VIRGINIA
No Wrong Door
ACCESS. OPTIONS. ANSWERS.

PRINCE WILLIAM
RAPPAHANNOCK-RAPIDAN

2023 ACCELERATOR PLAN:

Prince William & Rappahannock-Rapidan Areas of Virginia

INTRODUCTION

A No Wrong Door to Addressing Social Connectedness and Food Security

What are Social Determinants of Health (SDOH)?

Social Determinants of Health (SDOH) are the nonmedical factors that shape daily life and influence health and wellbeing—they are the environments where people are born, live, work, play, worship, and age.

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has identified five SDOH domains that are strongly linked to our health:

- **Built Environment //** Where we live has a lot to do with how healthy we are. Neighborhoods that provide residents with safe housing, schools, parks, and transportation, help us achieve and keep up good health.
- **Community-Clinical Linkages //** Access to reliable and affordable medical care is key to good health, especially for people in need of long-term supports. When health care, public health and community organizations work together, we all get better care.
- **Food and Nutrition Security //** What we eat plays a big role in maintaining good health and avoiding unnecessary trips to the doctor, which is why reliable access to enough high-quality food to avoid hunger and stay healthy is so important.
- **Social Connectedness //** Our relationships with other people and the sense of belonging we receive from being in community has a big impact on health. Positive bonds improve our well-being. Toxic social bonds can be harmful. Social support can protect us from the unhealthy effects of stress, trauma, anxiety and depression.
- **Tobacco-Free Policy //** Tobacco-free policies are preventive measures to help reduce tobacco use and tobacco-related illness and death. They can reduce the number of people who start to use tobacco, help people quit using tobacco, and protect people from exposure to tobacco products and secondhand smoke.

Why It All Matters

Social determinants of health offer a powerful way to understand the health and wellbeing of people in communities. In which SDOH domains does my community thrive? Where could improvements be made? Strategic policy, system, environment (PSE) and programmatic changes that address SDOH can improve equitable access to education, healthy food, social support, healthcare, housing and transportation—helping all Virginians live healthier lives.

Who Should Read This?

Anyone who is interested in learning how SDOH can be used to create healthier, more equitable communities will benefit from reading this plan. While this plan follows the journey of two specific Virginia health districts (Rappahannock-Rapidan and Greater Prince William Area), it also serves as an attainable and actionable model for community action across the Commonwealth. Publicly available data and reports like those available on the Virginia Community Health Improvement Data Portal can be used to draw connections between groups of people in any community who are experiencing health issues, and the SDOH domains where strategic community action is most needed to address those issues.

Where Can I Learn More or Find Help?

As your community works to address pressing health issues and the SDOH domains needing community action, there are resources that can help. Virginia Easy Access is a one-stop shop that connects individuals, caregivers and providers to long-term services and supports spanning across all SDOH domains. You can visit easyaccess.virginia.gov to use our award-winning Social Health Connector Tool and explore what your community has to offer.

Virginia Easy Access is part of a much larger initiative called No Wrong Door. No Wrong Door Virginia is housed within the Department for Aging and Rehabilitative Services.

Who We Are and Our Mission

The Virginia Department for Aging and Rehabilitative Services and specifically the No Wrong Door business area responded to a Request for Proposals from the Centers for Disease Control and Prevention (CDC) to develop a multi-sector action plan addressing SDOH domains. This Accelerator Plan focuses on two SDOH domains: Food and Nutrition Security and Social Connectedness in the Rappahannock-Rapidan Health District and Prince William Health Districts of Virginia.

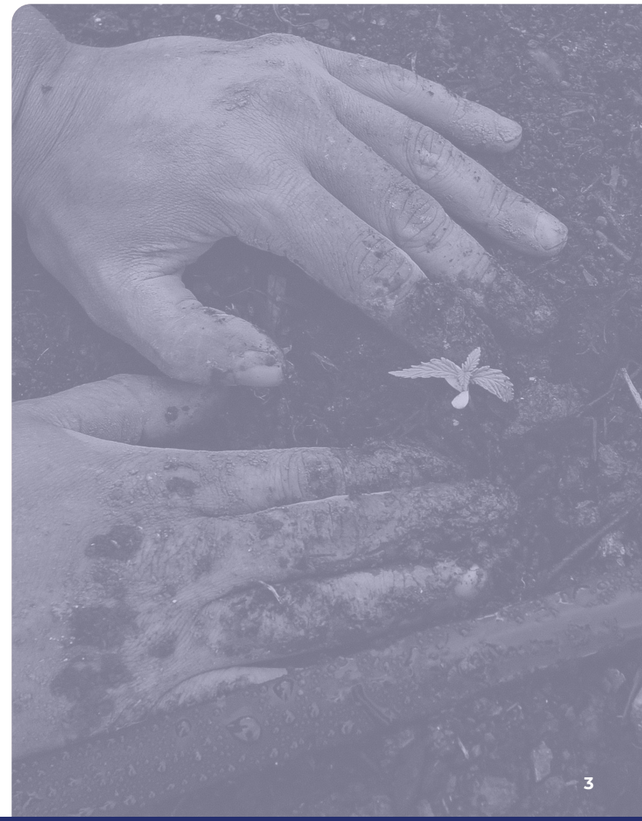
The plan was completed by a diverse group of local and state partners who all have a vested interest in health equity and improving health outcomes such as local health districts, Community Services Boards (CSBs), health systems, local governments, Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), nonprofits, and state governmental agencies. The Department for Aging and Rehabilitative Services No Wrong Door team led the planning with project liaisons from the two localities' AAAs: Prince William Area Agency on Aging and Encompass Community Supports.

Through the formation of a Leadership Team consisting of one representative from each partner organization, a shared mission statement was created to guide the contents of this implementation-ready accelerator plan and its intended outcomes.

Our mission is to address food security and social connection resources for underserved populations served by the Prince William and the Rappahannock-Rapidan Health Districts ensuring sustainable support through stronger partnerships and equitable community involvement to identify gaps and reduce access barriers to services.

Additional Resources

- Virginia Wellbeing
- Local Health Districts - Virginia Department of Health
- Data - Healthy Communities
- Poverty - Data
- Unemployment - Data
- Demographics - Data
- CDC/ATSDR Social Vulnerability Index (SVI)
- Environmental Justice Index (EJI)
- USDA ERS - Key Statistics & Graphics
- List of Cities in Virginia on Walk Score
- Virginia Health Care Foundation Data - Virginia Health Care Foundation



COMMUNITY BACKGROUND

Social Determinants of Health Priority Areas

This Accelerator Plan addresses two social determinants of health for the Greater Prince William Area (GPWA) and Rappahannock-Rapidan Health District (RRHD): Food and Nutrition Security and Social Connectedness.

The strategies outlined in this Plan are designed to reduce health disparities and inequities and improve health outcomes related to both physical and mental health chronic conditions among selected populations.

1. Food & Nutrition Security

2. Social Connectedness

About the Areas

The Prince William Health District, more commonly known as the Greater Prince William Area (GPWA), is located in Northern Virginia, approximately 35 miles southwest of Washington, DC. The GPWA is part of the National Capital Region, which includes counties and cities in the Washington metropolitan area. GPWA encompasses a total area of 349 square miles and includes Prince William County and the independent cities of Manassas and Manassas Park. Two major highways, I-66 and I-95, run through Prince William County. It is home to 508,259 residents with diverse cultural and ethnic backgrounds (see table below) and is expected to continue growing and diversifying.

Greater Prince William Area Resident Characteristics

Characteristic	Prince William County	Manassas City	Manassas Park City
Below poverty (%)	7.0	8.8	3.37
Foreign born (%)	23.4	26.2	35.6
Veterans (%)	13.0	8.7	8.2
With disability (%)	7.5	7.4	8.2
Age 55+ (%)	19.3	19.9	16.3
White (%)	44.6	42.6	36.0
Black (%)	20.2	12.8	12.8
Hispanic (%)	22.4	35.0	37.8
Food Insecure (%) – Overall*	4.5	4.7	4.7
Food Insecure (%) – Black	8.0	11.0	8.0
Food Insecure (%) – Latino (Hispanic)	10.0	9.0	10.0

**Prince William County = 21,310 people; Manassas City = 2,000 people; and Manassas Park City = 800 people.*
Total of approximately 24,110 food insecure residents.

The RRHD includes the counties of Fauquier, Rappahannock, Culpeper, Madison, and Orange, which are located in between the Northern and Central regions of Virginia. This region is home to more than 186,000 community members. Compared to Virginia as a whole, the RRHD is more rural, has a higher percentage of residents aged 65+, and is less racially and ethnically diverse (see table on the next page). Madison and Orange are both rural counties, and Rappahannock and Culpeper are designated as partially rural. A total of 16,389 households has one or more members who are living with a disability. An estimated 34,649 residents are age 65 or older. All five counties are fully or partly designated as medically underserved areas by the US Health Resources and Services Administration.

RRHD Area Resident Characteristics

Characteristic	Fauquier	Rappahannock	Culpeper	Madison	Orange
Households in poverty (%)	6.0	9.0	8.0	8.0	9.0
Food insecurity (%)	6.0	8.0	8.0	9.0	9.0
Age 65+ (%)	26.0	16.0	22.0	22.0	19.0
White (%)	83.0	91.0	74.0	86.0	79.0
Black (%)	7.0	4.0	14.0	9.0	13.0
Hispanic (%)	10.0	4.0	12.0	4.0	6.0
Food Insecure (%) – Overall*	5.8	7.3	6.6	7.0	8.8
Food Insecure (%) – Black	8.0	Not Available	14.0	4.0	19.0
Food Insecure (%) – Latino (Hispanic)	13.0	Not Available	10.0	Not Available	10.0

Fauquier County = 4,220 people; Rappahannock County = 540 people; Culpeper County = 3,420 people; Madison County = 960 people; and Orange County = 3,180 people.* ***Total of approximately 12,320 food insecure residents.*

Community Health Issues

The GPWA released a community health needs assessment (CHA) in 2019. Several health needs were identified through this assessment, including the following:

- Access to Healthcare & Delivery Systems
- Economic Stability
- Access to Mental Health Services
- Educational Opportunities
- Access to Affordable Housing
- Tobacco & Substance Use & Abuse
- Chronic Health Conditions
- Obesity, Nutrition, & Physical Activity
- Injury & Violence
- Immunizations & Infectious Diseases

Additionally, health inequities and disparities were identified as factors that impact health that must be addressed to build a healthier community for all. The development and completion of the CHA used a community-centered and data-driven approach to identify the top community health concerns by using surveys, local statistics, and public input to paint a picture of health and well-being in GPWA.

The RRHD released a CHA in 2020. Among the most commonly identified community health concerns were depression; other mental health conditions; substance abuse of illegal and prescriptions drugs; adult obesity/overweight; domestic violence; childhood obesity/overweight; and diabetes. Leading health care service needs included affordable health insurance; mental health services; and healthcare for the uninsured/underinsured. Leading community support service needs included after school programs; public transportation; and aging services. The CHA was designed to provide insight about community health needs and opportunities for community health improvement. Development of the CHA included a survey of community residents, a survey of community professionals, and analysis of a variety of community health indicators.

Selected Populations

The GPWA and RRHD CHAs identified specific populations disproportionately affected by health issues using data collected during the assessments. These populations include the most vulnerable: older adults, low income, minority, people with mental health concerns, and people with disabilities. To summarize already presented data and provide additional data on mental health concerns:

Chronic Health Conditions Are Experienced Widely Among Older Adults.

133,162
OLDER ADULTS LIVING IN THE
PRIORITY REGIONS

IN VIRGINIA OVER
1.4 MIL
ADULTS ARE 65 OR OLDER

80% OF ADULTS 65+ HAVE A CHRONIC HEALTH CONDITION

68% OF ADULTS 65+ HAVE 2+ CHRONIC HEALTH CONDITIONS

Older Adults With Chronic Health Conditions Are at a High Risk of Experiencing Poor Mental Health.

389,604 PEOPLE 56%
ACROSS THE PRIORITY REGIONS
REPORTED ≥ 1
POOR MENTAL HEALTH DAY
OVER THE PAST 30 DAYS

>20%
IN VIRGINIA ANY MENTAL ILLNESS (AMI) **IS PREVALENT IN >20% OF ADULTS**

INDIVIDUALS WITH CHRONIC CONDITIONS
ARE AT GREATER RISK OF
EXPERIENCING MENTAL HEALTH ISSUES THAN INDIVIDUALS WITHOUT

REFERENCES

Greater Prince William Community Health Assessment 2019 // A Community Health Needs Assessment Prepared for Planning Health District 9 2020 // Feeding America, Map the Meal Gap // Mental Health America

Food Insecurity is Experienced Most Frequently Among Black and Hispanic Households and Leads to Chronic Health Conditions.

36,430 PEOPLE ACROSS THE PRIORITY REGIONS
DON'T HAVE SUFFICIENT ACCESS TO HEALTHY & AFFORDABLE FOOD

>20%

OVER 20%
OF THE PEOPLE IN THE PRIORITY REGIONS EXPERIENCING FOOD INSECURITY **IDENTIFY AS BLACK OR HISPANIC**

6.17% OVERALL*
10.28% BLACK*
10.33% HISPANIC*

**Average Percentages*

RRHD Resident Characteristics

Characteristic	Fauquier	Rappahannock	Culpeper	Madison	Orange
Food Insecure (%) – Overall*	5.8	7.3	6.6	7.0	8.8
Food Insecure (%) – Black	8.0	Not Available	14.0	4.0	19.0
Food Insecure (%) – Latino (Hispanic)	13.0	Not Available	10.0	Not Available	10.0

Fauquier County = 4,220 people; Rappahannock County = 540 people; Culpeper County = 3,420 people; Madison County = 960 people; and Orange County = 3,180 people.* ***Total of approximately 12,320 food insecure residents.*

Greater Prince William Area Resident Characteristics

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Food Insecure (%) – Overall*	4.5	4.7	4.7
Food Insecure (%) – Black	8.0	11.0	8.0
Food Insecure (%) – Latino (Hispanic)	10.0	9.0	10.0

**Prince William County = 21,310 people; Manassas City = 2,000 people; and Manassas Park City = 800 people.*
Total of approximately 24,110 food insecure residents.

Target Populations and Health Disparities

As described previously, the selected target populations within the neighboring communities of GPWA and RRHD include older adults, individuals living in poverty, members of minorities, individuals with mental health concerns, and people with disabilities.

Among adults 65 and older, 80% have at least one chronic condition, while 68% have two or more. Approximately 18.5% of residents in GPWA are age 55+ and 21% of RRHD residents are age 65 and older. Individuals living in poverty are more likely to have chronic conditions when compared to individuals not living in poverty. Chronic conditions with the highest prevalence among individuals living in poverty include depression, asthma, obesity, diabetes, high blood pressure, and heart attack. Around 6.4% of GPWA residents live in poverty and 8% of RRHD households live in poverty. Members of minorities are disproportionately affected by chronic conditions. The prevalence of obesity, diabetes, and high blood pressure is higher among Black and Hispanic adults in comparison to White and Asian adults. An estimated 47% of GPWA residents are Black or Hispanic and 16.6% of RRHD residents are Black or Hispanic.

Chronic conditions and mental health conditions often co-occur. Chronic conditions like cancer, heart disease, or diabetes may make individuals more likely to have or develop a mental health condition. Individuals with chronic conditions are at a higher risk of depression and vice versa (individuals with depression are at higher risk for other chronic conditions). In GPWA, 66% residents reported one or more days of poor mental health in the past 30 days and 29% of RRHD residents reported one or more days of poor mental health. Adults with lifelong disabilities have increased odds of having a chronic condition when compared to adults with no limitations. These chronic conditions include coronary heart disease, cancer, diabetes, obesity, and hypertension. Approximately 7.7% of residents in GPWA are living with a disability and 16,389 households in RRHD have one or more members who are living with a disability.

In GPWA, looking at the community overall, 8.4% of individuals have diabetes, 26.3% have high blood pressure, and 34.4% have high cholesterol. Chronic conditions (asthma, cancers, diabetes, heart disease, and stroke) and mental health issues such as depression, anxiety, stress, and suicide are top health concerns for residents of the community. In RRHD, examining the community overall, 11% of individuals have diabetes, 38% have high blood pressure, and 39% have high cholesterol. A large percentage of residents in GPWA and RRHD are members of one or more populations disproportionately impacted by chronic conditions (older adults, individuals living in poverty, members of minorities, individuals with mental health concerns, and people with disabilities).

The proposed project will address two social determinants of health (food and nutrition security and social connectedness) in order to reduce health disparities and inequities, and improve health outcomes related to both physical and mental health chronic conditions among the identified target populations.

REFERENCES

National Council on Aging // Gallup-Healthways Well-Being Index // CDC Racial and Ethnic Approaches to Community Health (REACH) // Mental Health America // National Institute of Mental Health // National Health Interview Survey, 2006–2012 // Greater Prince William Community Health Assessment 2019 // A Community Health Needs Assessment Prepared for Planning Health District 9 2020

APPROACH

The Approach

This Accelerator Plan addresses two social determinants of health: food and nutrition security and social connectedness. Priority populations for these efforts are described in previous sections.

Identifying Areas of the Greatest Need & Opportunity

Together, community members and established Leadership Team (described later in "Multisectoral Partners") will implement these strategies and activities to reduce health disparities and inequities and improve health outcomes related to both physical and mental health chronic conditions among identified target populations.

The GPWA and RRHD Leadership Team have convened for more than seven months to co-create this Accelerator Plan to address the community needs highlighted by recent Community Needs Assessments. **Our process to identify areas of greatest need and opportunity is outlined below and is visualized in Appendix A.**

1. Completed Community Needs Assessments	Results and data are highlighted in previous sections
2. Identified social determinants of health and priority populations for improved outcomes	Looking at community needs and assets, the data-driven decision was made to focus on **Food Insecurity and Social Connectedness** for older adults, those with lower income, people of color, people with disabilities, and/or people with mental health concerns.
3. Multisectoral partners assembled for Leadership Team	Described in "multisectoral partners" section with roles and responsibilities described in Appendix B.
4. Developed shared mission statement	See below.
5. Completed "solutions inventory," or a landscape assessment of existing solutions	Co-created the list of **more than 40 unique existing community solutions that address food security and/or social connection** in the two catchment areas. The landscape assessment was designed to 1) identify what is working well, 2) reveal gaps in services, and 3) avoid duplication of services among providers. This process helped us see that there was significant need to improve coordination between partners/services, increase community awareness, and expand presence for certain undeserved areas and community groups are what is needed most. See the full list in Appendix C and further detail below.
6. Developed criteria to assess effectiveness and identify where deeper investment or scaling could improve outcomes	We wanted to "down-select" the vast number of services to a few models or solutions for further investment and scaling. **The Leadership Team selected the Mobile Outreach Program in the Rappahannock-Rapidan region to enhance the community outreach infrastructure.** While there was no commensurate program in the Prince William Area, they had multiple organizations offering mobile services that could be used for a similar purpose. The second model selected was community health fairs to increase information, "warm" referral*, and outreach. While the Prince William Area has many of these events to build upon, the Rapp-Rap region has essentially one annual event. As a result of this Accelerator Plan process, Rapp-Rap has identified key locations with plans to launch similar, smaller, and hyper-local health fairs. See four pillars that served as filtering criteria in Appendix D.
7. Developed logic model	Once we landed on the mobile outreach and health fair models, we created the logic model that is included in this plan to begin to set a timeline and output measures.
8. Identified primary intervention(s) for implementation	See Logic Model
9. Refined data and evaluation plan for future implementation	See Logic Model

Accelerator Plan Logic Model

The Logic Model below graphically represents the inputs, activities, short-term outcomes, intermediate outcomes, and long-term outcomes of the Policy, Systems, and Environmental changes focused on the social determinants of health domains: Food and Nutrition Security and Social Connectedness.

Using the process outlined in this Accelerator Plan, the Leadership Team has identified these solutions to address social connectedness and food security in Greater Prince William Area and the Rappahannock-Rapidan region of Virginia. The Logic Model details short, medium, and long-term outcomes that result from the outputs of the Plan activities.

	Planned Work		Intended Results			
	Solution	**Activities**	**Outputs**	**Short-Term Outcomes**	**Intermediate Outcomes**	**Long-Term Impact**
Food and Nutrition Security	Use Mobile Outreach Events, Art of Aging Expos, and Health Fairs to address health disparities in two SDoH domains: Food and Nutrition Security and Social Connectedness.	Offer information and referral to evidence-based and evidence-informed programs through Mobile Outreach Events, Art of Aging Expos, and Health Fairs available in locations such as local communities where people live, farmer's markets, churches, and senior centers. **Evidence-Based Programs** • Diabetes Self-Management Program (DSMP) • Diabetes Self-Management Education and Support(DSMES) • Chronic Disease Self-Management Education (CDSME) • Care Transitions Intervention • Matter of Balance • Tai Chi for Arthritis • Bingocize • Healthy IDEAS • Walk with Ease • Healthy Steps in Motion • Fresh Food Farmacy • Person-Centered Options Counseling	Outputs gathered through a mixed method approach to include pre-post event surveys and use of screening tools such as No Wrong Door Virginia's Social Health Connector. • # of events • # of presentations or social media posts to promote the events • # of people attending each event by underserved category and payer source • # of information sources shared • # of referrals made by type of evidence-based or evidence-informed program • # of partners engaged • # of screens by type (e.g., UAI, Hunger Vital Sign, USDA Two Item Food Security Screen, Nutrition Screening Initiative DETERMINE Checklist, Social Health Connector Screen, Three-Item UCLA Loneliness Scale) • # of No Wrong Door encounters • # of barriers to food security or social isolation identified	(Changes in knowledge, skill, attitudes, and values) • Increased awareness of available programs and services to address food insecurity and improve social connectedness • Increased availability and access to food and social connectedness as measured by # of people using evidence-based and evidence-informed programs • Increased multi-sectoral partners engaged in health promotion within underserved communities • Decreased barriers to access and use of health care & community services available to people in underserved communities	(Changes in behavior, practice, or process) • Increased health equity • Increased health promoting behaviors • Increased strengthening of evidence-informed programs and policies • Increased availability of health care and community services in underserved communities • Increased utilization of preventative health care and community services • Increased engagement in "food is medicine" and social activities to reduce the need for costly medical and social interventions • Positive changes in policy and programs to mitigate barriers to food security and social isolation • Improved policies that increase screening for social factors that impact health and promote access to programs that foster social connectedness and community-based activities	(Changes in condition, status, and experience) • Reduced morbidity and mortality associated with chronic disease • Decreased health care utilization and costs • Decreased health inequities • Decreased health disparities • Improved population health • Improved social connectedness • Decreased food insecurity • Reduced negative health effects of stress, trauma, anxiety, and depression
Social Connectedness	Hold fun and accessible events to one or more target populations and offer one or more evidence-based or informed solutions to reduce food insecurity and loneliness.	**Evidence-Based Programs** • Congregate Meals • Home Delivered Meals • Nutrition Education • Nutrition Counseling • Checking (telephone reassurance) • Senior Farmers Market Nutrition Program • Access to food banks, community pantries, etc. • Door-to-door transportation (senior centers) • No Wrong Door System • Personal Care/Respite • Senior Centers/Virtual Center for Active Adults • Adult Day Care				

Solutions & Outcomes

The Leadership Team collaborated and came to understand that many effective interventions already exist in these regions. However, community partners often operate in silos and are not aware of the events one another holds or programs that are offered.

Additionally, sometimes these interventions would only address one or two dimensions of health, while working together they realized they could exponentially increase the efficacy of each intervention for the people they serve.

The Leadership Team collaborated and came to understand that many effective interventions already exist in these regions. However, community partners often operate in silos and are not aware of the events one another holds or programs that are offered. Additionally, sometimes these interventions would only address one or two dimensions of health, while working together they realized they could exponentially increase the efficacy of each intervention for the people they serve. The collaboration also revealed some geographical and demographic gaps that could be filled by interventions that already exist. See Appendix C for the full list of more than 40 existing solutions that operate in this area.

With this understanding, the activities and strategies articulated for the Accelerator Plan are:

- Use Mobile Outreach Events, Art of Aging Expos, and Health Fairs in locations such as local communities where people live, farmer's markets, churches, and senior centers to address health disparities in two domains: **Food and Nutrition Security and Social Connectedness.**
- Hold fun and accessible events to *one or more* target populations (older adults, low income, minority, people with mental health concerns, and people with disabilities)
- Offer *one or more* evidence-based or informed solutions to reduce food insecurity and loneliness.

To deepen the collaboration across communities and to ensure the solutions we identified are actionable, each member of the Leadership Team provided specific responses to these prompts at the close of our Accelerator Plan period:

1. **What will you need** to successfully implement the activities and measurements in this Plan?
2. **What can you contribute** to successfully implement the activities and measurements in this Plan?

Common needs and contributions offered up for implementation include:

- Venues to host resource fairs, food distributions, and other evidence-based programs
- Promotion and outreach of community events, including social media and personal connections with popular local newspapers
- Certified trainers and event leaders, from tech training to public benefits enrollment to blood pressure screening to fitness instruction
- Technology solutions
- Compelling storytelling
- Data dashboards & evaluation skills
- Bilingual skills & translation services
- Volunteers for events & transportation
- Grant funding
- Resource guide compilation, design, & distribution

For the full list of identified needs & contributions, see Appendix F.

PARTNERSHIPS & RESPONSIBLE PARTIES

Leadership Team's Co-Created & Shared Mission Statement

DARS is joined by several multisectoral partners on the Leadership Team. Each partner assigned at least one staff member to serve on the Leadership Team.

On average, the Leadership Team convened on a monthly basis for the duration of the grant period, from February through August 2023. The roles and responsibilities for participating organizations can be found in Appendix B.

In Spring 2023, the Leadership Team created this shared mission statement:

Our mission is to address food security and social connection resources for underserved populations served by the Prince William and the Rappahannock-Rapidan Health Districts ensuring sustainable support through stronger partnerships and equitable community involvement to identify gaps and reduce access barriers to services.

Leadership Team Organizations

Partner Organization	Organizational Contacts	Role in Accelerator Plan & Team
Coryell-Robbins, LLC	Erika Robbins	• Measurement, learning, and evaluation partner
Virginia Department of Health, Division of Prevention and Health Promotion	Melicent Miller Mona Burwell	• Leadership team • Health sector and health equity expertise • Potential service provider at pop-up or mobile events
UVA Health • Prince William Medical Center • Haymarket Medical Center • Culpeper Medical Center	Diana Ayscue Jeffrey Say	• Leadership team • Health sector and health equity expertise • Potential service provider at pop-up or mobile events
Prince William Area Agency on Aging	Sarah Henry Ed Harrison Kathleen Wiley	• Leadership team • Project liaison • No Wrong Door regional lead • Older adult expertise • Nutrition and food security/delivery expertise • Long-term disability expertise • Potential service provider at pop-up or mobile events
Encompass Community Supports	Raymond Parks Kathleen Watson Susan Walters	• Leadership team • Project liaison • No Wrong Door regional lead • Mental health regional lead • Older adult expertise • Food security and delivery expertise • Long-term disability expertise • Established Mobile Outreach Program and vehicle for awareness and events
PATH Foundation	David Shang	• Leadership team • Facilitates Senior Service Collaborative • Potential service provider at pop-up or mobile events
Independence Empowerment Center	Bonnie Fulford	• Leadership team • Services by and for people with disabilities • Potential service provider at pop-up or mobile events
Aging Together	Ellen Phipps Anna Rogers	• Leadership team • Participatory community engagement expertise • Older adult expertise • Food security and nutrition expertise • Regional collaborative of 150 people/organizations • Potential service provider at pop-up or mobile events
Prince William Health District	Andrea Young Diane Anderson	• Leadership team • Potential service provider at pop-up or mobile events • Frequent mobile community outreach events for health screenings and services • Health sector and preventative medicine expertise
Rappahannock-Rapidan Health District	Meghan Cummins	• Leadership team • Potential service provider at pop-up or mobile events • Health sector and preventative medicine expertise

Leadership Team Organization (Continued)

Aging Together (Leadership Team) serves the counties of Culpeper, Fauquier, Madison, Orange and Rappahannock in the Commonwealth of Virginia.

The agency is partnership-driven and helps the region prepare for an unprecedented growth in the older population, assuring local residents will have the services and supports they need as they age. Aging Together is built on an alliance of more than 150 regional organizations and individuals who actively participate in one or more County Teams that work in their communities and collaborate across agencies, counties and interest areas. Participants are mostly volunteers that include senior citizens, home care and hospice agency staff, hospital representatives, service providers, faith community leaders, business employees, law enforcement and first responders, local government officials, and other concerned citizens. This unique model of collaboration assures success in developing programs and services that make sense at the local level, since those who work and live in a community are most aware of its gaps. Aging Together's model ensures that local community voices – the people who will utilize services and supports – are represented in the development and implementation of community solutions. This lived experience of need is a crucial input to the strategies and activities in this Accelerator Plan.

The Independence Empowerment Center (IEC) (Leadership Team) is a Center for Independent Living serving people with disabilities in the counties of Prince William and Fauquier, and the cities of Manassas and Manassas Park.

The center helps their consumers remain independent, to the greatest of their abilities, in their own communities. IEC promotes disability rights, equal access, and full community participation for persons with disabilities. As an advocacy-based organization, IEC is governed and operated by persons with disabilities for persons with disabilities.

The PATH Foundation (Leadership Team) is committed to advancing health equity for all residents in Fauquier, Rappahannock and Culpeper Counties.

The organization seeks to identify and address obstacles to health equity, with the goal of all community members having the opportunity to reach their full potential. The PATH Foundation is a philanthropic charitable foundation and has invested more than $48,000,000 in the community through grants, programs, and partnerships. The PATH Foundation invests in nonprofits and government agencies whose goals for wellness and community improvement align with the foundation's values. Advancing health equity is at the forefront of the PATH Foundation's work. By conducting a Community Health Needs Assessment every three years, PATH leadership has a guide for meeting the overall health needs of area residents.

The mission of Prince William Area Agency on Agency - PWAAA (Leadership Team and Project Liaison) is Empower independence, Enhance the quality of life, and Enjoy aging by offering a supportive network for older persons and their families through advocacy, education, coordination, and implementation of programs and services for older adults in our area.

PWAAA responsibilities include: maintaining the independence and quality of life for adults and their families and advocating, educating, coordinating and implementing programs and services for older adults. PWAAA serves older adults, their families and caregivers in the tri-jurisdictional areas of Prince William County, the City of Manassas and the City of Manassas Park. Programs and services provided include adult day care, in-home assistance, care transitions, legal assistance, and nutrition services. As the No Wrong Door Lead for the Prince William Area, PWAAA also provides Person-Centered Options Counseling for older adults, people with disabilities, and anyone seeking unbiased guidance on long-term services and supports.

The mission of Encompass Community Supports (known as Rappahannock Rapidan Community Services - RRCS prior to July 1, 2023) (Leadership Team and Project Liaison) is to improve the quality of life in Culpeper, Fauquier, Madison, Orange, and Rappahannock Counties by providing comprehensive behavioral health, developmental disability, substance use disorder, and aging services.

This mission is accomplished by offering a comprehensive array of services. In 1972, the local governments of Planning District 9 (Culpeper, Fauquier, Madison, Orange, and Rappahannock) formed the Rappahannock-Rapidan Community Services Board. At this same time, the Planning District Commission recommended that the newly formed Community Services Board also provide services under Title III of the Older Americans Act. These events formed and created a combined area agency on aging and community services board – a unique organization at inception, which continues to be the only such combined agency in Virginia. In 2011, the agency become known as Rappahannock Rapidan Community Services. As the No Wrong Door Lead for the Rappahannock-Rapidan Area, RRCS also provides Person-Centered Options Counseling for older adults, people with disabilities, and anyone seeking unbiased guidance on long-term services and supports.

The Virginia Department of Health (VDH) (CDC Funded State Chronic Disease Prevention Program) is dedicated to protecting and promoting the health of Virginians.

VDH is made up of a statewide Central Office in Richmond and 35 local health districts. These entities work together to promote healthy lifestyle choices that can combat chronic disease, educate the public about emergency preparedness and threats to their health, and track disease outbreaks in Virginia. VDH is a current CDC Arthritis Program grantee. Funding has allowed for the implementation of the Virginia Arthritis Program (VAP), which aims to expand the delivery of evidence-based lifestyle management programs and increase opportunities for walking throughout the state.

The Prince William Health District (PWHD) (Health Authority, Leadership Team) operates multiple programs to protect and improve the health and well-being of its residents (Prince William County, Manassas City and Manassas Park).

Services provided include: immunizations; environmental health services, including restaurant and pool inspections; family planning services; confidential diagnosis, treatment, and counseling for sexually transmitted diseases; tuberculin testing and diagnostic chest x-rays; confidential HIV testing and early intervention services; nutritional education and food vouchers for women, infants, and children (WIC) clients; processing of birth and death certificates, and investigation of reportable diseases. In collaboration with the Community Healthcare Coalition of Greater Prince William, PWHD's Population Health team developed the 2019 Greater Prince William Community Health Assessment (CHA). The team worked on data collection and analysis, report development, and overall project management of the CHA.

The Rappahannock-Rapidan Health District (RRHD) (Health Authority, Leadership Team) RRHD's mission is to attain optimal health for the people of our community through disease prevention, environmental safeguards, and health promotion.

The district includes the counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock. RRHD collaborated with five other regional organizations (Path Foundation, Fauquier Health, Novant Health: Culpeper Medical Center, UVA Health System, Culpeper Wellness Foundation) to guide the development of the 2020 Community Health Needs Assessment (CHA) for Health Planning District 9. Community Health Solutions provided research support, data analysis support, and drafting support for the CHA.

The UVA Health's (Healthcare Sector, Leadership Team) mission is Transforming Health and Inspiring Hope For All Virginians and Beyond.

This mission is achieved through programs and partnerships that are strategically focused on achieving health equity to improve health and upward mobility across the Commonwealth of Virginia, especially those that need it most.

UVA Health Prince William Medical Center is a 130-bed community hospital with a comprehensive offering of services in emergency, heart and vascular, outpatient surgery, diagnostic imaging and interventional radiology, women's and children's health including Level 3 NICU, stroke and neurology, therapy services, behavioral health, wound care and sleep medicine. The facility earned Magnet® re-designation in 2021 and its cardiology, maternity, and neurology programs have received national recognitions. Its increased scale provides streamlined access to patients throughout the region to exceptional complex care, the latest technology, groundbreaking research, and clinical trials.

UVA Health Culpeper Medical Center is a 70-bed community hospital with a comprehensive offering of services in emergency, surgery, imaging, women's and children's health, heart and vascular, cancer care, and rehabilitation. It has been recognized nationally for its pulmonary program's performance and achieved numerous accolades for maternity care. On campus at Culpeper Medical Center, there are five provider-based clinics which support the hospital and surrounding community for cancer care, surgical care, orthopedics, cardiology and OB/GYN services. This medical center has been serving the Culpeper community since the hospital first opened its doors in 1960.

UVA Health Haymarket Medical Center is a 60-bed community hospital with a comprehensive offering of services in emergency, surgery, diagnostic imaging and interventional radiology, stroke and neurology, women's health, and rehabilitation. Adjacent to the hospital within the Heathcote Health Center medical building, we have numerous primary and specialty clinics that support the hospital and the community ranging from our UVA Health Bull Run Family Medicine practice to OB/GYN, cardiology specialists and surgical specialists. These include general surgeons, as well as surgical specialists in breast surgery, bariatric weight loss surgery and anti-reflux, and urology. Heathcote Health Center opened in 2008 with a freestanding ED, which has since evolved into the current medical office building and hospital facility that opened in 2014.

EVALUATION & DATA INTEGRATION

Short-Term Outcomes Aligned with Logic Model

To evaluate the implementation of the Accelerator Plan, DARS will contract with an evaluation consultant for the overarching process and outcomes evaluation per the Logic Model. The DARS team will participate in evaluation activities such as surveys, interviews, case studies, and any other data collection efforts required to measure the impact of Food Security and Social Connectedness interventions on changes in chronic disease related disparities, risk factors and inequities.

Short-Term Outcomes Aligned with Logic Model

The logic model proposes short-term outcomes that reflect changes in knowledge, skill, attitudes, and value. By the end of the period of performance, these short-term outcomes are proposed to lead to expected NOFO outcomes including, but not limited to, increased strengthening of existing policies, increased organizational behaviors that promote health promotion and reduce health risks, increased availability and accessibility of health and social care services, and increased improvements in multi-sectoral partnerships. Specifically, the proposed model to use Mobile Outreach Events, Art of Aging Expos, and Health Fairs to address health disparities in Food and Nutrition Security and Social Connectedness is expected to result in information about available evidence-based and evidence-informed programs and referrals to needed supports including healthy food options and social connection. A natural extension of the model will be increased opportunities for social gathering and community involvement as well as increased engagement across health and social care sectors.

Changes in Knowledge, Skill, Attitudes, and Values

- Increased awareness of available programs and services to address food insecurity and improve social connectedness
- Increased availability and access to food and social connectedness as measured by # of people using evidence-based and evidence-informed programs
- Increased # of multi-sectoral partners engaged in health promotion within undeserved communities
- Decreased barriers to access and use of health care and community services available to people in undeserved communities

Changes in Behavior, Practice, or Process

- Increased health equity
- Increased health promoting behaviors
- Increased strengthening of evidence-informed programs and policies
- Increased availability of health care and community services in undeserved communities
- Increased utilization of preventative health care and community services
- Increased engagement in “food is medicine” and social activities to reduce the need for costly medical and social interventions
- Positive changes in policy and programs to mitigate barriers to food security and social isolation
- Improved policies that increase screening for social factors that impact health and promote access to programs that foster social connectedness and community-based activities

Changes in Condition, Status, and Experience

Ultimately, implementation of the Accelerator Plan seeks to impact the condition, status, and experience of community members to include, but not be limited to, decreased health inequities and disparities as well as improved population health.

- Reduced morbidity and mortality associated with chronic disease
- Decreased health care utilization and costs
- Decreased health inequities
- Decreased health disparities
- Improved population health
- Improved social connectedness
- Decreased food insecurity
- Reduced negative health effects of stress, trauma, anxiety, and depression.

Performance Measures

Short-Term Outcomes	Performance Measures
Increased awareness of available programs and services to address food insecurity and improve social connectedness	**Process** • # of events and type • # of presentations • # of social media posts • # of people attending events and population and payer types **Outcome** • % of people accessing evidence-based programs before & after intervention
Increased availability and access to food and social connectedness in underserved communities	**Process** • # of partners engaged • # of screens by screen type • # of referrals made by program & population/payer type • # of people using evidence-based & evidence-informed programs, by population & payer **Outcome** • % increase in available food & social connection programs • % increase in people accessing evidence-based programs before & after intervention, by population & payer types
Increased availability of other health care and community services in underserved communities	**Process** • # of referrals made by program & population/payer type • # of people using other health care & community services, by population & payer types **Outcome** • % increase in people accessing other health care & community services by population & payer types
Increased multi-sectoral partners engaged in health promotion within underserved communities	**Process** • # of partners engaged **Outcome** • % increase in partnerships from planning phase to year 1 to year 2 to year 3
Decreased barriers to access and use of health care and community services available to people in underserved communities	**Process** • # of identified barriers by population & payer types **Outcome** • # of barriers mitigated from planning phase to year 1 to year 2 to year 3
Increased health promoting behaviors	**Process** • # of people who complete evidence-based or evidence-informed programs, by population & payer types • # of people participating in screenings or risk assessment, by population & payer types • # of people participating in health education or skill activities development, by population & payer types • # of people that receive & follow up with referrals, by population & payer types • # of people enrolled in health promotion or disease prevention programs, by population & payer types **Outcome** • % increase in perceived health status • % increase in knowledge & skills pre & post evidence-based or evidence-informed program • % increase in healthy living measured by reductions in social isolation & reduced ED use & hospitalizations • % decrease in cost of services pre & post intervention
Increased strengthening of evidence-informed programs and policies	**Process** • # and types of educational materials produced, by program type • # of key stakeholders involved, by program type • # of people aware of program messaging & intend to take action, by program type • # of policies developed, by program type • # and characteristics of partners offering by program type • Types of resources & contributions provided by partners, by program type **Outcome** • % increase in revised or new policies, from planning phase to year 3 • % increase in availability of evidence-based or evidence-informed programs from planning phase to year 3 • % increase in partner contributions to health promotion from planning phase to year 3 • % decrease in healthcare costs for people engaged in evidence-based & evidence informed programs

Data Sources: Process Measures

Measures	Potential Data Sources
# of events and type	Primary data collection and tracking by event type
# of presentations	Primary data collection and tracking by presentation
# of social media posts	Social media analytics
# of people attending events and population and payer types	Primary data collection and tracking by event type using registration to collect information prior to events and a pre-survey or polls to collect information during events
# of partners engaged	Primary data collection and tracking using governance structure to map partners engaged in planning phase and over time
# of screens by screen type	Uniform Assessment Instrument, Social History, Social Health Connector
# of referrals made by program and population/payer type	CRIA2, Client Profile
# of people using evidence-based and evidence-informed programs, by population and payer	CRIA2, Client Profile
# of people using other health care and community services, by population and payer types	CRIA2, Client Profile
# of identified barriers by population and payer types	Primary data collection and tracking using governance structure
# of people who complete evidence-based or evidence-informed programs, by population and payer types	CRIA2, Client Profile
# of people participating in screenings or risk assessment, by population and payer types	CRIA2, Client Profile
# of people participating in health education or skill activities development, by population and payer types	CRIA2, Client Profile
# of people that receive and follow up with referrals, by population and payer types	CRIA2, Client Profile
# of people enrolled in health promotion or disease prevention programs, by population and payer types	CRIA2, Client Profile
# and types of educational materials produced, by program type	Primary data collection and tracking using governance structure
# of key stakeholders involved, by program type	Primary data collection and tracking using governance structure
# of people aware of program messaging and intend to take action, by program type	Primary data collection using a post-intervention survey or feedback form
# of policies developed, by program type	Primary data collection and tracking using governance structure
# and characteristics of partners offering by program type	Primary data collection and tracking using governance structure
Types of resources and contributions provided by partners, by program type	Primary data collection and tracking using governance structure

Data Sources: Outcome Measures

Measures	Potential Data Sources
% increase in available food and social connection programs	Primary data collection and tracking using governance structure
% increase in people accessing evidence-based programs before and after intervention, by population & payer types	CRIA2, Client Profile
% increase in people accessing other health care and community services by population and payer types	CRIA2, Client Profile
% increase in partnerships from planning phase to year 1 to year 2 to year 3	Primary data collection and tracking using governance structure
Number of barriers mitigated from planning phase to year 1 to year 2 to year 3	Primary data collection and tracking using governance structure
% increase in perceived health status	CRIA2, Client Profile
% increase in knowledge and skills pre and post evidence-based or evidence-informed program	Primary data collection and tracking by event type using registration to collect information prior to events and a pre-survey or polls to collect information during events
% increase in healthy living measured by reductions in social isolation and reduced ED use and hospitalizations	CRIA2, Client Profile, Medicaid Claims Data
% decrease in cost of services pre and post intervention	CRIA2, Client Profile, Medicaid Claims Data
% increase in revised or new policies, from planning phase to year 3	Primary data collection and tracking using governance structure
% increase in availability of evidence-based or evidence-informed programs from planning phase to year 3	Primary data collection and tracking using governance structure
% increase in partner contributions to health promotion from planning phase to year 3	Primary data collection and tracking using governance structure
% decrease in healthcare costs for people engaged in evidence-based and evidence informed programs	CRIA2, Client Profile, Medicaid Claims Data

Data Collection Methods

The DARS team will use a variety of data collection methods. These methods include:

- Collecting responses via pre and post intervention satisfaction surveys or referral follow-up screens
- Having open-ended conversations (e.g., interviews, focus groups) to gain an in-depth understanding of impact
- Capturing information through observation or through primary collection of data through screening, assessment, and follow-up
- Exploring secondary data available via multiple public sources

Implementation Timeline for Proposed Activities and Evaluation

Measures	Year 1				Year 2				Year 3			
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Increased awareness of available programs and services to address food insecurity and improve social connectedness				●		●		●		●		●
Number of events & type	●	●	●	●	●	●	●	●	●	●	●	●
Number of presentations	●	●	●	●	●	●	●	●	●	●	●	●
Number of social media posts	●	●	●	●	●	●	●	●	●	●	●	●
Number of people attending events & population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Increased availability and access to food and social connectedness in underserved communities **Increased multi-sectoral partners engaged in health promotion within underserved communities**				●				●				●
Number of partners engaged			●				●				●	
Number of screens by screen type	●	●	●	●	●	●	●	●	●	●	●	●
Number of referrals made by program and population/payer type	●	●	●	●	●	●	●	●	●	●	●	●
Number of people using evidence-based and evidence-informed programs, by population and payer	●	●	●	●	●	●	●	●	●	●	●	●
Increased availability of other health care and community services in underserved communities				●				●				●
Number of people using other health care and community services, by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Number of identified barriers by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Increased health promoting behaviors				●				●				●
Number of people who complete evidence-based or evidence-informed programs, by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Number of people participating in screenings or risk assessment, by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Number of people participating in health education or skill activities development, by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Number of people that receive and follow up with referrals, by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Number of people enrolled in health promotion or disease prevention programs, by population and payer types	●	●	●	●	●	●	●	●	●	●	●	●
Increased strengthening of evidence-informed programs and policies								●				●
Number and types of educational materials produced, by program type	●	●	●	●	●	●	●	●	●	●	●	●
Number of key stakeholders involved, by program type			●				●				●	
Number of people aware of program messaging and intend to take action, by program type	●	●	●	●	●	●	●	●	●	●	●	●
Number of policies developed, by program type			●				●				●	
Number and characteristics of partners offering by program type			●				●				●	
Types of resources and contributions provided by partners, by program type			●				●				●	

● Milestone Reporting on Data Collected ● Collection Period

Proposed Data Management Plan

DARS will construct a more complete data management plan during the initial months of implementation. The data management plan will include an expanded description of data quality and security standards that DARS will ensure during the data lifecycle (i.e., planning, data collection, analysis, and archiving).

DARS contracts with the technology vendor, PeerPlace, to deliver statewide Client Tracking and Case Management System for Area Agencies on Aging (AAAs). PeerPlace provides data management software for human service agencies and organizations. Headquartered in New York, PeerPlace provides best practice Commercial-Off-The-Shelf (COTS) client tracking and case management software to more than 900 organizations in more than ten states. PeerPlace runs as a native java web application running on web servers accessed by users. The web application is accessed using Secure Socket Layer (SSL) technology that protects information using both server authentication and data encryption to help ensure Customer Data is safe, secure, and available only to an authenticated user login.

PeerPlace also implements an advanced security method based on dynamic data and encoded session ID's tracked from the browser through proxy servers and to application servers, and hosts the web application in a secure server environment that uses a firewall and other advanced technology to prevent interference or access from outside intruders. PeerPlace development staff use secure Virtual Private Network (VPN) connections to access the production system from outside the physical hosting facility.

All DARS authorized users are required to meet enterprise data standards and information technology security requirements specified by the Virginia Information Technologies Agency (VITA). DARS provides training on data quality and includes standards on quality, security, privacy, and confidentiality in user agreements as follows.

- Require that each user of the PeerPlace tools review and sign the Acceptable Use Policy and Agreement prior to {agency name} requesting user ID and password with appropriate permission level for said user. {agency name} will retain signed copies of Acceptable Use Policy and Agreement for each user and provide evidence of signed and dated agreements during periodic confidentiality audits by DARS.
- Request permission levels for each user |appropriate for said user in relation to service to the client. Permission levels shall be based on a "Need to know" basis and no user shall access client-level data outside of the responsibilities performed as an employee of {agency name}.
- Require that users understand that client information entered into the PeerPlace tools must be accurate and must be corrected as soon as reasonably practicable upon realization or notification of such error. Any information errors or inaccuracies that results from {agency name} use of the PeerPlace tools will be the responsibility of {agency name} to correct immediately upon realization or notification of such error.

STRATEGY

Sustainability and Funding Strategy

The evidence-based and evidence-informed programs noted in this Accelerator Plan are already ongoing in the GWPA and RRHD communities.

Developing this plan provided a unique opportunity to have home and community-based service providers, healthcare providers, and public health providers together at the same table to assess and combine available resources. Collaboration amongst these multisectoral partners will provide opportunities to expand and diversify existing evidence-based and evidence-informed programs that address the social determinants of health domains, food and nutrition security and social connectedness. The sustainability of these efforts will result from a change in practice whereby collaboration amongst these partners becomes routine. Each partner offers different resources that will be used to embed the programs into the menu of services available to community members who are struggling with food and nutrition security and social connectedness. Examples of sustainability resources include Older Americans Act Title III-D, Title III-B, and Title III-E funding; local government funding; in-kind support; and establishment of fee-for-service or reimbursement arrangements with employers, insurance companies, and healthcare entities. In addition, the PATH Foundation, a philanthropic charitable foundation, is involved and invested in the implementation of this plan. As the multisectoral partners collaborate to blend and braid various funding and resources to support and sustain this work, the PATH Foundation may be able to help supplement this work if gaps or opportunities for further expansion and diversification arise.

APPENDIX A

Accelerator Plan Journey Map

The process used to create this Accelerator Plan and arrive at the strategies, activities, and outcomes outlined here.

1. Community Needs & Assets Assessment

2. Assemble Leadership Team

3. Select Focus Areas & Populations

4. Co-Create Mission Statement

5. Programs & Solutions Inventory

6. "Down-Select" & Finalize Activities

7. Data & Evaluation Plan

8. Draft & Revise Accelerator Plan

9. Submit Accelerator Plan

APPENDIX B

Roles & Responsibilities of the Leadership Team

Center for Disease Control (CDC)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

No Wrong Door (DARS)

VIRGINIA No Wrong Door
ACCESS. OPTIONS. ANSWERS.

DARS
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Project Liaisons (PWC & Rapp Rap)

- Point of contact in local communities
- Ensure everyone is around the table & interacting
- Maintain relationships
- Reach community members
- Identify effective interventions
- Liaise between community partners and individuals
- "An Interpreter for both sides" (NWD and local partners/ people feedback loop)

Leadership Team

- Come together to discuss and build an implementation-ready Accelerator Plan
- Be present and available for community meetings
- Help Liaisons (AAAs) connect with local communities and populations they may not already be reaching
- Operationalize the discussion

APPENDIX C

Solutions Inventory, or Existing Resources and Programs

The Leadership Team co-created this list of 44 programs/interventions/solutions already at work, in addition to the coalitions and collaborations they already participate in.

Solutions Inventory: Public Programs

U.S. Nutrition Policies and Programs		
Adults, Families, & Children	**Children/ Pregnant & Postpartum Women:**	**Older Adults**
• Supplemental Nutrition Assistance Program (SNAP) • SNAP-Ed (SNAP Education) • Food Distribution Program on Indian Reservations (FDPIR) • GusNip (formerly FINI) • The Emergency Food Assistance Program (TEFAP) • Charitable Food Program • Child & Adult Care Food Program (CACFP) • Expanded Food & Nutrition Education Program (EFNEP) • Medicaid	• Women, Infants, Children (WIC) • Head Start Program • National School Lunch Program (NSLP) • School Breakfast Program (SBP) • Summer Food Service Program (SFSP) • Fresh Fruit & Vegetable Program (FFVP)	• Meals on Wheels • Commodity Supplemental Food Program (CSFP) • Senior Farmers Market Nutrition Program (SFMNP)

Many of these serve our target populations AND provide social connection

What Other Programs or Groups Are Already at Work?

Think About Public, Private, Formal, Informal, Grassroots		
Solving For Food Security	**Solving For Social Connection**	**Solving For Both**
• Meals on Wheels • Hunger Hotline • Manna Ministry, Food Closet, Empowering Culpeper • Northern Va Food Rescue (Offshoot of Acts) • Farmers Markets & Snap Match, New to Some Areas • Piedmont Action Coalition on Hunger (PACH) • Food Farmacy (produce for older adults) • WIC Programs • Haymarket Food Pantry • Fauquier FISH Senior Nutrition • CHOW Wagon (Combating Hunger on Wheels) • Bread of Life Pantry • St. Thomas UMC Pantry • Mobile Food Pantry (Blue Ridge Area Food Bank) • Virginia Roadmap to End Hunger • Northern VA Food Rescue incl. Prince William Food Rescue (PWFT) & Fauquier Food Rescue	• Bingocize • Matter of Balance • Senior Centers • Virtual Senior Center • Support Groups e.g. caregivers, grief support • Social Isolation Workgroup Part of The Seniors Services Collaborative • YMCA Programs • Virginia Co-Op Extension • Lifelong Learning Institutes (Manassas) • Culpeper Senior Center • Substance Recovery e.g. AA, NA, ACOA, etc. • Healthy Ideas Program Depression Screening & Action Plan • WIC peer programs • Rapp at Home Sr. Village • Volunteering Opportunities[1] • Aging Together Including Community Conversations • Coming Soon: Social Health Connector from NWD	• Home-delivered Meal & Wellness Check • Flyers for Bingocize and Matter of Balance in Home-delivered Meals • Church Programs • Congregate Meals (Participants and Volunteers) • Acts Program / Senior Link • Volunteer Prince William (VA Cooperative Extension, Lions, Rotary, PTAs, etc.) • RRCS Mobile Outreach • No Wrong Door @ AAA • Northern Fauquier Assistance Coalition

We came up with 44 Solutions!

Volunteering Opportunities[1] *| Animal Shelter, School, Library, Church, Senior Centers, Power Pack, Silver Citizens, Generations Central, 4-h, Master Gardeners, Historic Preservation*

APPENDIX D

Narrowing the Focus for Solutions & Activities

This is how the Leadership Team narrowed down the full list of 44 solutions into a few models for investment, enhancement, and scaling. The question before us at this stage was: WHAT solutions will improve outcomes for food security and social isolation, and WHY do we think so?

To provide some objectivity to these questions, we applied these additional considerations and solicited individual and large-group feedback:

Considerations:

1. **Does the program offer Availability, Access, & Stability for intended people?**
2. **Can the program be enhanced or sustained through grant funding?**
3. **Does it reflect our mission statement?**
4. **Is the program measurable?**

APPENDIX E

List of Evidence-Based & Evidence-Informed Activities

The activities of the Accelerator Plan to be offered within our solution of mobile events and health fairs include one or more of these activities, including information and referral.

(These are also named as Activities in the Logic Model.)

Evidence-Based Programs	Evidence-Informed or Pilot Programs
• Diabetes Self-Management Program (DSMP) • Diabetes Self-Management Education and Support (DSMES) • Chronic Disease Self-Management Education (CDSME) • Matter of Balance • Tai Chi for Arthritis • Bingocize • Healthy IDEAS • Walk with Ease • Healthy Steps in Motion • Fresh Food Farmacy • Person-Centered Options Counseling	• Congregate Meals • Home Delivered Meals • Nutrition Education & Nutrition Counseling Mental Health First Aid • Checking (telephone reassurance) • Senior Farmers Market Nutrition Program • Access to food banks, community pantries, etc. • Door-to-door transportation (senior centers) • No Wrong Door such as Information and Referral • Personal Care/Respite Care • Senior Centers/Virtual Center for Active Adults • Adult Day Care • Mobile Outreach Programs

VIRGINIA
No Wrong Door
ACCESS. OPTIONS. ANSWERS.

EasyAccess.Virginia.Gov