Bon Secours

2026-2028 Community Health Implementation Plan

Bon Secours Richmond

RICHMOND, VA

2026–2028 Community Health Implementation Plan

Bon Secours Richmond

Adopted by the Bon Secours Richmond Board of Directors, April 28, 2026

As part of Bon Secours Mercy Health, Bon Secours Richmond is honored to uphold nearly two centuries of dedication to the communities we serve. This commitment has continually evolved to address the most pressing needs in each community, based on input from residents, businesses and other community members.

Guided by our Mission to extend the compassionate ministry of Jesus, Bon Secours continuously works to improve the health and well-being of our communities and bring good help to those in need — especially people who are poor, underserved and dying.

By listening to community voices from our partners and neighbors, Bon Secours Richmond has identified the greatest needs in our community. The Community Health Implementation Plan (CHIP) helps ensure our resources and strategies for outreach, prevention, education and wellness are directed where they can make the greatest impact.

We welcome written comments regarding the health needs identified in this CHIP. Please direct your feedback to Becky Clay Christensen at rebecca_christensen@bshsi.org, Sean O'Brien at sean_obrien@bshsi.org and Kerrissa MacPherson at kerrissa_macpherson@bshsi.org.

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Introduction

This Community Health Implementation Plan will address the prioritized significant community health needs listed through the CHNA. The Implementation Plan indicates which prioritized needs Bon Secours Richmond will address and how, as well as which prioritized needs it will not address and why.

Bon Secours Richmond intends to take a regional approach to address its CHNA and the identified prioritized needs and therefore the needs the hospitals intend to address and the strategies outlined are the same and combined into one Community Health Implementation Plan.

Beyond the programs and strategies outlined in this plan, Bon Secours Richmond will continue to address the needs of the community by operating in accordance with its mission to extend the compassionate ministry of Jesus by improving the health of its communities with an emphasis on the poor and underserved. This includes providing care for all individuals regardless of their ability to pay.

The strategies in the Implementation Plan will provide the foundation for addressing the community's significant needs between 2026–2028. However, Bon Secours Richmond anticipates some strategies and needs may evolve over that period. Bon Secours Richmond plans a flexible approach to addressing the significant community-identified needs that will allow for the adaptation of potential changes and collaboration with other community agencies and partners.

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Executive Summary

Background and Process

Living conditions, opportunities and many social and structural factors shape the true health of a community. This Community Health Needs Assessment (CHNA) examines qualitative input from community members, nonprofit leaders, public health and government agency leaders, physicians, advanced practice clinicians, Bon Secours associates and a diverse Community Health Advisory Group. We paired this feedback with publicly available data on health and social conditions in the Bon Secours Richmond area and survey responses from more than 2000 community members between September 2024 and March 2025. Together, this information provides a clear picture of key health concerns in our community.

Community input came from four main initiatives:

- Completing over 15 interviews with key community leaders with expertise in topics identified as high priorities
- Conducting a community engagement survey with over 2000 responses
- Convening a Community Health Advisory Group over seven meetings
- Holding six focus groups on specific topics

We also analyzed quantitative data from the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS) and the U.S. Census Bureau.

In Spring 2025, Bon Secours Richmond Community Health leadership and Advisory Group members reviewed this information and identified common themes. These discussions led to the consolidation of findings into three prioritized needs.

Identifying Significant Needs

After a yearlong CHNA engagement process, significant health needs were identified by analyzing publicly available data, survey results and qualitative feedback from the Community Health Advisory Group, focus groups and key informant interviews. While current service providers address many of the community-identified health needs, many are at capacity. The significant health needs identified were prioritized to better meet the needs of the community. The Community Health Advisory Group participated in prioritization conversations that explored themes from the focus groups and key informant interviews and how they related to the survey findings, as well as linkages and relationships between identified health needs.

Opportunity and Access

- Insufficient opportunities for generating wealth, which perpetuates generational cycles of poverty and can lead to poor health outcomes (e.g., affordable housing, financial literacy)
- Insufficient access to affordable primary and specialty care, resulting in health care that does not honor the dignity of everyone we serve (e.g., chronic disease management, rural access)

Systemic Solutions

- Traditional health care and community responses are often reactive "short-term fixes." However, we can also recognize and address the root causes of health needs (e.g., housing, mental health, violence, discrimination, addiction, etc.)

Community Representation

- Insufficient career pathways for low-income individuals from the communities we serve (e.g., community health workers, workforce pipelines)
- Unbalanced community representation in determining proposed solutions for addressing health needs (e.g., staff that is not representative of the communities served, board service, community engagement processes)

Implementation Plan

Bon Secours Richmond is committed to addressing all prioritized health needs of the community through the strategies described in this Implementation Plan.

Prioritized Health Needs

The table below lists the prioritized health needs identified through the CHNA and specifies which needs Bon Secours will address. All prioritized needs will be addressed by Bon Secours Richmond in the 2026–2028 CHIP.

Bon Secours Richmond is committed to addressing the community's prioritized health needs through the strategies described in this Implementation Plan. Bon Secours Richmond will address each need through regional strategies with various activation dates throughout the three-year implementation life cycle. Some of the strategies will take place in communities geographically associated with or tagged to a specific hospital.

Prioritized Health Needs	Hospital Addressing Need (Y/N)						
	St. Mary's Hospital	St. Francis Medical Center	Memorial Regional Medical Center	Richmond Community Hospital	Southside Medical Center	Southern Virginia Medical Center	Rappahannock General Hospital
Opportunity and Access	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Systemic Solutions	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Representation	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Implementation Strategies to Address Community-Level Social Determinant of Health Needs

Systemic Solutions

Description

Traditional health care and community responses are often reactive "short-term fixes." However, the root causes of health needs can also be recognized and addressed (e.g., housing, mental health, violence, discrimination, addiction, etc.)

In the 2025 CHNA, community members shared that mental health is their top priority health need. High Adverse Childhood Experiences (ACE) scores are strongly associated with poorer mental health outcomes and an increased risk of experiencing or perpetrating interpersonal violence. This underscores the need for trauma-informed intervention strategies and creates an opportunity to connect all adult patients experiencing interpersonal violence who have also experienced specific traumatic childhood experiences to the community-based mental health support they need.

In 2026, Violence Response Team (VRT) associates will institute a new screening process. Associates will begin asking three standardized screening questions to all eligible and consenting adult patients. These three screening questions ask if an adult patient was exposed to domestic violence as a child or experienced physical abuse and/or sexual abuse as a child. These questions will identify previous exposure to trauma and seek to connect patients to the evidence-based mental health supports that can prevent or lower the recurrence of violence.

Goal 1

To increase early identification and referral to mental health supports of adults affected by interpersonal violence so that by 2028, 90% of eligible and consenting adults are screened and 60% of patients who screen positive are referred to appropriate mental health services.

Strategy

Implement a standardized trauma screening and referral process within the Violence Response Team to identify adults with a history of interpersonal or childhood violence and connect them to evidence-based mental health services. Staff will receive training in trauma-informed care and data tracking to ensure consistent screening, referral and follow-up for all eligible and consenting patients. We will track impact using the following metrics:

- The percentage of eligible, consenting patients screened and
- The percentage of those who screen positive who are referred to appropriate community-based supports

Strategic Measures

- **Year 1 Strategic Measure**
  - Train all relevant VRT associates on the use of the three question screening tool and referral process.
  - 70% of eligible and consenting adult patients are screened.
  - 40% of patients who screen positive are referred to appropriate community-based supports.
- **Year 2 Strategic Measure**
  - 80% of eligible and consenting adult patients are screened.
  - 50% of patients who screen positive are referred to appropriate community-based supports.
- **Year 3 Strategic Measure**
  - 90% of eligible and consenting adult patients are screened.
  - 60% of patients who screen positive are referred to appropriate community-based supports.

Accountable Partners

- The Violence Response Team (part of the Community Health team) will partner with community organizations to address this goal.

Expected Impact of the Strategy

- Over time, implementation of this strategy will strengthen early identification of trauma, enhance access to appropriate mental health care and reduce the recurrence of interpersonal violence among patients. It will also build system-wide capacity for trauma-informed practices and improve coordination between clinical and community-based mental health resources.

Targeted Populations

- This goal and strategy target adult patients who have experienced or are currently experiencing interpersonal violence, including those with a history of childhood trauma such as exposure to domestic violence, physical abuse or sexual abuse. Screening will be universal and patients who may be at higher risk for recurrence of violence or barriers to accessing mental health care, such as women, adults with low income, racial and ethnic minorities and individuals with limited social support, will receive additional support. This strategy also indirectly supports health care providers and Violence Response Team associates by strengthening their capacity to deliver trauma-informed, culturally responsive care.

Description

In the 2025 CHNA, community members shared that Social Drivers of Health (SDOH) needs are interwoven and expressed a desire for systemic community-based responses. "Systemic" approaches include multiple nonprofits collaborating to create financial efficiencies so they can serve more community members, nonprofits leading policy advocacy for community health and nonprofits addressing the root causes of SDOH needs.

Goal 2

Support and foster the expansion of collaborative programs and initiatives that provide systemic community-based responses to SDOH needs.

Strategy

Bon Secours Community Health will prioritize investment in community organizations that use a systemic approach, as defined above. This strategy will be accomplished by allocating a larger percentage of its annual community benefit investment budget to community organizations that utilize a systemic approach in their work. By December 2028, Bon Secours will have increased its annual direct grants to community organizations with a systemic approach by 10% over 2026 investment levels.

Strategic Measures

- **Year 1 Strategic Measure**
  - Disburse at least $3 million in grant funding to community-based organizations.
  - Establish baseline of percentage of community organizations with a systemic approach.
- **Year 2 Strategic Measure**
  - Disburse an additional $3 million in grant funding to community-based organizations, reaching a cumulative total of at least $6 million by year-end.
  - Increase percentage of community organizations with a systemic approach that receive direct funding grants by 5% over the 2026 baseline by December 2027.
- **Year 3 Strategic Measure**
  - Disburse remaining funds to reach the $9 million total investment in grant funding to community-based organizations.
  - Increase percentage of community organizations with a systemic approach that receive direct funding grants by 10% over the 2026 baseline by December 2028.

Accountable Partners

- The Community Health team will partner with community organizations to address this goal, utilizing the infrastructure of the Community Benefit Investments program.

Expected Impact of the Strategy

- Implementation of this strategy is expected to increase cross-sector collaboration among community-based organizations receiving funding from Bon Secours Richmond by 2028, resulting in shared program funding and resource alignment. Coordinated efforts will aim to expand access to SDOH-related services — such as housing stability, food security and transportation — over the next three years. Through joint policy advocacy and systems-level interventions, partners will track reductions in duplicated services and improvements in targeted community health indicators (e.g., reduced emergency department utilization for preventable conditions, improved self-reported well-being). These outcomes will demonstrate progress toward a more equitable and efficient local health ecosystem.

Targeted Populations

- This strategy targets community members who are disproportionately affected by SDOH barriers, including low-income individuals and families, communities of color, immigrants and refugees, older adults and people living with chronic health conditions. We will place specific focus on residents experiencing housing instability, food insecurity, limited access to transportation and barriers to accessing preventive and primary health care. Additionally, the strategy seeks to strengthen the capacity of local nonprofits and community-based organizations that serve these populations, ensuring that systemic solutions are both community-driven and culturally responsive.

Implementation Strategies to Address Individual Level Health-Related Social Needs

Community Representation

Description

- Insufficient career pathways for low-income individuals from the communities we serve.
- Unbalanced community representation in determining proposed solutions for improving health outcomes (e.g., staff that is not representative of the communities served, board service, community engagement processes).
- In the 2025 CHNA, more than one-third of community members surveyed reported significant difficulties accessing the health care and social care they need. While routine Social Driver of Health (SDOH) screenings at Bon Secours facilities help many patients, some only receive a flyer or list of resources and many require more direct support to connect with community organizations. Community Health Workers are an essential part of an allied health care team that is representative of the communities they serve and can provide a trusted voice to patients and connect patients to community resources. Connecting patients to community-based organizations that address social and clinical health needs is an important aspect of community organizations as they continue to support patients in achieving the best possible health outcomes after they have left Bon Secours facilities.

Goal 3

To address these gaps, by 2028, the goal is to increase average health-related social need referrals by 10% over the 2026 baseline and maintain at least 80% of patients connected to appropriate community resources.

Strategy 1

Community Health Workers (CHWs) on the Violence Response Team and Neighborhood Engagement Teams will systematically screen patients for SDOH needs and provide direct referrals to appropriate community resources. They will track and report referral numbers and successful connections to ensure that more patients receive the support they need, aiming for a 10% increase in referrals sent by each CHW and for at least 80% of eligible and consenting patients to be linked to services.

CHWs will also systematically track and report the number of community referrals made and the percentage of eligible and consenting patients successfully connected to needed supports.

Strategic Measures

- **Year 1 Strategic Measure**
  - Generate baseline number of community referrals made by certified CHWs and by CHWs in training on behalf of vulnerable patients.
  - Generate baseline percentage of eligible and consenting patients connected to appropriate community supports per CHW.
- **Year 2 Strategic Measure**
  - Achieve a 5% increase over the 2026 baseline in:
    - Number of community referrals made by each certified CHW on behalf of vulnerable patients
      - Each certified CHW and CHW in training will connect 80% of eligible and consenting patients to appropriate community supports, or if unable to connect 80% of eligible and consenting patients, will have a 5% increase as compared to the previous year's baseline.
- **Year 3 Strategic Measure**
  - Achieve a 10% increase over the 2026 baseline in:
    - Number of community referrals made by each certified CHW on behalf of vulnerable patients
      - Each certified CHW and CHW in training will connect 80% of eligible and consenting patients to appropriate community supports, or if unable to connect 80% of eligible and consenting patients, will have a 5% increase as compared to the previous year's baseline.

Accountable Partners

- CHWs and their managers who are part of the Neighborhood Engagement Team and the Violence Response Team will be responsible for achieving the goals of this strategy.

Expected Impact of the Strategy

- Community representation in the workforce will be increased as CHWs are recognized as part of the allied health care team. The focus on a workforce pipeline for CHWs is part of a larger strategy to increase community representation across all aspects of the health care workforce. Implementation of this strategy is expected to increase the average number of community referrals made by each CHW by 10% over the 2026 baseline, maintaining at least 80% of eligible and consenting patients successfully connected to needed community resources. As a result, more patients experiencing SDOH barriers will access the services they need, reducing gaps in care and improving overall health and well-being. Additionally, systematic tracking of referrals will enhance accountability, strengthen collaboration with community organizations and inform continuous improvements in service delivery.

Targeted Populations

- This strategy targets patients experiencing barriers related to SDOH, including those with limited access to health care, housing instability, food insecurity, transportation challenges, or other social and economic needs. Priority is given to vulnerable populations, such as adults with low income, racial and ethnic minority groups, older adults and individuals with chronic health conditions or limited social support. By focusing on these populations, the strategy aims to ensure that patients most at risk of unmet social and health care needs are connected to appropriate community resources.

Strategy 2

Bon Secours Richmond will increase referrals to community organizations and streamline referrals for patients with social needs, aiming for a 15% yearly increase in referrals with an 80% or higher acceptance rate by community organizations in 2028. This strategy will ensure patients receive timely, personalized support while continuously monitoring and improving referral outcomes in partnership with community resources.

Additionally, Bon Secours Richmond will expand use of the Unite Us platform to improve collaboration with community partners and coordinate timely, patient-centered referrals. The goal is to ensure every patient with social needs receives personalized, actionable support through coordinated community resources.

Strategic Measures

- **Year 1 Strategic Measure**
  - Using 2025 referral numbers as a baseline, achieve a 15% increase in the number of referrals sent by Bon Secours Richmond associates to community organizations, preferably via the Unite Us platform.
- **Year 2 Strategic Measure**
  - Using 2026 referral numbers as a baseline, achieve a 15% increase in the number of referrals sent by Bon Secours Richmond associates to community organizations, preferably via the Unite Us platform.
  - Establish a baseline of referral acceptance rates to monitor how many referrals are successfully accepted and acted upon by community partners.
- **Year 3 Strategic Measure**
  - Using 2027 referral numbers as a baseline, achieve a 15% increase in the number of referrals sent by Bon Secours Richmond associates to community organizations, preferably via the Unite Us platform.
  - Improve or maintain referral acceptance rate to 80% or better.

Accountable Partners

- The Community Health team will work collaboratively with social workers, Community Health workers, case managers, nurses and other providers on the Community Health team and at facilities across Bon Secours Richmond, including Southern Virginia and the Northern Neck, to reach more vulnerable patients.

Expected Impact of the Strategy

- Connecting Bon Secours patients to community-based organizations will increase community representation in determining proposed solutions for improving patient health outcomes. The expected impact of this strategy is that more patients with social needs will receive timely, coordinated and personalized support, reducing barriers to health care and social services. By increasing successful referrals by 15% every year for three years, Bon Secours Richmond anticipates improved patient outcomes, stronger community partnerships and a reduction in unmet social needs across the community.

Targeted Populations

- The targeted populations for this strategy are patients with identified social needs who face barriers to health care, housing, food, transportation or other essential services. This includes vulnerable and high-risk community members who are more likely to experience gaps in care, particularly those receiving services at Bon Secours Richmond facilities. This strategy focuses on ensuring these individuals receive direct, coordinated support through timely referrals to community-based resources.

Implementation Strategies to Address Clinical Health Needs

Opportunity and Access

Description

- Insufficient opportunities for generating wealth, which perpetuates generational cycles of poverty and can lead to poor health outcomes (e.g., affordable housing, financial literacy).
- Insufficient access to affordable primary and specialty care, resulting in health care that does not honor the dignity of everyone we serve (e.g., chronic disease management, rural access).
- In the 2025 CHNA, community members noted that rural patients face different health needs and barriers to care compared with suburban and urban populations and they requested that Bon Secours take action to improve rural access to primary and specialty care.

Goal 4

In response, by December 2028, Bon Secours Community Health will increase the percentage of rural patients served by the Bon Secours Care-A-Van by 20% compared with the 2026 baseline of rural patients. Additionally, a cohort of rural patients with hypertension will be tracked, with a goal to bring blood pressure into a healthy range for 80% of the identified cohort by 2028.

Strategy 1

- Bon Secours Community Health will deploy the Care-A-Van mobile clinic program to provide regular primary and specialty care visits to underserved rural communities. This strategy will focus on the southern portion of the Bon Secours Richmond primary service area, with rural patients defined as those residing in Amelia County, Brunswick County, Dinwiddie County, the City of Emporia, Greensville County, Nottoway County, Prince George's County, Southampton County, Surry County and Sussex County. By increasing access to health care services for rural patients, by 2028, this program aims to increase rural patients from these counties by 20% over the 2026 baseline and to provide additional primary care support to a cohort of patients with hypertension.

Strategic Measures

- **Year 1 Strategic Measure**
  - Develop a rural community engagement and outreach plan.
  - Establish partnerships with at least two rural community organizations to serve as mobile clinic sites, including at least three community meetings.

  - Launch a pilot mobile clinic program with one monthly visit to rural communities, for a goal of three clinics by end of 2026.
  - Establish 2026 baseline of number of Care-A-Van patients that reside in rural counties.

- **Year 2 Strategic Measure**
  - Expand mobile clinic visits to 10 rural mobile clinics in 2027.
  - Increase the percentage of rural patients seen by the Care-A-Van by 10% as compared to the 2026 baseline.
  - In 2027, bring blood pressure into a healthy range for 70% of the identified cohort.
- **Year 3 Strategic Measure**
  - Increase mobile clinic outreach to two rural visits per month (with a goal of 20 rural mobile clinics in 2028).
  - Increase the percentage of rural patients seen by the Care-A-Van by 20% as compared to the 2026 baseline.
  - In 2028, bring blood pressure into a healthy range for 80% of the identified cohort.

Accountable Partners

- The Primary and Specialty Care team (part of Community Health) will work collaboratively with rural community partners.

Expected Impact of the Strategy

- As a result of this strategy, underserved rural populations will have significantly improved access to primary and specialty care through the Care-A-Van mobile clinic program. This increased access is expected to reduce health care disparities, ensure more equitable care and improve overall health outcomes for rural communities, while reaching 20% more rural patients than in 2026. Additionally, 80% of patients with hypertension in an identified rural cohort will achieve a healthy blood pressure range. The goal is to ensure rural patients have consistent, equitable access to health care, reducing disparities and improving community health.

Targeted Populations

- The targeted populations for this strategy and goal are underserved rural communities. Specifically, these are rural patients who face barriers to accessing primary and specialty health care — such as long travel distances, limited local health care providers and other socioeconomic or logistical challenges — compared with suburban and urban populations. Patients with hypertension will also receive additional support. The focus is on ensuring that rural patients have consistent, equitable access to care through the Care-A-Van mobile clinic program.

Resources Available

Due to the considerable and complex nature of the prioritized needs, several community organizations may be available to address one or more of the needs identified in the 2025 Community Health Needs Assessment:

Health Care Facilities and Services

- **Bon Secours Financial Assistance Team:** The Bon Secours Financial Assistance Program supports uninsured patients who do not qualify for government-sponsored health insurance and cannot afford their medical care. Insured patients may also qualify for assistance based on family income, family size and medical needs.
  - Financial hardship (e.g., finding a job that pays a living wage, being able to pay the bills)
  - Employment and unemployment (e.g., unsafe work conditions or inability to find a job)
- **Bon Secours Community Benefit Investments:** Between 2019 and 2022, Bon Secours provided over $14 million through community benefit investments to community partners serving the uninsured and underinsured populations.
  - Financial hardship (finding a job that pays a living wage, being able to pay the bills, etc.)
  - Housing (homelessness, affordable housing, utility payments, etc.)
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Discrimination (being treated unfairly because you are different in some way, like racism or ageism)
  - Education and literacy (being able to read, good schools)
  - Transportation (being able to get to work or to health care appointments)
  - Employment and unemployment (unsafe conditions at work or cannot find a job)
  - Problems related to food (finding healthy food, paying for food, etc.)
  - Families and communities (social isolation, violence between people who know each other, crime)
  - Experiences of violence
  - Discrimination while receiving health care services
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)

  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/ heart attack, obesity, etc.)
  - Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)
  - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
  - Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
  - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
  - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Children's health concerns
  - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **Bon Secours Center for Healthy Living Sarah Garland Jones Center, Bon Secours Community Health Clinic in Manchester and Bon Secours Petersburg Center for Healthy Living:** These healthy living centers promote well-being and community engagement in Richmond and in the Petersburg/Crater region.
  - Problems related to food (finding healthy food, paying for food, etc.)
  - Families and communities (social isolation, violence between people that know each other, crime)
  - Access to health care and mental health services (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - utrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)

- **Bon Secours Violence Response Team:** This program provides 24/7 care to patients who are victims of child abuse, sexual assault, community violence, domestic violence, elder abuse, human trafficking and strangulation.
  - Families and communities (social isolation, violence between people that know each other, crime)
  - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
  - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **Bon Secours Care-A-Van:** Mobile health clinics that provide free, primary, urgent and preventive health care to uninsured and vulnerable populations in a 60-mile radius of the City of Richmond.
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Transportation (being able to get to work or to health care appointments)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
- **Bon Secours Community Nutrition:** Improves community health, particularly in vulnerable communities, through nutrition counseling, healthy eating classes and advocacy for food access.
  - Problems related to food (finding healthy food, paying for food, etc.)
  - Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
- **Bon Secours Every Woman's Life:** This program provides breast and cervical cancer screening and early detection, clinical breast exams, mammograms, pelvic exams and Pap smears.
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
- **Bon Secours Instructive Visiting Nurse Association (IVNA):** IVNA is an immunization and wellness program that provides thousands of flu shots per year, along with other immunizations and wellness services, to the Greater Richmond community.
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)

- **Bon Secours Medical Group:** Over 450 physicians and advanced practice clinicians and associated staff providing primary and specialty medical care to the CHNA service area in over 150 locations.
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Children's health concerns
- **Bon Secours Prenatal Education:** Team of prenatal educators providing community education about childbirth, breastfeeding, postpartum care, newborn care and safety and more.
  - Families and communities (social isolation, violence between people that know each other, crime)
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
  - Children's health concerns
- **Bon Secours Hospital Emergency Departments:** Bon Secours Richmond includes seven acute facility hospitals with Emergency Departments that provide emergency care for acute physical and mental health needs.
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Experiences of violence
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
  - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Children's health concerns
  - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **Federally Qualified Health Centers and Safety Net Clinics:** Capital Area Health Network (CAHN), Central Virginia Health Services, CrossOver Healthcare Ministry, Daily Planet Health Services, Free Clinic of Powhatan, GoochlandCares, Hanover Interfaith Free Clinics, Health Brigade, Northern Neck Middlesex Free Health Clinic and others.
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Dental issues
  - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
  - Children's health concerns
- **Central Virginia VA Health Care System, providing medical care to veterans across Virginia**
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Experiences of violence
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
  - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **HCA Virginia Health System and Virginia Commonwealth University (VCU) Health**
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Experiences of violence
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Dental issues
  - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
  - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
  - Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
  - Children's health concerns
  - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

Health Departments

Virginia Department of Health Local Health Districts

- **Chesterfield Health District, Chickahominy Health District, Crater Health District, Piedmont Health District, Richmond/Henrico Health District, Southside Health District, Three Rivers Health District**
  - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
  - Families and communities (social isolation, violence between people that know each other, crime)
  - Environment (clean water, clean air, etc.)
  - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
  - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
  - Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)
  - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping

- Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
- Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
- Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
- Illnesses that spread (flu, COVID-19, hepatitis, TB, etc.)
- Children's health concerns
- Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

Other Local and National Resources

Additional community resources

- **Access Now:** Access Now is a volunteer specialty network for free clinic patients.
- **Anna Julia Cooper School:** This faith-based middle school in Richmond's East End serves youth with limited resources.
- **Area Congregations Together in Service (ACTS):** ACTS provides funds, support and other resources to those living in the Greater Richmond area who are at risk of losing their housing, utilities or transportation. Those served by ACTS do not qualify for government prevention assistance due to eligibility requirements and often fall through the cracks.
- **Armstrong Priorities Freshman Academy:** Armstrong Priorities Freshman Academy identifies students entering ninth grade at Armstrong High School below grade level and provides instruction in math and English to bring them up to grade level by the tenth grade.
- **Bay Aging:** Bay Aging is a premier provider of programs and services for people of all ages in the Northern Neck Region. Formed in 1978, Bay Aging is diverse in the programs it offers through three major divisions: Community Living, Bay Transit and Bay Family Housing.
- **Better Housing Coalition:** The Better Housing Coalition ensures every citizen in the Richmond region, regardless of their economic status, has good choices in where they live and opportunities to reach their fullest potential.
- **Boys & Girls Club:** The Club, which has an emphasis on Richmond's East End, provides life-skills training and serves more than 500 members with a daily participation of 150.

- **Boys To Men Mentoring Network of Virginia:** This organization works within seven school districts in the greater Richmond and Tri-City area. It provides school- and community-based group mentoring circles, supporting young men in their efforts to become more mature, responsible and accountable.
- **CancerLINC (Legal Information Network for Cancer):** CancerLINC helps cancer patients and their families overcome legal and financial obstacles.
- **Center for Nonprofit Excellence:** This organization develops the capacity of nonprofits through education, information sharing and civic engagement.
- **Challenge Discovery Projects:** Challenge Discovery Projects provides direct services to over 1,600 at-risk youth in Richmond, with an emphasis on the East End. They are committed to improving the emotional health and well-being of children and their families through programs that promote self-worth and positive, healthy relationships.
- **Children's Home Society of Virginia:** Children's Home Society of Virginia is a full-service, private, nonprofit 501(c)(3), non-sectarian licensed child-placing agency and one of Virginia's oldest adoption agencies.
- **ChildSavers:** ChildSavers provides a fundamental commitment to the mental well-being of children and the positive bond between adult and child. ChildSavers supports this with clinical treatment, education and training services, with an emphasis on Richmond's East End.
- **Circle Center Adult Day Services:** Circle Center provides comprehensive services dedicated to the well-being of older adults and their caregivers in RVA. They offer enriching programs of socialization, healthy aging and nutrition administered by a qualified team of health care professionals, recreational therapists, physical and speech therapists and social workers.
- **Comfort Zone Camp:** Comfort Zone Camp is a nonprofit bereavement camp that transforms the lives of children who have experienced the death of a parent, sibling or primary caregiver.
- **Commonwealth Catholic Charities:** This organization provides quality, compassionate human services to all people, especially the most vulnerable, regardless of faith.
- **Communities In Schools (Chesterfield, Henrico, Petersburg, Richmond):** Communities In Schools positions site coordinators inside schools to assess students' needs and provide resources to help them succeed in the classroom and in life.
- **Community Coalition of Sussex Virginia:** This grassroots organization supports the needs of residents of Sussex County.

- **Creighton Family Resource Center:** Creighton Family Resource Center works in partnership with Richmond City Health Department and Richmond Redevelopment & Housing Authority. They deliver health screenings, checkups, health education, nutrition, parenting classes, budget management and community resource information to an underserved community.
- **Cristo Rey Richmond High School:** Cristo Rey Richmond is a Catholic learning community that educates young people of limited economic means to become men and women of faith, purpose and service. Through a rigorous college preparatory curriculum, integrated with relevant work-study experience, students graduate ready to succeed in college and in life.
- **Dignity Grows:** Dignity Grows is the national nonprofit leader in the fight against Period Poverty, a debilitating, often overlooked form of health inequity. In partnership with Petersburg Public Schools, Dignity Grows ensures hygiene support for students.
- **Downtown Churches United:** The Hope Center is a union of area faith communities, organizations and other charitable partners committed to filling the essential needs of Greater Petersburg's financially distressed citizens.
- **Eastern Virginia Care Transitions Partnership:** This organization coordinates and delivers quality care and prevention services to older adults living in the Northern Neck Region.
- **ExCELL:** ExCELL provides literacy efforts for children, with an emphasis on Richmond's East End.
- **Family Lifeline:** Family Lifeline is a partner to families and individuals that delivers intensive home and community-based services to achieve an equitable, resilient community where families and individuals are connected, safe and living a healthy, meaningful life. Family Lifeline provides in-home education, wellness and support services to Central Virginia's children, parents and older adults.
- **Feed More:** Feed More collects, prepares and distributes food and meals with the mission to fight hunger in Central Virginia and the vision that none shall go hungry. Feed More is the core hunger relief organization in Central Virginia.
- **FRIENDS Association for Children:** This organization provides quality childcare and development in an underserved part of Richmond, with an emphasis on Richmond's East End.
- **Full Circle Grief Center:** Full Circle Grief Center provides comprehensive professional bereavement support to children, adults, families and communities in the Greater Richmond area. Full Circle offers grief counseling groups, consulting services and bereavement educational programs.
- **Girls For A Change:** This organization prepares Black girls for the world by helping them visualize their potential through discovery, development and social change innovation within their communities.

- **Great Aspirations Scholarship Program (GRASP):** GRASP works to ensure that every student has an equal opportunity for continuing education after high school, regardless of financial or social circumstances.
- **Greater Richmond Fit4Kids:** This nonprofit organization is dedicated to improving children's health and reducing the prevalence of childhood obesity in the Richmond region. Greater Richmond Fit4Kids offers innovative programs that promote physical activity and healthy eating in schools, community organizations and beyond.
- **Greater Richmond SCAN:** SCAN works to prevent and treat child abuse and neglect throughout the Greater Richmond area by protecting children, promoting positive parenting, strengthening families and creating a community that values and cares for its children.
- **GRTC (Greater Richmond Transit Company):** GRTC serves the City of Richmond, Chesterfield County and Henrico County with newly redesigned bus routes and the launch of PULSE BRT.
- **GRTC CARE (Community Assisted Ride Enterprise):** GRTC CARE provides curb-to-curb public transportation to disabled individuals who may not be reasonably able to use the GRTC fixed route bus.
- **Hanover and King William Habitat for Humanity:** This organization builds affordable homes for families and makes repairs to keep families, particularly older adults, in their homes.
- **Hanover Safe Place:** Hanover Safe Place provides services to victims of sexual or domestic violence and promotes violence prevention.
- **Healing Place/CARITAS:** Healing Place provides substance use rehab for homeless men and women.
- **Healthy Harvest Food Bank:** This food distribution organization offers comprehensive hunger solutions that target the region's most vulnerable neighbors. Serving six counties in Virginia's Northern Neck and Upper Middle Peninsula, it's the only organization of its kind in the region.
- **Henrico County Public Schools Career & Technical Education:** Students who complete CTE programs are prepared for a successful transition into postsecondary education and work. Opportunities are available for students to earn college credit through selected courses and to prepare for licensure and/or industry certifications related to their programs of study.
- **Higher Achievement:** By leveraging the power of communities, Higher Achievement provides a rigorous year-round learning environment, caring role models and a culture of high expectations. The program results in college-bound scholars with the character, confidence and skills to succeed.
- **HOME (Housing Opportunities Made Equal) of VA:** HOME advocates for fair housing by tackling systemically divisive housing practices through fair housing enforcement and research, advocacy and statewide policy work.

- **Homeward:** This planning and coordinating organization offers homeless services in the Greater Richmond region. Homeward's mission is to prevent, reduce and end homelessness by facilitating creative solutions through the collaboration, coordination and cooperation of regional resources and services.
- **Housing Families First:** This organization assists homeless women and their children to build their capacity to live productively within the community. It provides families experiencing homelessness with the tools to achieve housing stability. The goal is not only to assist families in finding permanent housing, but also to ensure that each family has access to the supportive services necessary to sustain housing long-term.
- **Jails and Juvenile Detention in Chesterfield County, Henrico County and Richmond City, Northern Neck Regional Jail, Pamunkey Regional Jail and Federal Correctional Institution in Petersburg:** These facilities partner with the Bon Secours Violence Response Team to promote the best possible outcomes for patients experiencing violence and/or trauma.
- **Justin J. Davis Heart Foundation:** The Justin J. Davis Heart Foundation identifies, shares and provides tools and resources which promote a healthy heart focus/ lifestyle within communities of the Crater Health District.
- **La Casa de la Salud:** This organization provides community-based support and education to Spanish-speaking individuals across the Richmond area.
- **Latinos en Virginia Empowerment Center:** This organization provides education, advocacy and support to Spanish-speaking individuals affected by violence in Virginia and ensures they can access services that empower them to become happy, healthy and self-sufficient.
- **LISC (Local Initiatives Support Corporation) Virginia:** LISC Virginia works with community organizations to revitalize underserved Richmond-area neighborhoods, leading to physical improvements, safer streets, increased property values and highly engaged residents. LISC Virginia supports community development organizations with grants, loans and expertise to help them construct businesses, community centers and affordable homes in low- and moderate-income neighborhoods.
- **Maggie Walker Community Land Trust:** The Maggie Walker CLT seeks to develop and maintain permanently affordable homeownership opportunities for low- and moderate-income households.
- **Medical Society of Virginia:** This physician-led organization provides medication assistance programs for uninsured patients.
- **Metropolitan Richmond Sports Backers:** This organization seeks to inspire people from all corners of the Greater Richmond community to live actively.

- **Middle Peninsula Northern Neck Community Services Board:** Serving the 10 counties of the Middle Peninsula and Northern Neck, this board provides services related to early intervention, intellectual disabilities, mental health, substance use prevention and treatment.
- **Multi-disciplinary/Sexual Assault/Domestic Violence Response Taskforces in Charles City County, Chesterfield County, Colonial Heights, Fort Lee/Kenner Army Health Clinic, Goochland County, Hanover County, Henrico County, City of Hopewell, King William County, King and Queen County, Louisa County, New Kent County, Northumberland County, Petersburg County, Powhatan County, City of Richmond, Richmond County and Westmoreland County:** As partners of the Bon Secours Violence Response Team, these task forces promote the best possible outcomes for patients experiencing violence and/or trauma.
- **National Alliance on Mental Illness (NAMI) Virginia:** NAMI Virginia was created in 1984 to provide support, education and advocacy for individuals and families in Virginia affected by mental illness.
- **Neighborhood Resource Center (NRC):** NRC builds relationships, advocates for positive change, shares resources and develops skills to enhance residents' lives through programs and partnerships in the Greater Fulton area of Richmond.
- **NextUp RVA:** NextUp provides RVA youth a strong system of accessible and equitable out-of-school time and expanded learning resources.
- **Northern Neck Family YMCA:** The YMCA offers youth development and physical activity programming.
- **Partnership for Housing Affordability:** The Richmond regional housing framework is for Chesterfield County, Hanover County, Henrico County, the City of Richmond and the Town of Ashland. The Partnership enables local officials and community representatives to implement solutions that will increase housing opportunities across the region.
- **Partnership for Smarter Growth:** This organization focuses on educating and engaging the communities in the Richmond region to work together to improve quality of life by guiding where and how we grow, including transportation services.
- **Peter Paul Development Center:** This community center in Richmond's East End offers child, youth and adult services, including a Senior Center Adult Day Care.
- **project:HOMES:** This organization improves the safety, accessibility and energy efficiency of existing houses and builds high-quality affordable housing throughout Central Virginia. project:HOMES serves low-income individuals and families by making critical home safety repairs and accessibility modifications and implements energy conservation measures in their homes.
- **Reach Out and Read:** Reach Out and Read prepares America's youngest children to succeed in school by partnering with doctors to prescribe books and encourage families to read together.

- **REAL LIFE:** REAL LIFE serves individuals impacted by incarceration, homelessness or a substance use disorder by giving them an opportunity to overcome their personal and community barriers that hinder their pathway to a thriving life.
- **Richmond Behavioral Health Authority (RBHA):** RBHA provides services in four major behavioral health areas: mental health, intellectual disabilities, substance use disorders, and access, emergency and medical services.
- **Richmond Hill Armstrong Leadership Program:** Richmond Hill is an ecumenical Christian fellowship and residential community that serves as stewards of an urban retreat center within a historic monastery. The Armstrong Leadership Program provides students with leadership training, personal development, mentoring, service projects, career and college preparation, weekend retreats and cultural enrichment.
- **Richmond Metropolitan Habitat for Humanity (RMHFH):** RMHFH is a nonprofit, non-proselytizing Christian housing ministry committed to making affordable and safe housing a reality for low-income families.
- **Richmond Metropolitan Transportation Authority:** The mission of the RMTA is to build and operate a variety of public facilities and offer public services, especially transportation-related, within the Richmond metropolitan area, each of which is operated and financed primarily by user fees.
- **Richmond Opportunities, Inc. (ROI):** ROI supports community transformation by creating pathways to self-sufficiency for people residing in Richmond's public housing communities.
- **RideFinders:** RideFinders offers real-time ride matching with interested commuters in your area who share similar work locations and hours.
- **River Street Education:** River Street Education's mission is to create a diverse and vibrant marketplace that connects local farmers, artisans and artists with the Petersburg community. Through its year-round farmers market, events and initiatives, River Street aims to support local farmers, promote healthier food options and enhance the overall well-being and vibrancy of Petersburg and surrounding areas.
- **Robinson Theater Community Arts Center (RTCAC):** RTCAC is a multi-purpose facility that inspires, encourages and restores healthy community life to the residents of the North Church Hill area of Richmond.
- **RVA Rapid Transit:** RVA Rapid Transit's mission is to connect all people of the Richmond region as we educate, organize and advocate for the design, construction and operation of a first-class metro-area rapid transit system.
- **Rx Partnership:** Rx Partnership increases medication access for vulnerable Virginians and strengthens the health safety net.

- **Sacred Heart Center:** Sacred Heart Center offers many programs to the Latino community, including English as a Second Language, GED Prep in Spanish, Plaza Comunitaria – Spanish Literacy, Citizenship, Pasitos Exitosos: First Steps to Success (a bilingual school-readiness program), College & Career Bound, Cielito Lindo summer camp, Latino Leadership Institute and more.
- **Safe Harbor:** Safe Harbor offers comprehensive services and support for people who are experiencing or have experienced domestic violence, sexual violence or human trafficking. Working from a trauma-informed and empowerment-focused lens, Safe Harbor seeks to help clients understand and address the impact of trauma and build resilience.
- **Salvation Army Red Shield Youth Center of Richmond:** Provides a safe, structured place where young people can laugh, learn, grow and belong through enrichment, academic support, character development, arts, sports and spiritual guidance.
- **Science Museum of Virginia:** The Science Museum of Virginia promotes Science, Technology, Engineering, Math and Health Care (STEMH) career interests within the region.
- **Shalom Farms:** Shalom Farms grows healthy produce and distributes it to underserved communities. They provide learning opportunities for children and adults on growing food, overcoming barriers to cooking and eating nutritionally.
- **Shepherd's Center of Chesterfield:** This is an interfaith ministry of older adults volunteering to improve the lives of other older adults, including medical transportation services.
- **Side by Side VA:** Side by Side creates supportive communities where Virginia's LGBTQ+ youth can define themselves, belong and flourish.
- **SOAR365 (formerly Greater Richmond ARC):** In partnership with families, SOAR365 creates life-fulfilling opportunities for individuals with disabilities.
- **Stop Child Abuse Now (SCAN):** SCAN's mission is to prevent and treat child abuse and neglect throughout the Greater Richmond area by protecting children, promoting positive parenting, strengthening families and creating a community that values and cares for its children.
- **SupportWorks Housing (formerly Virginia Supportive Housing):** SupportWorks Housing seeks to end homelessness by providing permanent housing and supportive services.
- **SwimRVA:** SwimRVA works to build social bridges through aquatics that cross physical, racial and economic barriers. SwimRVA serves as a catalyst for water safety, health and fitness, sports tourism, competitive aquatics and possibility for all Richmonders.
- **The Faces of Hope of Virginia, Inc:** This organization strives to educate children and their families about healthy options and encourages personal empowerment to make significant strides toward preventing and fighting childhood and adult obesity.

- **The Faison Center:** This school addresses the unique learning needs of children with autism.
- **The Hanover Center for Trades & Technology:** This organization strives to create effective partnerships among students, parents, staff and the community. It enables students to become workplace-ready and develop into lifelong learners prepared to succeed in a competitive and ever-changing world.
- **The Positive Vibe Foundation:** Positive Vibe is a nonprofit dedicated to providing transformative training and coaching to help individuals with disabilities lead fulfilling and independent lives.
- **United Methodist Family Services (UMFS):** UMFS offers a network of flexible community-based services. Mentoring, community respite, visitation, community-based clinical support and parent coaching are just a few of the formal and informal offerings to support at-risk families.
- **United Way of Greater Richmond & Petersburg:** Through coalition building, regional leadership, program investments and fundraising, United Way mobilizes the caring power of our community to advance the common good. They focus on the building blocks of a good life, including education.
- **University of Richmond Bonner Center for Civic Engagement:** This center offers volunteering, community-based learning and research focused on community relationships and impacting the Richmond community. University of Richmond is home to one of the largest Bonner Scholars Programs in the country.
- **Virginia Asthma Coalition:** With an emphasis on Richmond's East End, these organizations and individuals are devoted to reducing the morbidity and mortality associated with asthma.
- **Virginia Center for Inclusive Communities (VCIC):** Through workshops, retreats and customized programs that raise knowledge, motivation and skills, VCIC develops leaders who work together to achieve success throughout the Commonwealth.
- **Virginia Community Development Corporation (VCDC):** VCDC serves as a leader developing innovative affordable housing and revitalization of Virginia's communities by acting as a catalyst for creative and profitable private sector investments and by empowering nonprofit and other providers throughout the Commonwealth.
- **Virginia Health Care Foundation:** This foundation promotes and funds local public-private partnerships that increase access to primary health care services for medically underserved and uninsured Virginians.
- **Virginia Home for Boys and Girls (VHBG):** VHBG helps children across Virginia with emotional and behavioral health concerns by facilitating the healing process using a relationship-based, cognitive behavioral approach.

- **Virginia Hospital & Healthcare Association (VHHA) Foundation:** The VHHA Foundation supports collaboration, research and education in health care. It is on a mission to work with our hospital and health care partners to improve the overall health and well-being of the communities they serve and to be a guiding light on the road to a safer, more inclusive and accessible health care system.
- **Virginia Interfaith Center for Public Policy:** The center engages people of faith and goodwill to advocate for economic, racial and social justice in Virginia's policies and practices through education, prayer and action.
- **Virginia Literacy Foundation:** The Virginia Literacy Foundation provides funding and technical support to private volunteer literacy organizations throughout Virginia via challenge grants, training and direct consultation.
- **Virginia Poverty Law Center:** Virginia Poverty Law Center uses advocacy, education and litigation to break down systemic barriers that keep low-income Virginians in the cycle of poverty.
- **Voices for Virginia's Children:** Through championing public policies that improve the lives of Virginia's children, Voices for Virginia's Children identifies unmet needs and threats to child well-being, recommends sound policy solutions, provides objective input to policymakers and educates and mobilizes leaders and concerned citizens to support policy initiatives.
- **YMCA of Greater Richmond:** The YMCA offers after-school youth development and physical activity programming. YMCA out-of-school time (OST) programs benefit youth, families and schools by delivering accessible childcare, supporting learning recovery, fostering social-emotional development and promoting healthy daily activity. By offering safe and structured environments during high-risk hours — before- and after-school, on school holidays and all summer — these programs help prevent risky behaviors and reduce victimization.
- **YWCA Richmond:** YWCA Richmond helps women, children and families in the community of Richmond, VA through programs to eliminate racism and empower women.

Board Approval

Bon Secours Richmond 2026-2028 Community Health Implementation Plan was approved by the Bon Secours Richmond Board of Directors on April 28, 2026.

Board Signature: _____

Date: 4/28/26

For further information or to obtain a hard copy of this Community Health Implementation Plan, please email Becky Clay Christensen at rebecca_christensen@bshsi.org, Sean O'Brien at sean_obrien@bshsi.org and Kerrissa MacPherson at kerrissa_macpherson@bshsi.org.

Bon Secours CHIP Website: https://www.bonsecours.com/about-us/community-commitment/community-health-needs-assessment

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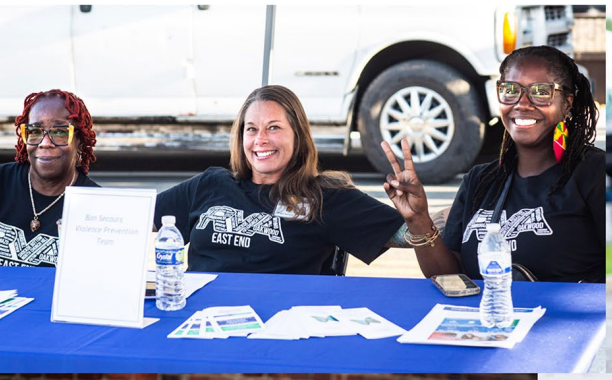

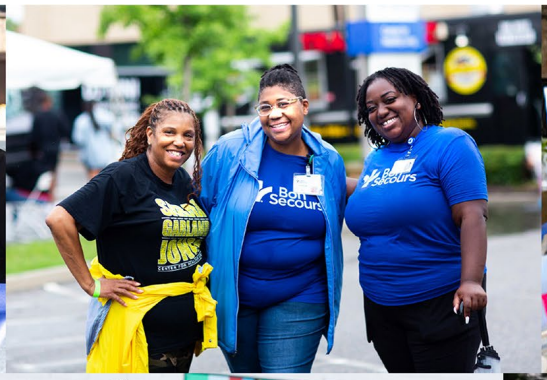

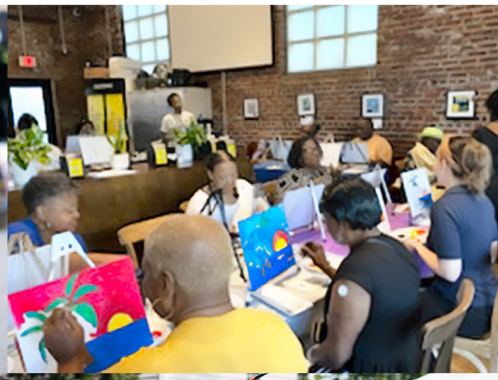

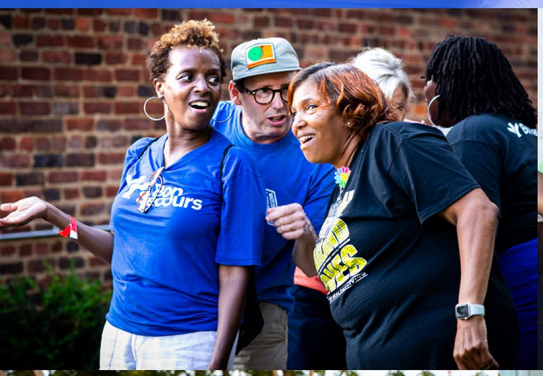

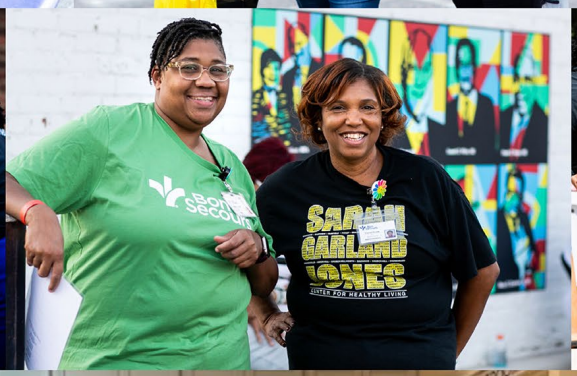

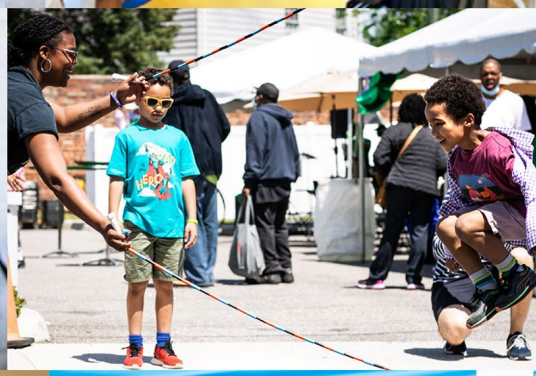

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