use screening d) Number and percentage who received a follow-up treatment plan of care and referral to appropriate treatment center	**2023** a) Yes- 254 patients screened b) 15% c) 32 positive screenings, 13% d) 6 referrals to treament, 18% **2024** a) No- suspended screening due lack of response rate using paper forms b) N/A c) N/A d) N/A

	1.4 Expand screening into additional clinics.	2024-2025			a) Expansion to additional clinics (Yes or No) b) Number of clinics onboarded to screening process c) Percentage of patients receiving screening d) Number and percentage of patients who had a 'positive' substance use screening e) Number and percentage who received a follow-up treatment plan of care and referral to appropriate treatment center	**2023** a) N/A b) N/A c) N/A d) N/A e) N/A **2024** a) No b) N/A c) N/A d) N/A e) N/A
	1.5 Give out harm reduction kits at appropriate clinics.	2024-2025		Community Benefit Endowment	a) Number of harm reduction kits	**2023** a) N/A **2024** a) 6
2. **The Pain Management (Opioid) Stewardship Committee** A multidisciplinary team responsible for promoting the proper use of pharmacologic and non-pharmacologic treatments for pain in patients within the Augusta Health system and community.	2.1 Develop educational materials to be distributed, focusing on topics, such as opioid safety or harm reduction.	2023-2025	Josh Dakon Krystal Moyers	Operational/Community Benefit Endowment ($500)	a) Number of unique materials developed b) Copies of materials made c) Number of locations distributed	**2023** a) 1 opioid safety brochure b) 300 c) 12 **2024** a) 0; Pain Management Stewardship Committee disbanded in 2024 b) 0; Pain Management Stewardship Committee disbanded in 2024 c) 0; Pain Management Stewardship Committee disbanded in 2024
3. **Mental Health Support for Seniors** Support Arrow Project in community outreach programming to uplift companionship and decrease signs of loneliness and depression in older adults.	3.1 Explore partnership with Arrow Project to increase mental health services for older adults.	2023	Krystal Moyers Abby Calvert Clint Merritt	Community Benefit Endownment 2023- $10,000 2024- $19,200	a) Partnership explored (Yes or No)	**2023** a) Yes **2024** a) N/A
	3.2 Arrow Project will host coffee talks at residential facilities to provide additional mental health support, including older adults.	2023-2025			a) Amount of funds dispersed to Arrow b) Number of locations Arrow attends c) Number of served 65+ d) Number of hand-offs received from AMG Neighborhood Clinic to Arrow e) UCLA Loneliness scale results	**2023** a) $10,000 b) 2 (GHH and Plaza) c) 13 (GHH) and 15 (Plaza) d) 0- not tracked e) **Pre Survey:** 55% of participants responded "I often feel this way" 20% responded, 'I sometimes feel this way" 25% responded, "I rarely feel

						this way" 0% responded, "I never feel this way" **Post Survey:** 40% responded, "I sometimes feel this way" 15% responded, "I often feel this way." 45% responded, "I rarely feel this way" 0% responded, "I never feel this way" **2024** a) $19,200 b) 2 (GHH and Plaza) c) 20 (GHH-weekly group sessions and 5 weekly one to one sessions) 15 (Plaza- weekly group sessions and 3 weekly one on ones) d) 0 e) **Pre Survey:** 60% of participants responded "I often feel this way" 30% responded, 'I sometimes feel this way" 10% responded, "I rarely feel this way" 0% responded, "I never feel this way" **Post Survey:** 40% responded, "I sometimes feel this way" 20% responded, "I often feel this way." 30% responded, "I rarely feel this way" 10% responded, "I never feel this way"
	3.3 Based on success of each site and amount of need, Arrow Project will possibly hold Coffee Talk programs for residents at other residential facilities.	2024-2025			a) Explored (Yes or No) b) Number of locations added	**2023** a) N/A b) N/A **2024** a)Yes b) 0; instead of adding more locations, 1:1 therapy was able to be provided to 8 participants weekly with a mental health provider

4. **Community Grant Funding** Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on improved nutrition and physical activity.	4.1 Call for funding applications to be completed on Smarter Select.	2023-2025	Krystal Moyers Trisha Fillion	Community Benefit Endowment 2023- $285,000 2024- $325,000	a) Number of organizations that receive funding b) Total amount of funding provided for Mental Health and Substance Use c) Percentage of total funding	**2023** a) 12 programs b) $194,500 c) 71% of the grant funding **2024** a) 6 b) $120,000 c) 37% of the grant funding
	4.2 Review funding applications and make funding recommendations through the Funding SubCommittee.					
	4.3 Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Mental Health and Substance Use.					
	4.4 Community Outreach Team will review community grant applications on a rolling basis as submitted in Smarter Select.					
5. **REVIVE!** Provide REVIVE! training to patients and concerned family members during mobile community clinic visits.	5.1 Provide REVIVE! training to a core group of team members.	2023	Roxanne Harris Abby Calvert	Operational/Community Benefit Endowment/Donor Funding- $250	a) Number of team members trained	**2023** a) 10 **2024** N/A
	5.2 Distribute Narcan/Naloxone at AMG Neighborhood Clinic.	2024			a) Explored (Yes or No) b) Number distributed	**2023** a) Yes b) 0 **2024** a) Yes b) 0; using provider discretion, there were no patients that needed or accepted the Narcan
	5.3 Extend the distribution of Narcan/Naloxone to two other clinics.	2024-2025			a) Extended distribution (Yes or No)	**2023** a) No; exploring ED/inpatient teams in 2024 **2024** a) No; was not able to be implemented through AMG Neighborhood Clinic
	5.4 Offer REVIVE! Training to patients and community members.	2023-2025			a) Number of training sessions provided b) Number trained	**2023** a) 3 b) 35 **2024** a) 6 b) 94

	5.5 Obtain Comprehensive Harm Reduction Licensure through the state.	2025			a) Licensure Obtained (Yes or No)	**2023** a) No, now partnering with Strength in Peers to extend their service area. **2024** a) No, now partnering with Strength in Peers to extend their service area.
	5.6 Collaborate with community partners to provide Harm Reduction Kits to the community.	2023			a) Number of community partners involved b) Number of harm reduction kits distributed	**2023** (a) 2 (VDH and VCSB) (b) 100 **2024** a) N/A b) N/A
6. **OB Community Outreach Referral Program** Offer a referral program for providers/community partners that targets patients in treatment or in need of treatment for substance use disorder. Referrals are also open to pregnant patients who are incarcerated, have a fetal anomaly diagnosed during their pregnancy, teen-agers, and women placing their baby for adoption. The program will provide the referred patient with a primary support person that will follow her throughout pregnancy.	6.1 Establish a referral process.	2023	Roxanne Harris	Community Benefit Endowment	a)Referral Established (Yes or No)	**2023** a) Yes **2024** a) N/A
	6.2 Establish a basic demographic profile of referred patients.	2023-2025			a) Criteria established (Yes or No) b) Criteria for patients in the program	**2023** a) Yes b) Pregnant women who are in the following categories: -Substance Use -Teens -Anomolies -Incarcerated women -Food Insecure -Other **2024** a) Yes b) Additional criteria added: -At risk for pre-eclampsia (Moms Under Pressure Program)
	6.3 Report out to the OB High Risk Meeting with OB and Ped to coordinate care for patients served.				(a) Coordination of care with OB High Risk Meeting (Yes or No)	**2023** a) Yes **2024** a) Yes
	6.4 Provide supportive care to patients referred as needed.				a) Total number of referrals received b) Percentage of patients followed by the navigator of the total deliveries for the year c) Total number of referrals from	**2023** a) 162 b) 14.7% c) 15 d) 19

					Middle River Regional Jail d) Total number identified as no prenatal care at the time of first interaction	**2024** a) 251 b) 18.5 c) 10 d) 25, with 4 additionals carried over from 2023
7. **Baby Steps** Provide a free, four-week cohort, four times a year that is open to all pregnant people and targets women who have limited resources and or support. Offers a non-traditional series of educational topics for pregnant women and support person including mental wellbeing.	7.1 Create a 4-week series of classes offered to expecting community members.	2023	Roxanne Harris Abby Calvert	Community Benefit Endowment	a) Program created (Yes or No)	**2023** a) Yes **2024** a) N/A
	7.2 Hold 4 cohorts per year that is offsetting the schedule of existing birthing classes.	2023-2025			a) Number of participants in each cohort	**2023** a) Cohort 1: 13 Cohort 2:14 Cohort 3:12 Cohort 4: 7 **2024** a) Cohort 1: 13 Cohort 2:13 Cohort 3: 5 Cohort 4: 4
8. **Mothering Together** Provide a free monthly support group for mothers, to help shape a community. This will have an emphasis on mental health support topics, educational information about child raising, a mindful craft, and snack to share in the company of others.	8.1 Hold a monthly support group locally.	2024-2025	Roxanne Harris Abby Calvert	Community Benefit Endowment	a) Number of participants b) Number of classes	**2023** a) N/A b) N/A **2024** a) 84 b) 12
9. **Mental Health Services in Underserved Areas** Support the growth of rural mental health providers by offering LCSW services in the Rockbridge area.	9.1 Assess the current state of mental health services in the Rockbridge area.	2024	Jackie Sims	Operational	a)LCSW hired (Yes or No) b)Number of days services were provided	**2023** a) N/A b) N/A **2024** a) No- unable to hire for the position b) 0
	9.2 Embed Augusta Medical Group Outpatient Behavioral Health services in Augusta Medical Group Buena Vista Clinic two days per month.	2024				
	9.3 Provide patients with behavioral health services.	2024-2025			a) Number of patients that received services from the LCSW	**2023** a) N/A **2024** a) 0

Health Need:	**Nutrition & Physical Activity**					
Goal:	To improve the wellbeing of area residents in order to prevent and manage chronic diseases through nutrition education, increased access to healthy foods, and greater participation in physical activity.					
Strategy or Program	Tactics	Timeframe	Accountability	Budget	Outcome Measures	Status
1. **The Farm at Augusta Health** Provide fresh, locally grown produce for use in our food system, to be served to our patients, employees, and visitors and to be integrated in clinically settings. Teach nutrition, sustainable agriculture, cooking and other educational workshops and classes to enhance knowledge in the community.	1.1 Continue The Farm at Augusta Health, a 1.5-acre high intensity production farm which uses sustainable agriculture practices and is located on Augusta Health's campus. Produce from the farm will be used in our food system, to be served to our patients, employees, and visitors, be integrated in clinical settings and be donated to local nonprofit organizations.	2023-2025	Krystal Moyers Catherine Hill Hannah Dorrel	Community Benefit Endowment 2023 - $171,375 2024- $228,391.06	a) Number of pounds of produce produced from the farm in total b) Number of pounds of produce produced by the farm and used by Augusta Health c) Number of pounds of produce used in Augusta Health's food system	**2023** a) 25,625.5 b) 12,478.2 c) 1,454.8 **2024** a) 24,341.25 b) 15,219.7 c) 1,970.5
	1.2 Nutrition, sustainable agriculture, cooking and other educational workshops and classes will be taught to enhance knowledge in the community. Classes may be offered in conjunction with community partners.	2023-2025			a) Number of education classes held through farm partnership b) Number of participants attending education classes held through farm partnership c) Number of recipes and other educational materials given out through workshops	**2023** a) 9 b) 104 c) 3,870 **2024** a) 4 b) 45 c) 6

2. **Crops to Community Food Boxes** To deliver fresh food boxes consisting of fresh meat, eggs, and produce from local farms to patients with low food access.	2.1 Deliver 50 fresh food boxes every other week to community members with low food access.	2023-2025	Catherine Hill	Community Benefit Endowment 2023 - $51,800 2024-$51,758	a) Number of pounds of local food distributed to individuals b) Number and percentage of individuals with low food access receiving food boxes c) Number of boxes provided to community members and patients with low food access d) Market value of produce provided to those with low food access e) Number of pounds of produce provided to Crops to Community Fresh Food Boxes from The Farm at Augusta Health	**2023** a) 14,370 b) 100% c) 1,250 d) $24,950 e) 5,326.9 **2024** a) 10,129.4 b) 100% c) 1,200 d) $16,993 e) 3,529.4
	2.2 Conduct phone surveys to gather feedback from program recipients.	2024-2025			a) Number and percentage of recipients who utilize the majority of their produce b) Number and percentage of recipients who now enjoy at least one new vegetable c) Number and percentage of recipients who report eating more veggies due to receiving a food box	**2023** a) N/A b) N/A c) N/A **2024** a) 0- Lack of response from participants b) 0 c) 0 d) 0
3. **Food FARMacy** Offer a prescription produce program for persons with specific chronic disease diagnoses. Through the program, participants will receive nutrition education, take part in cooking demonstrations and receive free produce from The Farm at Augusta Health.	3.1 Hold three Food FARMacy cohorts each year.	2023-2025	Catherine Hill	Community Benefit Endowment 2023 – $9,200 2024- $2,136	a) Three cohorts held (Yes or No)	**2023** a) Yes **2024** a) Yes (two 16-week cohorts)
	3.2 Conduct screenings to gather health outcomes.	2023-2025			a) Number of Food Farmacy participants who completed the program b) Number and percentage of participants who start the class and finish the program c) Number of pounds of produce given to Food Farmacy program participants d) Number and percentage of participants who saw a decrease in A1C/fasting blood glucose e) Number and percentage of participants who saw a decrease in blood pressure f) Number and percentage of	**2023** a) 26 b) 26/37 (70%) c) 3,000 d) 2/26 (8%) e) 14/26 (54%) f) 8/26 (31%) g) 12/26 (46%) h) 13/26 (50%) i) 4/26 (15%) j) 5/26 (19%) k) 7/26 (27%) l) 7/26 (27%) m) 6/26 (23%) n) 9/26 (35%) o) 17/26 (65%)

					participants who saw a decrease in total cholesterol g) Number and percentage of participants who saw a decrease in Body Mass Index h) Number and percentage of participants who saw a decrease in waist circumference i) Number and percentage of participants who decrease medication usage j) Number and percentage of participants who self-report an increase in energy k) Number and percentage of participants who feel more confident in cooking meals at home using fresh produce l) Number and percentage of participants who self-report an increase in consumption of fruits and vegetables m) Number and percentage of participants who self-report an increase in knowledge about healthy eating n) Number and percentage of participants who self-report food insecurity o) Number and percentage of participants who self-report feeling more confident in diabetes prevention/self-management strategies or knowledge of nutrition	**2024** a) 22 b) 22/37 (59%) c) 2,974.5 d) 3/22 (14%) e) 11/22 (50%) f) 10/22 (45%) g) 10/22 (45%) h) not measured i) not measured j) 6/22 (27%) k) 5/22 (23%) l) 15/22 (68%) m) 11/22 (50%) n) 4/22 (18%) o) 20/22 (91%)

4. **Food Pantry** Increase equitable access to nutritious food for patients that have screened positive for food insecurity and have a chronic disease diagnosis	4.1 Offer food pantry bags to patients and community members that screen as food insecure through the EMR and community events.	2023-2025	Abby Calvert	Community Benefit Endowment 2023- $21,400/grant funded 2024- $17,200	a) Number of bags distributed b)Number of patients served c) Number of pounds of produce distributed d) Number of pounds of shelf-stable items distributed	**2023** a) 4,970 b) 2,078 c) 6,826.13 d) 36,375.75 **2024** a) 3,399 b) 1,683 c) 4,953.10 d) 23,489
	4.2 Increase referring departments and clinics to the food pantry.	2023-2025			a) Total number of referring departments and clinics	**2023** a)22 **2024** a) 23
	4.3 Explore opportunities to survey patients about their food pantry experience.	2024-2025			a) Explored (Yes/No) b) Survey created (Yes/No) c) Total patients screened	**2023** a) N/A b) No c) N/A **2024** a) Yes b) No-asked patients if they would answer a paper or electronic survey and majority answered no c) 0

5. **Medically-based Fitness** Augusta Health Fitness will offer community members medically based fitness programming for free or reduced cost.	5.1 Offer medical fitness sessions twice per week with certified staff and send results to referring provider.	2023-2025	Olivia Hall Michael Campbell	Operational	a) Number and percentage of participants completing the program b) Improvement in SF-36 QOL Measure (average pre/post delta) c) Number and percentage of participants who complete the program and meet visit requirements	**2023** a) 314/412 = 76% b) RxEx Plus: -Physical Functioning- 13% -Physical Health- 20% -Emotional Problems- 16% -Energy/Fatigue- 16% -Emotional Well-Being- 11% -Social Functioning- 15% -Pain- 17% -General Health- 5% -Functional Activity- 21% RxEx Traditional: -Physical Functioning- 9% -Physical Health- 26% -Emotional Problems- 23% -Energy/Fatigue- 12% -Emotional Well-Being- 7% -Social Functioning- 13% -Pain- 10% -General Health- 4% -Functional Activity- 23% c) 48/55 = 87%
	5.2 Offer free or reduced cost independent fitness memberships to Fit4 Life participants that qualify based on need and provider referral.	2023-2025				2024 a) 261/330 (80%) b) RxEx Plus: -Physical Functioning- 9% -Physical Health- 32% -Emotional Problems- 9% -Energy/Fatigue- 11% -Emotional Well-Being- 7% -Social Functioning- 6% -Pain- 5% -General Health- 4% -Functional Activity-15% RxEx Traditional: -Physical Functioning- 14% -Physical Health- 26% -Emotional Problems- 15% -Energy/Fatigue- 11% -Emotional Well-Being- 6% -Social Functioning- 14% -Pain- 17% -General Health- 7% -Functional Activity- 25% c) 36/68 = 53%

6. **Active Lifestyles for Children and Families** Expand youth and family programming at the AH Fitness Center and continue to develop community partners in order to offer convenient and low-cost physical activity options for youth. i.e., tennis, swimming lessons, general fitness.	6.1 Expand utilization of family memberships at fitness center to include ages 9-12 (previously 13+).	2023-2025	Olivia Hall Stephanie Mims	Operational	a) Number of yearly fitness visits for 9-12 year olds b) Number of children 9-12 who participate in our child specific group classes c) Number of children who participate in our youth personal training program and clinics d) Percentage change in participation for youth tennis lessons and clinics	**2023** a) 62 active participants w/total of 273 visits b) 17 c) 8 d) 15% increase from 2022 **2024** a) 61 active partcipants w/ total of 274 visits b) 0 c) 11 d) 17% increase from 2023
	6.2 Reach out to local program partners to explore collaborative initiatives and youth scholarship opportunities.	2023-2025			a) Number of collaborations formed b) Number of scholarships given	**2023** a) Partnered with Wenonah (Tennis)- 63 participants b) 63 **2024** a) Partnered with Wenonah Elementary (Tennis)- 71 participants b) 71
7. **Nutrition Awareness Program/Sodexo's Mindful Meals** The Nutrition Awareness Program utilizes the Augusta Health cafeteria, cafes and vending as venues for nutrition information dissemination with regard to healthier food choices and food preparation methods, as well as provides access to healthier foods through the continuation of Sodexo's Mindful Program.	7.1 Focus on the Jazzman's venue in the Wellness building with a goal of 30% food and beverage items compliant with Sodexo's Mindful criteria.	2023-2025	Laura Johnson Steven Strickler	Operational	a) Percent of food and beverage items compliant with Sodexo's Mindful criteria (Goal: 30%)	**2023** a) 30% **2024** a) 30%
	7.2 Increase number of mindful meals/mindful cards distributed.	2024-2025			a) Number of Mindful Cards distributed b) Total Sales for Mindful Cards	**2023** a) N/A b) N/A **2024** a)89 b) $221.61
	7.3 Increase employee awareness around The Farm at Augusta Health project.	2023-2025			a) Number of promotional events, signage, and educational materials given out related to the farm project	**2023** a) Signage posted weekly featuring produce from the farm (number not tracked in 2023) **2024** a) 0

8. **Walkability Initiatives** Help to promote and increase physical activity in the community by providing a safe space for students to walk to school and learn pedestrian safety. Bring awareness of how to make Staunton, Augusta County, and Waynesboro more walk and bike-friendly	8.1 Partner with Waynesboro City schools to participate in Walk to School Week.	2023-2025	Catherine Hill	Community Benefit Endowment 2023 -$1,000 2024-$0	a) Number and percent of students participating b) Number of schools participating	**2023** a) Not tracked b) 5 **2024** a) Not tracked b) 5
	8.2 Hold a Walk-Bike Summit to determine ways to make our community more walk and bike-friendly.	2023-2025			a) Number of attendees	**2023** a) 46 attendees **2024** a) Not held in 2024
9. **Community Grant Funding** Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on improved nutrition and physical activity.	9.1 Call for funding applications to be completed on Smarter Select.	2023-2025	Krystal Moyers Trisha Fillion	Community Benefit Endowment 2023 - $285,000 2024-$325,000	a) Number of organizations that receive funding b) Total amount of funding provided c) Percentage of total funding	**2023** a) 3 programs funded b) $37,000 c) 13% of total grant funding **2024:** a) 6 programs funded b) $95,000 c) 29% of total grant funding
	9.2 Review funding applications and make funding recommendations through the Funding SubCommittee.	2023-2025				
	9.3 Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Nutrition and Physical Activity.	2023-2025				
10. **Diabetes Education** Provide members of the community- specifically those in vulnerable populations- with education to help them better manage their diabetes.	10.1 Provide at least two full 4-session Diabetes education programs for the community.	2023-2025	Kara Meeks	Operational $600 for 20 meters/supplies and $500 for education tools and incentives. Paper 1 box $50.00 Total $1200.00	a) Number of individuals attending the community diabetes education programs b) Per post-program education survey, participants will indicate knowledge increase in at least 2 areas of diabetes management c) Number and percentage of individuals who decreased their blood glucose levels	**2023** a) 20 b) N/A c) 3 out of 6 patients (50%) **2024** a) 11 b) 100% identified at least 4 improvements they will make. **2024 Diabetes Day Event** a) 18 participants b) 12/18 completed evaluation; 100% responded positively c) 18 participants had their blood glucose screened (could not track number decreased since this was a one day event)
	10.2 Provide Individual Diabetes Lifestyle Counseling to diabetic patients in conjunction with the Neighborhood clinic at Embrace, Valley Mission etc.				(a)Number of Neighborhood clinic patients receiving Diabetes Lifestyle education	**2023** a) 42 **2024** a) 0

	10.3 Provide community Diabetes Education presentations through requests from the AH Speakers Bureau.				(a)Number of individuals attending community Diabetes Education presentations	**2023** a)20 **2024** a) 0
11. **Diabetes Prevention Programs** Provide education and support to assist community participants in making lifestyle changes to promote moderate weight loss, increased physical activity and improved nutrition to prevent or delay the progression to diabetes.	11.1 Provide at least four full programs per year.	2023-2025	Caroline Hackley	Operational	**2023** a) Number and percentage of participants who complete the program b) Meet weight loss goal of 5-7% weight loss over 6 months. c) Meet goal of average of 150 or more minutes of physical activity per week. **2024** a) Total participants b) Percentage of participants that identified atleast 4 improvements they will make because of the class	**2023** a) 15/19 (79%) completed b) 8/15 (53%) c) Average minutes of activity: 234 **2024** The CDC DPP ended August 31, 2024. The new program (Prevent Diabetes 4 session classes) started September 2024 a) 13 participants b) 100%
	11.2 Increase attendance at Blue Ridge Healthy U Diabetes Prevention Program through referrals, advertisement and screening for employees and patients at our Augusta Medical Group offices and at community events.					
	11.3 Maintain active and certified Diabetes Prevention coaches.				a) Number of coaches	**2023** a) 4 **2024** a) 4
	11.4 Provide Diabetes Prevention Program cohorts both in-person and virtually.				a) Provide both in-person and virtual classes (Yes or No)	**2023** a) Yes **2024** a) No- only a virtual option was offered
	11.5 Increase outreach and attendance at monthly Diabetes Prevention Class through referrals from physicians.				a) Recieved referrals from physicians	**2023** a) Yes **2024** a) Yes

12. **Get Fresh** Partner with Waynesboro City Schools (or the local school district) to increase education of nutrition and physical activity in youth. This will include uplifting the work of their Agricultural Educator through educational resources and collaboration between staff. The program will also include facilitating a 4-week education series for youth and families to participate in cooking classes, physical activity exercises, and discussion-based learning around nutrition.	12.1 Explore partnership with the Agricultural educator to support nutrition education in Waynesboro City Elementary and Middle Schools.	2023-2025	Abby Calvert	Community Benefit Endowment	a) Explored (Yes/No)	**2023** a) Yes **2024** a) Yes
	12.2 Hold one Families Food and Fun 4-week series per semester at one of the Waynesboro City Elementary Schools.				a) Number of participating children b) Number of participating adults c) Total number of families	**2023** a) Week 1- 15 Week 2- 23 Week 3- 9 Week 4- 15 b) Week 1- 25 Week 2- 32 Week 3- 16 Week 4- 22 c) Week 1- 8 Week 2- 9 Week 3- 6 Week 4- 6 **2024 (Spring & Fall combined)** a) Week 1- 15 Week 2- 18 Week 3- 16 Week 4- 18 b) Week 1- 7 Week 2- 9 Week 3- 8 Week 4- 9 c) Week 1- 7 Week 2- 9 Week 3- 8 Week 4- 9

	12.3 Hold at least one Families Food and Fun class quarterly at the Ruth's WARM House in Waynesboro.				a) Number of classes offered b) Number of participating children c) Total number of participants (children and adults) d) Total number of families	**2023** a) 4 b) Month 1- 5 Month 2- 5 Month 3- 5 Month 4- 3 c) Month 1- 9 Month 2- 9 Month 3- 9 Month 4- 6 d) Month 1- 4 Month 2- 4 Month 3- 4 Month 4- 3 **2024** a) 1 b) 0- Ruth's Warm house had no participants for the program c) 0 d) 0
13. **Health Coaching** To provide guidance to community members through the process of creating a vision, goal setting and accountability for health and well-being, using a holistic approach involving pillars of lifestyle medicine and evidence-based approach to developing a healthy mindset and healthy habits.	13.1 Work with community partners to offer community health coaching.	2023-2025	Stephanie Mims, Michael Campbell, Lindy Higgins	Operational $1650	a) Height/Weight (BMI) b) Hip and Waist Circumference c) Blood Pressure d) Daily intake of Fruits and Vegetables e) Number of Days per Week of Exercise f) Level of Daily Stress (1-10 scale)	**2023** a) average BMI decrease of 2.4 kg/m^2 b) average decrease of 1.5 inches c) average systolic dropped 5 mmHg and diastolic mmHg d) average fruit intake increased by 2-3 servings and vegetables increased by 1-2 e) starting average was 0-2x per week/ 30-45 minutes each session; ending average was 2-4x per week/ 30-45 minutes each session **2024** a - e) This program has been discontinued for 2024 and 2025 due to staffing

14 **Pulmonary Nutrition Program** To provide patients with COPD, and other chronic pulmonary diseases, nutrition education to help manage symptoms, enhance health, and improve breathing status.	14.1 One class per month designed to increase participation of patients from Pulmonary Medicine and Pulmonary Rehab programs.	2023-2025	Caroline Hackley	Operational	a) Number of participants b) Percent of participants who plan to make at least 1 dietary change	**2023** a) 9 participants b) 100% **2024** a) 6 participants b) 100% This program was discontinued at the end of 2024 and will not continue in 2025 due to staffing and low participation
15. **The Dietary Approaches to Stop Hypertension (DASH) Eating Plan for Heart Health** To improve blood pressure management and promote weight loss in hypertensive patients with cardiac risk factors by providing education about the DASH program.	15.1 Offer two classes monthly, one in-person and one virtually. 15.2 Increase program participation with advertising to patients in Cardiac Rehab, Cardiac Success Clinic, AMG Providers and through advertisement at community events.	2023-2025	Caroline Hackley	Operational	a) Number of participants b) Percent of participants who plan to make at least 1 dietary change	**2023** a) 27 participants b) 100% (46% of the participants listed 2 or more dietary changes) **2024** a) 14 participants b) 100% This program was discontinued at the end of 2024 and will not continue in 2025 due to staffing and low participation