*Mobilizing for Action through Planning and Partnerships*

Charlottesville/Albemarle Community Health Assessment Council

**October 4, 2016**

Location: Charlottesville/Albemarle Health Department

1138 Rose Hill Drive, Charlottesville, VA 22903

**Attendees**

Forces of Change

* Jackie reviewed the Forces of Change assessment

Strategic Issues

* Lynanne reviewed Strategic issues matrix
* Discussed setting goals related to strategic issues

Disparities

* discussed looking at what are the major, upstream causes, before get to the point of 9-11 call
* discussed health disparities may be too big of an issue for us to make impact, need to instead focus on one issue
* discussed how while we have good built environ, people walking to work, etc. but still have high rates of diabetes, etc., showing not all parts of Charlottesville-Albemarle are unequally affected
* wants steps on economic, development level to improve equity
* want to develop community so that people from the community, so that those taking care of / in charge of look like those in the community
* need data and compile into way to tell a compelling story, this worked in community in CA that decided to work on health equity
  + also needed to seek funding for areas that needed it
* need to find specific issues within broader category of health equity to work on
* Q: are we looking at things that the public health system can address?
  + A: are going to work with community partners who focus in an area identified, such as transportation
  + A: may need more qualitative research to find out more about the disparities in community
* either use existing coalition or group or forming one to find out what are the issues we can actually work on, then work on those issues
* important to focus on a health issue and all of social determinants around it, also important to look at the health care delivery system itself
  + accessibility, and also accountability
* low income is one of the factors 🡪 health care systems are also one of the biggest employers
* challenges involved in getting those from low-income into job system, into more stable economic situation
* suggestion: in some communities, health system provides housing subsidy to keep people from bouncing back into health system with the same issues
* IPO group has been trying to address disparities in pregnancy outcomes since first MAPP in 2008
* example of how this group made a difference by breaking it into small parts to get dialog going
* Involved researching to get more info on the issues, focus groups, etc.
* we have birth and death rate data 🡪but don’t look at life expectancy here
  + has seen it done in other localities, how zip code can relate to life expectancy, and how can it be translated to health disparities more broadly
  + note: get life expectancy data
* Would like to see snap shot of two communities, see what’s different, then use this for what could work in our community
* Mental Health & Substance Abuse
  + We already have MHWC, do we need to re-do the goals from last MAPP?
  + MHWC has come up with broad goals, using some priorities from last MAPP, now focusing on prevalence of MH issues, opioid issues, MH & criminal justice system
  + important to have some overlap, with MAPP and MHWC
  + public awareness and stigma reduction
  + Opioid epidemic
  + Integrated care strategies 🡪 linking MH w primary care
  + MH & substance abuse is co-morbidity
    - Ex: PTSD and suicide
* reducing stigma, encouraging people to access the resources
* Health care system accessible and available to all
  + connection of services to person in crisis to the resources
    - sometimes providers don’t know the resources available or how to connect them
    - maybe need for social workers or some type of navigator to connect people to the services
    - TJHD does have a community health worker program, offered in both English and Spanish, have had multiple cohorts of CHW’s
    - problem now seems to be getting the CHW’s hired, funding for this
    - idea if can have team with CHW, social worker, and EMS, then could reduce amount of people needing services, getting arrested, etc.
    - after this MAPP is completed, can then seek out funding, maybe pilot program for CHW’s
    - investment back in community, etc. 🡪 this is what UVA health system is moving towards
    - SMJH does have navigators in their hospital
    - idea of project for access to the info so that the community members go to one provider, provider not offer that service, sends them to another, but they don’t offer that service
    - need a way so all agencies within community know where to send people, etc.
    - other areas have tried working thru this through their DSS’s
    - this is not just a local problem, it’s all over
    - renewed interest in coordinating services in post-partum depression and pregnancy & also substance abuse and pregnancy
    - is center in Lynchburg that has center for mom & baby to both go to while mom in treatment
    - example in SW VA (Lebanon) a PCP turned practice into center for treating substance abuse
    - in our area are not enough services and treatment available
  + preventative medicine
  + another goal: how can we diminish health disparities between communities
  + Objective: what are the health inequities by area and zip code and what are the preventative strategies to improve
  + Next steps
    - Planning council will come back with goals
    - then at Leadership Council meeting, will have goals, need to engage the coalitions working on these issues that are emerging
    - present what they’re working on, is that working, etc.
    - need for a collective of diff partners, understand and be clear on coalition’s function and what is their end goal