BON SECOURS RICHMOND HEALTH SYSTEM
CY 2021-2023 IMPLEMENTATION PLAN

The Bon Secours Richmond Health System Community Health Needs Assessment (CHNA) Implementation Plan utilizes the findings from the 2020 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 Southside Medical Center and Southern Virginia Medical Center. 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 community conversations were held. Quantitative data from various sources was collected and analyzed.

Two Community Conversations were held as part of the CHNA process in which 62 individuals participated from the jurisdictions of Brunswick, Dinwiddie, Chesterfield, Greensville, Petersburg, and Prince George within the Richmond South Core Service Area. The purpose of the conversation was to elicit feedback from community members about publicly 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) Identify the top 3 health issues that could be addressed over the next 2 years 2) Identify root causes contributing to this health issue (i.e. social determinants, racism, inequities, etc.) and 3) Identify what is currently being done to help address this health issue and where there are there gaps.

Conversations with 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 both hospital's Administrative Leadership Teams prioritized the following areas of focus for 2021-2023:

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: https://www.bonsecours.com/about-us/community-commitment/community-health-needs-assessment

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 Southside Medical Center and Southern Virginia Medical Center, 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 2030 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, the majority of localities within the core service area have slightly higher rates of uninsured individuals.

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.[2]

The two leading causes of death in the Virginia area are reported as cancer and heart disease. Diabetes is reported as the 7th leading cause of death. These are avoidable conditions that are largely impacted by the places where we live, learn, work, worship and play.

Food insecurity also has a significant impact on the development and management of chronic diseases. In the core services area, food insecurity rates are significantly higher when compared to other localities and regions in Virginia.[3]

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

In the 2021 Bon Secours Community Health Needs Assessment online survey, Chronic Disease was identified by the community as a leading health issue needing to be addressed.

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/2020/overview

[1] www.healthypeople.gov Access to Health Services

[2] http://www.cdc.gov/chronicdisease/overview/index.htm

[3] https://www.arcgis.com/apps/webappviewer/index.html?id=8aefe4aac0fb42f68e8efa368d3eac35

Healthy People 2030:

- 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 2030	**Virginia's Plan For Well-Being 2016 – 2020**
AHS-01 Increase proportion of people with health insurance AHS-04 Reduce proportions of people who can't get medical care when they need it NWS-02 Eliminate very low food security in children 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	2021	• 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	2022	• Work with area Free Clinics and FQHCs to assess safety net capacity and expand access for patients
Support area non-profits providing wellness services	2021	• Healthy food access and services • Disease prevention or improved individual health outcomes
Partner with clinical staff and non-profit organizations to discharge uninsured patients to Medical Homes	2022	• 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	2022	• Provide timely access to care to the uninsured • Reduce preventable hospitalizations
Explore a fixed-site clinic in South Richmond for uninsured	2021	• 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	2021	• Enhance understanding of nutrition for chronic disease patients • Conduct diabetes education and prevention • Teach healthy eating classes to 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	2022	• Leverage the collective influence of congregations to improve overall health status in the service area
Resources Required Funding, Staff, Advocacy		
PARTNERSHIPS		
Access Now Cameron Foundation Chesterfield, Crater, Piedmont, Petersburg, Western Tidewater, Southside, Halifax Health Departments Central Virginia Health Services Cross Over Ministry Feed More Greater Richmond Fit4kids		Honoring Choices Metro Richmond Sports Backers Petersburg Healthy Options Partnerships (PHOPs) Shalom Farms SOAR365 Virginia Healthcare Foundation

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.[4] 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. [5]

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.[6]

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. [7]

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.[8] 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.[9]

[4] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[5] https://www.nimh.nih.gov/health/statistics/disability/us-leading-categories-of-diseases-disorders.shtml
[6] https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
[7] https://www.nih.gov/news-events/opioids-digital-press-kit
[8] https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report
[9] https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

In the 2021 Bon Secours Community Health Needs Assessment online survey, Mental Health, Suicide, and Substance Abuse were all identified by the community as leading health issues needing to be addressed.

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 2030	**Virginia's Plan For Well-Being 2016 - 2020**
MHMD-01 Reduce the suicide rate MHMD-05 Increase proportion of adults with depression who get treatment MHMD-08 Increase proportion of primary care visits where adolescents and adults are screened for depression AH-R09 Increase proportion of public schools with a counselor, social worker, and psychologist 2030 Overarching Theme: • Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.	**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.

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	2022	• Equitable access to behavioral health services for all individuals
Advocate for increased substance abuse and alcohol/drug abuse programs and resources	2022	• 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	2021	• 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	2021	• Provide screenings, support groups, education, and programs
Increase mental health services and awareness in schools	2022	• 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	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	2022	• 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	2022	• 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	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	2022	• 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	Ongoing	• 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 HVIP (Hospital Violence Intervention Program) in Emergency Departments	2021	• Assess and identify the need for behavioral health services, including mental health and substance use disorder • Ensure warm handoff occurs from the point that the need is identified until resources are provided
Increase mental health awareness through annual Opioid education for all staff	Ongoing	• Provide annual opioid training to all staff

Expand Behavioral Health Services available through Community Health Programs	2022	• Identify new providers, volunteers, and partners to enhance services offered via mobile health and fixed-site locations
Expand resources available to employees	Ongoing	• Launch LifeMatters resource to all employees
Required Resources Funding, Partnership, Advocacy		
PARTNERSHIPS		
Cameron Foundation Community Service Boards Family Lifeline NAMI Central Virginia Safe Harbor		United Methodist Family Services Virginia Supportive Housing Voices for Children

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.[10]

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.[11]

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.[12] 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.[13]

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.[14]

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[10] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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

[12] http://www.cdc.gov/healthyplaces/transportation/access_strategy.htm

[13] http://www.cdc.gov/transportation/docs/transportation-fact-sheet.pdf

[14] http://vaperforms.virginia.gov/indicators/education/hsGraduation.php

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 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.

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, childcare, health care, housing, transportation and other necessities compared with hourly income earned. For the localities that make up the core service area, the annual medium household income ranges from $36,000 - $68,900, compared to the Virginia state average of $72,600.[15]

In the 2021 Bon Secours Community Health Needs Assessment online survey, social determinants of health (SDOH) were identified by the community as top root causes of poor health needing to be addressed.

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/

[15] https://www.countyhealthrankings.org/app/virginia/2020/measure/factors/63/data

- http://www.aecf.org/resources/early-warning-why-reading-by-the-end-of-third-grade-matters/

ALIGNMENT WITH NATIONAL/STATE PRIORITIES	
Healthy People 2030	**Virginia's Plan For Well-Being 2016 – 2020**
SDOH-01 Reduce proportion of people living in poverty SDOH-2 Increase employment in working-age people SDOH-04 Reduce proportion of families that spend more than 30% of income on housing AH-08 Increase proportion of high school students who graduate in 4 years EMC-D01 Increase proportion of children who are developmentally ready for school 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	2022	• Increase housing stock for individuals living in the region

Support area non-profits who are expanding home ownership and affordable rental housing options	2022	• Support low-income renters to help stabilize families
Support area non-profits who are closing the gaps along the education achievement continuum	2021	• All children reading at appropriate grade level • Increased STEM opportunities for children
Support area non-profits who are providing early childhood education programs and advocacy	2021	• Increase access to high-quality early childhood education • Provide opportunities for parents to have quality childcare during work hours
Support area non-profits who are providing financial literacy services	2022	• Stabilize individuals and families
Improve neighborhood infrastructure through corridor development	2022	• Align comprehensive services for independent living in economically distressed neighborhoods
Enhance the built environment and promote place-making	2022	• Support long-term sustainability of community spaces • 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	2021	• 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	2022	• 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	Ongoing	• Align clinical case managers with social workers to coordinate care
Hire Community Health Workers to work within communities	Ongoing	• 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	Ongoing	• 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	2022	• 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 Cameron Foundation Capital Region Collaborative Chesterfield CASA Children's Home Society of Virginia		Partnership for Smarter Growth Project Homes Sacred Heart Center Shepherd's Center of Chesterfield Science Museum of Virginia Smart Beginnings Southeast

County Supervisors Family Lifeline Financial Opportunity Centers Greater Richmond Transit Authority (GRTC) Homeward Housing Families First Local Initiatives Support Corporation (LISC) Maggie Walker Community Land Trust	Sports Backers Virginia Community Development Fund (VCDF) Virginia Home for Boys and Girls United Way of Greater Richmond and Petersburg YMCA of Petersburg

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:

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%. [16] This generational stress leads to significantly lower health outcomes for individuals and families.

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. [17] 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. [18]

In the 2021 Bon Secours Community Health Needs Assessment online survey, stress and trauma were identified by the community as top root causes of poor health needing to be addressed.

Evidence Based Sources:

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:

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

- 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 2030	**Virginia's Plan For Well-Being 2016 – 2020**
IVP-D04 Reduce intimate partner violence IVP-D05 Reduce contact sexual violence IVP-15/16 Reduce child abuse and neglect SDOH-05 Reduce proportion of children with a parent or guardian who has served time in jail EMC-D07 Increase proportion of children and adolescents who show resilience to challenges and stress AH-10 Reduce the rate of minors and young adults committing violent crimes 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.	**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	2022	• Address the impacts of trauma and adverse childhood experiences
Support area non-profits who are caring for victims, survivors and at-risk youth of domestic and sexual violence	2021	• Decrease rate of domestic abuse and child abuse/neglect
Support community forums that aim to decrease community violence and crime and childhood trauma	2021	• Work with area organizations, agencies, and government to reduce the negative impacts on individuals and families
Support area Trauma-Informed Community Networks	Ongoing	• 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	2022	• Increase community-based services for victims of trauma and abuse
Support Clinicians Against Gun Violence Campaign	Ongoing	• Identify and organize clinicians who advance positive social change
Provide department specific staff education on trauma informed care	Ongoing	• Increase staff awareness level of trauma and implement interventions to become more trauma-informed

Required Resources Funding, Partnerships, Advocacy	
PARTNERSHIPS	
Cameron Foundation Family Lifeline FVSAU Child Advocacy Center Greater Richmond SCAN	Safe Harbor United Methodist Family Services Voices for Children