

2025-2028



Central Virginia
Health District
**Community Health
Improvement
Plan**

Organizational Overview

Central Virginia Health District (CVHD) is one of thirty-five local health districts that are part of the Virginia Department of Health. The district headquarters is in Lynchburg with locality health departments located in Amherst, Appomattox, Bedford, and Campbell counties. The mission, “We nurture the community's wellbeing by practicing public health, meeting the needs of the present while planning for the future” is done through the dedicated work of the departments outlined below. Efforts of each department are led by the Health Director with support from the district management team.

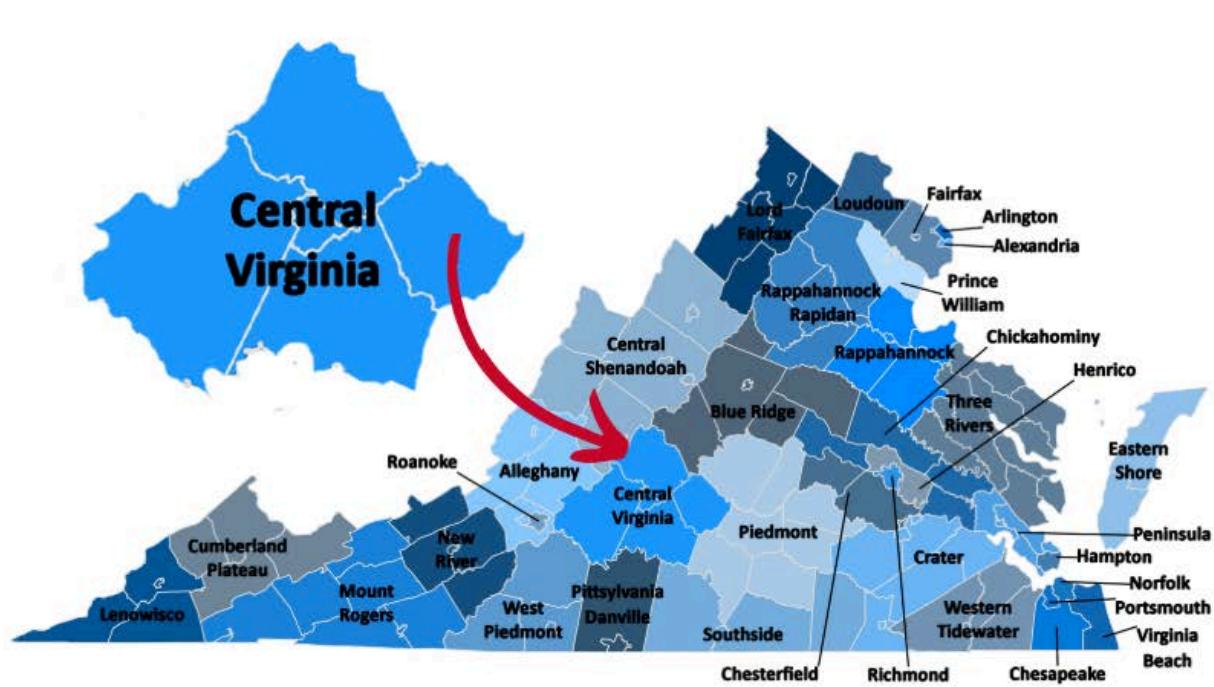
Central Virginia Health District
Departments:

- Administration and Human Resources
- Business Office – accounting, eligibility, and vital records
- Emergency Preparedness & Response
- Environmental Health
- Epidemiology
- Infant & Toddler Connection
- Nursing
- Population Health
- Women Infants & Children (WIC)

Scope and Purpose of the Community Health Improvement Plan (CHIP)

This improvement plan aligns with the work of Centra's community health needs assessment which was developed through collaborative efforts with Centra's Community Health Department, University of Lynchburg and the health districts in each respective service area. Data that was included in the CHNA included community survey data, secondary data, and both stakeholder and community focus groups.

The CVHD CHIP utilizes data for Lynchburg City, Amherst, Appomattox, Bedford and Campbell Counties. In addition to data from the 2024 CHNA, VDH data dashboards will also be used to evaluate the plan after three years. Focused efforts will be driven by the data based on localities and/or populations that present the greatest need. The CVHD CHIP will be a guiding instrument to focus the work that is being done collectively with external partners and within our district departments to improve outcomes related to each priority area.



Priority Needs Identified through 2024 Lynchburg Area Community Health Needs Assessment (CHNA) & 2024 Bedford Area Community Health Needs Assessment (CHNA)

	Lynchburg Area	Bedford Area
1	Access to Healthcare Services	Mental Health & Substance Use Disorders & Access to Services
2	Mental Health & Substance Use Disorders & Access to Services	Access to Healthcare Services
3	Food Insecurity and Nutrition	Food Insecurity & Nutrition
4	Homelessness & Housing	Issues Impacting Children & their Families: Child Abuse & Neglect Childcare
5	Issues Impacting Children & their Families: Child Abuse & Neglect Childcare	Homelessness & Housing
6	Aging and Eldercare	Transportation
7	Coordination of Resources & Outreach	Aging and Eldercare
8	Chronic Disease	Dental Care & Dental Problems
9	Transportation	Coordination of Resources & Community Outreach
10	Financial Stability & Assistance	Chronic Disease

Development of the 2025-2028 Central Virginia Health District CHIP

The CVHD CHIP was developed by looking at the priority areas of need from the Centra CHNA along with VDH priorities and data, then ranking the top four areas to be addressed.

Centra CHNA-Bedford & Centra CHNA-Lynchburg Area

Factors that played into the decision of what to address included:

Data

Showing the need to address the priority area to include areas of focus.

Organizational Capacity

Identification of priority areas in which CVHD was able to provide resources, programs or support.

Community Capacity

Identification of priority areas in which CVHD is working with established partnerships, coalitions, or collaboratives with the same or similar goals in mind.

Central Virginia Health District CHIP Priorities

Chronic Disease Prevention / Food Insecurity & Nutrition

Maternal Child Health

Coordination of Resources & Outreach

Substance Use Disorders & Recovery

The CHIP goals and strategies will focus on initiatives that the health district is currently working on and wish to expand and/or enhance measurable outcomes. CVHD has Community Health Workers & Peer Recovery Specialists and will be assigning one to each priority area of this plan. In addition, the health district will work with our hospital system, community partners and the collaborative/coalition that aligns with each priority area to look at evidence-based strategies for collective impact. Researched strategies will be listed for consideration.



CHRONIC DISEASE PREVENTION / FOOD INSECURITY & NUTRITION

Prevalence rates for diabetes, hypertension and smoking are significantly higher in the Central Virginia Health District than in Virginia as a whole. The CHNA data highlights that our community feels that access to healthy food is a top concern. Poor eating habits and lack of exercise are on the rise as notable health concerns based on the CHNA.

CVHD, Centra, JHC and CAN have programs and education targeted toward chronic disease prevention. The Nourish Network is an established collaborative of over 45 representatives from a variety of organizations who are focused on increasing access to healthy and nutritious foods and decreasing food insecurity in the district.

Goal – Increase access to healthy foods and improve eating habits for WIC participants.

Objective 1 - Increase utilization of and redemption rate for WIC vouchers to promote healthy food options for qualifying families.

Strategy 1: Survey WIC participants to determine obstacles preventing clients from seeking WIC services and redeeming WIC vouchers by August 2025.

Strategy 2: Use survey results to develop a plan in conjunction with WIC to increase utilization and redemption rates by December 2025.

Strategy 3: Monitor and evaluate the plan through December 2028 making changes/additions as needed.

Strategy 4: Work with the Nourish Network partners to promote the WIC program and educate families about WIC services. *Ongoing through June 2028.*

Goal – Increase availability of evidence-based chronic disease prevention programs.

Objective 1 – Increase the number of community members served through CDC's Diabetes Prevention Program.

Strategy 1: Increase the number of CVHD DPP cohorts completed by CHW's from 2 to 4 by December 2026. *8-12 participants enrolled per cohort, this goal would increase clients served by 200% and continue at that rate with at least 4 cohorts per year through June 2028.*

Strategy 2: Increase the number of CHW's from partner organizations conducting the DPP program from 1 to at least 4 by June 2028.

Strategy 3: Monitor and evaluate the plan through December 2028 making changes/additions as needed.

Objective 2 – Establish a Heart Healthy Initiative in collaboration with Centra Community Health and other partners as needed.

Strategy 1: Focus efforts on the Diamond Hill neighborhood by establishing a Healthy Heart Learning Collaborative by August 2025.

Strategy 2: Train at least 2 CHW's to teach ambassadors to do blood pressure checks in targeted areas by December 2025.

Strategy 3: Train at least 2 CHW's to conduct the blood pressure self-monitoring nutrition education classes by December 2025.

Strategy 4: CHW's will have completed at least 10 Blood Pressure Self-Monitoring (BPSM) Nutrition classes by June 2028.

Strategy 5: CHW's will identify smokers in the program and offer support via the Quitline or other resources. - *Ongoing through June 2028.*

Strategy 6: Work with Nourish Network partners to promote the Healthy Heart program and support initiatives. - *Ongoing.*

Goal – Review evidence-based intervention strategies with Nourish Network and explore feasibility for collective impact. See Appendix 2



SUBSTANCE USE DISORDERS

Although we are beginning to see a decline in overdose deaths across the state, the rate of overdose is still a public health concern. CVHD has worked closely with the Central Virginia Addiction and Recovery Recourses (CVARR) coalition with the same goals in mind – reducing overdose deaths and creating an environment where recovery from SUD's is possible and supported. We have a Partnering 4 Recovery program at CVHD that utilizes Peer Recovery Specialists (PRS) for Lynchburg and Bedford recovery court programs. In addition, the PRS's support pro-social events, alumni groups, courses at the Amherst County Jail and support CVARR initiatives throughout the year.

Goal – Focus efforts on overdose prevention and recovery community.

Objective 1 – Increase funding and capacity for the Partnering 4 Recovery program to support the recovery community.

Strategy 1: Seek OAA and other funding to support increasing capacity of the Partnering 4 Recovery program by December 2025.

Strategy 2: Develop a plan to provide peer support to those on parole with a SUD related crime for localities that have interest by January 2026.

Strategy 3 -Work with EMS in all localities to develop a system for referral to peer services when responding to substance use related calls by December 2027.

Objective 2 – Reduce the number of overdose deaths in CVHD by 10% in collaboration with CVARR

Strategy 1: Formulate a Narcan distribution plan to increase Narcan distribution across the district by at least 10% by January 2026.

Strategy 2: Encourage the use of test strips and develop a dissemination plan by January 2026.

Strategy 3: Target education and outreach to Hispanic and rural communities. *Ongoing.*

Goal - Review evidence-based intervention strategies with CVARR and explore feasibility for collective impact. See Appendix 2



Click [HERE](#) for more information on CVARR, their initiatives, and strategic planning.

MATERNAL CHILD HEALTH

MCH data for our health district indicates some vast disparities based on locality, race and ethnicity. For instance, **Amherst** and **Appomattox** counties have the highest prevalence of women (approximately 1 out of 10) who sought late or no prenatal care which can be an indicator of low birthweight, preterm births, and other complications. Disparity data is only available for Lynchburg due to lower numbers in the surrounding counties. In **Lynchburg**, black women have higher rates of late or no prenatal care, low birthweight births and preterm births. In addition, the black infant mortality rate is more than double that of white infants. The greatest disparity for Hispanic women in Lynchburg is the large percentage (17.9%) of women who receive late or no prenatal care. This compares to 11% for black women and 6.3% for white women.

CVHD has many programs to support maternal child health to include BabyCare, Child Passenger Safety, Safe Sleep, WIC, and Infant & Toddler Connection (Early Intervention). There is also a Maternal Child Health Collaborative that is well attended by our many community partners that support maternal child health programs and initiatives.



Goal – Improve access to postpartum care and screenings for women.

Objective 1- Utilize the BabyCare program to focus on postpartum care through the work of CVHD's Nursing Department and MCH CHW.

Strategy 1: Increase the number of women in the BabyCare program that receive postpartum visit 21-56 days after giving birth. *Ongoing through June 2028.*

Strategy 2: Increase the number of women in the BabyCare program who receive postpartum depression screening. *Ongoing through June 2028.*

Strategy 3: Ensure that women in the BabyCare program who experience postpartum depression receive medication for depression (if warranted). *Ongoing through June 2028.*

Goal - Decrease the % of women receiving late or no prenatal care to at least the VA state % in coordination with the maternal child health collaborative

Objective 1- Work with the Maternal Child Health Collaborative and safety net providers to develop a coordinated plan.

Strategy 1: Complete a community engagement survey to determine reasons for late or no prenatal care by March 2026.

Strategy 2: Use results of survey to engage MCH collaborative partners in creating a plan to increase access to prenatal care by June 2026.

Strategy 3: Partners will initiate interventions from the plan and evaluate success.
July 2026 through June 2028.

Strategy 4: Focus prenatal efforts on Black, Hispanic, and rural populations in which data indicates disparities.
Ongoing through June 2028.

Goal - Review evidence-based intervention strategies with Maternal Child Health Collaborative and explore feasibility for collective impact. See Appendix 2.



COORDINATION OF RESOURCES & OUTREACH

This is the first time that coordination of resources and outreach showed up as a need in the CHNA. Based mainly off information from the stakeholder and target population focus groups, the community noted that a need for better communication and awareness of resources exists.

CVHD, Centra, JHC and CAN have utilized CHW's to help fill this gap, but a more coordinated system would certainly help. In January of 2025 a Community Health Worker and Language Access was established. This hub, located at United Way of Central Virginia, provides an opportunity for CHW's across agencies to come together monthly to discuss resource sharing, collaboration, training and share best practices. In its infancy, we see the CHWLA Hub as a community approach to working on this CHNA need.



Goal - Utilize the CHWLA Hub to develop a coordinated approach for referrals and outreach.

Objective 1 - The CHWLA Hub will develop a system to connect community members to CHW's for linkage to services.

Strategy 1: Review how referrals and connections to CHW's are currently being implemented for each organization in the Hub by October 2025.

Strategy 2: Using information from strategy 1 and discussing potential options, formulate a plan for a coordinated CHW referral system by January 2026.

Strategy 3: Test the system and makes changes/enhancements based on feedback from the CHWLA Hub. *January 2026 through July 2028.*

Objective 2 – Station CHW's at United Way throughout the week to assist walk-in referrals and language access materials.

Goal 2- Build the capacity of CHW's across all localities in the district.

Objective 1 - Utilize the CHWLA Hub as a convenor for community health workers.

Strategy 1: Increase training, certification and recertification options for CHW's.

Ongoing through July 2028.

Strategy 2: Educate the public and partners on CHW work and impact. *Ongoing through July 2028.*

Strategy 3: Determine through CHNA and other data where targeted resources and outreach are most needed and develop a plan for reaching targeted communities by March 2026.

Goal - Review evidence-based intervention strategies with CHWLA Hub and explore feasibility for collective impact. See *Appendix 2*.



More information on the Community Health Worker & Language Access Hub can be found [HERE](#).

Appendix 1: VDH Dashboard Data to Support CHIP

Chronic Disease

PREVALENCE RATES	VA	CVHD
Diabetes (VDH, 2023)	11.8	17.2
Hypertension (VDH, 2023)	35.6	44.0
Current Smoker (VDH, 2022)	12.11	18.7

Substance Use Disorders

OVERDOSE DEATH RATE PER 100,000 (VDH)						
	Virginia	Lynchburg	Amherst	Appomattox	Bedford	Campbell
2023	28.7	22.1	18.9	18.7	23.8	14.5
2020	25.8	20.8	31.6	18.7	25.1	27.1

Unintentional Overdose Visits – ED Rate per 10,000 ED visits (VDH)						
	Virginia	Lynchburg	Amherst	Appomattox	Bedford	Campbell
2024	46.8	86.8	81.7	61.7	48.3	55.7
2021	65.1	115.2	113.7	122.0	89.1	83.7

Neonatal Abstinence Syndrome (NAS) rate per 1,000 births (VDH)						
	Virginia	Lynchburg	Amherst	Appomattox	Bedford	Campbell
2023	4.6	9.0	12.5	11.4	18.4	2.6
2020	5.8	7.4	26.8	5.9	9.0	17.9

Maternal Child Health

MCH INDICATORS 2023	VA	LYN	AMH	APPO	BED	CAM
% Late or No Prenatal Care	5.8	8.4	10.2	10.0	6.1	4.2
% Low Birthweight Births	8.5	8.5	7.8	10.0	8.2	9.3
% Preterm Births	9.8	8.0	6.9	9.4	7.2	9.7
Infant Mortality Rate (per 1,000 live births)	5.8	5.2	5.8	11.1	2.9	9.6

MCH LYNCHBURG DISPARITY	LYN	BLK	HISP	WHT
% Late or No Prenatal Care	8.4	11.0	17.9	6.3
% Low Birthweight Births	8.5	17.7	6.4	5.3
% Preterm Births	8.0	15.7	6.4	5.0
Infant Mortality Rate (per 1,000 live births)	10.5	23.5		6.6

Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

CHRONIC DISEASE/FOOD INSECURITY & NUTRITION

WIC & Senior Farmers' Market Nutrition Programs (FMNP)

Brief Explanation: Provides vouchers for WIC and senior participants to buy fresh produce at farmers' markets and produce stands. It promotes nutrition access and local agriculture. The federal WIC FMNP benefit ranges from \$10 to \$30 per year, and the federal Senior FMNP benefit ranges from \$20 to \$50 per year; some states supplement these amounts.

Feasibility: Moderate

Collaboration with local markets and farmers; coordination with Nourish network is possible but may require state-level approval for WIC-authorized market vendors.

Cost: Low to Moderate

Voucher costs supported by federal funding through the USDA Food and Nutrition Services; implementation costs mostly involve coordination, marketing, and vendor training.

Time: 3 to 6 months

This project is dependent on existing partnerships and growing seasons.

Rural/Urban Focus: Works well in both, but especially impactful in rural areas with limited grocery store access.

Additional information on this project being done before can be found [HERE](#).



Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

CHRONIC DISEASE/FOOD INSECURITY & NUTRITION

The WIC Shopping Experience: A Qualitative Study Examining Retail-based Strategies to Increase WIC Retention and Redemption Rates

Brief Explanation: A qualitative study revealed possible strategies for improving the WIC shopping experience to overcome barriers like confusion over finding eligible products, difficulty checking out, and perceived stigma. These strategies include convenient product placement, shelf-talkers to identify WIC-eligible items, WIC-only sections, bundling WIC products, and improving staff training. Such strategies must be acceptable to both stores and customers.

Feasibility: Moderate to High

Can be addressed via store partnerships with CVHD and Nourish Network; labeling interventions are low-cost and actionable, retail staff training could be supported by state WIC programs.

Cost: Low

Shelf labels, flyer, training material printing, and relocating products; no major infrastructure costs.

Time: 3-6 months

Store-level improvements can be made quickly with partners who are willing.

Rural/Urban Focus: Urban stores may have more WIC options, but rural improvements may show higher impact due to fewer alternatives.

Additional information on this project being done before can be found [HERE](#).



Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

CHRONIC DISEASE/FOOD INSECURITY & NUTRITION

A Review of Interventions to Increase WIC Enrollment and Participation

Brief Explanation: A systematic review of multiple (20) interventions/studies to increase WIC enrollment and participation rates. Promising interventions include enhanced communication strategies (e.g., texting, reminder calls), use of technology (apps), reducing administrative burden, and co-location of services (e.g., WIC + health clinics). BUT two interventions showed notable effectiveness...

- **CRUNCH Program:** Used cooking demonstrations, farmer's market tours, and community garden visits to increase Farmer's Market Nutrition Program (FMNP) check redemption among WIC participants.

*Creating a system to book tours & utilizing CHWs
- **NY WIC Evaluation:** Tested three tools – shopping orientations, pictorial food cards, and guided grocery store tours – to improve understanding of eligible WIC foods and retention.

Standardized orientations and food cards were most effective.

Feasibility: Moderate to High

Cooking demos and market tours can be facilitated via partnerships with the Nourish Network and local extension offices; shopping orientation materials and pictorial cards can be created or adapted from existing resources and delivered during intake or outreach events.

Cost: Low to Moderate

Cooking demos and market tours involve coordination and materials but can be supported through volunteers or funded by grant; visual tools and orientations have low ongoing cost after initial development.

Time: 3 to 6 months

Visual tools and orientations can roll quickly; market-based engagement may follow seasonal schedules.

Rural/Urban Focus: Effective in both; but more meaningful in rural areas where in-person guidance and community-based engagement can build trust and reduce barriers to redemption.

Appendix 2

A Review of Interventions to Increase WIC Enrollment and Participation (continued.)

Additional information on this project being done before can be found [HERE](#).

Articles reviewed:

- Seidel, M., Brink, L., Hamilton, M., & Gordon, L. (2018). Increasing WIC farmers' market nutrition program redemption rates: Results and policy recommendations. *Progress in Community Health Partnerships: Research, Education, and Action*, 12(4), 431–439.
- Intervention(s): Quasi-experimental design of cooking demonstrations, tours of Farmer's Markets, and community garden visits
- Effects: Redemption rate of Farmer's Market Nutrition Program checks among research participants and nonparticipants was 46.5% and 39.0% ($p < 0.001$), respectively
- Results: CRUNCH was successful in increasing the WIC Farmer's Market Nutrition Program check redemption rate among Wilkinsburg WIC participants
- Sekhobo, J. P., Peck, S. R., Byun, Y., et al. (2017). Use of a mixed method approach to evaluate the implementation of retention promotion strategies in the New York State WIC program. *Evaluation and Program Planning*, 63, 7–17.
- Intervention(s): Compare the three strategies: a standardized Shopping Orientation curriculum (1), a Pictorial Foods Card (2), and a Guided Shopping Tours at a local WIC vendor
- Effects: Shopping orientation had the highest change in participation, guided shopping tours had the lowest
- Results: A standardized shopping orientation along with a pictorial food card can help educate new WIC families on what items are eligible



Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

SUBSTANCE USE DISORDERS

Culturally Adapted Healthcare - *Expanding on current initiatives.*

Brief Explanation: Tailors health education, treatment, and outreach to the cultural and linguistic needs of specific populations—such as Hispanic communities—helping reduce disparities in SUD care access and improving engagement in services like Narcan use and peer support. Culturally adapted care can include...

- What's being done already: matching specialists to patients by race or ethnicity; adapting patient materials to reflect patients' culture, language, or literacy skills.
- What can be done further: offering education via community-based health advocates; incorporating norms about faith, food, family, or self-image into patient care; and implementing patient involvement strategies.

Feasibility: Moderate

CVHD can partner with community leaders, CVARR, and bilingual providers; utilizing bilingual staff and peer recovery specialists.

Cost: Moderate

Costs include translation, cultural training, and staff although CVHD's current peer recovery specialists are competent in those areas.

Time: 3 to 6 months

Cultural training and material development can be implemented in phases; community trust-building takes time.

Rural/Urban Focus: Effective in both setting, but especially important in underserved rural Hispanic communities.

Additional information on this project being done before can be found [HERE](#).

Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

SUBSTANCE USE DISORDERS

Naloxone Distribution in Treatment Centers and Criminal Justice Settings

Brief Explanation: Naloxone distribution programs in criminal justice and treatment facilities, targeting individuals who are about to be released from supervision and/or cease treatment to receive overdose response training and naloxone kits prior to their exit from the program or facility. Individuals with a history of incarceration are at higher risk of overdose in general.

Feasibility: Moderate

CVHD can collaborate with local jails, rehab, and treatment providers (like Horizon Behavioral Health, Blue Ridge Regional Jail); requires MOU and coordination with correctional systems; CVARR's involvement in SUD efforts can help streamline entry into justice/treatment systems.

Cost: Low to Moderate

Narcan is currently a free resource; costs mostly involve staff time for training delivery and logistics; minimal infrastructure required beyond basic training materials and storage.

Time: 3 to 6 months

Time needed to establish partnerships with justice/treatment facilities, conduct staff training, and integrate naloxone education into discharge planning; pilot testing in one or two facilities and then expanding it out

Rural/Urban Focus: Applicable to both, but particularly crucial in rural areas because they often lack immediate access to emergency care or treatment post-release.

Additional information on this project being done before can be found [HERE](#).

Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

MATERNAL CHILD HEALTH

Preconception Education Interventions

Brief Explanation: Preconception education interventions provide education and counseling to women of reproductive age/pregnant women information about the risks and benefits that affect a birthing person's overall health before, during, and after pregnancy in a variety of topics like nutrition, controlling chronic disease, reducing alcohol consumption, and improving mental health standard part of preconception care is ongoing wellness visits or well-woman care.

Feasibility: High

health education and outreach are already provided by CVHD – can train staff or CHWs to deliver education during existing programs or partner clinics; aligns with preventive services already funded or offered like WIC.

Cost: Low

Costs are mainly printing, training, and time investment; leverages existing staff and partnerships

Time: < 3 months

Can be integrated quickly into current community health outreach and services.

Rural/Urban Focus: Effective in both; especially relevant in rural areas where preconception education is often limited.

Additional information on this project being done before can be found [HERE](#).



Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

MATERNAL CHILD HEALTH

Group Prenatal Care

Brief Explanation: Group prenatal care, led by a trained health care provider, focuses on grouping pregnant people with similar characteristics (e.g., gestational ages, ethnicity, age) to meet regularly and learn care skills, participate in a facilitated discussion, and develop a support network.

Feasibility: Moderate to High

Partner with local clinics to host sessions; require trained facilitators and space but this can be built on existing provider infrastructure; developing a system to assign people into groups.

Cost: Low to Moderate

Primary cost is provider time and coordination – can use grant funding or reallocate staff; lower cost than one-on-one care if used for higher-risk or underserved groups.

Time: 3 to 6 months

Pilot groups can be initiated using current MCH partners.

Rural/Urban Focus: Effective in both settings, but particularly helpful in rural areas where social support and access to care are limited.

Additional information on this project being done before can be found [HERE](#).



Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

MATERNAL CHILD HEALTH

Mobile Reproductive Health Clinics

Brief Explanation: Mobile reproductive health clinics are medically equipped vans with clinicians that offer reproductive and prenatal health services in partnership with hospitals and health care systems. This typically serves vulnerable populations in underserved areas, reducing barriers like transportation, cost, and provider access.

Feasibility: Low to Moderate

Requires investment in vehicles, staff, scheduling, and partnerships with local communities, hospitals/clinics, and organizations; need funding.

Cost: Moderate to High

Vehicle, equipment, staff, and operational costs.

Time: 9 to 12 Months

Possibly up to a year for procurement, renovation, staffing, and launching routes & system.

Rural/Urban Focus: Very ideal for rural and underserved communities where clinic access is limited.

Additional information on this project being done before can be found [HERE](#).



Appendix 2

Evidence-based Strategies for Collaborative Action-includes examples of researched strategies to begin discussion with respective collaborative and interested partners. Strategies were chosen based on priorities of the CHIP.

COORDINATION OF RESOURCES & OUTREACH

Social Service Integration

Using Electronic Referrals to Address Health Disparities and Improve Blood Pressure Control

Coordinating Data Sharing Across Agencies: Strategies to Address Common Challenges

Additional Methods- The following are proposed concepts and do not currently have an evidence base.

- Centralized Referral Hub: A designated “hub” (e.g., CHWLA Hub) acts as a central point to receive client needs and connect them to appropriate services.
- Closed-Loop Digital Referral Platform (e.g., Unite Us, IRIS, NowPow): secure online platform that allows partner organizations to send, accept, and confirm referrals.
- Universal Intake Form (“Common App” Style): A single application form that collects info once and routes it to multiple programs.
- CHW-Led Outreach and Navigation model: Trained Community Health Workers (CHWs) help clients navigate services through warm referrals and maintain follow-up.
- Data-Sharing Agreements + Shared Database: Formal MOUs between organizations to allow secure data sharing related to client referrals and service use.
- Resource Navigation + SDOH Mapping Dashboard: Use CHNA and other local data to identify high-need areas and align outreach and resources accordingly.
- Partner & Public Education Campaign: Train agencies and the public on how referrals work, what CHWs do, and how to access the shared system.



