To: Members of the President's Council on University-Community Partnerships and Members of the Public Health Working Group

From: UVA President Jim Ryan and CEO of UVA Health and Executive Vice President for Health Affairs Dr. Craig Kent

Subject: Response and Next Steps Regarding the Public Health Working Group Report

Thank you for your diligent work and commitment to addressing the critical issues related to public health in our community. The recommendations produced by the working group have provided clear directions for improving access to care, addressing health care disparities, coordinating medical services, addressing food security, and other initiatives. We support the near-, medium-, and long-term recommendations in the report. The following document outlines work completed to date as well as plans for future initiatives as they relate to the recommendations in the Public Health Working Group report. In addition, an appendix describes additional work underway in community care and outreach programs. UVA and UVA Health are fully committed to collaborating with the community partners to address the public health needs in our region and beyond.

Guiding Principles:

I. **Health Equity Zones (HEZ) and the Rhode Island Department of Health (RIDOH)**

   a. **Health-Equity centered** means that measuring and responding to population health disparities should be the primary organizing principle for our approach to prevention.

   b. **Place-based** indicates that an equitable prevention approach should focus on providing resources to specific geographic areas, rather than funding all places equally.

   c. **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.

   d. **Social determinants of health (SDoH)** are the primary root causes of health inequities. Successful, equity-centered prevention efforts absolutely must address the social determinants of health.

II. **Summary/Conclusion Section – Public Health Working Group (Guiding Principles)**

   a. Build trust by centering people who have disparities in ongoing conversations, in collecting feedback, and in development. Believe and trust these people. Prove UVA's commitment to the community.

   b. Ensure that all data can be disaggregated across demographics including by race, age band, and socio-economic status.

      i. Make data available by specialty and ensure that the community can understand actual impact.

      ii. Link data to plans for quality improvement in transparent ways.

   c. Allow Black, Indigenous, and people of color to make decisions for themselves about how their work is crafted. (Central VA Clinicians of Color)

d. Support public health recommendations in a structural, sustainable way – including being honest with the community about feasibility and projected timelines.

III. **Charge to the Group:** To advance greater coordination between community-based initiatives in Virginia's Planning District 10 (BRHD) and the University to improve health outcomes and reduce racial disparities.

IV. **Scope of Work:**

- Review Public Health data to understand trends and gaps with a focus on SDoH.
- 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 UVA Health strategic plan that complements existing community efforts, including the other working groups and consider the SDoH.
- Emphasize priority goals to strengthen health equity partnerships between the University and community.
- Develop actionable steps to engage the community efforts, such as MAPP2Health 2019 and 2022 reports, Food Justice Network, Move2Health Equity, Central Virginians of Color Network and the Community Mental Health and Wellness Coalition.
- Identify opportunities for how a strategic communication/public service announcement (PSA) to increase understanding of SDoH.
- Identify areas in which sufficient activity is not yet occurring and unique efforts and focus could be launched to advance the public health priorities.
- Create actionable steps for supporting existing community efforts, opportunities to increase understanding of social determinants of health, and areas where UVA should launch unique efforts.
- 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.

V. **Deliverables by the Public Health Working Group Report:**

a. Final Report to include elements described in the scope of work above, including:

i. **recommendations for UVA Health System Strategic Plan**,

ii. recommendations for **strengthening health partnerships between the University and the community**,

iii. actionable steps for supporting existing community efforts,

iv. opportunities to increase understanding of social determinants of health, and

v. areas where **UVA should launch unique efforts**.

b. Develop recommendations for a phased approach of actionable items for achieving the goal that could be achieved in the near and long term.

i. List of near-term actionable steps that the University can take to engage with, leverage and support existing community efforts.

ii. List of long-term actionable steps that would complement existing work and fill identified gaps

Phases of Recommendations: PHWG Report Submitted June 2023 Phase 1: Near Term (0 mos. – 18 mos.) Phase 2: Medium Term (18 mos. – 3 years) Phase 3: Long Term (3 years – 5 years)
Physical Health Recommendations
Recommendation No. 1: Near Term (0 mos. – 18 mos.) **Develop a DEI Scorecard to track disparities in health outcomes and patient satisfaction – linked to plans for quality improvement and accountability** • Provide timely and transparent data on how patient feedback, particularly feedback from historically marginalized communities, is incorporated into quality improvement within the health system
UVA Health • UVA Health utilizes inpatient, outpatient, and emergency room patient satisfaction scores to affect continuous improvement. This data can be segmented by race, and ethnicity. • It is difficult to report on quality outcomes by race and ethnicity given the risk stratification required to accurately compare outcomes. • UVA Health System Board Quality Subcommittee oversees quality for the health system and is committed to ensuring excellent quality outcomes for all patients. • Beginning in August 2024, UVA Health will make ratings and comments of all providers public on its website. •

Recommendation No. 2: Near Term (0 mos. – 18 mos.)

Invest in resources that directly address health inequities

- Research applications that support Black birthing experience by partnering with Birth Sisters of Charlottesville
- Partner with Pregnancy Outcomes Coalition and others to invest in piloting applications within the health system and community
- Advocate for increased Medicaid reimbursement for doula services

UVA Health

- UVA Health's department of OB/GYN under the leadership of our the Chairperson is committed to educating and supporting Black mothers. Some activities include:
  - Diaper drive
  - Community information sessions and conversations
  - Gynecologic cancer screenings
- UVA Health's government relations and finance teams are very willing to advocate to the Department of Medical Assistance Services (DMAS) for increased Medicaid reimbursement for doula services.
- More broadly, UVA Health is committed to investing in resource to address health inequities:
  - House on Oak Lawn purchase and planning for community center
  - Fresh Produce provided to communities via donation to UVA Health efforts (Local Food Hubs)
  - Medicaid re-enrollment education with the Community Partner – Move2HealthEquity
  - Free Sports Physicals – quarterly at local high schools, middle schools and Health Fairs
  - Mobile Health Van purchased and launching 8/2024 – initially serving Fifeville and Southwood

Recommendation No. 3: Near Term (0 mos. – 18 mos.)

Collect, Report, and Track in a circular, iterative fashion, quantitative data paired with qualitative data to assess progress toward eliminating health inequities

- 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)
- In partnership with Blue Ridge Health District (BRHD), engage regularly with the communities we serve to establish two-way communication about the state of public health in the region

UVA Health

UVA Health is accredited by the Joint Commission, and by way of this accreditation, must meet Health Equity-Related Standards. Improving health equity for the hospital's patients is a

quality and safety priority. Our health equity work provides us with the ability to assess our progress towards reducing health inequities. We have started the process of documenting whether admitted inpatients to UVA Medical Center have any one of the five Health-Related Social Needs (HRSN) - Food Insecurity, Housing Instability, Transportation Problems, Utility Difficulties, and Interpersonal Safety. Other initiatives to address health inequities include our mobile care van and telehealth projects with Native American Reservations & Tribal Elders.

Recommendation No. 4: Medium Term (18 mos. – 3 years)

Form meaningful, two-way partnerships with large partners in the health care

- Provide funding, technical resources and representatives with decision-making authority to existing and emerging community collaboratives including: (a) The Improving Pregnancy Outcomes coalition, (b) Move2Health Equity, (c) The Community Mental Health and Wellness Coalition, (d) The Charlottesville Food Justice Network, etc.
- Fund and directly support the implementation of the 2022 MAPP2Health Community Health Improvement Plan

UVA Health

UVA Health has formed a meaningful two-way partnership with Sentara Martha Jefferson Hospital in order to expand access to pediatric neurodevelopmental and behavioral healthcare. The clinic will triple the number of pediatric mental health providers at UVA from 6 to 18, reducing wait times and expanding access by bringing together developmental pediatricians, pediatric psychologists, child psychiatrists, and integrative medicine specialists. The new clinic will provide equitable access for all children, regardless of their insurance coverage or their family's ability to pay. It will accept both private insurance and Medicaid to help expand access for low-income and underserved children. Interpreters will be available for patients and families for whom English is not their first language.

UVA Health is building on partnerships with local community experts by one of three mechanisms: providing technical resources, funding or representation on existing non-profit boards such as Move2Health Equity, the Community Mental Health & Wellness Coalition, the improving pregnancy outcomes coalition, the Charlottesville Food Justice Network, and the Charlottesville Free Clinic.
Details regarding: Charlottesville Free Clinic (CFC) Partnership:

- 153 volunteers at the CFC who are employees of UVA Health (staff, students, faculty)
- Reduced price and free services to support the CFC (Laboratory testing, Diagnostic imaging, etc.)

La Clinica Latina: Partnership with the Charlottesville Free Clinic (CFC), which has been open since 2016. Provides free primary healthcare twice a month to Hispanic patients in their own

language by culturally proficient physicians and students. (Latino Health Initiative Director - Dr. Max Luna)

Recommendation No. 5: Long Term (3 years – 5 years)

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

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

UVA Health

UVA Health is committed to serving the community and providing medical services to community members through the following programs: sponsorship of local community events (i.e., Indie Film Festival and panel on maternal mortality), United Day of Caring, Sports Physicals for uninsured middle school/high school students, volunteering at local Charlottesville Free Clinic, Community Paramedicine Program, Homeless Consult Service, Interactive Home Monitoring (IHM), Medicine HOME Program, Virginia at Home Program (VaH), Latino Health Initiative, Fifeville Community Health Stations, Oak Lawn Property, Mobile Van Care Clinic, and Community Health Worker Program (Well AWARE). Additional work includes the Southern Albemarle Community Project to coordinate medical services for community members using a telemedicine hub. The goal being to expand virtual urgent care by deploying more E-visits. Partnership with Coran Capshaw/Red Light Management and UVA Health to open 6th street clinic in a residential public housing setting (tentative open date 11/30/2025).

Recommendation No. 6: Long Term (3 years – 5 years)

Policy Work.

- Advocate for 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.
- 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.
- 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.

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

UVA Health

UVA Health offers several free services to assist patients with enrollment into Medicaid. The first is eligibility workers who are paid by UVA Health with the sole focus of identifying and assisting eligible patients enroll in Medicaid. The second is a collaboration with the Albemarle County Department of Social Services, in which social workers are jointly funded by UVA Health and the Albemarle County with the goal and authority to make decisions on Medicaid eligibility for patients in Albemarle County and surrounding localities.

Enrollment services are offered to all potentially eligible patients. Success rates are higher for inpatients and outpatients with repetitive services (infusions) because of the multiple and/or lengthy needs for care. We are constantly evaluating the processes to bolster success rates in the ambulatory and ED places of service where it is more challenging to assist. While enrollment services offered to inpatients (who generally accumulate the largest bills) is robust, improvements are needed for outpatient services and UVA Health is committed to bolstering these resources.

Behavioral Health Recommendations

Recommendation No. 7: Long Term (3 years – 5 years)

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 is not limited to, providing the following services:

- Clinical group work
- Independent psycho-social support
- Peer support
- Wellness/community
- Integrative care
- Food court/food truck
- Community event/gathering lounge/space
- Sliding scale opportunities for all services
- Long-term/ongoing behavioral health support

UVA Health

With the purchase of the home on Oak Lawn in Fifeville, there is the opportunity to establish place-based initiatives guided by assessments of community needs – including the MAPP2Health Community health improvement plan & President's Council on UVA-Community Partnerships. Twice a month community health stations at Abundant Life Ministries on Prospect Avenue have provided preventative screening and food from the Local

Food Hub to address food insecurity. UVA Health's partnership with the Fifeville Neighborhood Association (FNA) and other community groups will help us explore how to best use the historic home to support community needs.

Recommendation No. 8: Medium Term (18 mos. – 3 years)

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

- 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.
- 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.
    - 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.
- 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.

UVA Health

At UVA Health, our efforts to provide culturally competent providers center around our onboarding process and ongoing professional development of our medical teams. For example, we utilize computer-based learning (CBL) modules as well as competencies in LGBTQ+ care (SOGI-Sexual Orientation and Gender Identity) to advance awareness, knowledge, and compassion of our professionals. The use of technology also allows us to improve culturally appropriate patient care through language services: in-person English as second language interpreters, 24/7 language interpreters via iPad technology. We also offer bystander training to mitigate bias and discriminatory behaviors (Stepping in 4 Respect).

Recommendation No. 9: Medium Term (18 mos. – 3 years)

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.

- Mentorship
- Technical assistance
- Apprenticeship
- Internship

- Community health workers

UVA Health

UVA Health's "Earn While You Learn" is a workforce development program that addresses critical shortages and the need for meaningful employment opportunities in our community. It offers on-the-job training for unskilled jobseekers interested in a career in health care.

- Programs: Emergency Medical Technician, Phlebotomy Trainee, Medical Assistant, Sterile Processing Technician, Certified Nurse Assistant, Pharmacy Technician, Surgical Support Technician

Recommendation No. 10: Medium Term (18 mos. – 3 years)

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.

- 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.
- Establish a protocol for brief emergent psychiatric intervention in Emergency Department coupled with coordination with community partners.
- Establish partial hospitalization program in coordination with community-level support.

UVA Health

As previously mentioned, UVA has partnered with Sentara Martha Jefferson Hospital to Expand pediatric Neurodevelopmental and Behavioral Health Care.

Food Security Recommendations

Recommendation No. 11: Near Term (0 mos. – 18 mos.)

Health system-wide food insecurity screening

- Short screening linked to patient encounter with data recorded, that will automatically trigger the next step.
  - Generate a list of community resources and contacts (in patients' language of choice whenever feasible).
  - Provide the list to the patient with discharge and financial assistance paperwork.
- Screening data stored in the patients' Electronic Health Records (ensure that patients are informed and can opt out if they wish).
- Measure food insecurity as it intersects with health outcomes by tracking what can be assessed across different races and other demographics.
- 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.

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

UVA Health

In the past several years, society has learned how a person's zipcode can have as much of an impact on their health outcomes as their genetic code. Health Related Social Needs (HRSN) or Social Determinants of Health (SDoH) are the primary drivers for up to 80% of a person's overall health and health outcomes. In April 2023, UVA Health began utilizing two electronic medical record programs (Rainbow Wheel and Compass Rose) to help us collect, analyze, and coordinate the care of patients with health-related social needs who are admitted to our adult inpatient service at UVA Medical Center.

Recommendation No. 12: Long Term (3 years – 5 years)

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

- 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.
- Semi-regular listening sessions/consult with community to ensure investment is in line with needs (compare voices to data).
- Engage in advocacy work related to food security.
    - 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.)
    - 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.

UVA Health

UVA Health has served as a stakeholder in food access from multiple departments throughout UVA Medical Center, School of Nursing, School of Medicine, UPG, and our UVA Community Health facilities. This includes initiatives in the following areas: Fresh Farmacy, Education and application assistance for SNAP benefits, JABA Home Delivery Program, Meals on Wheels, Central VA Food Resource Program, Feed More: Eastern VA Program and working with Multiple health insurance food programs (Mom's Meals, Post-Discharge Care, and Humana Well Dine, etc.). Additional initiatives include the following areas: Black Farmers and African American Pastors Council (AAPC) Initiative and UVA Faculty and Staff volunteering with Loaves & Fishes and Cultivate Charlottesville.

Gun Violence Prevention Recommendations
Recommendation No. 13: Near Term (0 mos. – 18 mos.) **Student Identification** • 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.
UVA Health Refer to work being done by the **Community Safety Working Group. Goal 3:** Improve coordination and information flow among community members, service providers, schools, and law enforcement. Under Goal 3: School based recommendations for Charlottesville City Schools. Safety protocols are grounded in evidence-based practices, specifically utilizing the Virginia Student Threat Assessment Guidelines developed by Dr. Dewey Cornell and colleagues at the School of Education at UVA.
Recommendation No. 14: Near Term (0 mos. – 18 mos.) **Transition Plans** • Using the Child Adolescent Needs and Strengths (CANS) model, which assesses mental, physical, educational, criminogenic, psychosocial, environmental strengths and needs, conduct semi-structured interviews with students at Blue Ridge Detention Center to help inform student-centered care coordination.
UVA Health The CANS model has been used in other health care settings (i.e. Massachusetts Community Health Center) as it was a requirement by grant funders. It was administered by mental health providers only and took quite some time to perform and document and was largely seen as a barrier. It may be used by Department of Social Services (DSS) but does not appear to be intended for the medical provider. Teen Health within UVA Health, uses a mnemonic called HEADSS or SSHADESS to take a strengths-based social history. The Pediatric Department has recently purchased a more formal curriculum from the American Association of Pediatrics (AAP) called Reaching Teens which uses a strengths-based approach. In summary, a strengths-based history taken with the use of positive childhood experiences/HOPE framework (healthy outcomes from positive experiences) is used in the clinical setting opposed to the CANS model. Note: HEADSS – an adolescent review of systems (part of a standard History and Physical Examination); Home, Education, Activities/employment, Drugs, Safety/Suicidality and Sex. SSHADESS – Strengths based approach: Strengths, School, Home, Activities, Drugs, Emotions, Sexuality and Safety

Example of a Well child template(s) at UVA Health

SAFETY Review: (Check below for all that were discussed today)

- ☐ Car seat facing backwards until 2yo
- ☐ Baby proof at home
- ☐ Working smoke detectors in house (check with local fire department, if needed)
- ☐ Firearms (if present) are safely locked and stored
- ☐ Water safety – don't leave unattended in bath or pool
- ☐ Other:

Recommendation No. 15: Long Term (3 years – 5 years)

Care Coordination/Case Management

- 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.

- A standard evidence-based assessment tool like the CANS or the Youth Assessment and Screening Instrument (YASI) 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.

UVA Health

See answer to recommendation No. 14 for CANS/YASI in the health system. The UVA Health Department of Pediatrics employs a strengths-based approach in the clinical setting.

As it pertains to care coordination, refer to work being done by the **Community Safety Working Group. Goal 4:** Connect Youth to Caring Adults and Activities. Under Goal 4: Bolster Reentry Program and Support. Project Safe Neighborhoods (Comprehensive Care Coordination Program): The CSIG, along with Andy Block, Ron Huber, and other community members have been working to plan and prepare for the full implementation of Project Safe Neighborhoods. Additionally, as part of Goal 4: Chronic absenteeism in Charlottesville City Schools is addressed using a case management approach for both students and families with Student Support Liaisons playing a crucial role; also multidisciplinary collaboration with school social workers, counselors, teachers, administrators, and community providers has been implemented.

Recommendation No. 16: Near Term (0 mos. – 18 mos.)

Programming

- 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.

UVA Health

As it pertains to at-risk youth and community engagement, refer to work being done by the **Community Safety Working Group. Goal 4:** Connect Youth to Caring Adults and Activities. Under Goal 4: Youth Council Initiative which is a collaboration between UVA Frank Batten School of Leadership & Public Policy, The Equity Center, City of Promise, and Charlottesville local government set to launch in the Fall of 2025. Additionally, as part of Goal 4: providing mental health support for youth through a partnership with ReadyKids by providing small-group mentoring and focused conversations for Starr Hill Pathways seventh- and eighth-grade girls on youth confidence, mental health/self-care, and identity development.

Coordinate with Other Working Groups

Local Economy

- Invest in the local economy by supporting existing groups working to provide culturally specific behavioral health care.
  UVA Health: Formed meaningful two-way partnerships with Sentara Martha Jefferson Hospital in our partnership to expand access to pediatric neurodevelopmental and behavioral healthcare. (See response to recommendation #4.)
- **See Behavioral Health recommendations 2a-2c: UVA should directly fund existing culturally competent providers to provide community level services**)
  UVA Health: The purchase of Oak Lawn is a Place Based Initiative in partnership with Fifeville Neighborhood Association (FNA) has the potential to support the work of culturally competent providers to provide community level services in the Oak Lawn Historic Home.

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.
  UVA Health: Possible expansion of Oak Lawn to include Child Care

Affordable Housing

- While creating the plan for affordable housing, consider access to behavioral health, physical health, and healthy foods. Invest in health care hubs in existing low-income housing developments to increase access to health care.
  UVA Health: Current efforts around housing are underway and being led by the the University (UVA) and not the health system.

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
  UVA Health: Launch of the Earn While You Learn program at UVA Health

Departmental Community Outreach – UVA School of Medicine (Community Engagement)

- FY 2022-2023 Each department and center was charged with finding ways to deepen their relationships with the communities we serve by participating in community events.
- 28 Departments and 6 Centers – hosted or participated in more than 154 service opportunities throughout the academic year (FY 2022-2023).
- 64 events: Community Resource fairs or educational outreach (i.e. smoking cessation classes, World Voice Day Awareness)
- 34 events: Community run/walk for fundraising or to promote a healthy lifestyle
- 21 events: Outreach to K-12 or undergraduate students by hosting camps or volunteering providing tours of UVA or making local school presentations
- 19 events: Medical services or screenings at free clinics or community events
- 13 events: Community Service (i.e. United Way Day of Caring, Habitat for Humanity, community trash clean-up, creating holiday cards for seniors and packing meals for countries with food insecurity
- 3 events: Charity events like Cystic Foundation Brewer’s Ball

Transforming health and inspiring hope for all Virginians and beyond

CARE IN THE COMMUNITY:

- **Mobile Van Care Unit**: Primary care and expanding access to care in a mobile environment
- **Community Health Stations/Oak Lawn**: Preventive care/health screenings & health education
- **Latino Health Initiative** (LHI): Aims to improve health/wellbeing local Latino community
- **Consultation and Care for the Homeless**: Primary care once per week at the Haven Day Shelter
- **International Family Medicine Clinic**: working in partnership with the International Rescue Committee providing full medical and counseling care to refugees of all ages.
- **Westhaven Cares Center**: Nursing led care in public housing neighborhood of Westhaven

CARE BEYOND MEDICINE:

- **Beyond Program**: Patient and family Assistance for basic needs (transportation, food, housing, temporary assistance with utilities, etc.); Resources to assist patients/families.
- **Food Access Program**: Providing healthy food and addressing food insecurity in our local neighborhood communities via community health stations (Fifeville, Southwood, Westhaven)

CARE BEYOND HOSPITAL WALLS:

- **Community Paramedicine Program:** Pre/Post hospitalization program to provide supportive care for patients with an increased risk of hospital or ER readmission
- **Virginia at Home**: Home based primary care program for older adults living with complex medical concerns and needs who are confined to their home, assisted living or memory care facility
- **WellAWARE**: Community Health Worker program, In Home care, community advocacy and healthcare navigation assistance
- **Interactive Home Monitoring program**: Provides continuity of care post discharge by providing a dedicated team of case managers, clinicians and behavioral health therapists.
- **La Clinica Gratuita**: Partnership between UVA Health LHI and the Charlottesville Free Clinic (CFC) open since 2016. Provides free primary healthcare twice a month to Hispanic patients in their own language by culturally proficient physicians and students
- **Earn While You Learn**: Program introduces career opportunities that are mutually beneficial to both the community and the medical center.

COMMUNITY OUTREACH AND ENGAGEMENT IN THE CURRICULUM AND RESEARCH PROGRAMS:

- **Social Issues in Medicine (2005-Present)**: Course taken by all first year medical students at UVA School of Medicine; Introducing students to the societal context in which medicine is practiced. Statistics: Over 2,550 medical students, 76,500 student volunteer hours and 78.6 years of community service.
- **SmART Clinic/Opiod Abatement**: Principal Investigator Dr. Ait-Daoud Tiouririne. Street Medicine Access Reduction and Treatment. Grant funding from the Virginia Opiod Abatement Authority Opiod (OAA) in partnership with The Haven local day shelter provide comprehensive care and specialized care by an addiction specialist.