



2024-2025

MAPP2Health Community Health Needs Assessment

February 18, 2025

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CHA/CHIP: The Nuts + Bolts

WHO

- All Non-profit hospitals
- Healthcare system partners

WHY

Requirement of the Internal Revenue Service

- Understand Community Needs & Strengths
- Decision Making that's Data-Driven
- Address Root Causes

WHAT

An 18-month assessment of the community. The results can then be used to plan, leverage resources, execute, and evaluate implementation initiatives to improve health.

WHEN

Published every three years



**MOBILIZING
FOR ACTION**
— THROUGH —
**PLANNING &
PARTNERSHIPS**

MAPP 2.0



CHA Frameworks

- Mobilizing for Action Through Planning & Partnerships (MAPP)
- Community Commons: Community Health Needs Assessment Tool
- ACHI: Community Health Assessment Toolkit
- County Health Rankings: Handbook for Participatory Community Assessments
- Community Toolbox

2022 MAPP2Health Structure + Process

Focus on Health Disparities + Racism as a Public Health Crisis



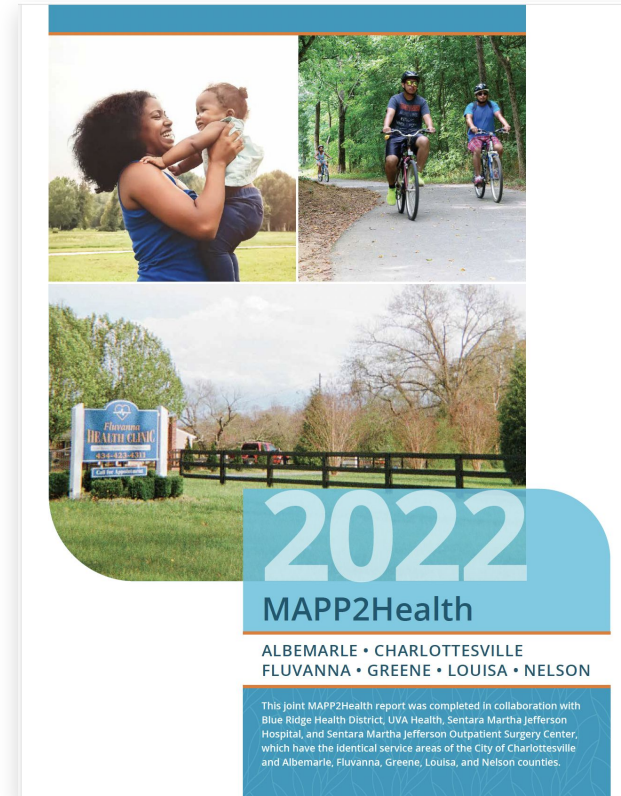
Reviewed Local, State, and Regional health data for trends and disparities, particularly along social determinants of health and for people of color and underserved communities.



85 agencies and organizations plus community members divided into Leadership + Locality Councils, attending Zoom meetings to give input and participate in focus groups



Move2healthequity.org commissioned four Photovoice projects. Participants were asked to photograph barriers to the policy targets



Where We've Been: 2022 MAPP2Health

FOCUS

Health Disparities

"Differences between groups in health and health care that stem from broader inequities"

Health Equity

Elimination of disparities for the highest level of health

Social Determinants of Health (SDoH)

The social and economic factors that shape our health behaviors

Racism + Discrimination

Both negatively affect health firsthand and by creating inequities across the Social Determinants through the lifespan, within groups, and subgroups of people

PRIORITIES

Healthy eating and active living

Mental health including substance use concerns

Health equity and access to care

Healthy and connected communities for all ages

POLICY TARGETS

Transportation

Healthcare Workforce

Digital Access + Skills

Mental + Behavioral Health

Transportation CHIP Objectives

BETTER TRANSIT, FASTER SERVICE

- Improve public transit
- JAUNT rural assessment
- **Decrease ride time from ED Discharge**
- **Shared GPS App**
- **Community Voice in Transit Decision-making**
- Microtransit
- Mobility Program

CHIP 2023 Convener Tracker

	A	B	C	D	E	F	G	H	I	J	K	L
					Year (1, 2, or 3)	Convener	Lead 2	Contributors	Production Months	Target Completion Date	Revised Completion Date	Status
1				MAPP2Health 2022-2023 Community Health Improvement Plan								
				Policy target: Transportation								
2				GOAL 1T: Improve all transit infrastructure	1-3							
3				1.0 Obtain approved contract to allow installation of mobility accessible, age-friendly bus shelters where needed	3	CAT	Board of Supervisors	VDOT		12/31/2025		
4				Task 1.0.1 Finalize bus shelter design to include mobility accommodations	3	CAT		CAA, VDRPT, VDOT				
5				Task 1.0.2 Conduct inventory of which shelters are on VDOT roads and non-VDOT property	3	CAT	TSP Consultant	VDRPT				
6				1.1 Produce a governance study for a mechanism to increase funding for regional transit and manage those funds	1	TJPDC (Lucinda)		Local Jurisdictions, AECOM Consulting, Funding Agencies:		12/31/2023		60-79%
7				Task 1.1.1 TJPDC reports out publicly on governance study progress	1	TJPDC (Lucinda)				3/23/2023		Completed
8				Task 1.1.2 TJPDC meets with all jurisdictions to discuss funding sources	1	TJPDC (Lucinda)		Local Jurisdictions		9/1/2023		20-39%
9				Task 1.1.3 TJPDC hosts steering committee meeting prior to completion of report	1	TJPDC (Lucinda)		Steering Committee: https://tjpd.org/wp-content/uploads/GS-Steering-Committee.pdf		11/30/2023		
10				1.2 Improve infrastructure for getting patients to and from health system hospitals and providers	1	BRHD	Sentara MJH and	CAT, Jaunt, UTS		12/31/2024		
11				Task 1.2.1 Review needs from UVA on discharge and after-hours discharge at the ED	1	BRHD		UVA ED's Joey Usher and Gary Morris; UVA's Jaunt		12/31/2023		20-39%
12				Task 1.2.2 Assess the need for on-demand rides - particularly from UVA ER after hours	1	Sentara MJH + RM BRHD						
13				Task 1.2.3 Implement, if necessary, on-demand ride service for eligible patients getting discharged from both UVA and SMJH ED	2-3	BRHD	Sentara MJH					
14				1.3 Improve scheduling service for Jaunt	1	Jaunt						
15				Task 1.3.1 Jaunt Transit Development Plan posted to Jaunt website	1	Jaunt				2/1/2023		Completed
16				Task 1.3.2 Launch passenger portal (app-based response) for scheduling	2	Jaunt				12/31/2023		1-19%
17				1.4 Jaunt locality service is sufficient for residents' needs						12/31/2025		
18				Task 1.4.1 Conduct rural needs assessment for expanding service in localities	2	Jaunt				7/31/2024		

CHIP 2023-2025

New activities that were implemented with organizations that were already motivated – because the initiative aligned with what they had planned to do – have been successful.

INITIATIVE

1. Rider Advocacy Group Exploration
2. Digital Navigator Training
3. Diversifying Standardized Patients
4. Establish a CHW Network
5. Clinical Certifications Offered Locally and with Job Support
6. High-quality Community + Medical Interpretation Training
7. Community Paramedicine Collab
8. Yancey Telemedicine Discovery

CONVENER

CAA
Broadband Office
UVA Health's CSC
BRHD

SMJH/UVA Health

UVA Health + IRC
UVA Health's
SCOPES Program
UVA Telemedicine



CHIP 2025

ONGOING SUCCESS

Transportation, Telemedicine, and Community Paramedicine have had the most success and launched programs that will continue beyond 2025

PROGRAM

1. PATH Mobility Management
2. Bus Field Trips and Trainings
Walkability Audits
Bus Stop at The Center
3. Community Paramedicine
4. Southern Albemarle Telemedicine
5. Trail, Transit, Bike/Ped Improvements
Trailblazer Program
Loop de Ville

OWNER

TJPDC
CAA

**Wintergreen Fire
& Rescue**
UVA Telemedicine
City, PEC,
BPAC, CAT,
Jaunt, County

**Ready
to *Ride?***

Call 888-879-7379



How to **Ride**

1

Call PATH toll-free at
888-879-7379 or fill out

2

A transportation
counselor will connect

3

The counselor will
guide you through the



MAPP2Health 2024

Core Group

**4 PEOPLE;
3 ORGANIZATIONS**

- Maintains communication across partners and facilitates meetings
- Gathers steering committee feedback
- Lead decision-makers
Assigns funding and resources
- Data gathering + analysis
- Meets every other week

Steering Committee

**10-12 PEOPLE;
ORGANIZATION LEADS**

- Provides input and feedback on major steps of MAPP
- Meets monthly



Community SURVEYS + FOCUS GROUPS

- Randomized in-person surveys (door-to-door)
- Key Informant Interviews
- Focus Groups
- Photovoice

Stakeholders ORGANIZATION + AGENCY LEADS

- Stakeholder Survey

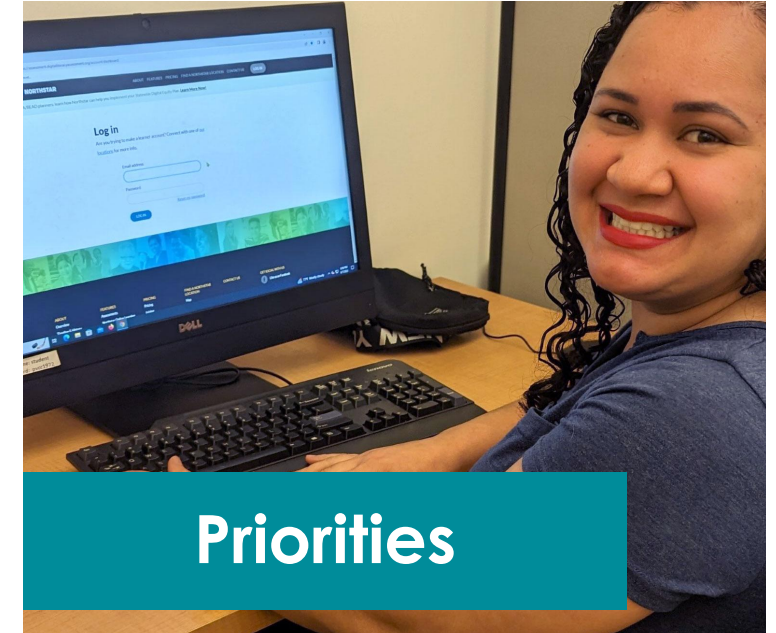
Process: MAPP2Health 2024



Reviewed quantitative Census, County, and State data for trends and disparities. Identify where and with whom to do the assessment.



Process qualitative data from surveys + focus groups. Report this back to the Core Group and Steering Committee for evaluation,

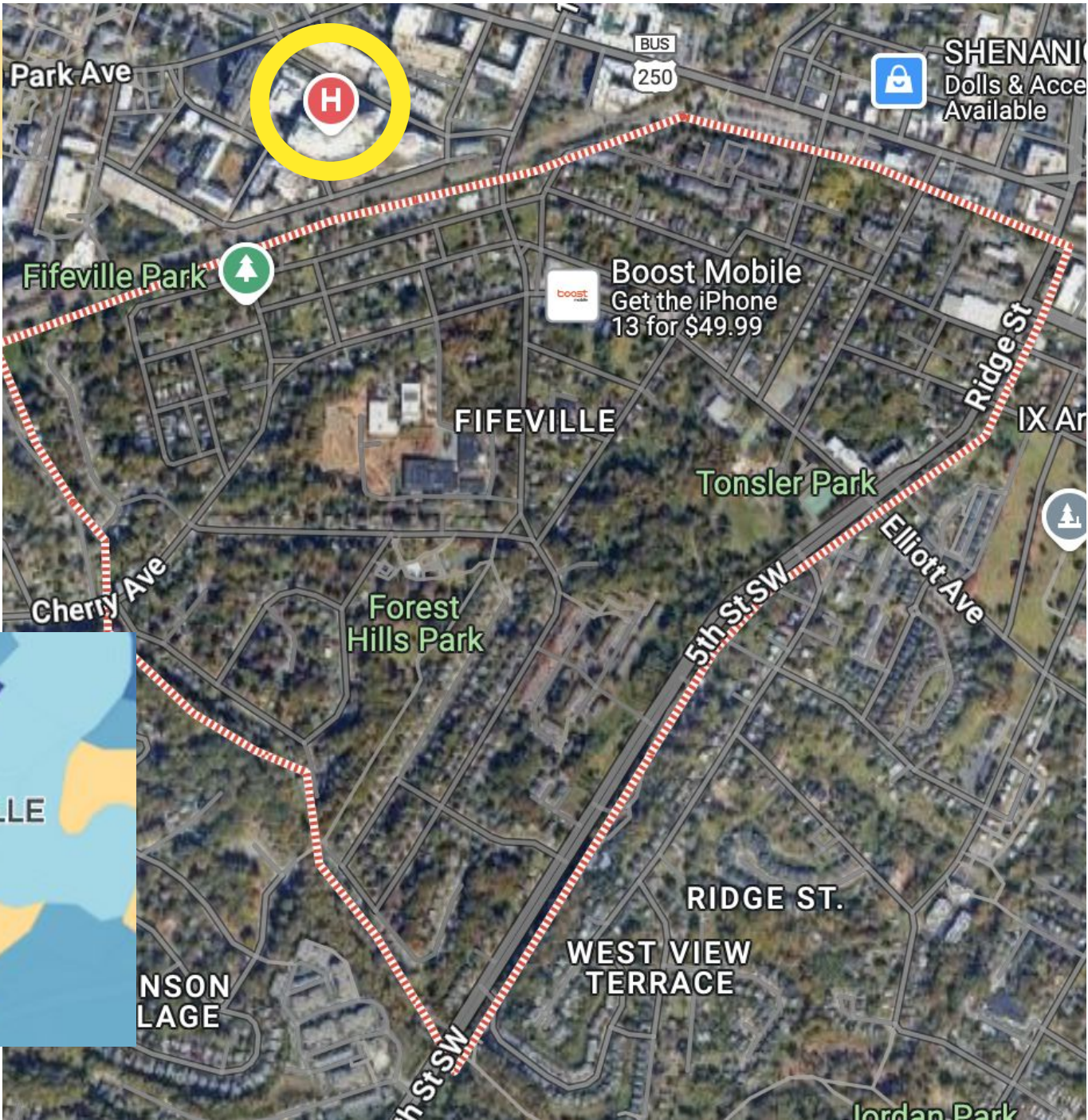


Determine priorities and establish resources and workgroups to implement change.

BRHD includes Albemarle, Charlottesville, Fluvanna, Greene, Louisa, Nelson

Surveys: 5 Census Tracts

County	Census tract code	Census tract name
Nelson	9501.01	Arrington-Wingina
Louisa	9502.01	Town of Louisa
Greene	301.01	Stanardsville
Albemarle	106.03	Branchlands
Fluvanna	202	Columbia/Fork Union

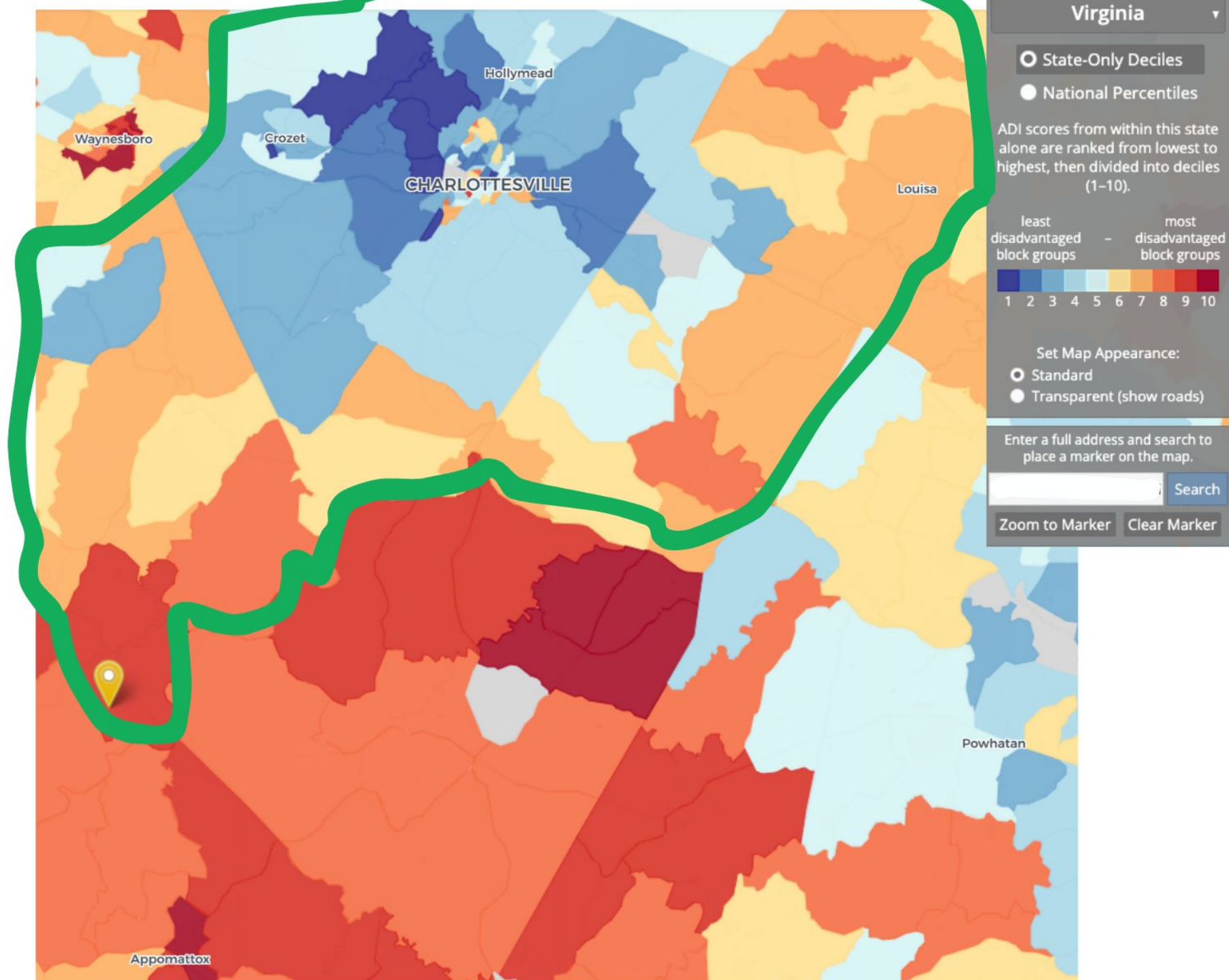


Neighborhood Atlas (ADI)

"It allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level)... to inform health delivery and policy, especially for the most disadvantaged neighborhood groups."

Indicators include:

- Education
- Employment
- Income
- Rent/Mortgage
- Home ownership
- Motor vehicle
- Phone
- Plumbing
- Crowding
- Poverty thresholds





Key Informant Interviews

Folks associated with
community partners/ at risk of
poor health outcomes,
convenience survey

267
respondents

17
events / locations

Focus Groups

Similar questions to interviews,
folks associated with
community partners/ at risk of
poor health outcomes,
facilitated

22
respondents

4
different groups



Analysis: Survey Results



Problems

- Diabetes
- Blood pressure
- Mental health
- Weight issues
- Heart problems



Obstacles

- Access to healthcare
- No time
- Healthy Food access
- Money
- Transportation
- Aging
- Lack of exercise

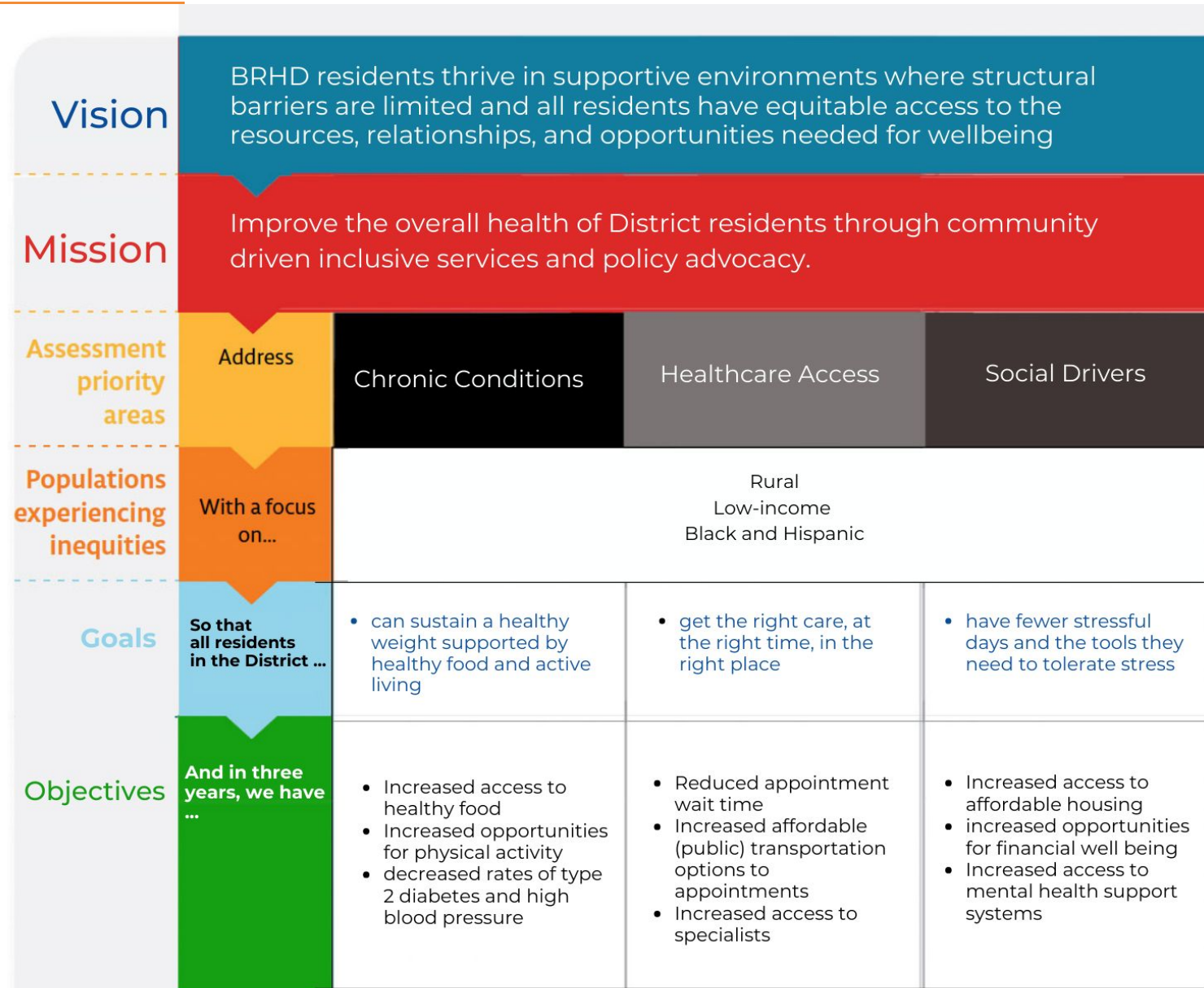


Supports Needed

- Money
- Doctors close by
- Community support
- Health information
- Recreational opportunities/gyms
- Mental health support
- Home maintenance
- Access to affordable timely care
- Transportation
- Access to healthier food

What's Next

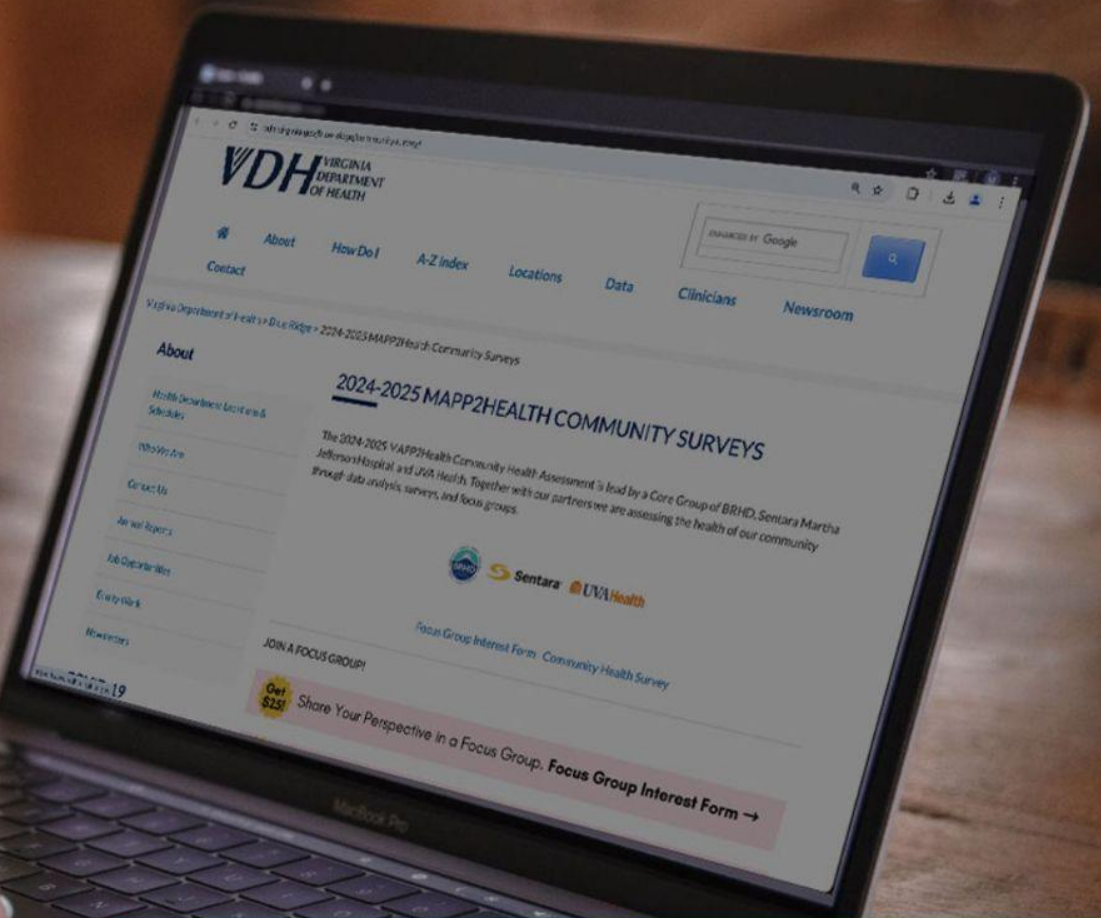
NOW	Priorities
FEB–MARCH	Focus Groups
MARCH - APRIL	Objectives + Strategies
MAY – JULY	CHIP + Complete Report
SEPTEMBER	Report
OCTOBER	Grants
2026	Implement
2026–2028	Tracking/Dashboard



Thank you

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Connect to your CHA!