BON SECOURS RICHMOND HEALTH SYSTEM
FY2020 – FY2022 IMPLEMENTATION PLAN

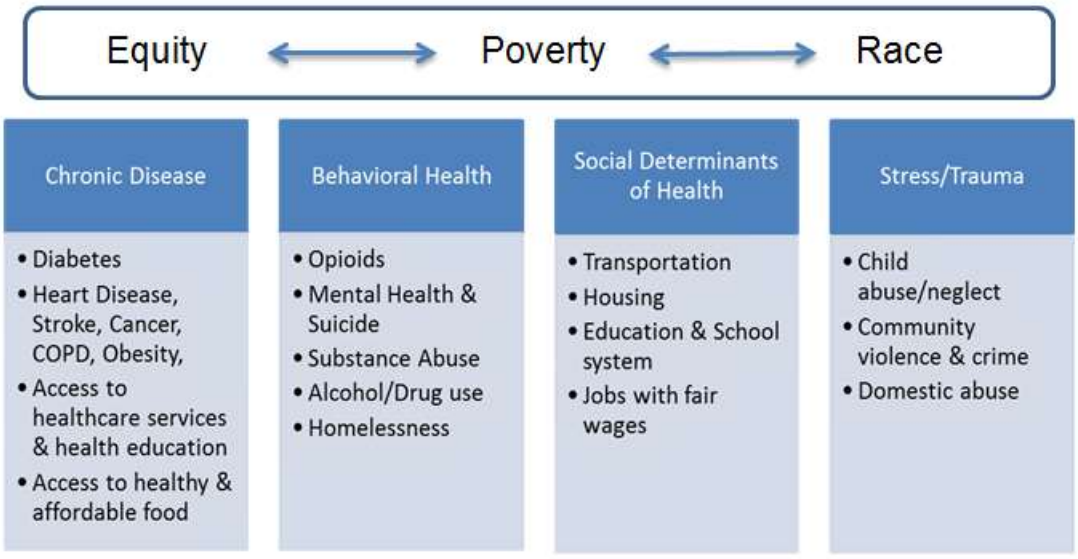
The Bon Secours Richmond Health System Community Health Needs Assessment (CHNA) Implementation Plan utilizes the findings from the 2019 CHNA to identify priority areas that will be addressed over the next three years.

Bon Secours Richmond Health System prepared a "joint CHNA report," within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Bon Secours Richmond Health System, including Memorial Regional Medical Center, Richmond Community Hospital, St. Francis Medical Center, St. Mary's Hospital, and Rappahannock General Hospital. The CHNA report reflects the hospitals' collaborative efforts to conduct an assessment of the health needs of the community they serve.

The CHNA examines qualitative input provided by community members coupled with quantitative data on health conditions in the area. Together the information forms a snapshot of important areas of health concern. In order to obtain input from the community, three initiatives were advanced; a Community Health Needs Assessment Steering Committee was convened, a community engagement survey was conducted and several community conversations were held. Quantitative data from various sources was collected and analyzed.

Seven Community Conversations were held as part of the CHNA process in which 60 individuals participated from all of the core jurisdictions of Hanover, Henrico, Chesterfield and Richmond City within the Richmond Core Service Area and Lancaster and Northumberland within the Northern Neck Core Service Area. The purpose of the conversation was to elicit feedback from community members about publically available health data describing health conditions in the service areas and to review the survey results to further explore the findings. The top 10 health issues as identified from the survey results were presented to the attendees and they were asked to 1) rank the health issues according to which issues impacted them and the people close to them the most and 2) from a community perspective, rank the issues that should be addressed to improve the overall health of the region.

Conversations with the CHNA Steering Committee, community members, and community leaders reaffirmed the survey findings and identified significant linkages between identified heath needs. Additionally, the themes of Equity, Poverty, and Race were discussed as underlying concerns related to all of the health issues and causes identified. Leaders within the Community Health Division in conjunction with the Bon Secours Executive Strategy Team prioritized the following areas of focus for 2019-2021:



The detailed process, participants and results are available in Bon Secours Richmond Health System's Community Health Needs Assessment Report which is available at Bon Secours' website: www.bonsecours.com.

The table below indicates the most significant health needs in our service area identified through the CHNA process.

Prioritized significant community health need	Addressed by Bon Secours Richmond Health System
Chronic Disease	Yes
Behavioral Health	Yes
Social Determinants of Health	Yes
Stress/Trauma	Yes

As a result of the joint CHNA, Bon Secours Richmond Health System, including Memorial Regional Medical Center, Richmond Community Hospital, St. Francis Medical Center, St. Mary's Hospital, and Rappahannock General Hospital, will address the same prioritized health needs of the community as identified in its joint CHNA and use the same strategies in which to address each need. The joint CHNA and Implementation Plan reflects the hospitals' collaborative efforts to address the health needs of the community they serve.

The following Implementation Plan includes many Bon Secours programs and initiatives but also incorporates community partnerships, resources, and advocacy to help drive impact.

PRIORITY: CHRONIC DISEASE

GOAL: Improve overall chronic disease status by increasing equitable access to high quality health care services.

BACKGROUND ON STRATEGY

Research shows that high rates of health insurance coverage positively impact a community's overall health status. Access to health care services improves quality of life, school and work productivity and overall mortality rates.[1] The Healthy People 2020 goal for health insurance aims for 100% of the population to have some form of health insurance coverage. Compared to Virginia where ten percent (10%) of adults are uninsured, in the City of Richmond, the percentage of uninsured adults is higher.[2] In the other Richmond Core Service Area counties, the rate of uninsured adults is aligned with the rate in Virginia.

Access to health care services is also significantly impacted by the availability of physicians. The rate of primary care providers per 100,000 residents in the City of Richmond and the counties of Chesterfield and Henrico is lower when compared to the rate in Virginia. The City of Richmond, Chesterfield and Henrico counties contain Medically Underserved Areas as defined by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).[3]

Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems.[4]

The three leading causes of death in the metropolitan Richmond area are reported as cancer, heart disease and stroke. Diabetes is the 7th leading cause of death. Thirty percent (30%) of Virginians are obese (BMI >30) which is consistent with the percentage in the metropolitan Richmond area.[5] The Healthy People 2020 goal is 25% or lower.[6]

In the 2019 Bon Secours Community Health Needs Assessment online survey, Chronic Disease was identified by the community as second leading health issue needing to be addressed in the Richmond Core Service Area.

Lack of health insurance coverage is a significant barrier to seeking needed health care services particularly in the management of a chronic condition.

[1] www.healthypeople.gov Access to Health Services
[2] www.countyhealthrankgins.org, Richmond City, 2018
[3] https://data.hrsa.gov/tools/shortage-area/mua-find
[4] http://www.cdc.gov/chronicdisease/overview/index.htm
[5] https://www.stateofobesity.org/states/va/
[6] https://www.healthypeople.gov/2020/topicsobjectives/topic/diabetes

Evidence Based Sources:

Centers for Disease Control and Prevention:

- https://www.cdc.gov/DiseasesConditions/
- https://www.cdc.gov/nchs/fastats/health-insurance.htmt

County Health Rankings:

- https://www.countyhealthrankings.org/app/virginia/2018/overview

Healthy People 2020:

- https://www.healthypeople.gov/

Virginia's Plan for Well-Being 2016 – 2020

- http://www.vdh.virginia.gov/Administration/VPfWB/documents/pdf/Virginia's%20Plan%20for%20Well-Being.pdf

ALIGNMENT WITH NATIONAL/STATE PRIORITIES

Healthy People 2020/2030	**Virginia's Plan For Well-Being 2016 – 2020**
AHS-1 Increase the proportion of persons with health insurance AHS-3 Increase the proportion of persons with a usual primary care provider AHS-5 Increase the proportion of persons who have a specific source of ongoing care AHS-6 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines 2030 overarching goal: • Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death. • Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.	**AIM 3: Preventive Actions** Goal 3.1 Virginians follow a healthy diet and live actively By 2020, the percent of Virginia adults who are overweight or obese decreases from 64.7% to 63.0% **AIM 4: System of Health Care** Goal 4.1 Virginia has a strong primary care system linked to behavioral health care, oral health care and community support systems By 2020, the percent of adults in Virginia who have a regular health care provider increases from 69.3% to 85.0% By 2020, the rate of avoidable deaths from heart disease, stroke, or hypertensive disease in Virginia decreases from 46.76 to 40.00 per 100,000 persons

OBJECTIVE #1: Support community partners providing high-quality clinical services to uninsured and underinsured populations through investment and advocacy.		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
Support safety net clinics providing chronic disease management services	Summer 2020	• Enable uninsured patients with chronic diseases to manage their health conditions • Facilitate patients' ability to acquire affordable medications • Enhance understanding of chronic conditions and the prevention thereof • Reduce emergent health care visits
Expand safety net clinic capacity through coordination of services to maximize care	Fall 2019	• Work with area Free Clinics and FQHCs to assess safety net capacity and expand access for patients
Support area non-profits providing wellness services	Winter 2021	• Disease prevention or improved individual health outcomes
Advance pediatric asthma initiative with the Community Health Collaborative	Ongoing	• Coordinate programs with VCU Health to address pediatric asthma in the metro-Richmond area • Reduce the number of pediatric patients in the community with uncontrolled asthma symptoms • Support initiatives to reduce asthma triggers in the home
Partner with clinical staff and non-profit organizations to discharge uninsured patients to Medical Homes	Fall 2019	• Reduction of readmissions due to lack of appropriate follow up care • Increased control of chronic disease through available follow-up appointments
Facilitate Health Insurance Expansion and Enrollment	Ongoing and Marketplace open enrollment period	• Increase the number of residents with Marketplace insurance products • Increase the number of residents with Medicaid insurance products • Enhance understanding of insurance usage to first time consumers and ensure continued coverage

OBJECTIVE #2: Provide direct health services to the uninsured through Community Health Programs, Medical Group Practices, and Inpatient and Outpatient Services.		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
Provide primary care services to the uninsured through Care-A-Van, mobile health clinic	Ongoing	• Provide timely access to care to the uninsured • Reduce preventable hospitalizations
Explore a fixed-site clinic in South Richmond for uninsured	Winter 2020	• Identify opportunity to fixed-site clinic creation to complement existing safety net clinics and the Care-A-Van mobile clinic • Expand access to care
Provide comprehensive chronic disease management services to patients	Ongoing	• Provide timely access to care for patients with chronic health condition • Ensure the highest level of quality care is available to all patients living in the Greater Richmond Region • Provide access to affordable medications
Provide nutrition education and chronic disease education through Community Nutrition Outreach and other wellness programs	Ongoing	• Enhance understanding of nutrition for chronic disease patients • Conduct diabetes education and prevention • Teach healthy eating classes to Richmond Public School students
Provide complex case management and nurse navigation	Ongoing	• Ensure patients can navigate the complex health environment • Coordinate multiple social determinant of health needs
Expand congregational health education and offerings	Fall 2020	• Leverage the collective influence of Richmond's congregations to improve overall health status in the East End
Co-lead East End Diabetes Coalition	Winter 2020	• Partner with VCU Health and other non-profit providers to catalog diabetes providers in the East End and connect community members to resources
Resources Required Funding, Staff, Advocacy		

PARTNERSHIPS	
Access Now Boys and Girls Club Capital Area Health Network Care-A-Van Churches Center for Healthy Hearts Chesterfield, Chickahominy, Henrico, City of Richmond, and Three Rivers Health Districts Creighton Court Resource Center Crossover Clinic & Community Pharmacy Daily Planet Diabetes Treatment Center Faces of Hope	Free Clinic of Powhatan Goochland Cares Hanover interfaith clinics Health Brigade Hospital Corporation of America Medical Society of Virginia Northern Neck Food Bank RX Partnership Shalom Farms Tricycle Garden VCU Health System YMCA

PRIORITY: BEHAVORIAL HEALTH

GOAL: Improve behavioral health status by increasing the availability of appropriate, quality mental health and addiction services.

BACKGROUND ON STRATEGY:

According to 2017 data from the National Institute of Mental Health (NIMH), an estimated 46.6 million American adults (approximately 1 in 5) have a seriously debilitating mental illness.[7] Mental illness disorders are the leading cause of disability in the United States, accounting for nearly twenty percent (20%) of all years of life lost to disability and premature mortality. [8]

Untreated mental health disorders are shown to have a serious impact on physical health and are linked with the prevalence, progression, and outcome of some of the most pressing chronic diseases, including diabetes, heart disease, and cancer. Persons suffering from one or more mental illness disorder(s) have a forty percent (40%) higher risk of developing these diseases than the general population. People with serious mental illness are nearly twice as likely to develop these conditions.[9]

Opioids are a class of drugs that include pain relievers available legally by prescription, the illegal drug heroin, and synthetic opioids such as fentanyl. Opioid pain relievers have traditionally been effective in treatment for relieving pain. However, over the past decade, the United States' has seen a rapid increase in prescribing of opioids leading to widespread dependence, addiction, overdose incidents and skyrocketing death rates across the nation. [10]

[7] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[8] https://www.nimh.nih.gov/health/statistics/disability/us-leading-categories-of-diseases-disorders.shtml
[9] https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
[10] https://www.nih.gov/news-events/opioids-digital-press-kit

According to the 2018 Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), approximately 10.3 million people aged 12 or older misused opioids in the past year. Although this number has decreased from 11.7 million in 2017, this statistic still corresponds to roughly 3.7 percent of the population.[11] The Centers for Disease Control and Prevention reports that the total economic burden of prescription opioid misuse alone is an estimated $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.[12]

The National Alliance to End Homelessness reported a total of 552,830 people who experienced homelessness on a single night in 2018. This number represents 17 out of every 10,000 people in the United States. [13] As reported in Homeward's January 2019 snapshot report of individuals and families experiencing homelessness in the Richmond region, a total of 429 adults and 68 children were counted. While most people experiencing homelessness in the Richmond region typically stay in local shelters, 152 unsheltered individuals were counted in 2019.[14]

Evidence Based Sources:

County Health Rankings:

- www.CountyHealthRankings.org

Healthy People 2020:

- www.healthypeople.gov

Substance Abuse and Mental Health Services Administration (SAMHSA):

- http://www.samhsa.gov/treatment

Virginia's Plan for Well Being 2016 – 2020:

- http://www.vdh.virginia.gov/Administration/VPfWB/documents/pdf/Virginia's%20Plan%20for%20Well-Being.pdf

ALIGNMENT WITH NATIONAL/STATE PRIORITIES	
Health People 2020/2030	**Virginia's Plan For Well-Being 2016 - 2020**
MHMD-1 Reduce the suicide rate	**AIM 4: System of Health Care**

[11] https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report
[12] https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
[13] https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/
[14] http://homewardva.org/images/PITSNAPSHOTS/2019/January2019generalsnapshotFINAL.pdf

MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment MHMD-11 Increase depression screening by primary care providers 2030 Overarching Theme: • Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.	Goal 4.1: Virginia has a strong primary care system linked to behavioral health care, oral health care, and community support systems.

OBJECTIVE #1: Support regional community partners working to increase quality behavioral health services through investment and advocacy.

ACTION PLAN

Activity	Target Date	Anticipated Impact or Result
Support area non-profits who provide comprehensive behavioral health services to the uninsured	Summer 2021	• Equitable access to behavioral health services for all individuals
Advocate for increased substance abuse and alcohol/drug abuse programs and resources	Winter 2021	• Identify regional partners who have existing capacity and work with partners to expand resources
Support homeless individuals and families to find stable and affordable housing	Summer 2020	• Work with housing and homeless partners to ensure every child and adult has stable and affordable housing
Collaborate with community partners to increase mental health awareness	Ongoing	• Provide screenings, support groups, education, and programs
Increase mental health services and awareness in schools	Fall 2019	• Work with Free Clinics and FQHCs to bring low or no cost mental health services into area public school systems

Advocate for peer recovery teams	Spring 2021	• Identify opportunities for peer recovery teams to be imbedded in local area non-profits and/or health systems
Increase school partnerships to increase opioid education and decrease opioid use	Fall 2019	• Build relationships with non-profits, schools, and health care provider to drive better health outcomes for children
OBJECTIVE #2: Enhance the scope and quality of behavioral health services available to the community through traditional healthcare models.		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
Increase the proportion of people who receive appropriate treatment for mental health disorders	Fall 2021	• Implement diverse health solutions that respond to the needs of vulnerable populations
Increase non-opiate treatment options as well as promote public education of opioid misuse	Fall 2021	• Reduce overall opioid use and misuse
Increase depression screening by primary care providers	Ongoing	• Ensure patients receive depression screening and follow-up in primary care settings
Develop strategies to overcome mental health provider shortage	Winter 2021	• Improve mental health provider stability • Decrease wait time for patients • Ensure behavioral health practitioners are available in Emergency Departments
Integrate behavioral health with primary care	Fall 2020	• Collaborate with the Health Departments, Safety Net Providers, and Community Providers to increase number of mental health patients who receive counseling following their Primary Care Physician's recommendation • Enhance capacity for the treatment of anxiety/depression in primary care settings • Ensure behavioral health practitioners are available in primary care

Implement SBIRT in Emergency Departments	Spring 2020	• Ensure warm handoff occurs from the point that the need is identified in ED until resource are provided • Identify, reduce and prevent problematic use, abuse, and dependence on alcohol and illicit drugs
Increase mental health awareness through annual Opioid education for all staff	Fall 2019	• Provide annual opioid training to all staff
Expand Behavioral Health Services available through Community Health Programs	Spring 2020	• Identify new providers, volunteers, and partners to enhance services offered via mobile health and fixed-site locations
Expand resources available to employees	Fall 2019	• Launch LifeMatters resource to all employees
Required Resources Funding, Partnership, Advocacy		
PARTNERSHIPS		
Caritas Challenge Discovery Projects Chesterfield, Chickahominy, Henrico, City of Richmond, and Three Rivers Health Districts Chesterfield Department of Mental Health Support Services Childsavers Daily Planet Greater Richmond SCAN (Stop Child Abuse Now) Hanover Community Services Board Henrico Area Mental Health and Developmental Services		Hospital Corporation of America National Alliance on Mental Health Richmond Behavioral Health Authority Richmond City Public Schools SAARA of Virginia Safe Harbor Substance Abuse Free Environment (SAFE) United Methodist Family Services VCU Health System

PRIORITY: SOCIAL DETERMINANTS OF HEALTH
GOAL: Reduce health disparity by ensuring that every community has social and economic opportunities to thrive.

BACKGROUND ON STRATEGY:

The true health of a community is defined by the conditions, opportunities and social cohesions where we live, learn, work, play and worship – these economic and social conditions are defined as Social Determinants of Health. Social Determinants of Health directly impact and shape an individual's overall health – from the resources and support available in our neighborhoods and homes, to the quality of our education opportunities, to the availability of fresh fruits and vegetables, and the safety of our workplaces. These conditions in which we live are an underlying cause of today's major societal health issues including heart disease, diabetes, obesity and depression.[15]

As identified in Virginia's Plan For Well-Being 2016-2020, place (where people live, work, and play) has a critical impact on health. Places are critical for social gatherings, physical activities that shape well-being, and provide safety and connectedness to one's family, neighborhood, and community.[16]

The Centers for Disease Control and Prevention supports implementation of active transportation initiatives and changes to transportation policy as a means of improving overall health of a community. By expanding access, availability and safety of a variety of transportation options a community can prevent chronic disease, reduce motor-vehicle-related injury and deaths, improve environmental health, and increase access to basic needs.[17] An absence of alternatives to automobile travel has a greater adverse effect on vulnerable populations including the poor, the elderly, people who have disabilities, and children. This immobility results in limited access to jobs, health care, social interactions, and healthy foods.[18]

Studies have shown that students are 4 times more likely to drop out of school if they are unable to read at the third grade reading level by the end of the third grade. For every year that a child lives in poverty, they are twenty-six percent (26%) more likely not to graduate high school, over 6 times the rate of proficient readers at the same age.[19] An average of seventy-three percent (73%) of students in the Richmond Core Service Area in the 2016-2017 school year passed the third grade Reading SOLs, which falls below the Healthy People 2020 goal of eighty percent (80%). In the Richmond region, twenty percent (20%) of children ages 0-5 live in poverty totaling over 16,000 children. Of those, almost 900 students in 2013-2014 were held back before the 3rd grade costing over $9.4 million to the region.[20]

Housing quality refers to the physical condition of a person's home as well as the quality of the social and physical environment in which the home is located. Aspects of quality housing include home safety, air quality, space per individual, and the presence of mold, asbestos or lead. Low quality housing is

[15] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[16] http://www.vdh.virginia.gov/Administration/VPfWB/documents/pdf/Virginia's%20Plan%20for%20Well-Being.pdf
[17] http://www.cdc.gov/healthyplaces/transportation/access_strategy.htm
[18] http://www.cdc.gov/transportation/docs/transportation-fact-sheet.pdf
[19] http://vaperforms.virginia.gov/indicators/education/hsGraduation.php
[20] http://www.capitalregioncollaborative.com/

directly associated with various negative health outcomes, including chronic disease, susceptibility to injury and poor mental health. Low-income families are more likely to inhabit poor quality housing and experience at least 1 of the 4 common housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing. In the Richmond region, thirteen (13%) of individuals and families live in low quality housing.[21]

Living wage is defined as the minimum income necessary for a worker to meet the basic needs of themselves and their families. Living wage estimates the cost of food, child care, health care, housing, transportation and other necessities compared with hourly income earned. For a single adult in the Richmond region, the estimated living wage is currently $13.23. For a family of 5, it is $19.33. The current minimum wage in Virginia is $7.25. [22]

Evidence Based Sources:

Centers For Disease Control and Prevention:

- https://www.cdc.gov/

Virginia's Plan For Well-Being 2016 – 2020:

- http://www.vdh.virginia.gov/Administration/VPfWB/documents/pdf/Virginia's%20Plan%20for%20Well-Being.pdf

County Health Rankings:

- http://www.countyhealthrankings.org

Capital Region Collaborative:

- http://www.capitalregioncollaborative.com/

Virginia Department of Labor and Industry:

- http://www.doli.virginia.gov/

Virginia Department of Education:

- http://vaperforms.virginia.gov/indicators/education/hsGraduation.php

Others:

- http://www.doe.virginia.gov/statistics_reports/graduation_completion/cohort_reports/
- http://www.aecf.org/resources/early-warning-why-reading-by-the-end-of-third-grade-matters/

ALIGNMENT WITH NATIONAL/STATE PRIORITIES

[21] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing
[22] https://livingwage.mit.edu/metros/40060

Centers for Disease Control and Prevention	Virginia's Plan For Well-Being 2016 – 2020
http://www.cdc.gov/transportation/recommendation.htm http://www.cdc.gov/transportation/docs/transportation-fact-sheet.pdf Healthy People 2030 Overarching Themes: • Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all. • Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.	Addresses the need for transportation laws and infrastructure that promote well-being **AIM 2: Strong Start for Children**

OBJECTIVE #1: Collaborate with and support community partners working to address social, economic, and environmental factors that influence health through investment and advocacy.		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
Support area non-profits who are building affordable housing units that offset displacement	Summer 2020	• Increase housing stock for individuals living in the region
Support area non-profits who are expanding home ownership and affordable rental housing options	Summer 2020	• Support low-income renters to help stabilize families
Support area non-profits who are closing the gaps along the education achievement continuum	Summer 2020	• All children reading at appropriate grade level • Increased STEM opportunities for children
Support area non-profits who are providing early childhood	Summer 2020	• Increase access to high-quality early childhood education

education programs and advocacy		• Provide opportunities for parents to have quality childcare during work hours
Support area non-profits who are providing financial literacy services	Summer 2020	• Stabilize individuals and families
Improve neighborhood infrastructure through corridor development	Summer 2020	• Align comprehensive services for independent living in economically distressed neighborhoods
Enhance the built environment and promote place-making	Ongoing	• Support long-term sustainability of community spaces such as the Sarah Garland Jones Center in the East End • Enhance community oneness and collaboration • Provide space for Health Education and workforce development • Improve aesthetics of neighborhood
Promote active transportation and public transportation through advocacy for and provision of place making in the neighborhoods we serve	Ongoing	• Increase sidewalks and bike lanes in low-income neighborhoods • Improve quality of public transit system
Advocate for living-wage jobs and workforce training	Ongoing	• Increase job equity and job opportunities in the communities we serve • Reduce barriers to employment
Support entrepreneurship tied to local supply chain and entrepreneurial offerings in the public school system	Summer 2020	• Increase entrepreneurial education and understanding in middle and high schools
Advocate for food access and food education	Ongoing	• Increased access to healthy, affordable foods and basic necessities
Enhance hospital greenspace to improve community livability	Ongoing	• Utilize hospital greenspaces for National Night Out and other community gatherings
OBJECTIVE #2: Increase screenings and coordination of resources to support individuals with needs related to the social determinants of health.		
ACTION PLAN		

Activity	Target Date	Anticipated Impact or Result
Create social determinants of health teams to support individuals and families	Fall 2019	• Align clinical case managers with social workers to coordinate care
Hire Community Health Workers to work within communities	Fall 2019	• Provide resources and support to individuals in culturally competent and supportive environments
Provide social needs screenings through direct programs, CMS grants and other initiatives to better understand health needs	Ongoing	• Screen patients for social determinants of health and connect them to available community resources to improve overall health outcomes
Equip clinical and community health teams to coordinate resources with patients based on identified needs	Winter 2019	• Provide low-cost transit options connecting individuals to healthcare, jobs, housing, and education • Connect individuals to low-cost healthy food options
Invest in infrastructure that supports fundamental needs of individuals	Ongoing	• Partner with local and state government to expand public transportation options • Invest in home ownership programs in perpetuity
Required Resources Funding, Partnership, Advocacy		
PARTNERSHIPS		
ACTS Better Housing Coalition Capital Region Collaborative Chesterfield, Chickahominy, Henrico, City of Richmond, and Three Rivers Health Districts Children's Home Society of Virginia Church Hill Activities & Tutoring (CHAT) City of Richmond County Supervisors Cristo Rey Family Lifeline Financial Opportunity Centers Friends Association		Neighborhood Resource Centers Next Up RVA Partnership for Smarter Growth Peter Paul Development Center Project Homes Reynolds Community College Richmond Opportunities Inc. RVA Rapid Transit Richmond Hill Salvation Army Boys and Girls Club Senior Connections Side by Side Smart Beginnings

Greater Richmond Transit Authority (GRTC) Habitat for Humanity Higher Achievement Homeward Housing Families First Legal Aid Justice Center Local Initiatives Support Corporation (LISC) Maggie Walker Community Land Trust	Sports Backers Swim RVA Tricycle Virginia Community Development Fund (VCDF) Virginia Home for Boys and Girls Virginia Interfaith Center for Public Policy YMCA

PRIORITY: STRESS/TRAUMA

GOAL: Promote the well-being, safety, and overall health of individuals by decreasing the occurrences of Adverse Childhood Experiences within communities.

BACKGROUND ON STRATEGY:

In the 2019 Bon Secours Community Health Needs Assessment online survey, stress and trauma were identified by the community as one of the top five causes of poor health needing to be addressed in the Richmond Core Service Area.

Barriers to health in other priority areas, particularly those falling under the social determinants of health, as well as systemic policy challenges make it difficult for low-income families to find stability. In the most economically disadvantaged communities, children have less than a 5% chance of reaching the top 20% of income distribution if they grew up in a family in the bottom 20%. [23]

Adverse childhood experiences (ACEs) are traumatic events occurring before age 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance use, domestic violence and other household dysfunctions. A breakthrough study in the 1990s, conducted by the CDC along with Kaiser Permanente, found a significant relationship between the number of ACEs a person experienced and a variety of negative outcomes in adulthood, including substance abuse, poor physical and mental health, and risky behaviors. [24] The more ACEs experienced, the greater the risk for these outcomes.

ACEs are a predictor of social stability and are considered the largest potentially modifiable impact to health costs, with additional negative impacts on education and workforce outcomes. [25]

Evidence Based Sources:

[23] https://www.capitalregioncollaborative.com/wp-content/uploads/2018/03/Snapshot-2018-for-web.pdf
[24] https://www.childwelfare.gov/topics/preventing/preventionmonth/resources/ace/
[25] https://www.capitalregioncollaborative.com/wp-content/uploads/2018/03/Snapshot-2018-for-web.pdf

Centers For Disease Control and Prevention:

- https://www.cdc.gov/

County Health Rankings:

- http://www.countyhealthrankings.org

Capital Region Collaborative:

- http://www.capitalregioncollaborative.com/

Virginia Department of Labor and Industry:

- http://www.doli.virginia.gov/

Virginia's Plan For Well-Being 2016 – 2020:

- http://www.vdh.virginia.gov/Administration/VPfWB/documents/pdf/Virginia's%20Plan%20for%20Well-Being.pdf

ALIGNMENT WITH NATIONAL/STATE PRIORITIES	
Health People 2020/2030	**Virginia's Plan For Well-Being 2016 – 2020**
DH-20 Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings. 2030 Overarching Themes: • Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death. • Promote healthy development, healthy behaviors and well-being across all life stages. • Create social, physical, and economic environments that promote attaining full potential for health and well-being for all. • Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.	**AIM 1: Healthy, Connected Communities** **AIM 2: Strong Start for Children**

OBJECTIVE #1: Support community partners who are collaborating to promote safer, supportive communities through investments and advocacy.	
ACTION PLAN	

Activity	**Target Date**	**Anticipated Impact or Result**
Support area non-profits who are providing comprehensive case management services	Summer 2020	• Address the impacts of trauma and adverse childhood experiences
Support area non-profits who are who are caring for victims, survivors and at-risk youth of domestic and sexual violence	Summer 2020	• Decrease rate of domestic abuse and child abuse/neglect
Support community forums that aim to decrease community violence and crime and childhood trauma	Summer 2019	• Work with area organizations, agencies, and government to reduce the negative impacts on individuals and families
Co-lead Community Health Coalition to bring ACEs programming and trauma-informed care to the region	Ongoing	• Advance a plan in collaboration with the Community Health Coalition that will address Adverse Childhood Experiences and ensure all facilities are providing trauma-informed care
Support area Trauma-Informed Community Networks	Spring 2021	• Expand cross-sector collaboration, education, and awareness of trauma and trauma-informed services

OBJECTIVE #2: Enhance programs that provide direct services to individuals and families who have experienced stress and trauma.
ACTION PLAN

Activity	**Target Date**	**Anticipated Impact or Result**
Provide comprehensive Forensic Nursing services	Ongoing	• Ensure all victims of violence, abuse, and stress have access to high-quality, timely forensic nurses for evaluation and treatment

Expand counseling, services, and support for individual through Community Health programs	Spring 2021	• Increase community-based services for victims of trauma and abuse
Launch Clinicians Against Gun Violence Campaign	Fall 2019	• Identify and organize clinicians who advance positive social change
Provide department specific staff education on trauma informed care	Fall 2021	• Increase staff awareness level of trauma and implement interventions to become more trauma-informed

Required Resources Funding, Partnerships, Advocacy	
PARTNERSHIPS	
Anna Julie Cooper School Armstrong Priorities Freshman Academy Capital Region Collaborative Chesterfield, Chickahominy, Henrico, City of Richmond, and Three Rivers Health Districts Church Hill Activities & Tutoring (CHAT) Comfort Zone Commonwealth Parenting Excel VCU Faison School for Autism First Things First Friends Association Full Circle Grief Center Greater Richmond SCAN (Stop Child Abuse Now) The Hanover Center for Trades and Technology	Henrico County Public Schools Career & Technical Education Higher Achievement Partners in Parenting Partnership for Non-Profit Excellence Peter Paul Development Center Reach Out and Read Richmond Cycling Corps Sacred Heart Center Salvation Army Boys and Girls Club Science Museum of Virginia United Way of Greater Richmond & Petersburg Virginia Literacy Foundation YMCA YWCA