Yolo County Department of Health Services



Joint Work Group Minutes

Date: Thursday, July 23, 2015 Time: 8:45 am - Noon

Location: Bauer Building, Thomson/Walker Rooms

Attendees: Sheila Allen, Craig Blomberg, Betsy Campbell, Kellymarie Chen, Thomas Coleman, Haydee Dabritz, Romel Der, John

Gilbert, Genevieve Hansen, Rodney Higgins, Lori Howton, Steve Jensen, Louise Joyce, Ashley Logins-Miller, John McKean, Lisa Musser, Valerie Olson, George Pennebaker, Elida Serratos, LaRae Shaw-Meadows, Diane Sherwin,

Brad Toy, Rebecca Tryon, Emily Vaden, Yunji Yoon, Lynn Zender

Welcome

• Emily welcomed the group and around the table introductions were performed.

Sharing of Goals from Each Group

• Please see Attachments A, B, and C.

Discussion of Organization and Overlap

- Overlapping topics include:
 - Housing
 - Transportation
 - o Information system and outreach (culturally & linguistically appropriate)
 - Physical activity
 - Nutrition
 - o Affordable & Accessible health care
 - Active transportation system
 - o Evidence-based
 - o Data and reporting it
 - o Health literacy (comprehension, culturally & linguistically appropriate)
 - Health messaging (accuracy)
 - o Internal collaboration/communication
 - Awareness of other programs

Brainstorming Current Efforts

• Please see Attachments D and E.

Yolo County Department of Health Services



What is a CHIP?

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Next Steps

Chronic Disease Prevention

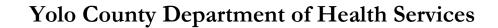
Date	Time	Location
August 20	2:30 - 4:00	Gonzalez Building (25 N. Cottonwood), Community Room
September 17	2:30 - 4:00	Bauer Building (137 N. Cottonwood), Thomson Room

Healthy Aging

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Date	Time	Location
August 20	8:45 – 10:15	Gonzalez Building (25 N. Cottonwood), Community Room
September 24	8:45 - 10:15	Bauer Building (137 N. Cottonwood), Walker Room

Mental Health

Date	Time	Location
August 20	10:30 – Noon	Gonzalez Building (25 N. Cottonwood), Community Room
September 24	10:30 – Noon	Bauer Building (137 N. Cottonwood), Walker Room



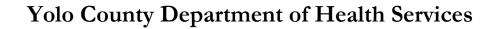


Attachment A

Chronic Disease Prevention Goals and Strategies

Chronic Disease Prevention Work Group Goals and Strategies

Category	Education/Health Care	Diet		Communication/ Collaboration	Environment/Physical Activity
Goal	Increase use of preventive health care and effective chronic disease management.	Increase consumption of fruits and vegetables.	Decrease consumption of fast food and sugar sweetened beverages.	Strengthen the support network for chronic disease prevention and management.	Increase percent of population adhering to recommended physical activity standards.
Initial Brainstorming	 Improve health literacy and knowledge about chronic disease management. Increase access to preventive health care/screening 	 Increase consumption of fruit and Increase number of residents who Americans. Increase consumption of healthy f guidelines/requirements. 	follow dietary guidelines for	 Increase number of trainings/education for staff and organizations working with target populations so they can bring health to all policies/programs (whether health related or not). Create health behavior messaging better education and consistent messages for providers. Increase agency collaboration for health messaging. 	 Improve infrastructure to encourage safe and fun physical activity. Increase safe locations for people to be active/play.
Strategies	•	Measure choices for kids in schools?Availability would be a strategy	•	•	 Increase number of locations for residents to be safe while being active/play (by x%?
Parking lot	 What measures for effective chronic management? How to measure knowledge? 	 Bought doesn't mean consumed. Environment is hard to measure in a consistent in relation to the community. Does Davis have a strategy for measures unsweetened drinks that just passed? 	•	 Measuring alignment Measure – count MOUs for agencies working with around a population or service. Measure by creation of network and relationships. 	 Woodland is adding that to the general plan. Parks and recs data for recreational activity.





Attachment B

Healthy Aging Goals and Strategies

Healthy Aging Work Group Goals and Strategies

Category	Housing/Safety	Outreach & Info	Transportation	Healthcare Wellness
Goal	All older adults have affordable, accessible, and safe housing.	Insure an integrated, accurate, and well-publicized information system for older adult services.	All older adults are aware of and have affordable, accessible, and safe transportation	Improve systems of care including prevention, early diagnosis, and treatment of aging adults, focusing on dementia, chronic disease management, and social engagement.
Initial Brainstorming	 Increase reasonably priced housing opportunities for seniors. Reduce/decrease/find a solution to homelessness. More spaces in affordable day care centers. Fall prevention. Ability to remain safely in clients/elderly home. 	 Increased coordination/collaboration with community groups to share resources. Increase awareness and accessible information for seniors. 	 Affordable accessible transportation 	 Increase opportunities for support in mental wellness and spirituality. Seek preventive care, wellness exams. Access to specialty care. Increase number of providers who accept Medicare. Change Medicare reimbursement rates.
Strategies	 Tools to use in the home Safety walk-through by another 	 Create a transportation hub that includes information and connection to services. Identify all providers of information and outreach – bring together to assure collaboration. Create a unified database or a system to integrate regular updates of information. Create a media campaign to increase public awareness of I&A. 	Access current availability	
Parking lot	Faith based volunteers			



Attachment C

Mental Health Goals and Strategies

Mental Health Work Group Goals and Strategies

Category	Access to Care	Reducing Stigma	Quality of Care
Goal	Yolo County community members of all ages have access to high quality behavioral health services.	Reduce mental health stigma and discrimination by promoting wellness, social justice and inclusion	Continue to develop and implement evidence based and promising practices and develop mechanisms to regularly evaluate data to improve outcomes.
Initial Brainstorming	 Increase access to care. Bilingual (Spanish, Russian) coordination between providers. Increase rural health care (Hispanic, Russian) Access to Care (transportation, telemedicine – psychiatry, health) Increase outpatient venues especially for Medi-Medis Increase access to mental health services (ie transportation) Un-served, underserved (identify who they are) Transportation Increase VA in Yolo County (access to services, transportation, cross professional agreements) 	 Decrease stigma through education. IE: MH Dx is as "common" as HTR, or diabetes. Wraparound Identify gaps in services Increase knowledge and awareness of perinatal/postpartum mental health (maternal mental health disorders) Identify population experts. Identify services Remove stigma Increase mental health – wellbeing of perinatal populations. 	 Increase Trauma Informed – ACES across the County Improve mental health and wellbeing among perinatal population. Increase Medicare Medi-Cal providers, increase reimbursements. Wrap around services Standard of Care. How does mental health fit in? Value, Ownership/Partnering. Increase coordination between providers. Improve follow-up care after acute inpatient stay (ie case management) Substance abuse services. Identify alternative method service delivery. Home visiting m.h. specialist Start Patient support groups (bilingual, lead by clinician) Increase sense of community/connectedness Population experts Increase capacity for support/treatment & resources (ie peer groups, etc) Diagnosed person family/friends support. Increase volunteerism and community training for para-professionals & peer partners/consumers Increase assertive case management. Marginalized populations, homeless, rural poor. Wrap around care. Schools, PCP, WIC, Community resources Increase telemedicine
Strategies	•	•	
Parking lot	Culturally and linguistically appropriateIntegratedAge appropriate	•	



Chronic Disease Prevention

Chronic Disease Prevention Goal 1: Strengthen the support network

for chronic disease prevention and management.

PARTNER	Program	Notes	GAPS	REP
Non-profits	American Heart, Cancer, etc			
HHSA	 Healthy Living for Older Adults NHV WIC NEOP training IHSS & other HHSA staff NEOP Tobacco Prevention 		Maybe add NEOP training to orientation for IHSS providers?	
Schools	Teachers, nurses			
Healthcare providers	Case managers, MD's health educators			
Assisted living/board & care				
STEAC				
IOPCM partnership	Disease management			
Promoteres				
Utilizing gyms to provide info				
Health Fairs				
Faith Based organizations	 Food Rotating Winter Shelter's 4th & Hope 			
Senior Centers	•			
Food resources	Food bankSchool lunch program		Training for all case managers	
Referral network	Yolo Healthy AgingSenior Link			
Diagnosis based pathway	American heartCancer			

Chronic Disease Prevention Goal 1: Strengthen the support network for chronic disease prevention and management.

PARTNER	Program	Notes	GAPS	Rep
Pharmacies	 Vaccinations Urgent Care models			
Dentists	Blood pressure checks			
ETMs & First Responders	•			
Mental Health Ride along Program	•	Riding with first responders		
Classes	•	Exercise		

Other Gaps:

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Potential Strategies:

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Chronic Disease Prevention Goal 2: Increase consumption of fruits and vegetables.

PARTNER	Program	Notes	GAPS	REP

Other Gaps:

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Potential Strategies:

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Chronic Disease Prevention Goal 3: Decrease consumption of fast

food and sugar sweetened beverages.

PARTNER	PROGRAM	Notes	GAPS	REP
Food Bank		Cooking classes		
Woodland United Methodist Church	Free Meal			
Community Gardens				
Gleaners				
Meals on Wheels			Expand (nutrition and reach)	
Congregate meals				
Schools		Providing healthier food & drink options. Removing soda machines – replacing with water.		
Employers		Places of employment providing incentive programs to employees	Expand	
			Developing wellness policies	
Esparto High School	Garden/cooking classes		Making healthy meal prep mandatory curriculum in school districts.	
HHSA	Wellness Center	Cooking classes		
	NEOP/HY	Spa water		
Grocery stores	Providing imperfect fruits and vegtables at discount prices.	Market Match (Raley's & Nugget)		
Farmer's Markets	Market match		Cooking classes	
SNAP Education		Including migrant populations		
Promotores				
Davis Beverages	Default drink for kids meal is water or milk.			

Other Gaps:

- Education of why it is important to make healthy food choices media.
- Improve water
- Making good/health food affordable.

Potential Strategies:

Chronic Disease Prevention Goal 4: Increase the percentage of the population adhering to recommended physical activity standards.

PARTNER	PROGRAM	NOTES	GAPS	REP
Woodland Bike Campaign				
RISE bike program				
Davis	Bicycle Safety Helmets			
Health care providers		Messaging		
Municipal parks & rec depts.		Messaging & programsPar coursesLabyrinth courses		
City General Plan		Encouraging pedestrian & biking, safe paths/planning		
Clubs & Organizations		Messaging and programs		
Yolo County	Employee Incentives			
UCD	Employee Incentives			
Prison Bike Donation Program				
Schools		Messaging & programs		
Religious organizations		Messaging & programs		
Media/Outreach		Messaing		
Law Enforcement		Safe environment/planning		
City of Woodland	 Commit2Fit 			
Safe Routes to School	• Helmets			
Themed months		May – Bike Month		

Other Gaps:

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Potential Strategies:

- Identify evidence based models
- Employee wellness/work environment (waking mtgs, etc)
- Bikeshare
- Stretches etc at crosswalk

Chronic Disease Prevention Goal 5: Increase use of preventive health care and effective chronic disease management.

Chronic Disease Prevention Goal 5: Increase use of preventive health care and effective chronic disease management.

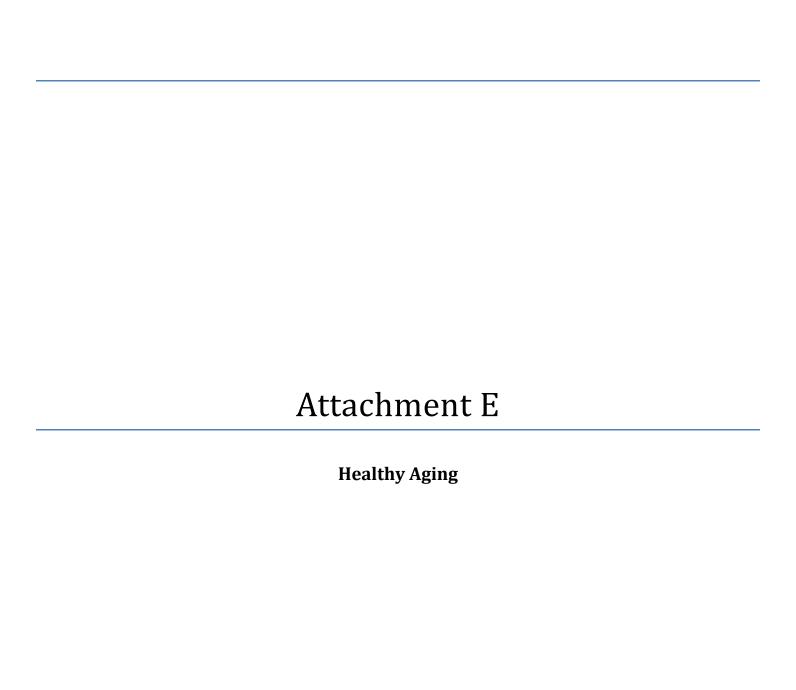
PARTNER	Program	Notes	GAPS	REP

Other Gaps:

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Potential Strategies:

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Healthy Aging Goal 1: All older adults are aware of and have affordable, accessible and safe transportation.

PARTNER	Program	Notes	GAPS	REP
State of CA		\$ for active transportation		
Broderick Christian Center		Serves WS		
SACOG – Sac Area Council of Government	Funding & Planning			
American Cancer Society/VA		Serves specific populations		
Woodland General Plan		includes pathway system, active transportation	County/City Plan to include pathways	
Community Care Car		Volunteers		
Davis Community Transit				
Yolo Bus & Yolo Bus Special			Change Yolo Bus Special to universal access.	
Assisted Living Facilities have vans		Expand access to facilities that don't?		

Other Gaps:

- West Sacramento WS has applied for ATP grant
- Rural Areas

Gap? Davis: Establish greenbelt system and active transportation coordinator.

Potential Strategies:

- Access current availability
- Universal form for access to ADA transportation
- Expand Voucher system to accommodate all who need it (expand locations & more #)
- Follow SF model for free transportation for seniors and include disabled.
- Shared access/system

Healthy Aging Goal 2: Improve systems of care including prevention, early diagnosis and treatment of aging adults, focusing on dementia, chronic disease management and social engagement.

Identified Partners/Programs

Effective/Regular "engagement" w/older adults who need service (more personal connections, relationships)

PARTNER	PROGRAM	Notes	GAPS	REP	
Adult Day Care	 Care of people with dementia Social engagement Case Management IHSS 				
Construction Instruction	Trade unionapprenticeships	Provides home modifications			
A4AA Nutrition Ed	•	Starting 10/1/15			
Congregate Meals	•				
Multipurpose senior services	•				
Davis Senior Center	 Retrofitting 				
St. John's Retirement Village	 Alzheimer's Café 				
Friendship line	•				
Davis Community Church	Caregiver supportOther support				
RISE	 Senior groups 				
Citizens Who Care	•				
Alzheimer's Association	•				
MDA	•				
Cache Creek Casino	 Tobacco reduction 				
Del Oro Respite Service	•				
Yolo Hospice/Adult Day Care	 Caregiver Support 				

Healthy Aging Goal 2: Improve systems of care including prevention, early diagnosis and treatment of aging adults, focusing on dementia, chronic disease management and social engagement.

Groups

Healthy Aging Goal 2: Improve systems of care including prevention, early diagnosis and treatment of aging adults, focusing on dementia, chronic disease management and social engagement.

PARTNER	Program	Notes	GAPS	Rep
Health care Providers	•			
Partnerships Care Coordination Programs	 Home visiting Care transitions Complex case management IOPCM Chronic Kidney disease case management 			
VA	Respite Care			
HHSA	Home visiting program (Healthy Living)			Yes – Lisa Muss er, Amy Dyer
Grandparent Car Seat Program	•			Dyei

65 Providers (Sheila)

Other Gaps:

- Home modification (NCCT, Jail)
- Family/patient early recognition of symptoms
- Faith based pastoral model
- Senior Prom

Healthy Aging Goal 3: All older adults and vulnerable populations have affordable, accessible, and safe housing.

Identified Partners/Programs

PARTNER PROGRAM NOTES GAPS REP AT WG?
•

- Faith based volunteers
- Tools to use in the home

Safety walk-through by another

Healthy Aging Goal 4: Ensure an integrated, accurate, and well-publicized information system for older adult services.

Identified Partners/Programs

PARTNER PROGRAM NOTES GAPS REP AT WG?

- Create a transportation hub that includes information and connection to services.
- Identify all providers of information and outreach bring together to assure collaboration.
- Create a unified database or a system to integrate regular updates of information.
- Create a media campaign to increase public awareness of I&A.