RAHD

Community Health Improvement Plan

Mary Washington Healthcare

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A Message from the Core Team

Dear Reader,

The Core Team from Rappahannock Area Health District (RAHD) and Mary Washington Healthcare (MWHC) would like to take a moment to thank the community of Planning District 16 for all of the hard work that was put into the Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) process over the past 11 months. Since we began this process -- from the introduction of the Mobilizing for Action through Planning and Partnerships (MAPP) process through the development of the CHA, and now with the completion of the CHIP -- we have had the privilege of advancing Public Health 3.0 by strengthening existing partnerships, forging new partnerships, and connecting countless unlikely partnerships. The passion and drive in our community is something of which everyone should be proud.

The goal of the CHIP is to use the data that were collected in the CHA to make informed decisions about how the community would like to address the most pressing issues facing our localities today. The CHIP can only be written and implemented with the participation and engagement of the community. After coming out of a tough couple of years with COVID-19, we had hoped for a robust turnout, while still understanding that people are burned out and may not have much capacity to offer. We were overwhelmed by the generosity of time, resources, and effort that were offered during these meetings.

A total of 114 people attended the three Community CHIP meetings. During the strategy solicitation process in the second CHIP Community meeting, we were presented with well over 100 strategy recommendations, which is more than we could have ever hoped for! This initial CHIP contains *3 priorities, 6 goals, 16 objectives, and 45 strategies* from a wide range of community partners, and represents our plans for the future that we want to see in our community.

We sincerely hope that the efforts that were put forth by this amazing group will be appreciated and utilized for years to come. We believe that the strategies in this plan will make a measurable impact on the health of our community.

Sincerely,

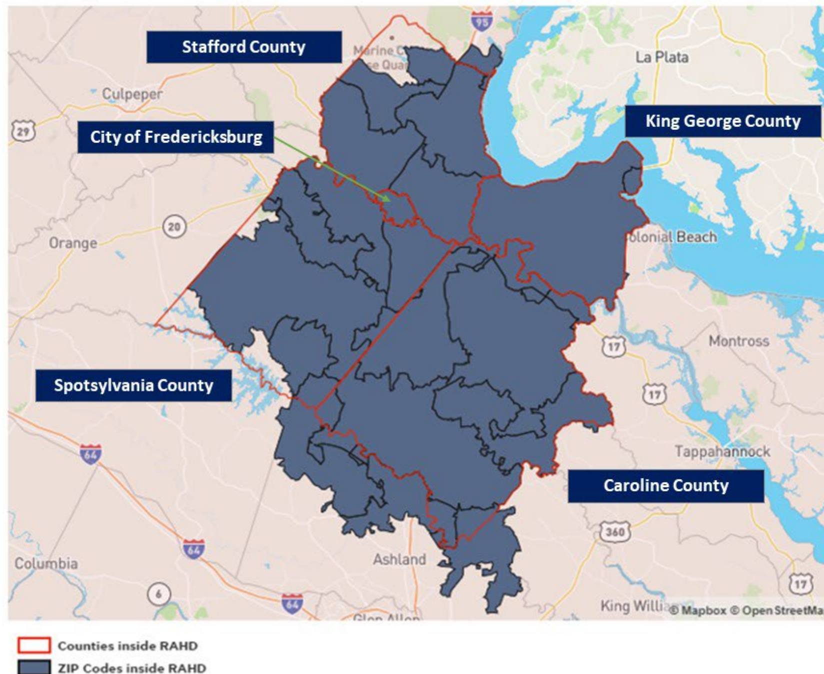
The Core Team

Allison Balmes-John, Ashish Shrestha, Devyn Bell, Naomie Murdock, Olugbenga Obasanjo, Phil Brown, Susie Hammock, and Xavier Richardson

Our Service Area

RAHD is a 1,388-square mile regional health entity composed of five localities in northeast Virginia, including Caroline, King George, Spotsylvania, and Stafford counties as well as the City of Fredericksburg.[1] This area is also known as Planning District 16 (PD16) in accordance with the Planning District Commissions outlined in the Virginia Regional Cooperation Act. This term is frequently used to identify the area by many community partners and community members.

RAHD serves a population of 382,930 people per the 2020 Census estimates. Population counts for each locality range from 27,381 (King George County) to 156,748 (Stafford County). RAHD is composed of both urban and rural areas; RAHD localities cover a wide range of rural population percentages, from 1.2% rural in the City of Fredericksburg to 78.4% rural in King George County.[2] PD16 has seen a tremendous amount of growth over the last decade. According to the US Census Bureau, Stafford County is the 5th fastest growing county in the state, and Spotsylvania is the 7th. The City of Fredericksburg has seen the highest population increase with 21.1% and Caroline County with the lowest with 7.8%. According to the University of Virginia Weldon Cooper Center, Demographics Research Group, the population in RAHD is expected to increase, on average, 16% by 2030.



[1]United States Census Bureau, 2010.

[2] Census Population Estimates, 2010.

Introduction

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)?

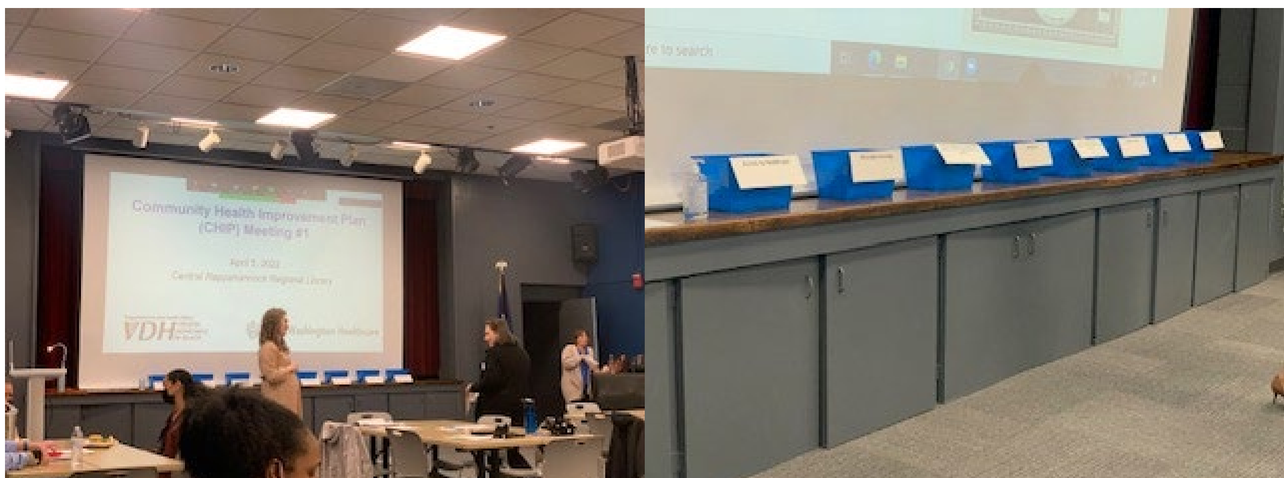
A CHIP is a long-term, systematic effort developed to address the community's most pressing public health issues. The CHIP is based on the results of the Community Health Assessment (CHA). Community partners interested in working toward improving the health and wellbeing of the residents of PD16 were able to review the CHA data and compare them with state and national data to determine the most feasible strategies to address the issues.

HOW WILL THE PLAN BE USED?

The CHIP is used as a structured plan to guide partners through the process of community health improvement. The finalized CHIP contains the goals, objectives, and strategies that were determined by the community that will guide our collective efforts. The progress of the strategies will be tracked continuously and updated quarterly in a separate online dashboard (found here *add link). Members of the CHIP team as well as community members will have access to this information any time through this online dashboard.

HOW WAS THE PLAN DEVELOPED?

This plan was developed by RAHD and MWHC in collaboration with 107 CHIP Community Partners throughout PD16. The formatting of the CHIP was derived from the Kansas Health Institute CHIP Handbook.



A Chronological Overview of the CHIP Process

February 8, 2022: Core Team Meeting

The Core Team (see appendix D) met to discuss the data found in the CHA and compared it with state and national priorities to determine the top 14 issues (see p. 6 for description of the tool that was used). The issues that were chosen during this meeting were (listed in alphabetical order):

1. Access to Healthcare
2. Affordable Housing/Homelessness
3. Alcohol Abuse
4. Cancer
5. COVID-19
6. Education/Literacy
7. Heart Disease/Stroke/Hypertension
8. Infant and Maternal Care in the African American Community
9. Mental Health
10. Obesity
11. Opioid Abuse
12. Public Health Policy and Planning
13. Transportation
14. Workforce Development/Good Jobs

February 23, 2022: CHA/CHIP Steering Team Meeting

The CHA/CHIP Steering Team, which was formed during the CHA process, is comprised of partners from many areas of the Local Public Health System (see Appendix D for list of organizations represented), met to review the data from the CHA for the top 14 priorities that were selected by the Core Team. The team was asked to break into small groups and consider the following questions for each priority to narrow down the list:

1. How many people are affected by this issue?
2. How does the issue affect the quality of life, economic burden on the community, and any other pertinent criteria?
3. Are public health strategies available to successfully address the issue? Is the problem responsive to interventions?
4. What is the level of community concern?
5. How feasible it is to solve this issue in your community, considering political climate, resources, and capacity?

Once individuals from the small groups answered the questions for each priority, they were instructed to rank each priority from 1-14. The priorities with the highest ranking were moved on to the next step which included community input and finalization of the top 3 priorities.

Based on the 5 questions referenced above and the data from the CHA, the CHA/CHIP Steering Team narrowed the top 14 priorities down to the top 8 priorities, which were (listed in no particular order):

1. Mental Health
2. Access to Healthcare
3. Substance Abuse
4. Education
5. Obesity
6. Affordable Housing/Homelessness
7. Infant and Maternal Care in the African American Community
8. Chronic Disease

April 5, 2022: CHIP Community Meeting #1 (hybrid)

After the CHA/CHIP Steering Team met to determine the top 8 priorities, we held the first CHIP Community meeting. During this meeting, we reviewed the CHA process, the social determinants of health and why they are important, the CHA data for the top 8 priorities, the top priorities for the state of Virginia and for the United States, the MAPP process, the CHIP development process, and the use of the feedback that was gathered at this meeting to move forward.

An overview was given of grant funding opportunities from rolling mini grants of up to $5,000 as well as larger grants that will only be available annually, from Mary Washington Hospital Foundation and the Stafford Hospital Foundation. These grant opportunities are an amazing opportunity for partners to accelerate the progress of their strategies as well as a great opportunity for Mary Washington Hospital Foundation and the Stafford Hospital Foundation to support the strategies that are selected.

Once all data were reviewed, participants were given $1,000 in play money and were instructed to “spend” the money on the priorities that they felt were the most pressing to determine the top priorities for the community. Participants had the choice of spreading out their spending or they could put all of it on one or two issues, in whatever manner they wanted to prioritize it. Since this meeting was hybrid, the online participants were given the same exercise and their results were combined with the in-person results. Once all of the money was

"spent", the totals were tallied from both the in-person and virtual groups, and the top 3 priorities were announced. They were: mental health, affordable housing, and access to healthcare.

April 26, 2022: Affordable Housing Goal Setting Meeting

During this focus group session, the Core Team invited a small but diverse group of subject matter experts to discuss the priority area of affordable housing. Initial discussions about where the goals should be focused were based on data and were focused on evidence-based approaches. The group was intentional about setting a solid direction, while still being broad enough to welcome a variety of strategy suggestions. By the end of this meeting, the goals for affordable housing were set.

April 27, 2022: Access to Healthcare Goal Setting Meeting

During this focus group session, the Core Team invited a small but diverse group of subject matter experts to discuss the priority area of access to healthcare. Initial discussions about where the goals should be focused were based on data and were focused on evidence-based approaches. The group was intentional about setting a solid direction, while still being broad enough to welcome a variety of strategy suggestions. By the end of this meeting, the goals for access to healthcare were set.

April 29, 2022: Mental Health Goal Setting Meeting

During this focus group session, the Core Team invited a small but diverse group of subject matter experts to discuss the priority area of mental health. Initial discussions about where the goals should be focused were based on data and were focused on evidence-based approaches. The group was intentional about setting a solid direction, while still being broad enough to welcome a variety of strategy suggestions. By the end of this meeting, the goals for mental health were set.

May 3, 2022: CHIP Meeting #2 (in-person)

During the second CHIP Community meeting, we reviewed all previous steps in the MAPP process, as well as the goals that were determined by the Core Team and select partners in separate goalsetting meetings. We then spilt the large group into the three priority areas, each of which was facilitated by a member of the Core Team. During these small group discussions, community partners were reminded of the goals and were provided with three different colored suggestion forms, with each color representing a different level of strategy suggestion. Those who had strategy suggestions that were based on work that was already being done, and who felt that felt that their work could contribute to the goals that had been set, would fill out the green suggestion form. Those who had an idea for a strategy that was based on something that hadn't been implemented yet, but was very close to being ready, would fill out the yellow suggestion form. Those who had an "outside of the box" idea that needed a lot more support,

funding, etc, would fill out the blue form. Robust discussion was had in each group, and by the end of the meeting, our team had approximately 100 strategy suggestions from the community.

Series of Core Team Meetings

Once the Core Team reviewed all of the strategy suggestions, they were categorized based on the goals for each priority that they would work toward and the color of the form, the team then removed any that did not have sufficient information to move forward as well as those that did not address the goals that had already been established. After that, the team began reaching out to those persons whose strategies passed the initial review in order to determine if they would be feasible. The PEARL Test from NACCHO, which is a simple rubric to help quickly narrow down a long list of strategies to the most likely to succeed, was adapted and used (see Appendix A) to further narrow down the strategies. An effort was made to balance the number of green, blue, and yellow forms. A series of meetings were held to get all of the strategies finalized before the last CHIP Community meeting.

June 21, 2022: CHIP Meeting #3 (hybrid)

The third and final CHIP Community meeting was a hybrid meeting. The purpose of this meeting was to conduct a final overview of all of the steps that had been taken to determine the priorities, goals, objectives, and strategies and to receive any feedback to review before the finalization of the document. The group split into three small groups as well as a virtual group. The groups reviewed all of the strategies and provided any thoughts or feedback. Specifically, the Core Team requested feedback on the populations served (did we miss anyone?) as well as the language used (are we being as inclusive as we can be?). Feedback was recorded for review at a later time. The group then reconvened to celebrate the effort put forth by the community so far and to specifically recognize those who were selected to implement the CHIP.

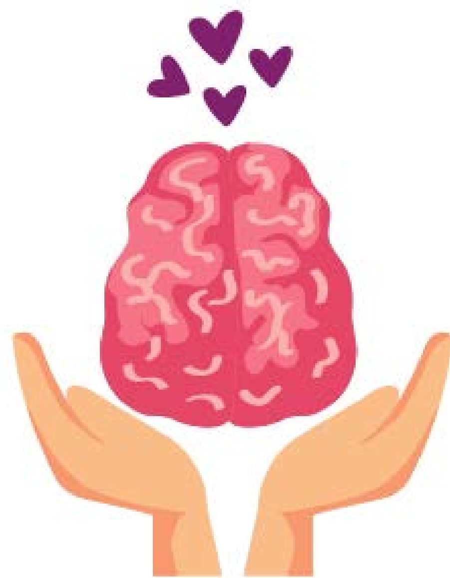
June 30, 2022: Post-CHIP Core Team Meeting

During this Core Team meeting, each of the suggestions gathered from the last CHIP community meeting was reviewed. Those who pointed out how a marginalized group could be included in the existing strategies were noted, and the organizations who agreed to carry out the strategy were contacted to discuss the possible changes. Suggestions that covered brand new strategies were noted, and those who recommended the new strategy were contacted to set up a meeting to discuss the process for adding a strategy. Some suggestions were not feasible or actionable, and those were noted, but no changes were made. A final health equity review was also conducted and recommendations were made to make the plan more equitable.

ACTION PLAN

The following pages contain the action plan of the CHIP. The goals, objectives, and strategies found on these pages are the result of countless meetings, discussions, and deliberations from a large variety of organizations. Every effort was made to ensure that this action plan targets Social Determinants of Health (see Appendix E) and as many underserved and marginalized communities as possible, while also aiming for the largest impact. A list of available resources in PD16 that can be accessed can be found in the appendices (see Appendix B).

This CHIP is a living document that will change over time. As periodic changes are made, they will be recorded in the Record of Adoptions and Changes, which can be found in the appendices (see Appendix C).



PRIORITY 1: MENTAL HEALTH

PRIORITY 1: MENTAL HEALTH

Goal 1: To enhance collaboration among traditional and non-traditional partners to address mental health.

Objective 1: Provide students and staff with resources that facilitate awareness about behavioral health that align with each school and/or division's suicide prevention plans by June 30, 2025.

Strategy 1: Mental Health America of Fredericksburg (MHAfred) will present Signs of Suicide (SOS), an evidence-based suicide prevention education program for middle schoolers and high schoolers, at each school district within PD16 that partners with MHAfred through June 30, 2025. During this same timeframe, MHAfred will also present SOS to other entities such as youth groups, private schools, several homeschools, juvenile detention centers, and underserved communities. Where SOS has been presented, MHAfred will partner with other organizations to support student or youth led clubs that promote mental wellness.

Strategy 2: Rappahannock Area Community Services Board (RACSB) will provide Mental Health First Aid training to a minimum of 10% of personnel in each interested school within PD16 by June 30, 2025.

Strategy 3: By June 30, 2025, RACSB and MHAfred will coordinate the implementation of teen Mental Health First Aid within one high school in PD16 where the criteria set forth by Mental Health First Aid USA is met. Additionally, another high school or school division will be in the implementation process by June 30, 2025.

Strategy 4: Through March 14, 2023, RACSB will pilot the provision of behavioral health services through the Children and Adolescent Behavioral Health Pandemic Supports program to over 100 children in a PD16 school district. The focus will be on children who currently do not receive these services through other mechanisms.

Strategy 5: By June 30, 2023, RACSB will evaluate results from the Children and Adolescent Behavioral Health Pandemic Supports program pilot and modify the program as needed. Results will be communicated to other PD16 school districts looking for expansion opportunities.

Social Determinants of Health Addressed in this Goal

Education Access and Quality and Social and Community Context

Responsible Partners

Mental Health America Fredericksburg (MHAfred) and Rappahannock Area Community Services Board (RACSB)

PRIORITY 1: MENTAL HEALTH

Goal 2: To improve access to behavioral health services, including prevention, treatment, and recovery.

Objective 1: Expand access to, and awareness of, telehealth behavioral health services in at least one rural community within PD16 by March 31, 2023.

Strategy 1: Starting July 1, 2022 and ending March 31, 2023, MHAfred will work with Caroline County stakeholders to evaluate strategies for overcoming barriers to accessing telehealth mental health services for residents without internet and with limited transportation options. The evaluation results will determine additional strategies.

Objective 2: Increase normalization of, and education about, currently available mental health resources, especially to underserved populations by June 30, 2025.

Strategy 1: Through June 30, 2025, RACSB and MHAfred will partner to promote existing services, such as counseling, emergency services, telehealth, grief counseling, support groups, and new 988 services through social media, websites, community partners, and tabling events, in English and at least one additional language.

Strategy 2: Through June 30, 2025, RACSB will continue to promote and host evidenced-based curriculums including but not limited to: ACE Interface; Mental Health First Aid; safeTALK; Applied Suicide Intervention Skills Training (ASIST); and REVIVE! to stakeholders and interested community members (including African-American, Asian, disabled, Latinx, and LGBTQIA+ communities).

Strategy 3: Starting July 1, 2022 to June 30, 2025 MHAfred and RAHD will partner to market the HELPLINE using print media, social media, and outreach to underserved population groups and primary care physicians. MHAfred will increase the number of HELPLINE follow-ups per year from 1,200 to 10,000.

Social Determinants of Health Addressed in this Goal

Education Access and Quality; Health Care and Quality; and Social and Community Context

Responsible Partners

Mental Health America Fredericksburg (MHAfred) and Rappahannock Area Services Board (RACSB)

PRIORITY 2: AFFORDABLE HOUSING

PRIORITY 2: AFFORDABLE HOUSING

Goal 1: To develop and promote policies that ensure equitable housing opportunities for all.

Objective 1: Form a diverse group of advocates to address the issue of Affordable Housing in PD16 by December 31, 2022.

Strategy 1: By July 1, 2022, George Washington Regional Commission (GWRC) will identify members of the community with a vested interest in the issue of affordable housing to participate in the group.

Strategy 2: GWRC will create a framework document, which will include assigning roles and responsibilities and identifying top priorities of the group, by December 31, 2022.

Objective 2: Develop and implement strategies to address top priorities of the group by June 30, 2025.

Strategy 1: Develop strategies to address top priorities of the group by December 31, 2023.

Strategy 2: Have at least 1 meeting with each local government, including rural localities, to discuss the identified priorities of the group by June 30, 2025.

Strategy 3: Meet with state representatives to discuss the identified priorities of the group by June 30, 2025.

Social Determinants of Health Addressed in this Goal

Neighborhood and Built Environment; Social and Community Context; and Economic Stability

Responsible Partners

George Washington Regional Commission, Fredericksburg Area Association of Realtors, Caroline County Habitat for Humanity, Greater Fredericksburg Habitat for Humanity, Healthy Generations, Micah Ecumenical Ministries, Tricord Inc, and private citizens

PRIORITY 2: AFFORDABLE HOUSING

Goal 2: Increase the number of safe, sustainable communities with affordable housing options throughout PD16.

Objective 1: By June 30, 2025, increase the number of new homes built in PD16 for underserved populations.

Strategy 1: A collaborative, compromised of Micah Ecumenical Ministries, Virginia Supportive Housing, Mary Washington Healthcare, and the City of Fredericksburg, will evaluate potential housing sites and recruit partners for a multi-faceted housing development for the street and chronic homeless population. Site control and zoning permission will be in place by March 2023. The development will include 60-80 multifamily units developed by Virginia Supportive Housing and 30-50 small, single-family detached or duplex homes known as the Jeremiah Community, which will be developed by Micah Ecumenical Ministries.

Strategy 2: The collaborative will obtain necessary resources and approvals for site development for construction to begin by Spring 2024.

Strategy 3: The collaborative will develop a robust network of support services targeted for the people moving into the housing development by June 20, 2025.

Social Determinants of Health Addressed in this Goal

Neighborhood and Built Environment; Social and Community Context; and Economic Stability

Responsible Partners

Micah Eumenical Ministries, Virginia Supportive Housing, Mary Washington Healthcare (MWHC), and City of Fredericksburg

PRIORITY 3: ACCESS TO HEALTHCARE

PRIORITY 3: ACCESS TO HEALTHCARE

Goal 1: To improve access and collaboration for preventative services for all members of the community.

Objective 1: Expand Diabetes Prevention and Blood Pressure Self-Monitoring programs into the community by leveraging collaborations with traditional and non-traditional partners, focusing on population groups with existing disparities (e.g. African Americans, Hispanics, Native Americans, Seniors, low income) by June 30, 2025.

Strategy 1: The Rappahannock Area Young Men's Christian Association (YMCA) will join the Unite Us network of community providers to streamline the referral process for the Diabetes Prevention and Blood Pressure Self-Monitoring programs by December 31, 2022.

Strategy 2: The Rappahannock Area YMCA, MWHC, and other organizations will educate and provide program awareness to healthcare providers, Care Coordinators, Community Health Workers, and community leaders by providing periodic presentations starting by November 30, 2022 and continuing on a quarterly basis.

Strategy 3: The Rappahannock Area YMCA, MWHC, and other organizations will train one additional facilitator per locality, including correctional staff, to support the Diabetes Prevention and Blood Pressure Self-Monitoring programs by June 30, 2025.

Objective 2: Provide opportunities for patients throughout PD16 to improve their health literacy by June 30, 2025.

Strategy 1: RAHD will train two RAHD staff and two Healthy Generations staff to be trainers of the Health Education and Literacy (HEAL) program by September 30, 2022.

Strategy 2: By December 31, 2022, RAHD will create a training schedule to improve health literacy by working with organizations that serve the elderly, lower income neighborhoods, Spanish speaking communities, and the incarcerated and recently released population, while expanding the training to other populations impacted by health disparities and inequities.

Strategy 3: From January 1, 2023 through June 30, 2025, RAHD will host at least four HEAL trainings per quarter at public libraries and other community locations throughout PD16, including rural and underserved communities.

PRIORITY 3: ACCESS TO HEALTHCARE

Goal 1: To improve access and collaboration for preventative services for all members of the community.

Objective 3: Increase utilization of the Unite US platform in PD16 from 90 programs by 25% (approximately 23 programs) related to top three identified CHIP priorities (mental health, affordable housing and access to healthcare) in PD16 by June 30, 2025.

Strategy 1: RAHD and MWHC will increase awareness of the Unite US user group by providing quarterly educational sessions starting October 1, 2022 to improve equitable access to services through June 30, 2025.

Strategy 2: RAHD and MWHC will work with providers to increase the number of service episodes for the Unite Us platform specific to mental health, affordable housing, and access to healthcare in PD16 from 151 by 20% (approximately 30 service episodes) each year through June 30, 2025.

Objective 4: Through June 30, 2025 train residents of PD16 on how to use the regional transit system to ensure transportation to healthcare appointments is more achievable.

Strategy 1: Through June 30, 2025, Healthy Generations will use their Transit Travel Training program to train 50 residents of PD16 per year, especially the elderly and disabled, how to utilize FXBGO! Fredericksburg Regional Transit.

Strategy 2: Through June 30, 2025, Healthy Generations will train 36 members of the public per year how to use FXBGO! Fredericksburg Regional Transit to ensure that they can then train others.

Objective 5: Provide support to HIV positive residents and continue to work on HIV prevention initiatives through June 30, 2023.

PRIORITY 3: ACCESS TO HEALTHCARE

Strategy 1: From July 1, 2022 to December 31, 2022, through "COVID Safe Outreach and Testing Events" Fredericksburg Area Health and Support Services (FAHASS) will provide HIV testing to 100 people from remote, low-income communities, and screen, refer, and connect 25 people to other services they may need, including mental health, housing, and the insurance marketplace.

Strategy 2: FAHASS will work with Mosaic Care Center to enroll 20 new people in the PrEP program, which includes monitoring and targeted PrEP treatment from January 1, 2023 to December 31, 2023.

Strategy 3: Starting July 1, 2022 until June 30, 2023, FAHASS will continue to expand Medical and Non-Medical Case Management to HIV+ individuals, ensuring that they are in care and improving the viral suppression rate of the agency from 94% to 96%. FAHASS will also work with Mosaic Care Center to access people living in remote areas via telemedicine.

Social Determinants of Health Addressed in this Goal

Education Quality and Access; Health Care Quality and Access; Social and Community Context; and Economic Stability

Responsible Partners

Rappahannock Area YMCA, Mary Washington Healthcare (MWHC), Rappahannock Area Health District (RAHD), Healthy Generations, Fredericksburg Area Health and Support Services (FAHASS), Mosaic Care Center

PRIORITY 3: ACCESS TO HEALTHCARE

Goal 2: To support the development of a comprehensive strategy and pipeline to increase the community's healthcare workforce.

Objective 1: Create a new Patient Care Technician (PCT) position that would allow students to acquire both Certified Nurse Aide (CNA) and Clinical Medical Assistant (CMA) certifications in 12 weeks and sit for a single certification by January 31, 2024.

Strategy 1: Germanna Community College (GCC) will secure funding for PCT instruction and student support by June 30, 2023.

Strategy 2: GCC will develop PCT curriculum, which will include health equity and cultural humility training, by June 30, 2023.

Strategy 3: GCC will implement PCT program by January 31, 2024.

Objective 2: Expand Dual Enrollment offering for CNA and RMA programs within high schools throughout the service area by June 30, 2025

Strategy 1: GCC will increase the number of dual enrolled students in area high schools, which will include those in rural and underserved areas, by establishing two additional Nurse Assistant/Medication Aide programs within the college service by January 31, 2025

Strategy 2: GCC and other philanthropic organizations will assist with a minimum of $50,000 in student fees through grants and scholarships (with at least 5% of students being minorities or from underserved areas) through June 30, 2025.

Strategy 3: GCC will help develop a minimum of seven hiring contracts between students and clinical agencies through June 30, 2025. When possible, these contracts will be associated with tuition payment in exchange for a designated amount of service at the facility. At least one contract will be for a minority or disabled student.

PRIORITY 3: ACCESS TO HEALTHCARE

Goal 2: To support the development of a comprehensive strategy and pipeline to increase the healthcare workforce.

Objective 3: Build a career ladder for mental health providers by June 30, 2024

Strategy 1: GCC, in partnership with RACSB, will develop a career plan for mental health jobs with course offerings, training, certifications, and degree programs by GCC, professional organizations, and local organizations, including health equity and cultural humility training, by June 30, 2023.

Strategy 2: GCC, in partnership with RACSB, will secure any necessary approvals and funding for the courses, certifications, and degree programs by December 21, 2023.

Strategy 3: GCC, in partnership with RACSB, will begin offering courses leading to mental health certifications, licensing, and/or degrees by June 30, 2024, ensuring these programs will be available to those in underserved areas.

Objective 4: Expand GCC nursing program to graduate 220 registered nursing candidates per year by June 30, 2025

Strategy 1: GCC will expand the current nursing facilities by January 31, 2024 to allow for the admission of an additional 130 nursing students annually, with at least 5% of students being either minority, disabled, or individuals over 60 years old.

Strategy 2: GCC will hire nine additional full-time nursing faculty, including at least one minority, disabled, or over 60 years old faculty member, by June 30, 2025 to provide didactic and clinical instruction for incoming students.

Strategy 3: By June 30, 2025, GCC will secure additional clinic sites throughout the region, including rural and underserved areas, to accommodate additional clinicals for students.

Strategy 4: By June 30, 2025, GCC will hire adjunct faculty to provide clinical instruction for nursing students unable to be facilitated by full time faculty.

PRIORITY 3: ACCESS TO HEALTHCARE

Goal 2: To support the development of a comprehensive strategy and pipeline to increase the healthcare workforce.

Objective 5: Support current mental health providers within PD16 and students working towards mental health credentials by March 31, 2025.

Strategy 1: Starting July 1, 2022 and ending March 31, 2025, MHAfred will provide additional support to providers listed in MHAfred's HELPLINE, including networking opportunities, monthly newsletters, expanding the number of providers offering supervision to students seeking a degree and graduates seeking licensure by 50, and increasing the number of providers using the Unite US platform by 50%.

Strategy 2: Starting July 1, 2022 and ending March 31, 2025, MHAfred and GCC will partner and work to offer 240 volunteer hours per year to students enrolled in Germanna's Paraprofessional Counseling Career Studies Certificate program and need direct and indirect service hours. The volunteer hours will come from working on the HELPLINE and support programs.

Social Determinants of Health Addressed in this Goal

Education Quality and Access; Health Care Quality and Access; Social and Community Context; and Economic Stability

Responsible Partners

Germanna Community College (GCC), Rappahannock Area Community Services Board (RACSB), Mental Health America of Fredericksburg (MHAfred)

APPENDICES

APPENDIX A: PEARL TEST

The PEARL Test is a prioritization tool that is provided by the National Association of City and County Officials (NACCHO). This tool is used in the MAPP process to narrow down a long list of strategies based on logic and reason. This allows us to remove bias and to implement strategies based on a set of standards. This has been adapted to our needs.

For each strategy suggestion, ask:
Is the strategy consistent with the essential services and public health principles? (Yes/No)
Is the strategy financially feasible? (Yes/No)
Does it make economic sense to apply this strategy? (Yes/No)
Will the stakeholders and the community accept the strategy? (Yes/No)
Is funding likely to be available to apply this strategy? (Yes/No)
Are organizations able to offer personnel time and expertise or space needed to implement this strategy? (Yes/No)
Do current laws allow the strategy to be implemented? (Yes/No)
What is the potential impact on the strategic goal? (Low/Medium/High)
What is the cost of this strategy in terms of dollars, people, and time? (Low/Medium/High)
Is it likely that the strategy can be successfully implemented? (Yes/No)
Does the strategy address inequities? (Yes/No)

Source: https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

APPENDIX B: ASSET LIST

A full list of resources available to community members and organizations throughout PD16 can be found here

This list will be updated annually. If you would like to make an addition to the list or if you see a correction that needs to be made, please contact us. Just specify that you are interested in making a change to the asset list and someone will be in contact with you to discuss your suggestion.

APPENDIX C: RECORD OF ADOPTIONS AND CHANGES

This plan was initially adopted on:		
Changes Made	**Person Responsible**	**Date of Change**

This table is to be used by RAHD and MWHC staff only. The original copy will be updated as continuously as needed, however the online version will only be updated quarterly. All records of change may not be visible if viewing the online version.

APPENDIX D: CORE TEAM AND STEERING TEAM LIST

The Core Team

Rappahannock Area Health District:

Allison Balmes-John, Population Health Manager

Ashish Shrestha, Population Health Data Analyst

Devyn Bell, Community Engagement Specialist

Olugbenga Obasanjo, MD, District Health Director

Susie Hammock, Accreditation and Quality Improvement Coordinator

Mary Washington Healthcare:

Naomie Murdock, Manager of Community Programs

Phil Brown, Director of Corporate Strategy

Xavier Richardson, Senior Vice President and Chief Corporate Development Officer, Mary Washington Hospital; President of Mary Washington Hospital and Stafford Hospital Foundations

CHA/CHIP Steering Team Organizations

- Central VA Housing Coalition
- Community Foundation of the Rappahannock River Region
- Disability Resource Center
- Fredericksburg City Public Schools
- Fredericksburg Branch NAACP
- Fredericksburg Regional Food Bank
- Healthy Generations Area Agency on Aging
- Geico
- George Washington Regional Commission
- Germanna Community College
- Local Pediatrician
- Mary Washington Healthcare
- Mayfield Civic Association
- Rappahannock Area Community Services Board
- Rappahannock Area Health District
- Rappahannock EMS Council
- Rappahannock United Way
- Smart Beginnings Rappahannock Area
- Stafford County Government

APPENDIX E: ABBREVIATIONS // TERMINOLOGY

Abbreviations:

CHA – Community Health Assessment // interchangeable with CHNA, or, Community Health Needs Assessment

CHIP – Community Health Improvement Plan

MWHC – Mary Washington Healthcare

RAHD – Rappahannock Area Health District

Terminology:

Core Team – The Core Team is a small group of people from both RAHD and MWHC who worked collaboratively to produce both the CHA and the CHIP.

CHA/CHIP Steering Team – This team also assisted with both the CHA and the CHIP. During the CHIP process the Steering Team was vital in narrowing down the initial 14 priority areas to 8 priority areas.

Goal – A goal is a broad idea that we are working toward.

Objective – Less broad idea about what the strategies should lead up to, which also leads toward the goal. Our objectives are considered SMART. They are Specific, Measurable, Attainable, Realistic, and Time-Bound

PEARL Test - The PEARL Test is a tool that is provided by the National Association of City and County Officials (NACCHO). This tool is used in the MAPP process to narrow down a long list of strategies based on logic and reason. This allows us to remove bias and to implement strategies based on a set of standards.

Public Health 3.0 - Refers to the period from the late 19th century through much of the 20th century when modern public health became an essential governmental function with specialized federal, state, local, and tribal public health agencies.[3] During this period, public health systematized sanitation, improved food and water safety, expanded our understanding of diseases, developed powerful prevention and treatment tools such as vaccines and antibiotics, and expanded capability in epidemiology and laboratory science.

[3] Centers for Disease Control and Prevention. (Link)

Terminology (continued):

Strategy – A very specific idea of how to achieve the objective and ultimately the goal. Strategies were determined by community partners and will be carried out by community partners. Our strategies are considered SMART. They are Specific, Measurable, Attainable, Realistic, and Time-Bound.

Social Determinants of Health – the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[4]

Subject Matter Expert – A person who is considered an expert in their field, or at least in some part of their field. Subject matter experts were involved in the entire CHIP process, but were especially important in the goal setting phase.

[4] Centers for Disease Control and Prevention. (Link)