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

Brainstorming Current Efforts

- Please see Attachments D and E.

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

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 vegetable across the lifecycle. • Increase number of residents who follow dietary guidelines for Americans. • Increase consumption of healthy foods consistent with dietary guidelines/requirements.		• 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 appropriate • Integrated • Age appropriate	• •	

Attachment D

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 bank • School lunch program		Training for all case managers	
Referral network	• Yolo Healthy Aging • Senior Link •			
Diagnosis based pathway	• American heart • Cancer			

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:

-

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 NEOP/HY	Cooking classes 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 & programs • Par courses • Labyrinth 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		

Potential Strategies:

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

Other Gaps:

-

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:

-

Potential Strategies:

-

Attachment E

Healthy Aging

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 union • apprenticeships	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 support • Other 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 Musser, Amy Dyer
Grandparent Car Seat Program	•			

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.