**Caroline CHA/CHIP Kickoff Meeting**

**Wednesday, January 29, 2020**

**Caroline Community Services Center, 17202 Richmond Turnpike, Milford, VA 22514**

**Meeting Minutes**

**Start Time: 12:20pm**

**Introduction by Rappahannock Area Health District Director, Dr. Brooke Rossheim**

* Rappahannock Area Health District (RAHD) provides community health services to PD16 (counties of Caroline, King George, Spotsylvania, Stafford, and the City of Fredericksburg). This includes operation of the health departments in each locality. Even though RAHD and the Caroline Health Department have different names, we are all one organization.
* There has been a push in the last few years towards population health, which focuses on the community as a whole. Although we focus on disease and disease measures, we also focus on the social determinants of health, such as education, income, housing, ability to exercise, safety, etc. These are all as important as the healthcare process of “taking care of diseases”
* RAHD completed its first community health assessment (CHA) in Fredericksburg in 2017. After the CHA, we move on to the Community Health Improvement Plan (CHIP). We use a tool called “MAPP” to guide this process, and the entire process takes about a year. In Fredericksburg, food insecurity was identified as a focus area, and this led to the development of the Eat Green Fredericksburg program.
* We seek the support of local government, schools, faith community, general public, etc. The idea is to create a community collaborative (MAPP process), where everyone’s input is sought after. We want to understand the challenges and existing resources in Caroline County.

**Presentation by Allison Balmes-John, Population Health Coordinator, RAHD**

* Introduction of attendees. Representatives from the following organizations were in attendance:
  + Virginia Cooperative Extension
  + Empowerhouse
  + Fredericksburg Regional Food Bank
  + Germanna Community College
  + Caroline County Public Schools
  + Caroline Libraries
  + Mental Health America Fredericksburg
  + Quin Rivers Community Action Agency
  + Health Generations Area Agency on Aging
  + Rappahannock Area Community Services Board
  + Caroline County Parks & Recreation
  + Town of Port Royal
  + Spotsylvania Regional Medical Center
  + disAbility Resource Center
  + Mary Washington Healthcare
  + Caroline Family YMCA
  + Caroline County Department of Social Services
  + The Mix House
  + Caroline CERVE
  + Alzheimer’s Association
  + Caroline County Fire and Rescue
  + Caroline County Sheriff’s Office
  + Rappahannock United Way
  + Virginia Community Food Connection
  + Caroline County Administration
  + Smart Beginnings Rappahannock Area
  + Glory Outreach
  + Rappahannock EMS Council
  + Caroline County Parent Resource Center
* Reviewed definition of health, highlighting that health is not merely the absence of disease, and that health refers not only to physical wellness but also mental and social wellness. With this broad definition of health, health becomes a shared responsibility.
* Discussed CDC’s “Invest in your Community” Infographic. Recognized that clinical care accounts for about 20% of our health in the community, and the other 80% of our health is attributed to health behaviors (e.g. eating well and exercising), physical environment (e.g. clean air and water), and socioeconomic factors (e.g. education and good jobs). Socioeconomic factors have been found to have the largest impact on health. Another key concept: that your zip code, or where you live, can be more important to your health than your genetic code.
* Defined health equity using American Public Health Association’s definition: “Everyone has the opportunity to attain their highest level of health”. Health equity is not the same concept as health equality, in which everyone is given the equal opportunities- equal opportunities do not always enable people and communities to be their healthiest selves.
* Through the CHA, we are trying to understand the health of the community and the assets out there to address these problems. This can allow us to look more closely at the root causes of health issues, and informs the development of a CHIP.
* The CHIP is the “how” of the process- how are we going to address the problems we identify? Focus is on action. It takes about 2-4 years to actually implement the CHIP. We build metrics to track our progress along the way, which we can then use to see how far we have come and where we can improve.
* The process used to complete the CHA/CHIP is available through the National Association of State and Territorial Health Officials, and is known as MAPP: Mobilizing for Action through Planning and Partnerships. All components of MAPP are mobilized by the community.
* Overview of MAPP:
  + Similar to other strategic planning processes
  + Right now we are the Organize for Success, Partnership Development step. We have been reaching out to external organizations to partner, and have been planning for the rest of the process.
  + Soon will go on to stage two: Visioning. This involves thinking about where we would like to see Caroline 5, 10, or 20 years down the line.
  + Phase 3 of MAPP consists of 4 Assessments. These assessments set MAPP apart from other planning tools, and are really at the crux of this framework. The 4 Assessments include:
    - Community Health Status Assessment: Involves looking at data and numbers, such as those indicators available on the County Health Rankings website
    - Community Themes and Strengths Assessment: More of a qualitative assessment, seeking to hear the voice of the community. Can take place in surveys, interviews, focus groups, community meetings, etc.
    - Forces of Change Assessment: Looks at internal and external factors, such as federal/state policies, events that draw attention toward or away from certain health issues
    - Local Public Health System Assessment: Examines how Caroline is delivering the ten essential public health services
  + Phase 4: Once we have all of the information collected from the 4 assessments, we sort through this data to identify the priority issues for this community. These first 4 steps make up the CHA portion of the process.
  + Phase 5: moving into developing the CHIP, or the plan itself. Identify goals and the strategies that will help us reach those goals.
  + Phase 6: The Action Phase- cycle of planning, implementing strategies, and evaluating
* Strategic thinking: what MAPP drives towards. Involves thinking broadly about information, identifying alternatives to address issues. Thinking about how the decisions we make now affect us in the future. Increases communication and participation. Ultimate goal: getting people moving in the right direction to address these issues
* The MAPP paradigm shift:
  + Shift in terms of what our operations are internally, to thinking of the needs/problems, assets/resources available in the community
  + Moving from healthcare medical model to a broader perspective
  + Recognizing that one person or organization does not know everything, but everyone knows something and has something to contribute to the process
* Benefits of CHA/CHIP:
  + Gathers input from the community, rather than just the health department making decisions
  + Builds partnerships across agencies
  + Helpful in writing grants
  + Prioritizes health problems rising to the top
  + Real driver: improving health outcomes

**Small Group Discussions and Large Group Sharing**

* Attendees broke into groups of 5-6 to discuss a series of questions about what a healthier Caroline County would look like. These discussions will help inform the Vision statement, to be developed at the first Steering Team meeting. Responses were recorded by each group and collected by RAHD staff.
* Groups had the opportunity to share key takeaways from these discussions with the large group. The following thoughts were raised:
  + Some groups were familiar with the definition of health provided today.
  + Organizations have programs, but they run into barriers.
  + There is a need to work on building relationships, making sure we’re physically collaborating and working together. This involves awareness, buy-in, and trust: how do we get constituents to trust our resources if we don’t trust each other?
  + Some goals for further down the line: improve upon inequities to be better than the state average. Keep developing to a point where we have an innovative one-stop shop (for example, having a website of resources so that people do not have to go to 20 different places to find help)
  + Would like to see equity of access in relation to housing, employment, mental health, and exercise
  + We are one of the largest counties in the state of Virginia, which has innate challenges with access
  + Housing and diversity of housing (apartments and condominiums) are not readily available
  + People drive far for jobs or housing options
  + Theme of communication: we are sandwiched in between cities, which creates a hurdle of communication. No news channels, media, newspaper that pulls feed on a daily basis. Getting out a united message about health can be challenging. As a county, there is a need for communications specialists or public relations to help with this
  + Connecting families to services is a challenge
  + There is a lack of reliable internet throughout the county, which has secondary effects on agencies.
  + There is a general sense of resistance to change – so we want to remove the fear of change from our older generation. We want to get people to embrace change
  + With looking at access, one access issue, worsens another access issue. For example, if you don’t have internet, you don’t know a service is available. If you do not have transportation, you cannot use the library technology. If no transportation, cannot get to class that teaches you healthy exercises you can do at home without equipment. So issues “piggy back” on top of one another
  + Considering spiritual wellness as well as physical and mental wellness:
  + The different churches have resources that you often might not have. Churches want to collaborate with partners and identify populations that we need to work with
  + At basis of all of this – we can have amazing services in the community (YMCA, doctors, grocery stores), if you cannot get to them, or if they cannot get to you, they are worthless. Transportation and lack thereof is a huge challenge.

**Overview of options for Participation in the CHA/CHIP Process**

* Steering Team- will oversee the CHA/CHIP process, establish work groups, meet approximately once per month.
* Work Groups- “boots on the ground”- will work on specific tasks in the MAPP Process, likely on obtaining community input, collecting and reviewing data, and developing the CHIP. Shorter time commitment.
* Other options to be involved by helping with expertise, resources, or simply staying involved and supporting/championing the project
* The process takes about a year, and the Steering Team will meet for the first time in February. Assessments will begin in March

**Question and answer session:**

* Based on your experience of Fredericksburg CHA/CHIP, how does that impact how you approach this process?
  + One of our biggest lessons learned is keeping people involved throughout the process, because it is easy for these things to fall off the radar. We will have updates going out a lot in addition to monthly Steering Team meeting to keep people involved and informed. We didn’t communicate well enough the first go-round for Fredericksburg.
  + All meeting minutes, agendas, will be posted on external website
* Is the Fredericksburg CHA available on the website?
  + Yes (<http://www.vdh.virginia.gov/rappahannock/>)
* Announcement that the Caroline Census complete count committee has been meeting and has finished developing flyers in English and Spanish. We want to promote the census widely, as each person counted represents about $2000 per person per year in funds going to the community.

**Meeting adjourned at 1:40pm.**