



PRESIDENT'S COUNCIL ON
UVA-COMMUNITY PARTNERSHIPS

PUBLIC HEALTH WORKING GROUP RECOMMENDATIONS

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INTRODUCTION

As one of his first acts as President of The University of Virginia, President Jim Ryan created the President's Council on UVA-Community Partnerships.

The goal of the Council is to work with President Jim Ryan to identify opportunities for the University to foster good-neighbor relationships with surrounding communities.

The council listened to the community, and after conducting a wide-reaching survey, they were able to distill what they learned to focus on **four** priority areas:

- **jobs and wages**
- **affordable/workforce housing,**
- **public/equitable healthcare, and**
- **youth/education.**

From these focal areas, the President's Council **working groups were formed of community members and university personnel to make recommendations to the president** about the ways in which the University might embody being both good and great **as they act as a good neighbor in the region.**

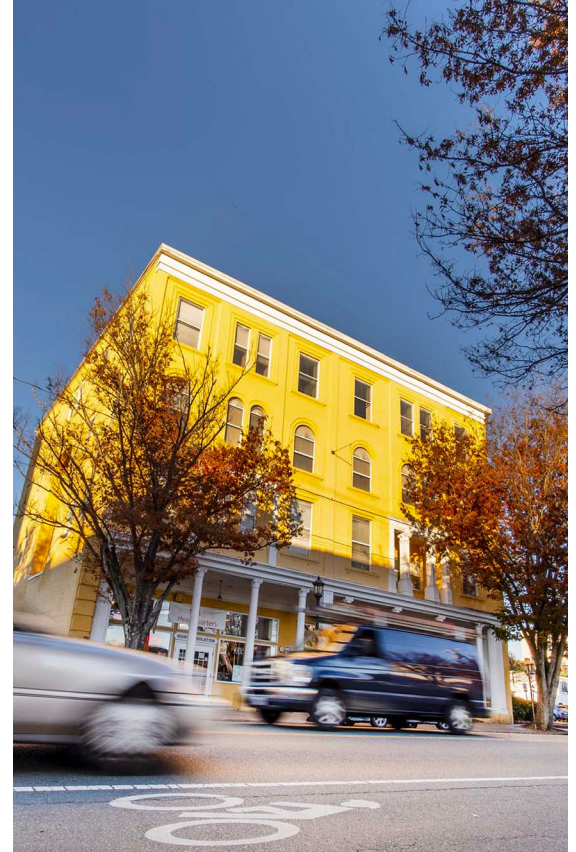
The Report to University of Virginia President James E. Ryan (2019), called for The University to:

"partner with the plurality of communities that it serves to ensure all residents have equitable access to high-quality, affordable health care, including medical, mental health, substance use support services, and dental care."

(University-Community Working Group, 2019, pp. 3)

The council further suggested that The University should work with community partners to support access to nutritious food and safe spaces for recreation, as a means by which to address public health. The Public Health Working Group was created to address this challenge.

This work aligns with recommendations of the University of Virginia's Racial Equity Task Force, which articulated a goal to "Build Pathways of Staff Success:"



UVA Center for Community Partnerships (Photo by Sanjay Suchak, University Communications)

Improve career development, salary equity, and hiring of historically underrepresented groups for leadership positions and contracting opportunities so that Black and Latinx Staff and Contractors benefit from job promotion and wealth building.

(McDonald, K., Solomon, I. H., & Wilson, B. B., 2020, pp. 13-14)

Moreover, this work aligns with Goal II of the University's 2030 Strategic Plan, "Cultivate the Most Vibrant Community in Higher Education." Specifically, the plan states that The University will:

Be a community that consistently lives its values.

We will live by and promote the values at the heart of the University, including **service, excellence, honor, diversity and inclusion, free speech and academic freedom, and student self-governance**. Also, we will both study and be accountable as an institution to address pressing societal challenges, including environmental sustainability, social mobility, educational inequities, and health disparities. (University of Virginia, 2019, pp. 19)

and

Be a strong partner with and good neighbor to the Charlottesville region.

We are an anchor institution, and we will work side by side with our neighbors to **help ensure that the Charlottesville region is among the best and most equitable places to live, work, and study**. We will approach this work with humility and respect, and with the ultimate goal of creating a general sense that we are all part of the same community. (University of Virginia, 2019, pp. 19)

The Public Health Working Group, led by co-chairs, Jacklene (Jackie) Martin and Tracy Downs, **met regularly from 2021 through late 2022 to learn from community members and organizations**. This allowed them to evaluate the strengths and weaknesses of the University and to deeply examine potential opportunities and threats related to public health.

All efforts to listen, learn, discuss, and explore were taken in order to identify clear, community informed steps that the University can take in order to advance greater coordination between community-based initiatives in Virginia's Planning District 10 and the University to improve health outcomes and reduce racial disparities. The group also worked to **learn about the ways in which other major players in the region are working toward public/equitable healthcare**.

The examination of these best practices, combined with community and institutional knowledge have allowed the Public Health Working Group to formulate the following report. The report details the **charge for the group, scope of work, deliverables, considerations, research and engagement, and recommendations.**

FRAMING OF THE REPORT

Health Disparities

Health Equity means that **everyone has opportunities to live long, healthy, productive lives – no matter who they are, how they identify, or where they live.** (Robert Wood Johnson Foundation, 2017).

Significant health disparities have persisted despite the advancements and novel contributions of biomedical research to scientific advances in the etiology, prevention, and treatment of human diseases. Advancing health equity and reducing health disparities will require extending beyond traditional research paradigms focused on individual-level differences to societal investments focused on broader social, environmental, structural, and systemic drivers of population health and health disparities.

The evidence is robust that health disparities result from the complex interplay of factors that operate at multiple levels (e.g., biological, behavioral, environmental, social, economic, organizational, and policy). Addressing health disparities will require initiatives that account for this multi-level complexity.

According to the National Institute of Health (2022), populations with health disparities include:

- Racial and ethnic minority populations
- Less-privileged socioeconomic status (SES) populations
- Underserved rural populations
- Sexual and gender minority (SGM) populations

Additional populations at risk for health disparities:

- Individuals with disabilities
- Individuals with multiple chronic conditions
- Individuals with stigmatized health conditions (obesity, HIV, mental health conditions)
- People with lower educational attainment
- Populations for whom English is a second language or with limited literacy skills

- Refugee populations and recent immigrants, or people with undocumented status
- Individuals with two or more of the identities in these list

Authentic engagement of patients, communities, and interested mission-driven community partners is vital in identifying the needs and priorities of the affected communities and developing effective and sustainable solutions.

Neighborhood Atlas – Area Deprivation Index (ADI) and Place Based Investments

Living in a disadvantaged neighborhood, has been linked to a number of healthcare outcomes, including higher rates of diabetes and cardiovascular disease, increased utilization of health services, and earlier death. Health interventions and policies that do not account for neighborhood disadvantage may be ineffective. Launched in 2018, [The Neighborhood Atlas website](#) was created in order to freely share measures of neighborhood disadvantage with the public, including educational institutions, health systems, not-for-profit organizations, and government agencies, in order to make these metrics available for use in research, program planning, and policy development.

The **area deprivation index (ADI)** is a multidimensional evaluation of a region's socio-economic conditions, is associated with health outcomes, to identify and screen patients for social determinants of health. It is composed of seventeen factors describing income, education, employment, and housing quality; it is a composite score for each of nine-digit ZIP code.

The ADI is a factor-based index that uses seventeen U.S. census *poverty, education, housing, and employment indicators* to characterize census-based regions.

Area Deprivation Index

Category	US Census Indicator
Poverty	<ul style="list-style-type: none"> • Median Family Income (\$) • Income Disparity • Families below poverty level (%) • % Population below 150% poverty threshold (%) • Single parent households with dependents < 18 y.o. (%) • Households without a motor vehicle (%) • Households without a telephone (%) • Occupied housing units without complete plumbing (%)
Housing	<ul style="list-style-type: none"> • Owner occupied housing units, (%) • Households with > 1 person per room, (%) • Median monthly mortgages, (\$) • Median gross rent, (\$) • Median home value, (\$)
Employment	<ul style="list-style-type: none"> • Employed person 16+ in white collar occupation, (%) • Civilian labor force unemployed (aged 16+), (%)
Education	<ul style="list-style-type: none"> • Population aged 25+ with < 9yr education, (%) • Population aged 25+ with at least a high school education, (%)

Public Health Framework for Reducing Health Inequities



Image 1: Public Health Framework – Reducing Health Inequities

Source: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Model, 2006



Image 2: Achieving Health and Mental Health Equity at Every Level

Source: Portrait of Promise: California Statewide Plan to Promote Health and Mental Health Equity/California Department of Health

Health Equity Zones (HEZ) and the Rhode Island Department of Health (RIDOH). Health Equity Zones and the work by the Rhode Island Department of Health uses health promotion and disease prevention approaches to close the health equity gap. The RIDOH's first attempt to move beyond traditional approaches to prevention was the "Centers for Health Equity and Wellness" (CHEW) initiative. The CHEW initiative, established and funded from 2012 to 2015, aimed to champion, build capacity for, and sustain community organizations that were already promoting health and wellness through prevention.

Each CHEW resided in a low-income neighborhood in Rhode Island and was supported by a community-based agency or organization that applied for funding to address a priority project identified by the local community. For all of RIDOH's good intentions, however, it became clear over the duration of the project that the initiative did not deliver on the level of power-sharing, community engagement, and self-determination that had originally been promised. As a result, the CHEW communities did not feel sufficiently connected with the projects and programs they were supposed to create.

In 2015, RIDOH built on lessons learned through the CHEW initiative to launch the "Health Equity Zone" (HEZ) initiative—the second iteration to advance health equity through a new approach to prevention. While the CHEW initiative rhetorically affirmed the importance of community leadership and engagement, HEZs were structured as community-led collaboratives, with the long-term goal of supporting each HEZ to develop into a self-sustaining, self-funding entity that can respond to evolving community needs and priorities. Additionally, unlike the CHEW initiative, RIDOH provides seed funding to the HEZs through a "braided" funding model, which can allow collaboratives greater flexibility in choosing their priorities. Braided funding can also help sustain an HEZ when it's ready to pivot to a new priority or focus.

Each HEZ has a dedicated RIDOH project officer assigned to guide the implementation of the model and provide technical assistance and support, as well as a local "backbone organization" that acts as an organizational centerpiece and convening body for the HEZ. In designing the HEZ model, RIDOH developed a theory of change to help articulate the initiative's long-term goals and describe the preconditions necessary to achieve those goals. RIDOH's theory of change looks like this:

- "If Rhode Island collaboratively invests in defined geographic areas to develop sustainable infrastructure, and aligns a diverse set of resources to support community-identified needs, then we will positively impact the socioeconomic and environmental conditions driving disparities, and improve health outcomes" (ChangeLab Solutions and Rhode Island Department of Health, 2021, p. 5).

As the HEZ initiative has grown and matured (Years 1-5), the RIDOH identified four key components to successful and sustainable implementation of the model. The HEZs exemplify a (1) health equity-centered approach to prevention work that leverages (2) place-based, (3) community-led solutions to address the (4) social determinants of health (SDoH).

- **Health equity-centered** means that measuring and responding to population health disparities should be the primary organizing principle for your department's approach to prevention. Health equity must be at the center of your organization's culture, and departmental structures should strive to incorporate equity-informed decision making for both day-to-day practices and your long-term mission and vision. Please also make sure that health equity principles extend to external partnerships with communities, businesses, nonprofits, consultants, and government agencies.
- **Place-based** indicates that an equitable prevention approach should focus on providing resources to specific geographic areas, rather than funding all places equally. People live in communities, and communities exist within a limited physical space. Because of this, health outcomes are closely tied to where people live: the surrounding environment that encompasses their homes, workplaces, schools, and community centers. Any successful prevention effort must confront environmental factors that contribute to health inequities.
- **Community-led** signifies that the state or local department of health must share power with community members in a meaningful way and allow them to choose projects based on their own needs and priorities. Prevention efforts that are primarily guided by health officials and experts rarely turn out to be sustainable. This is because the community those experts are trying to help does not feel connected to and empowered by the solutions that health experts are proposing. State and local health department

leaders must trust that communities best understand their own problems and priorities. Public health serves the public, not the other way around.

- **The social determinants of health** are the primary root causes of health inequities. SDoH include factors like access to education, quality job opportunities, safe housing, political participation, and healthy food. Successful, equity-centered prevention efforts absolutely must address the social determinants of health

DEVELOPMENT OF THE REPORT

Charge to the Group

To advance greater coordination between community-based initiatives in Virginia's Planning District 10 and the University to improve health outcomes and reduce racial disparities.

Scope of Work

- Review public health data to understand trends and gaps, with a focus on the social determinants of health.
- Conduct landscape analysis of existing community efforts in relevant areas of work.
- Engage the Equity Center and other partners to conduct community engagement to build trust and gain a deeper understanding of community priorities, barriers, needs, and solutions.
 - Attention should be paid to the growing understanding of racism as a public health crisis.
- Develop recommendations for UVAHS strategic plan that complement existing community efforts, including the other working groups, and consider the social determinants of health.
 - Emphasize priority goals to strengthen health equity partnerships between the University and the community.
- Generate a list of near-term actionable steps that the University can take to engage with, leverage, and support existing community efforts such as MAPP2Health 2019 and 2022 reports, Food Justice Network, Move2Health Equity, Central Virginia Clinicians of Color Network, and the Community Mental Health and Wellness Coalition.
- Identify opportunities for how a strategic communication/PSA initiative can increase understanding of social determinants of health.
- Identify areas in which sufficient activity is not yet occurring and unique efforts and focus could be launched to advance the public health priorities identified in the report.

Deliverables

1. Final Report to include elements described in the scope of work above, including: recommendations for UVA Health System Strategic Plan, recommendations for strengthening health partnerships between the University and the community, actionable steps for supporting existing community efforts, opportunities to increase understanding of social determinants of health, and areas where UVA should launch unique efforts.
2. Develop recommendations for a phased approach of actionable items for achieving the goal that could be achieved in the near and long term.
 - **List of near-term actionable steps** that the University can take to engage with, leverage and support existing community efforts.
 - **List of long-term actionable steps** that would complement existing work and fill identified gaps.

RESEARCH & ENGAGEMENT

The Public Health Working Group worked diligently to listen to community members, and organizations, and want to thank everyone who contributed to this collective effort. Review of the MAPP2Health Report (2019, 2022) revealed a necessary focus on physical and mental health care, specifically including maternal health outcomes. Food insecurity rose to the top of the social determinants of health with data indicating widening trends in food insecurity in our communities and with other President Council workgroups focused on other social determinants including jobs and housing.

RECOMMENDATIONS

A. Physical Health Recommendations

1. Develop a diversity, equity, and inclusion scorecard to track disparities in health outcomes and patient satisfaction, linked to plans for Quality Improvement and accountability.
 - a) Provide timely and transparent data on how patient feedback, particularly feedback from historically marginalized communities, is incorporated into quality improvement within the health system.
2. Invest in resources that directly address health inequities.
 - a) Research applications that support the black birthing experience ([Irth](#), [Wolomi](#), etc.) and partner with Birth Sisters of Charlottesville, the Improving Pregnancy Outcomes coalition and others to invest in piloting applications within the health system and community.
 - b) Advocate for increased Medicaid reimbursement for doula services.
3. Collect, report and track in a circular, iterative fashion, quantitative data paired with qualitative data to assess progress toward eliminating health inequities.
 - a) Use this data to communicate and track a public commitment to antiracist practice with targets and actions (see [Mt. Sinai Road Map for Action to Address Racism](#), [Duke University Moments to Movement](#), etc.)
 - b) In partnership with the Blue Ridge Health District, engage regularly with the communities we serve to establish two-way communication about the state of public health in the region.
4. Form meaningful, two-way partnerships with large partners in the health care network.
 - a) Provide funding, technical resources and representatives with decision-making authority to existing and emerging community collaboratives including the Improving Pregnancy Outcomes coalition, Move2Health Equity, the Community Mental Health and Wellness Coalition, the Charlottesville Food Justice Network, etc.
 - b) Fund and directly support the implementation of the [2022 MAPP2Health Community Health Improvement Plan](#)

5. Coordination – coordinate medical services for community members in local, place-based clinics.

a) Supply each clinic with access to EPIC, patient information system, at an allowable level to assist with coordination of services to include food access, Medicaid participation, behavioral health services, etc.

b) Establish a training program to create and/or fortify clinics that support the Blue Ridge Health District clinics and area free clinics, in order to provide sustainable, community-based preventative care.

c) Build out care teams to top license to ensure optimum resource utilization (ex. Medical Doctor / Nurse Practitioner / Registered Nurse / Clinical Health Worker & Case Manager).

6. Policy

a) Medicaid enrollment – Define market penetration goal for Medicaid and track this data, ensure that those eligible are being brought into the system instead of waiting for them to figure out that they are eligible.

1) Use hospital-based social workers to identify who is eligible and assist them with the completion of any paperwork while provider to patient access is possible.

2) Monitor who is eligible and what percent are enrolled on an on-going basis to inform action and decision making. Report this out so that it is community knowledge.

3) Streamline the process for Medicaid reimbursement while patients are present in the hospital by utilizing hospital social services staff, and systems upgrades.

B. Behavioral Health Recommendations:

1. Create a community-based behavioral health mall, allowing those in need of preventative or immediate services to get the support that they need all in one space. The behavioral health mall could address concerns related to direct care, workforce, and community engagement stability.

The space should include, but not be limited to, providing the following services:

- a) Clinical group work
- b) Independent psycho-social support
- c) Peer support
- d) Wellness/community
- e) Integrative care
- f) Food court / food tuck
- g) Community event/gathering lounge/space
- h) Sliding scale opportunities for all services
- i) Long-term/ongoing behavioral health support

2. UVA should directly fund existing, culturally competent providers to provide community level services including but not limited to:

a) Sister Circle - a program run by The Women's Initiative; Charlottesville aims to meet the unique needs of people from across the African diaspora who identify as women by providing culturally responsive mental health counseling and treatment through a trauma-focused lens and more.

b) Central Virginia Clinicians of Color Network - provides support and professional development to clinicians of color to elevate the standards of care and therapeutic services for diverse populations.

(1) Resourcing and partnering with them would allow them to train more clinicians of color, who can offer mental health services to more people of color in the community.

c) Birth Sisters of Charlottesville - a woman of color community-based doula collective supporting women of color through their birth journey and into motherhood. Their aim is to amplify the resiliency of Black, Indigenous, Women of Color by drawing on life experiences, shared values, training, and sacred legacies to provide culturally rooted, trauma intuitive perinatal services and advocacy. They serve women in the City of Charlottesville and the surrounding counties.

3. Grow the community capacity to support people with behavioral health needs, by supporting a pipeline for both formal and peer-based training and job acquisition.

- a) Mentorship
- b) Technical assistance
- c) Apprenticeship
- d) Internship
- e) Community health workers

4. Expand behavioral health treatment options to include options that allow those dealing with behavioral health needs to have their needs met in ways that are safe, responsible, and respectful. Note that these recommendations may represent a significant cost savings for The University.

a) Suboxone bridge prescriptions – links those suffering from opioid related substance abuse disorder with counselors and health coverage for a period of 30 days (about 4 and a half weeks) following an overdose.

b) Establish a protocol for brief emergent psychiatric intervention in Emergency Department coupled with coordination with community partners.

c) Establish partial hospitalization program in coordination with community-level support.

C. Food Security Recommendations

1. Health system-wide food insecurity screening.

a) Short screening linked to patient encounter with data recorded, that will automatically trigger the next step.

1) Generate a list of community resources and contacts (in patients' language of choice whenever feasible).

b) Provide the list to the patient with discharge and financial assistance paperwork.

b) Screening data stored in the patients' Electronic Health Record, (ensure that patients are informed and can opt out if they wish).

c) Measure food insecurity as it intersects with health outcomes by tracking that can be assessed across different races, and other demographics.

d) Make it a job duty of current or future staff to ensure that the list of community food security resources is comprehensive and up to date.

e) Expand food distribution in-house by investing in storage options allowing departments to prescribe healthy foods for patients to take home following their visit.*

2. See UVA Health as a stakeholder in food access/justice campaigns.

a) Invest in community-led initiatives. Community member and business owner Troy Robinson, has explored a unique food access idea with the help of the UVA School of Law. Explore this game changing idea.

- b) Semi-regular listening sessions / consult with community to ensure investment is in line with needs (compare voices to data).
- c) Engage in advocacy work related to food security.
 - 1. Engage in advocacy work related to SNAP benefits, and support this work with research, ex: health outcomes with Pandemic Electronic Benefit Transfer (P-BET) program (Virginia Department of Social Services, n.d.).
 - 2. Engage in advocacy work by partnering with local community partners on bills related to equitable access to food, and work with community partners to decrease the impact of proximity to healthy food on community members. This may include ensuring that healthy, EBT eligible foods are brought to community members.

In response to a dramatic increase in gun violence in the community, recommendations on prevention strategies focusing on youth have been added to this report.

D. Gun Violence Prevention Recommendations

1. Student Identification (Near-Term)

- a) Support expansion of threat assessment protocols in school system by providing evidence-based research, promising approaches, financial support, and practical tools such as overlaying truancy with justice involvement for a more robust understanding of who is at risk.

2. Transition Plans (Near-Term)

- a) Using the Child Adolescent Needs and Strengths (CANS) model which assesses mental, physical, educational, criminogenic, psychosocial, environmental strengths and needs conducting semi-structured interviews with students at Blue Ridge Detention center to help inform student centered care coordination.

3. Care Coordination/ Case Management (Long-Term)

- a) Intensive case management has been found to be effective in uptake of services (alternatively, a decline in unmet needs); increasing duration of service use by youth, reducing “loss to follow up” and reducing use of facilities/institutions (hospitals, jails

etc.) with accompanying cost savings. There is also evidence that increased case management improves outcomes for recipients in some domains including decreases in reoffending; reports of having a caring adult at home, at school and outside of home and school; quality of peer relationships; engagement with school and decreases in substance abuse and potentially harmful behavior. Assessing the current ecosystem of care coordination is prudent to identify gaps and areas of improvement.

b) A standard evidence-based assessment tool like the CANS or the YAZI will yield varied risk factors like substance use, unstable housing, childcare, workforce, and education needs. Intake, coupled with data collecting and reporting capabilities that emphasize user experience, are central to the goal of individualized assessment and treatment.

4. Programming (Near-Term)

a) At-risk youth are often service-averse and/or difficult to retain in programs because of instability, family dynamics, or mistrust and hopelessness. Engagement would come with services, activities that include social and emotional learning, and paid employment. Establishing and supporting youth programming specifically for at-risk youth or youth in the juvenile justice system is important.

PHASED RECOMMENDATIONS

To best strategize for implementation of the Public Health Working Group recommendations, the following is a tiered list that can guide implementation. Phase 1 includes short-term recommendations that can be implemented in under eighteen months. Phase 2 includes medium-term recommendations that may take eighteen months to three years. And finally, Phase 3 includes recommendations that may be implemented in the long-term, specifically between three to five years.

Phase 1: Continued Assessment and Application

- Recommendation 1: **Invest in resources that directly address health inequities.** (Physical Health)
- Recommendation 2: **Collect, report and track in a circular, iterative fashion, quantitative data paired with qualitative data to assess progress toward eliminating health inequities.** (Physical Health)
- Recommendation 3: **Health system-wide food insecurity screening.** (Food Security)
- Recommendation 4: **Develop a diversity, equity, and inclusion scorecard to track disparities in health outcomes and patient satisfaction, linked to plans for Quality Improvement and accountability.** (Physical Health)
- Recommendation 5: **Student Identification: Support expansion of threat assessment protocols in school system.** (Gun Violence Prevention)
- Recommendation 6: **Intensive care coordination/case management** (Gun Violence Prevention)
- Recommendation 7: **Establish and support youth programs** (Gun Violence Prevention)
- Recommendation 8: **Use the Child Adolescent Needs and Strengths (CANS) model** (Gun Violence Prevention)

Note: Many recommendations started during Phase 1 will be continuous in their development. Establishment of these tools will be started in the short-term, but implementation will be continued following their creation.

Phase 2: Continue to Grow, Support, and Develop

- Recommendation 9: **Grow the community capacity to support people with behavioral health needs, by supporting a pipeline for both formal and peer-based training and job acquisition** (Behavioral Health)

- Recommendation 10: **Expand behavioral health treatment options to include options that allow those dealing with behavioral health needs to have their needs met in ways that are safe, responsible, and respectful.** (Behavioral Health)
- Recommendation 11: **Form meaningful, two-way partnerships with large partners in the health care network.** (Physical Health)
- Recommendation 12: **UVA should directly fund existing, culturally competent providers to provide community level services.** (Behavioral Health)

Phase 3: Building Towards Integration and Advocacy

- Recommendation 13: **Policy: Advocate for Medicaid enrollment** (Physical Health)
- Recommendation 14: **Create a community-based behavioral health mall, allowing those in need of preventative or immediate services to get the support that they need all in one space.** (Behavioral Health)
- Recommendation 15: **See UVA Health as a stakeholder in food access/justice campaigns.** (Food Security)
- Recommendation 16: **Coordination: coordinate medical services for community members in local, place-based clinics.** (Physical Health)

COORDINATE WITH OTHER WORKING GROUPS

1. **Local Economy:** Invest in the Local Economy, by supporting existing groups working to provide culturally specific behavioral health care. (See Behavioral Health recommendations 2a-2c)
2. **Early Childhood Education:** Invest in affordable childcare options for all UVA faculty and staff to aid in the recruitment and retention of high-quality health care team members. (See changes in Policy and Informatics 5c)
3. **Affordable Housing:** While creating the plan for affordable housing consider access to behavioral health, physical health, and access to healthy foods. Invest in health care hubs in existing low-income housing developments to increase access to health care. (See changes in Policy and Informatics 5c)
4. **Pipelines and Pathways:** Create hiring targets and packages that encourage the recruitment and retention of high-quality, health care professionals to include everyone on the spectrum of the care team (See changes in Policy and Informatics 5c)

SUMMARY AND CONCLUSION

In summary, the Public Health Working Group recommends that the following broad recommendations be used to share the manner in which the University interacts with the local community.

1. Build trust, center people who have disparities in ongoing conversations, feedback, and development, and believe them. Prove UVA's commitment to the community.
2. Ensure that all data can be disaggregated across demographics including by race, age band, and socio-economic status
 - a) Make data available by specialty and ensure that the community can understand actual impact.
 - b) Link data to plans for Quality Improvement in transparent ways.
3. Allow Black, Indigenous, and people of color to make decisions for themselves about how their work is crafted. (*Central VA Clinicians of Color*)
4. Support public health recommendations in a structural, sustainable way - including being honest with the community about feasibility and projected timelines

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Jessica Harris, Program Manager, The Equity Center at The University of Virginia

Nicole Pherson, Administrative Staff, University of Virginia

Appendix: Comparison Tables – UVA Health Strategic Plan and MAPP2Health

<p>UVA Health Cultivating Healthy Communities and Belonging for All Best Place to Work</p>	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health</p>
<ul style="list-style-type: none"> • Employee Engagement • Good Employer • UVA Health Leadership Academy • Annual UVA Health System Innovation Competition • Investing in our RNs, MDs and Interprofessional talent • Maintain Magnet Status Nursing Credentialing • Enhancing Human Resources Services 	<p><u>Workforce (Healthcare System)</u> Providers and staff reflect the diverse patient population</p> <ul style="list-style-type: none"> • Advocate for funding and programs, trainings and classes that encourage people of color and multi-language speakers to join the workforce <p><u>Mental Health Recommendations (Healthcare System)</u> Expand capacity for racially and culturally responsive behavioral health care</p> <ul style="list-style-type: none"> • Implement comprehensive strategies to address the behavioral health workforce shortage
<p>UVA Health Cultivating Healthy Communities and Belonging for All Community Engagement and Health Equity</p>	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health Healthy and Connected Communities for all ages</p>
<ul style="list-style-type: none"> • Community Health Needs Assessment (CHNA) • Access to Primary Care Services • Strive for a workforce that resembles the communities we serve • Open new community based Neighborhood clinics and outreach sites that address our community's needs • Expanding UVA Health Recruitment from our communities to support upward mobility "Earn While You Learn Program" 	<p><u>Workforce (Healthcare System)</u> Providers and staff reflect the diverse patient population</p> <ul style="list-style-type: none"> • Advocate for funding and programs, trainings and classes that encourage people of color and multi-language speakers to join the workforce • Incorporate multi-lingual Community Health Workers (CHWs) from nearby communities as patient support and Navigators • Collaborate to create a CHW network that can train, outsource, refer, and staff district partners with Health Navigators on request • Incentivize healthcare systems to broaden clinical training opportunities to the public, particularly outside of 9am-5pm working hours <p><u>Medicaid, Health Insurance & Payment (Healthcare System)</u> Enroll all eligible patients in Medicaid</p> <ul style="list-style-type: none"> • Offer Medicaid enrollment trainings for first responders, local government employees,

Appendix: Comparison Tables – UVA Health Strategic Plan and MAPP2Health

	<p>and other public sector, client-facing employees in order to identify eligible residents and bundle services</p> <p><u>Mental Health Recommendations (Healthcare System)</u></p> <p>Expand capacity for racially and culturally responsive behavioral health care</p> <ul style="list-style-type: none"> • Invest in racially and culturally responsive behavioral health services • Implement organizational policies and practices to eliminate racial and cultural inequities in behavioral health <p>Promote policies, systems and environments that improve behavioral health and wellness</p> <ul style="list-style-type: none"> • Expand stigma reduction and mental health literacy training in places where we live, work, learn, and play • Expand access to housing supports, telehealth, and transportation for individuals with behavioral health needs <p><u>Digital Access and Literacy (Built Environment)</u></p> <p>Integrate Digital Navigators into the healthcare landscape</p> <ul style="list-style-type: none"> • Funding for training curriculum and education of Community Health Workers (CHWs) to assist and teach communities (telehealth services and Medicaid enrollment) • Provide affordable access to connect to healthcare services – Digital access equity centers that provide centralized locations with reliable digital technological support
<p>UVA Health Cultivating Healthy Communities and Belonging for All</p> <p>Value Based Care</p>	<p>MAPP2 Health Priority Area:</p> <p>Healthy Equity and Access to Care</p> <p>Mental Health</p>
<ul style="list-style-type: none"> • Programs that support employee Wellbeing • Expand Access to Care for UVA Employees • Expand Primary care access across UVA Health both in person and virtually • Infrastructure for scholarship in public health sciences and advances in clinical performance in value-based care models 	<p><u>Transportation (Built Environment)</u></p> <p>Improve transportation infrastructure</p> <ul style="list-style-type: none"> • Partner with Healthcare systems to improve nearby bus stops and increase route frequency to health system hospitals and providers • Develop GPS apps to track bus routes • Develop a robust rideshare network and voucher system for patients

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	<ul style="list-style-type: none"> • Work with donors to expand Medicaid transportation contracts to nonprofits and organizations with patient roster's under 50 clients <p><u>Digital Access and Literacy (Built Environment)</u> Create digital literacy improvement and bridging services for users in multiple languages</p> <ul style="list-style-type: none"> • Access current digital literacy and training programs (for end-users) and evaluate the most effective programs to scale-up in multiple languages <p><u>Referral and Communication Networks (Healthcare System)</u> Easily connect and refer patients to providers regardless of the healthcare setting</p> <ul style="list-style-type: none"> • Review current systems for information sharing and referrals to determine gaps and opportunities for connection <p><u>Mental Health Recommendations (Healthcare System)</u> Expand capacity for racially and culturally responsive behavioral health care</p> <ul style="list-style-type: none"> • Invest in racially and culturally responsive behavioral health services • Implement organizational policies and practices to eliminate racial and cultural inequities in behavioral health <p>Promote policies, systems and environments that improve behavioral health and wellness</p> <ul style="list-style-type: none"> • Advocate improved financing and insurance coverage for behavioral health needs • Expand access to housing supports, telehealth, and transportation for individuals with behavioral health needs
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Appendix: Comparison Tables – UVA Health Strategic Plan and MAPP2Health

UVA Health Strengthening Our Foundation One UVA Health Team	MAPP2 Health Priority Area: No Direct Priority Areas
<ul style="list-style-type: none"> Alignment across all Mission Areas Consistent Patient Experience Avoid Duplication by Centralizing Services <ul style="list-style-type: none"> Revenue Cycle and Contracting Integrating UVA Community Health Sites with UVA Medical Center – One UVA Health System 	<div>////////////////////</div> <div>////////////////////</div> <div>////////////////////</div> <div>////////////////////</div>
UVA Health Strengthening Our Foundation Easy Access	MAPP2 Health Priority Area: Healthy and Connected Communities for all ages Healthy Equity and Access to Care Mental Health
<ul style="list-style-type: none"> Enhance the Patient Experience Modernize Ambulatory and Inpatient Patient Progression for a seamless patient experience Open New Ambulatory Sites of Care Recruit more providers to enable the right care, in the right place, at the right time Strengthen our Nursing and Allied Health Professional Workforce <ul style="list-style-type: none"> Establish a Center for Advanced Practice Enhance our Digital Front Door <ul style="list-style-type: none"> Easier Self Service Patient Experiences Reduce Administration Burden on UVA Health Employees 	<p><u>Transportation (Built Environment)</u></p> <p>Improve transportation infrastructure</p> <ul style="list-style-type: none"> Partner with Healthcare systems to improve nearby bus stops and increase route frequency to health system hospitals and providers Develop GPS apps to track bus routes Develop a robust rideshare network and voucher system for patients Work with donors to expand Medicaid transportation contracts to nonprofits and organizations with patient roster's under 50 clients <p><u>Referral and Communication Networks (Healthcare System)</u></p> <p>Easily connect and refer patients to providers regardless of the healthcare setting</p> <ul style="list-style-type: none"> Review current systems for information sharing and referrals to determine gaps and opportunities for connection <p><u>Mental Health Recommendations (Healthcare System)</u></p> <p>Increase access to care</p> <ul style="list-style-type: none"> Integrate mental health and substance use services in primary care settings Develop mental health Partial Hospitalization Programs Improve behavioral health interventions in the emergency department Create in-patient psychiatric beds for children and youth

Appendix: Comparison Tables – UVA Health Strategic Plan and MAPP2Health

<p>UVA Health Strengthening Our Foundation Superior Patient Outcomes</p>	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health</p>
<ul style="list-style-type: none"> • Leaders in Delivery of Safe, High-Quality and Patient Centered care • Sustained infrastructure for consistent measurement of our quality scorecard targets • Enhance coding efforts to improve our understanding of the risk profile of each of our patients • Implement additional clinical pathways to reduce unwarranted variation in patient care 	<p><u>Social Determinants of Health</u> Maternal Mortality Rates by Race and Hispanic Origin</p> <p><u>Mental Health Recommendations (Healthcare System)</u> Expand capacity for racially and culturally responsive behavioral health care</p> <ul style="list-style-type: none"> • Invest in racially and culturally responsive behavioral health services • Implement organizational policies and practices to eliminate racial and cultural inequities in behavioral health
<p>UVA Health Strengthening Our Foundation Resource Stewardship and Philanthropy</p>	<p>MAPP2 Health Priority Area: Healthy Eating and Active Living Healthy and Connected Communities for all ages Healthy Equity and Access to Care Mental Health</p>
<ul style="list-style-type: none"> • Responsible Steward of Funds – across all missions • Pursue Transformational philanthropic gifts • Enhance patient affordability by efficiency and effectiveness • Digital Innovation Investment to solve complex challenges • Expand Donor funding programs - Grateful Patients, UVA Alumni, Friends, Foundations and Industry 	<p><u>Transportation (Built Environment)</u> Access to Healthy Food and Active Living</p> <ul style="list-style-type: none"> • Advocacy for local government investment in bus, bike and pedestrian infrastructure <p><u>Workforce (Healthcare System)</u> Providers and staff reflect the diverse patient population</p> <ul style="list-style-type: none"> • Lobby for academic institutions to offer loan repayment for clinical trainings • Obtain grant funding and paid opportunities for community members to become Peer Health Navigators <p><u>Medicaid, Health Insurance & Payment (Healthcare System)</u> Improve access to alternative payment and insurance plans</p> <ul style="list-style-type: none"> • Work with donors and grant specialists to create training programs and a grant “hub” so providers and healthcare systems can support sliding scale or pay-what-you-may programs

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<p>UVA Health Expanding Our Excellence and Enabling Discoveries for Better Health Statewide Expansion</p>	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health</p>
<ul style="list-style-type: none"> • Create a UVA Health Network <ul style="list-style-type: none"> ○ To enhance our ability to deliver care closer to home for all Virginians • Broaden Statewide footprint through strategic relationships with like-minded organizations • Grow Tertiary and Quaternary Care Capacity to meet the needs of the most complex patients statewide and beyond • Launch a Clinically Integrated Healthcare Network • Expand upon our multistate research and education collaborations 	<p><u>Workforce (Healthcare System)</u></p> <p>Incentivize providers to practice in rural or underserved communities</p> <ul style="list-style-type: none"> • Publicize incentives for relocation and service area opportunities among provider networks • Provide opportunities for local businesses to contribute resources and funding to bolster provider relocation to their communities <p><u>Mental Health Recommendations (Healthcare System)</u></p> <p>Increase access to care</p> <ul style="list-style-type: none"> • Integrate mental health and substance use services in primary care settings • Develop mental health Partial Hospitalization Programs • Create in-patient psychiatric beds for children and youth <p>Promote policies, systems and environments that improve behavioral health and wellness</p> <ul style="list-style-type: none"> • Expand stigma reduction and mental health literacy training in places where we live, work, learn, and play • Advocate improved financing and insurance coverage for behavioral health needs • Expand access to housing supports, telehealth, and transportation for individuals with behavioral health needs
<p>UVA Health Expanding Our Excellence and Enabling Discoveries for Better Health Destination Programs</p>	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health</p>
<ul style="list-style-type: none"> • Build nationally ranked destination clinical and research programs • Provide High-quality and Safe patient care for the most complex healthcare needs • Recruit and retain and nurture world-class faculty members • Grow our service lines and major clinical programs • Raise UVA Health’s reputation and brand awareness statewide and elevating our national and international profile • Invest in our distinctive areas of expertise 	<p><u>Social Determinants of Health</u></p> <p>Maternal Mortality Rates by Race and Hispanic Origin</p> <p><u>Mental Health Recommendations (Healthcare System)</u></p> <p>Expand capacity for racially and culturally responsive behavioral health care</p> <ul style="list-style-type: none"> • Invest in racially and culturally responsive behavioral health services

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<p>UVA Health Expanding Our Excellence and Enabling Discoveries for Better Health Research with Translational Impact</p> <ul style="list-style-type: none"> • Create a New Research facility and program focused on biotechnology and translational clinical care • Expand our nationally distinctive research programs by recruiting over 100 net new physicians and scientists • Significantly expand access to clinical trials with the creation of a statewide clinical trials network 	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health including substance use concerns</p> <p><u>Social Determinants of Health</u> Maternal Mortality Rates by Race and Hispanic Origin</p> <p><u>Mental Health Recommendations (Healthcare System)</u> Improve Behavioral health and wellness</p> <ul style="list-style-type: none"> • Neurobehavioral basic and translational research
<p>UVA Health Expanding Our Excellence and Enabling Discoveries for Better Health Distinction in Education</p> <ul style="list-style-type: none"> • Provide world-class 21st century and socially responsible health sciences educational programs that prepare diverse learners to be prominent scholars and leaders of the future • Support our educators in achievement of excellence • Reward our educators for outstanding performance • Continue efforts to achieve or exceed national benchmarks for diversity across all educational programs • Develop allied health programs to build pathways for creating a stable workforce • Renew and expand NIH T-32 training programs (i.e. basic CV research training grant, global biothreats training grants, etc.) 	<p>MAPP2 Health Priority Area: Healthy Equity and Access to Care Mental Health</p> <p><u>Providers and Staff reflect the diverse patient population (Healthcare System)</u></p> <ul style="list-style-type: none"> • Advocate for funding for educational scholarships, programs, trainings, and classes that encourage people of color and multi-language speakers to join the workforce • Improve simulations at medical schools and clinical training environments so patient “actors” are diverse in race, age, gender identity, and socio-economic status • Incorporate medical interpreters and translators into clinical training curricula <p><u>Mental Health Recommendations (Healthcare System)</u> Expand capacity for racially and culturally responsive behavioral health care</p> <ul style="list-style-type: none"> • Implement comprehensive strategies to address the behavioral health workforce shortage