MAYOR’S BLUE RIBBON COMMISSION ON HEALTH POLICY

Report to Dwight C. Jones, Mayor of City of Richmond

November 3, 2010

Carolyn N. Graham
Chair
A MESSAGE FROM THE CHAIR
OF THE
MAYOR’S BLUE RIBBON COMMISSION ON HEALTH POLICY

Mayor Dwight C. Jones is to be commended for the guidance and foresight he has shown in recognizing the importance of addressing the complicated issues related to health and health equity. In creating the Blue Ribbon Commission on Health Policy (“Commission”), he has taken a bold step in prioritizing health disparities for the most vulnerable citizens of the City of Richmond.

This report would not have been possible without the dedication and commitment shown by the members of the Commission. Not only did they freely give of their time each month for meetings, they worked continuously in their workgroups to support this effort. Without their expertise, guidance, and unwavering commitment to the City of Richmond and its citizens, this report would not have been possible. Their sacrifices made this such a rich experience.

I would like to extend special recognition to Dr. Roice Luke, Mr. Chris Darling, and Dr. Michael Royster for providing the Commission with vital educational information critical to understanding some of the issues related to health disparities in the City of Richmond.

Dr. Joseph Boatwright deserves special recognition for his continuing support, counsel, and passion demonstrated for the citizens of the City of Richmond and his commitment to assuring equity in health care accessibility for each citizen regardless of social, economic, and other factors that may influence their ability to access health care.
Dr. Frank Royal, while not a member of the Commission, must also be recognized for his wise counsel and passion for the citizens of Richmond and their health care needs. I shall never forget his wisdom.

A special thank you goes out to City Council Members Doug Conner, Cynthia Newbille, Martin ‘Marty’ Jewell, Charles Samuels, Bruce Tyler, Christopher Hilbert and Ellen Robertson and their staffs for recruiting residents within their districts to participate in focus groups and surveys.

I would also like to thank Superintendent Yvonne Brandon for allowing the Commission to host focus groups and meetings at Martin Luther King, Jr. Middle School, George Wythe High School, and Thomas Jefferson High School.

Thank you to the citizens of Richmond for your willing participation in the focus groups, surveys and other discussions.

Finally, a very heartfelt thank you goes out to Dwanna Lee and other committed, dedicated, and hard working staff of the Office of the Deputy Chief Administrative Officer of Human Services; our consultant, Dr. Elaine Crider, who spent long hours researching, writing, and rewriting; and to all of the volunteers who helped to make every aspect of this project an overwhelming success.

Dr. Carolyn N. Graham
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EXECUTIVE SUMMARY

In January 2010, Mayor Dwight C. Jones signed Mayor’s Order #2010-01, which established the Blue Ribbon Commission on Health Policy (“Commission”). The establishment of this Commission was a direct result of the Mayor’s concerns about the disparity in health outcomes across the City of Richmond. The Commission was comprised of a distinguished group of health experts, including physicians, academicians, hospital executives, community clinic providers, and mental health providers, who worked together from March 2010 through August 2010 to respond to the Mayor’s charge, which specifically required that they:

- Address the City of Richmond’s health priorities, goals, and aspirations for the city’s residents;
- Propose strategies that the City of Richmond might pursue in addressing the barriers to health care, as well as the city’s health disparities that cause so many to lose life prematurely;
- Recommend ways to strengthen health care resources, particularly human resources in shortage areas where there is a concentration of health disparities; and
- Strengthen and support the work currently being done by the Commonwealth of Virginia in primary/preventive and behavioral health, as well as by private providers.

To understand the problems of the uninsured, the Commission reviewed several studies and reports that examined the depth of the issue and closely explored the relationship between social and economic factors and health
outcomes. The review of the literature revealed that the number of uninsured adults and children is increasing, and that the majority of the uninsured were more likely to be working full or part time, racial and ethnic minorities, living in less safe environments, and have less educational attainment than those who are insured. In addition to the social and economic factors, the uninsured were more likely to have poorer health outcomes than those with insurance. Health measures such as access to medical care, less timely prenatal care, and increased low birth weight of babies are all disproportionately occurring in areas of the city with the most low income households and in households without health insurance.

At the conclusion of their collaborative efforts, Commission members identified 45 specific recommendations that would help reduce disparity between those who were insured and those who were not. Using a facilitated process, the group was able to prioritize the recommendations and agreed on five recommendations to present to Mayor Jones. The top five recommendations are:

1. Develop public policy to mitigate against social factors that give rise to poor health outcomes.
   A. Include health and health equity as a primary consideration in decision-making.
   B. Provide tax incentives for healthcare professionals to work and practice in underserved areas and neighborhoods (particularly OB/GYNs, primary care physicians, pediatricians, child psychologists/psychiatrists, and dentists).
   C. Provide financial incentives for corner stores to sell healthy food options.
   D. Provide financial incentives to place grocery stores in food deserts.
E. Require the inclusion of green spaces, trails, bike and walking paths and lanes in all new and revitalized community plans.

F. Create a “Mayor’s Healthy Richmond” initiative using social marketing.

2. Develop a responsive infrastructure that will facilitate the provision of a wide range of prevention and intervention services for at-risk youth and families in an efficient and effective manner following all of the well-documented principles and evidence-based practices in this domain, including but not limited to pursuing and making an application for a SAMHSA Systems of Care Grant and conducting a study of the system of Mental and Behavioral Health In-home Services and Day Treatment Services.

A. Ensure that all children receive an independent comprehensive diagnostic evaluation completed by a licensed mental health professional prior to the start of Intensive In-Home (IIH) or Therapeutic Day Treatment (TDT) services. The services will not be authorized unless the diagnostic evaluations indicate that the respective service and the related level of care is the least restrictive most clinically appropriate service option available.

B. Maintain a comprehensive list of providers authorized to deliver IIH and/or TDT services within the city limits. The providers will be selected based on a number of qualitative factors, including credentialing of staff and documented efficacy of clinical approaches.

C. Assist the guardians/parents of the targeted children in selecting a provider from a list of public and private providers authorized by the city.

D. Create utilization review (UR) and quality assurance (QA) processes that ensure that the targeted Richmond children receive quality services from members of the provider network. In addition, the city will utilize the UR
and QA data and processes to ensure that the services are effectively coordinated across all public and private child serving systems, which in turn will eliminate duplication of effort.

E. Implement a comprehensive consumer education program to include the following:

1. Training and education of school personnel who are instrumental in interfacing with these providers in the public school settings
2. Ongoing consumer education and communication through local civic organizations, churches, city agencies to include speaking engagements, brochures, bulletins, website, etc. to support and empower the parents/guardians as they access services on behalf of their children.

3. Reorganize the work of local government to focus on health and health equity.

   A. Create a City of Richmond interdepartmental council designed to build bridges across all aspects of city government and the public/private health sector to work collaboratively developing policies that support equitable access to health across populations and neighborhoods. Include school system and private health care provider representatives on council in addition to government officials. Initiatives recommended for interdisciplinary council to address include but are not limited to:

      1. Assess the potential impact of policies on health and health equity and to identify policy options that most consistently promote health and health equity.
2. Re-activate the Richmond Public School’s School Health Advisory Board; develop guidelines for foods served at school (including vending machines); require physical activity for grades K-12; implement the Center for Disease Control’s Coordinated School Health Program.

3. Within each department of city government review and revise policies, practices, and procedures to ensure they promote health and social equity.

B. Create a comprehensive workplace health promotion program for city employees, particularly public school employees, whose involvement serve as guidance for children and their families.

4. Identify models that work including but not limited to investigating the merits of establishing “medical homes” for the uninsured and reviewing models such as the East End Partnership for Families, and the Northside Partnership—collaborations between community groups and human service organizations working together to improve the lives of families.

5. Sponsor an annual health fair as an introductory initiative focused on health education and health screenings to residents.

In addition to these recommendations, there are two critical actions that must be given high priority to assure a successful implementation of health reform for the City of Richmond. First, it is essential that the City of Richmond maintain a presence of physicians in the community. As in other jurisdictions, low rates of reimbursement and challenges related to managed care and other care management
strategies have increased the administrative burden with relatively little financial increases for physicians. As a result, many communities have experienced a dramatic loss of practicing doctors. To encourage physicians to locate their practices in the City of Richmond, the city should implement an incentive program including but not limited to support housing purchasing and tax incentives for providers to practice and locate in the City of Richmond.

The responsibility for establishing health priorities and policies must reside with the City of Richmond. The current responsibility for the city’s health policies does not reside with the City of Richmond, but with the Commonwealth of Virginia. As such, the ability of the city to identify its own policies and priorities and drive its own initiatives is limited. The City of Richmond must regain responsibility for its own health priorities consistent with the needs of its citizens and not continue to be driven by the priorities and needs as identified and set by the Commonwealth of Virginia.

Once the Mayor has approved the priority recommendations, the Commission will assist in assuring fidelity to the plan developed to implement the recommendations.
INTRODUCTION

As the current Mayor, Dwight C. Jones, campaigned for office, he traveled across the City of Richmond and listened intently to the concerns expressed by its citizens. He heard story after story about health care delivery and accessibility. He heard tales of the difficulty citizens had in finding doctors and getting the health care services they needed. After taking office in 2008, Mayor Jones became even more acutely aware of the disparity in health care resources and outcomes for many of the city’s most economically challenged residents.

He was particularly concerned and affected by staggering statistics that showed among other things:

- Significant disparities in birth outcomes, life expectancy rates, and excess morbidity and mortality for certain citizens of the City of Richmond;
- Great disparity between the health status of residents based on educational levels;
- Shorter life expectancy and mortality rates of African Americans compared to the rates of other racial and ethnic groups; and,
- Higher rates of teenage pregnancy and birth rates to single mothers residing in high poverty areas.

Mayor Jones knew of the tremendous amount of research that had been done over the years to study the issue of health disparities and the uninsured; yet the disparity in health care between those with and without health care resources continued to grow. Although several studies have been helpful in identifying concerns and problems, the City of Richmond continues to have segments of the
population who disproportionately have poorer health outcomes and unequal access to health care services.

Additionally, while the suburban counties surrounding Richmond saw growth and development in specialty areas of care, little of that was occurring in the city, where the reverse appeared to be the trend. The numbers of physicians in primary and preventive care and child psychiatrists practicing within the city were steadily declining. While most studies examined the impact on the health status of the residents of the City of Richmond, Mayor Jones wisely recognized that in addition to the growing health disparities, the loss of community-based physicians had major economic implications for the city as well.

To address his concerns and in an earnest search for answers, Mayor Jones established a Blue Ribbon Commission on Health Policy to advise him on health policy issues in the City of Richmond. Dr. Carolyn N. Graham, Deputy Chief Administrative Officer for Human Services, was asked to lead the effort for the Administration. The Commission is comprised of a distinguished group of physicians, health policy experts, hospital administrators, and state and local government officials.

The Commission members were divided into workgroups to address the needs of children; youth; adults; and elders and special populations. In addition to defining a healthy community, each group identified issues specific to their group and developed recommendations to address the concerns. Along with their recommendations, the elder’s workgroup identified a set of values that they felt were important to remember in looking for solutions to the complex issues faced by
elders as they age. It is noted that while developed by the elder’s workgroup, the values would be applied to each group. These values were stated as:

• City residents should reside in environments that are conducive to healthy living.
• The community should embrace practices that improve its population’s social, health, and behavioral well being, education, and safety.
• Access to a full range of high quality, affordable services should be available with priority attention given to eliminating gaps in services in areas with greatest need.
• There should be public-private partnerships to help assure that human capital, financial and technological resources and other infrastructure are available and responsive to needs.
• Health care reform and similar initiatives at the national, state and local levels should be taken into account in developing service options.

The work of the Commission was done within the context of the shifting national landscape of health care reform and a local environment of expanding need and shrinking resources. This report seeks to be responsive to those factors, while recognizing that the health care system’s fragmentation that has emerged over time in the City of Richmond will not be undone overnight, nor as the result of one commission’s report. It will take years of consistent, focused energy and resources to make the changes necessary for Richmond’s health care delivery system to become properly aligned to meet the needs of its residents and contribute to the economic revitalization of its economy.
THE NATION’S HEALTH

According to the National Center for Health Statistics, the United States spent $2.2 trillion (16% of the Gross Domestic Product), on health care in 2007, with 46 percent coming from public funds such as Medicaid and Medicare.¹ Thirty-one percent of all health care expenditures went for hospital care, followed by 21 percent for physicians and clinical services, 10 percent for pharmaceuticals, and approximately six percent for nursing home care.² The United States spends more per capita for health care than any other industrialized country yet, it ranks 37th overall,³ 24th for life expectancy,⁴ 29th for diabetes prevalence,⁵ 18th for adult obesity,⁶ 27th for opiate use,⁷ and 23rd for number of physicians per 1000 population.⁸ These rankings are much worse when we factor in the disparity that exists for minority and ethnic populations.

Federal and state policy makers and health policy experts have struggled to find the answer to these alarming statistics. How can the United States spend so much on health care and still rank so poorly among industrialized countries? The answer to this question is not simple; yet current research into social, environmental, and economic influences on health supports the belief that the gap between high health care spending and low health outcomes is greatly influenced by several factors, including high rates of poverty, racial and ethnic origins, educational attainment, environmental pollutants and stressors, the availability of health care resources, and the growing number of uninsured. Health begins long before we need a physician. Our health begins in our homes, families, organizations, neighborhoods, and the policies that shape them.

### THE UNINSURED

The issue of the uninsured continues to be a major concern for the nation. The US Census Bureau has documented the rising rate of uninsured in this country since 1999.

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*Table 1 – Rising Rate of Uninsured
Source: US Census Bureau, 2010*

The US Census Bureau’s most recent estimate of 50.7 million uninsured represents 16.7 percent of the population. According to the Kaiser Foundation, most non-elderly Americans (approximately 60 percent) receive insurance through

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their employer.\textsuperscript{10} This statistic could lead one to surmise that those without health insurance are non-working adults. The opposite is true. According to the Kaiser Family Foundation,\textsuperscript{11} 90 percent of the uninsured live in households with low or moderate incomes—defined as households between 133 percent and 400 percent of the federal poverty level.\textsuperscript{12} Further, the average cost of employer sponsored family coverage in 2010 is $13,770.00, and the majority of workers with low or moderate income simply cannot afford the cost of the premiums.\textsuperscript{13} In their Primer titled \textit{The Uninsured}, Kaiser further described the uninsured as poor or near poor, non elderly adults—including young adults between the ages of 19 and 29, minorities, native or naturalized US citizens, lacking educational attainment beyond high school, and in worse health than the insured.\textsuperscript{14}

The physical, emotional and financial burden of being uninsured has a tremendous impact on the individual and on the health care system overall. This burden has been well documented and includes decreased access to medical care, increased rates of undiagnosed chronic care conditions such as diabetes and hypertension, increased rates of non compliance with medical treatment, delayed access to primary and preventive care, decreased access to specialist and specialty care, increased rates of hospitalizations for avoidable conditions, increased financial

\textsuperscript{10} The Kaiser Commission on Medicaid and the Uninsured. 2009. \textit{The Uninsured A Primer, Key Facts About Americans Without Heath Insurance}. (#7451-05).
\textsuperscript{11} Ibid.
\textsuperscript{13} Ibid.
\textsuperscript{14} The Kaiser Commission on Medicaid and the Uninsured. 2009. \textit{The Uninsured A Primer, Key Facts About Americans Without Heath Insurance}. (#7451-05).
burden from high medical bills, and diminished savings and assets to pay health care debt.\textsuperscript{15}

Programs such as the Children’s Health Insurance program (CHIP) have been introduced as a means to address the problem of uninsured children. Today, each state has their own version of the CHIP program, yet these programs are income limited and do not address or capture all of the uninsured children. Most of the other programs that provide services to the uninsured are not insurance programs but subsidized services offered by community based providers such as Federally Qualified Health Centers and hospital based programs such as the one offered by the partnership between Virginia Commonwealth University Health Systems (VCUHS) and the University of Virginia (UVA) Medical Center. Additionally, community physicians and charitable organizations provide and/or arrange for the uninsured to receive care often without reimbursement. The passage of the Affordable Care Act promises to relieve some of the burden of the uninsured.

\textbf{HEALTH CARE REFORM}

The recent passage of the Affordable Care Act promises to reduce the number of uninsured in the nation and includes a requirement that each individual have health insurance.\textsuperscript{16} Some of the provisions of the national health care strategy include expanding Medicaid for the low income, assessing penalties for failure to purchase health insurance, providing subsidies to assist individuals in purchasing

insurance, and modifying insurance regulations to prohibit denials based on pre-existing conditions.\footnote{Ibid.}

The Affordable Care Act does not stop with requiring insurance for all Americans; it also creates funding for school based health clinics targeted at improving the physical health and well being of students, and promises increased funding for community health centers. The law includes the requirements for an essential package of health care benefits that must be offered by each private health insurance plan; including primary care, hospitalization, and prescription drugs at a minimum, and seeks to assure the quality of health care provided by mandating that there be specific benchmarks and evaluation of care provided to individuals.

One of the provisions of the law that is consistent with the direction proposed by the Commission is the focus on health equity, which requires uniform reporting and data collection on race and ethnicity, gender, geographic location, socioeconomic status, education, and language. The law creates a multi-million dollar prevention fund to focus efforts on reducing the need to utilize healthcare services. If those funds are strategically focused on promoting health equity in the City of Richmond, there is tremendous potential to improve health of the city’s residents.

As envisioned, health care reform will provide health insurance coverage to over 700,000 Virginians by 2019. Individuals and small businesses would be eligible for tax incentives to help offset the costs of covering their families and
small business employees. Insurance companies would be prohibited from placing caps on health care coverage, and increased funding for community health centers could be available to the Federally Qualified Health Centers (FQHCs) in the City of Richmond. Elders in the City of Richmond could see some relief from the cost of their prescription drugs, since the law requires a 50 percent discount on brand name drugs.

Chart 1—Time Line of Affordable Care Act Implementation
While there are high hopes nationally for the full implementation of health care reform, the Virginia General Assembly, during its 2010 Legislative Session, adopted legislation making it illegal for the federal government to require Virginians to purchase health insurance. Virginia Attorney General, Kenneth Cuccinelli, has sued the US Department of Health and Human Services citing the conflict between the Virginia law and the federal law requiring Virginians to purchase health insurance. While this case continues, Governor Robert McDonnell is moving ahead with plans to develop a locally generated health reform program for Virginia. A panel has been installed and has been asked to look at Medicaid reform, insurance market reform, delivery and payment reform, capacity, technology, and purchasing issues.  

SOCIAL DETERMINANTS OF HEALTH

In February 2008, The Robert Wood Johnson Foundation established the Commission to Build a Healthier America (RWJ Commission) to examine the factors, excluding medical services, which influence overall health. The RWJ Commission was asked to recommend strategies that would improve the health of all Americans. The Commission membership was comprised of policy, health, business, and education experts and a notable list of educators, entrepreneurs, news anchors, researchers, professors, and business owners.

19 Ibid.
According to the RWJ Commission, “[n]ationally and in almost every state, shortfalls in health are greatest among the most-disadvantaged adults, yet, even those considered middle class are less healthy than adults with greater social and economic advantages.”^20^ This statement is consistent with current research exploring the relationship between social and economic factors and health status. Health statistics frequently show that families with lower incomes, with less educational attainment, residing in environments that are less safe, and from diverse racial and ethnic groups are more likely to have poorer health outcomes.

Through a series of town hall meetings, visits to various states, and reviews of studies and research documents, the RWJ Commission members found that Americans are not as healthy as they should be; good health requires personal responsibility; health is more than health care; and strong collaborations between leaders in health, business, education, and housing must occur in order to identify workable strategies to improve the health of all Americans.^21^

The RWJ Commission also found that social, racial, ethnic, economic, environmental, and behavioral factors all have a significant impact on the health of adults and children; and that the same factors that have such a profound impact on health also have a significant impact on other sectors, such as crime, employability, better health decisions, and decreased poverty. As such, the RWJ Commission recommended strategies for improving health outcomes as well as approaches that could address and improve the social factors that significantly impact health,

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^21^ Ibid.
including but not limited to income levels, discrimination because of race and ethnicity, educational attainment, and environmental influences.  

For the Commonwealth of Virginia, the RWJ Commission found the following social factors significant to health:

- Nineteen percent of Virginia adults live in households with incomes that are less than 200 percent of the federal poverty level (FPL);
- Fifty-one percent of Virginia adults have graduated from college or attended college;
- Seventy percent of Virginia adults are Caucasian;
- Hispanics and African Americans are more likely to be less healthy than non-Hispanic whites in Virginia;
- Virginia’s children are evenly split between lower, middle, and higher income households in the state;
- One third of Virginia’s children live in households without family members who have educational attainment beyond high school; and,
- Sixty percent of Virginia’s children are non-Hispanic whites, 22 percent are African American, and 8 percent are Hispanic.  

The findings of the RWJ Commission provided a good backdrop for the Mayor’s Blue Ribbon Commission on Health Policy to begin to explore health in

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22 Ibid.
23 Ibid.
the City of Richmond. In practically every measure, the statistics related to the City of Richmond were dramatically different from those experienced by the nation and by the Commonwealth of Virginia.
HEALTH IN THE CITY OF RICHMOND

The City of Richmond has long struggled with the issue of how to improve health outcomes and health care access for its residents. In 2000, a group of safety net providers came together to work collaboratively and address the problems of the uninsured. Through this collaboration, Richmond Enhancing Access to Community Healthcare (REACH) was created to “promote collaboration among safety net providers, strengthen the health care delivery system, and increase access to quality comprehensive health care services” for the most vulnerable citizens in the City of Richmond.\textsuperscript{24} Through this effort, a comprehensive Community Health Services Plan (CHSP) was developed. In completing the CHSP, REACH considered several factors including Richmond city demographics, utilization patterns, and financial resources available for services. At the completion of their research, REACH developed a set of recommendations that when fully implemented, promised to dramatically improve health care access to the uninsured. Some of the recommendations of REACH have been implemented and are ongoing in the City of Richmond. Yet, Richmond’s challenging economic environment requires another look at the difficulties faced by the uninsured in accessing necessary health care services.

\textsuperscript{24} REACH. Bridging the Health Care Gap. A Community Health Services Plan for the Greater Richmond Virginia Region. November 2007.
## CITY OF RICHMOND DEMOGRAPHICS

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<td>Occupied housing units</td>
<td>84549</td>
<td>92</td>
</tr>
<tr>
<td>Vacant housing units</td>
<td>7733</td>
<td>8</td>
</tr>
</tbody>
</table>

*Table 2—City of Richmond Demographics*

*Source: US Census Bureau, 2000*
The population of Richmond is majority African American, with whites making up the next largest racial group. Latinos, Asians, American Indians, and mixed race individuals each comprise a small percentage of Richmond residents.

Chart 2—Racial Distribution City of Richmond
Source: US Census Bureau, 2000
In addition to the general demographic information, an appreciation of the health demographics of the City of Richmond is also needed to assess the health needs of Richmond communities.25

<table>
<thead>
<tr>
<th></th>
<th>City of Richmond</th>
<th>Virginia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Live Births</td>
<td>16.4</td>
<td>13.7</td>
</tr>
<tr>
<td>Non-Marital Births</td>
<td>63.7</td>
<td>35.8</td>
</tr>
<tr>
<td>Percent Pre-Natal Care Begun In 13 Weeks</td>
<td>88.7%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Induced Pregnancy Terminations</td>
<td>2,882</td>
<td>27,410</td>
</tr>
<tr>
<td>Teen Pregnancy Rate/1000</td>
<td>68.2</td>
<td>26.3</td>
</tr>
<tr>
<td>Infant Death Rate/1000</td>
<td>10.9</td>
<td>6.7</td>
</tr>
<tr>
<td>Cancer Deaths</td>
<td>411</td>
<td>13,489</td>
</tr>
<tr>
<td>Heart Disease Deaths</td>
<td>182.2</td>
<td>176.2</td>
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<tr>
<td>Cardiovascular Disease Deaths</td>
<td>51.3</td>
<td>42.0</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease Deaths</td>
<td>80</td>
<td>3008</td>
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<tr>
<td>Unintentional Injury Deaths</td>
<td>90</td>
<td>2769</td>
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<tr>
<td>Diabetes Deaths</td>
<td>50</td>
<td>1529</td>
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<tr>
<td>Suicide Rates</td>
<td>20</td>
<td>938</td>
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<tr>
<td>Chronic Liver Disease</td>
<td>25</td>
<td>640</td>
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<tr>
<td>Primary Hypertension and Renal Disease Deaths</td>
<td>25</td>
<td>570</td>
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</table>

Table 3—City or Richmond Health Statistics
Source: Virginia Department of Health—Statistics and Reports, 200826

26 Ibid.
In addition to common health related statistics, one other statistic stands out. According to the Central Virginia Health Planning Agency, the number one discharge diagnosis from all Richmond city hospitals is psychosis, possibly related to the amount of stress and dysfunction inherent in populations greatly impacted by social and economic factors that influence health.\textsuperscript{27} While the discharge data statistic is revealing in itself, Virginia’s present system of care for the provision of mental health services to meet the needs of Richmond’s children with serious emotional disorders is broken and fragmented. Of particular concern is the most intensive level of community-based services which includes Intensive In-Home (IIH) and Therapeutic Day Treatment (TDT) services. Access to these services is very fragmented and often puts families at risk for selecting services and providers who may not be qualified or may not provide the services that best match the child and families’ needs. In accordance with “best practices” a client should be clinically assessed by an independent clinician separate from providers of services to ensure that the level of client’s needs and the services selected are directly supported by a clinical assessment and indicators. Once the needs are identified, then the Provider should be selected.

While the Department of Medical Assistance (DMAS) has implemented some enhancements to the basic qualifications of staff and providers, there is no capacity through the state licensing or DMAS audit provisions to ensure ongoing quality and proper credentialing of staff congruent with the services offered by a Provider. There needs to be a system to ensure proper quality assurance and utilization reviews of all providers.

\textsuperscript{27} Summary provided by the Central Virginia Health Planning Agency.
Finally, there needs to be a system of accountability to ensure proper cost containments on access to the city’s funding of youth services through the Comprehensive Services Act, such as Richmond’s local share of the Medicaid expenses for many of these clients.

SOCIAL DETERMINANTS OF HEALTH IN THE CITY OF RICHMOND

Much of the disparity in health outcomes is caused by social factors that have a proven and dramatic impact on health. As illustrated in Table 3—City of Richmond Health Statistics, the City of Richmond lags behind the Commonwealth of Virginia in almost all health indicators with the exception of the percent of women seeking prenatal care before 13 weeks.\(^28\) Further exploration of City of Richmond statistics reveals that educational attainment, unemployment rates, and poverty levels fall below the state’s rates and may contribute to the poor health outcomes of the city. A person’s living environment, racial and ethnic group, educational attainment, and income level all play a role in the health of a community. Unfortunately, for some of its communities, the City of Richmond faces significant challenges related to these social and economic factors. In short, the social determinants of health are the root factors in determining the health of Richmond residents and the Nation’s citizens.\(^29\)


Chart 3—City of Richmond Educational Attainment\textsuperscript{30}
Source: Virginia Employment Commission, 2008

Chart 4—12 month unemployment rates for the City of Richmond and Commonwealth of Virginia\textsuperscript{31}
Source: Virginia Employment Commission, 2008


\textsuperscript{31} Ibid.
The pattern of unemployment rates for the City of Richmond has paralleled the pattern of unemployment for the Commonwealth of Virginia, although the unemployment rate has been higher within the city. However, during the last several months, unemployment rates for the Commonwealth of Virginia have remained stable, while the unemployment rate for the City of Richmond has continued to rise.

POVERTY LEVELS

In 2008, the median household income for the City of Richmond was $38,385.00, with approximately 25 percent of the population living in poverty. As illustrated by the chart below, African Americans have the greatest rates of poverty and whites in the City of Richmond have the lowest rates.

Chart 5—City of Richmond Poverty Rates by Race
Source: US Census Bureau, 2008
After decades of decline, total population has stabilized; while poverty population has increased by nearly 20 percent since 1970.

Using infant mortality and children’s general health status as markers, the RWJ Commission found that children in the Commonwealth of Virginia are not as healthy as they could be. Additionally, children who resided in homes with lower household incomes, including children in middle income households, were more likely to have poorer health indicators. The map below shows the concentration of Child Poverty by Census Tract.
Children who resided in households with only a high school education were more likely to be of poorer health than children who resided in households with some level of college or college graduates. Specifically, women with between 12 and 15 years of education attainment experience infant mortality rates that are 60 percent higher than women with more education.\textsuperscript{32}

\textsuperscript{32} Ibid.
In addition to the impact of education on infant mortality, research has also documented a relationship between poverty and low birth weight, a factor that influences infant mortality.
KEY STUDIES

As the Commission prepared to undertake its work, it was provided with a series of studies completed over the last decade that examined the health care needs in the City of Richmond. The reports served as background material for the Commission’s efforts and provided statistical information on national, state, or local health concerns. These reports explored issues such as trends in insurance coverage; profiles of the uninsured; and vital and health statistics for the state, nation, and the City of Richmond.
1. *Bridging the Healthcare Gap A Community Services Plan for the City of Greater Richmond, Virginia Region*

The REACH report is a comprehensive “Community Health Services Plan for providing quality, integrated, health care services to low-income uninsured members of the Richmond Metropolitan Area.” The plan was developed to be a coordinated regional strategy to improve health services and assist in the identification of locations to target programs and services for those without insurance. The report explored utilization patterns, fragmentation of the delivery system, funding resources, coordination of care issues, information technology needs, capacity issues, and cultural and system barriers to care.

The REACH report revealed significant information about the uninsured in the Metro Richmond area. In particular, the report showed that the uninsured were a cross section of residents of Richmond and spanned the life cycle. According to the report, the majority of the uninsured were without insurance for a brief period while they transitioned between jobs or other life changing events. The report showed utilization patterns, including the use of safety net providers, inpatient hospital visits, emergency room visits, and ambulance use. After careful research and analysis, the REACH report made the following recommendations:

- Restructure REACH to serve as facilitating body for the safety net;
- Secure stable long term funding for the safety net;
- Provide the right level of care the first time;
- Increase clinic capacity to serve more patients;
• Establish pathways to “exchange” patients and their information across providers to increase efficiency and effectiveness across the system of care;
• Improve clinical and utilization outcomes and develop better ways to show return on investment, value and improved outcomes; and,
• Increase shared health safety net accountability.

Some of the recommendations made in the REACH report have been implemented.\textsuperscript{33}

2. Unequal Health Across the Commonwealth A Snapshot

This 2008 Virginia Health Equity Report was developed by the Virginia Department of Health Office of Minority Health and Health Equity to provide a framework for understanding the complexities related to disparities in health care for Virginia’s residents. These disparities can be tracked to the disproportional impact of the Social Determinants of Health (SDOH) on certain populations. These SDOH include economic and education opportunities, quality and affordable housing, health promoting physical environments, family and community stability, cultural norms, food security, childhood living conditions, discrimination, transportation, and access to health care services. As suggested by the report, adversely impacted communities can become healthier if SDOH are addressed and reduced and/or eliminated.

\textsuperscript{33} REACH. Bridging the Healthcare Gap. A Community Services Plan for the City of Greater Richmond Virginia Region. 2007
In order to eliminate health disparities, the report recommends an intensive effort to assure high quality, culturally and linguistically appropriate, equitable access to health services. The report also encourages promotion of healthy behaviors, including diet and exercise, as well as a strategy to address the social and economic factors that are at the root of health inequities. Finally, the report advocates for a coordinated strategy across all disciplines that promote the reduction of health disparities and inequity.\textsuperscript{34}

3. The Uninsured: Key Facts About Americans Without Health Insurance

This report by the Kaiser Foundation (Kaiser) provides basic information about the uninsured across America. Using data between 2006 and 2008, Kaiser offers a national view of the uninsured, provides key information on the availability of private and public health insurance coverage, examines how the uninsured have changed over time, and provides a number of suggestions for reducing the number of uninsured. The report puts a face on the problem of the uninsured by defining who they are, why they do not have insurance, and the challenges they face by not having health insurance.

As the report points out, about 60 percent of nonelderly Americans receive insurance coverage through their employers. The remaining 40

percent are covered by Medicaid, CHIP or another state subsidized program; persons who cannot afford insurance coverage through their employer; or those who work for an employer who does not offer health insurance. Public insurance programs such as Medicaid and CHIP provide coverage primarily to women, children, and persons with disabilities. As such, adults without dependent children are not usually eligible and have to find other options for coverage. As incomes increase, the number of Americans covered by insurance also increases, indicating that the problem of the uninsured is largely a problem for those who are poor, near poor, or have incomes less than 200 percent of the federal poverty level. According to the Kaiser report, young adults between the ages of 19 and 29 make up a disproportionate share of the uninsured. Additionally, individuals who are minorities and those with lesser educational attainment, regardless of race, are more likely to be uninsured.

For most nonelderly Americans, employer sponsored health insurance is an option, though not without limitations. Employer sponsored health insurance may require the employee to contribute to the cost of their insurance, and almost always requires them to pay the cost of coverage for their covered family members. There is great variability in the rates of employer sponsored health insurance, and because the programs are usually voluntary, some employees choose not to purchase the coverage. Other employees are not eligible for health insurance coverage because they are part-time or face other limitations.
The issue of inequity in health care is also explored as the report delves into the barriers to health care based on insured status—showing that those without health insurance are more likely to go without health care, including preventive care and prescriptions. As the report highlights, the uninsured are more likely to have problems accessing medical care than those with insurance. Persons without insurance coverage also report that they do not have a usual source of care, that they receive no preventive or primary care, go without care when it is needed because of its costs, and go without medication due to the cost of prescriptions. The lack of insurance and financial resources also makes them non-compliant with medical treatment and more likely to be hospitalized for preventable conditions, requires them to pay up front for medical care, increases their risk for amassing medical bills, and use savings and assets to pay health care costs, which leave them at risk of being able to pay off medical debt.

With the growing numbers of uninsured comes a growing level of uncompensated care. The Kaiser report discussed the financing of uncompensated care and delineated the burden of uncompensated care on the uninsured, hospitals, community clinics, and physicians. In 2008, the federal government provided more than $57 billion in funding for uncompensated care. The majority of this funding goes to hospitals (61%) and some direct service program providers including Veterans Affairs and Federally Qualified Health Centers (FQHCs) (25%). Although funding for FQHCs has increased over the last few years, the increases in funding have not kept pace with the cost of care provided to the uninsured. Today, according to Kaiser, federal grants provided to FQHCs account for about 48 percent of the cost of care.
Physicians receive little to no funding for uncompensated care from the federal government and over time, financial demands and changing practice patterns have resulted in a decline in levels of charity care provided by community physicians.

The Uninsured: Key Facts about Americans without Health Insurance offered a number of charts and tables to illustrate its findings. The report ended with a number of suggestions for decreasing the number of uninsured. These suggestions include strengthening or expanding existing coverage mechanisms, improving the affordability of coverage, improving the availability of coverage, and changing how health insurance is financed and organized.35

4. County Health Rankings—2010

This report was developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The report provides information about the health of residents of counties across Virginia. It facilitates county-to-county comparisons on a number of health indicators. The report ranks county morbidity and mortality factors (health outcomes). It also weighs health factors, specifically health behaviors (smoking, diet, exercise), clinical care (access to care and quality of care), social and economic factors (education, income, employment, family and social support and community safety), and the physical environment (environmental

quality). The City of Richmond ranked 124 for health outcomes and 129 for health factors.\textsuperscript{36}

5. *Chronic Disease in Virginia: A Comprehensive Data Report*

This report defines chronic disease as “diseases that are prolonged, do not resolve spontaneously, and for which complete recovery is rarely achieved.” There are certain groups that are at higher risk for chronic disease than others. The report identifies those groups as African Americans, women, young children and teenagers, persons with diabetes, smokers, and people with a family history of chronic diseases.

This report provides a thorough discussion of health disparities, disparate populations, and their specific risks for certain types of chronic diseases. For example, in examining the risk for people with disabilities, the report identifies four types of disabilities and the number of people between the ages of 16 and 64 who have one or more disability. The report also identifies modifiable and non-modifiable conditions that place a person at risk for certain chronic diseases. These factors include smoking, alcohol use, weight, physical activity levels, race, family history, and gender. The discussion of each chronic disease includes a discussion of specific risk factors, prevalence, mortality, and costs.\textsuperscript{37}


6. *Profile of Virginia’s Uninsured and Trends in Health Insurance Coverage, 2000-2006*

The Urban Institute prepared a profile of the uninsured in Virginia for the Virginia Health Care Foundation. At the time of the report, there were fewer than one million people who were uninsured in Virginia. The majority of the uninsured were working families with 73 percent of uninsured adults and 76.6 percent of children living in families with at least one person in the household working full time.

Using a series of tables, the report found that 14.4 percent of all non-elderly Virginians lack health insurance and 29.9 percent of self-employed individuals lack health insurance. Uninsured rates are highest for low-income families, and those living at or below 200 percent of the federal poverty level. In families where there is no working adult, the rate of uninsured adults is twice that of uninsured children. At the time of the report, Hispanics had a greater risk of being uninsured than any other racial/ethnic group. Also, non-US citizens were over three times more likely to be uninsured than US citizens living in Virginia.

In looking at insurance trends, the report identified that the percentage of Virginians without health insurance did not change between 2004 and 2006. It also found that the trends for children differed from the trends for adults. The rising rate in uninsured children is directly related to the decrease in employer-sponsored insurance. The economic downturn and resultant loss of employment bought with it a decrease in the number of people with
employer sponsored insurance. The impact on children was less severe because of the gains in Medicaid and CHIP coverage.\textsuperscript{38}

\textsuperscript{38} Kenney, G., Palmer, L., Cook, Allison., Williams, A. The Urban Institute. Profile of Virginia’s Uninsured and Trends in Health Insurance Coverage, 2000-2006
THE HEALTH POLICY COMMISSION

On January 28, 2010, Mayor Jones issued Mayor’s Order 2010-01 establishing the Blue Ribbon Commission on Health Policy. The specific charge issued to the Commission included the following instructions:

• Develop reports identifying the City’s health priorities including the issue of health disparities, identifying potential funding necessary to address the priorities and recommending strategies that the City of Richmond might employ in addressing them;

• Produce policy documents that identify the city’s health outcome priorities, their benchmarks, and the strategies to effect the desired changes;

• Propose strategies that the City of Richmond might pursue in addressing the barriers to health care;

• Recommend ways to strengthen health care resources, particularly human resources in shortage areas where there is a concentration of health disparities; and

• Recommend strategies to strengthen and support current efforts taken by primary/preventive and behavioral health providers targeted toward addressing health.

One of the important issues to be considered by the Commission was the influence of social determinants of health (SDOH) on the health outcomes of residents who are disproportionately affected by poverty, discrimination, and other social factors. The Mayor’s order specifically asked that the Commission identify
social factors that give rise to the health care problems of Richmond’s residents and develop recommendations that can be implemented both in the short term and in long term to ameliorate health disparities.

In addition to the specific charge provided in the Mayor’s order, the Commission recognized the potential impact that health care reform might have on issues of access over the next few years. As such, Commission members were asked to contemplate the potential impact of health care reform on any efforts undertaken by the City of Richmond to address health disparities.

In his charge to the Commission, Mayor Jones requested clear guidance on the most appropriate direction to take to reduce the disparity in health outcomes for the City of Richmond. The specific language asked the Commission to “identify the city’s health outcomes, priorities, their benchmarks, and strategies to effect the desired changes.” In addition, the Commission was directed to present the Mayor with recommendations:

• “About the City of Richmond’s health priorities, goals, and aspirations for the city’s people;
• That propose strategies that the City of Richmond might pursue in addressing the barriers to health care, as well as the City’s health disparities that cause so many to lose life prematurely;
• That recommend ways to strengthen health care resources, particularly human resources in shortage areas where there is a concentration of health disparities; and
• On ways to strengthen and support the work currently being done by the Commonwealth of Virginia in primary/preventive and behavioral health, as well as by private providers.”

STRUCTURE/ORGANIZATION

The Mayor’s Blue Ribbon Commission on Health Policy is comprised of a notable group of community based physicians, health policy experts, hospital administrators, academicians, and mental health experts. Each member was selected because of his/her contributions and passion for improving health outcomes for the residents of the City of Richmond. After identifying the individuals who were thought to be most appropriate for the Commission, an invitation was extended to each potential member. After the inaugural meeting, it was apparent that some critical views were missing and the membership was expanded to include members with additional expertise.

Dr. Carolyn N. Graham, Deputy Chief Administrative Officer for Human Services, was named the chair of the Commission. In addition to Dr. Graham, the Commission was comprised of Mr. Chris Accashian; Dr. John Baumann; r. Richard Bennett; Dr. Joseph Boatwright, III.; Mr. Tracy Causey; Dr. Robert Cohen; Dr. Damian Covington; Mr. Jeffrey S. Cribbs, Sr.; Mr. R. Chris Darling; Dr. Leonard Edloe; Ms. Sheryl Garland; Dr. Sandy M. Gibson; Mr. Reggie Gordon; Mr. Terone Green; Dr. Monroe Harris; Dr. Horace Jackson; Dr. Daniel M. Jannuzzi; Dr. Lerla Joseph; Dr. Jack Lanier; Dr. Roice D. Luke; Dr. William Murray; the Honorable Cynthia Newbille; Ms. Deborah D. Oswalt; Mr. Michael Robinson; Dr. Michael
Mayor Dwight C. Jones attended the inaugural meeting of the Commission and spoke to the members about the significance of the work they were to undertake. The first meeting was held in March 2010 and subsequent meetings were held monthly through August 2010. Each meeting usually included a presentation by one of the members, presentations by the workgroups, and/or time for the members to work within their workgroups. The members were also provided with summaries of community engagement sessions, such as focus groups and survey results.

PRESENTATIONS

Corporate Profiles of Hospitals/Acute Care

Dr. Roice Luke provided a comprehensive profile of hospitals and acute care in Richmond. He began the discussion with the historical view of regionalization and the profile of several hospital systems and their transformation from a single hospital to a multi-locality regional hospital. The Hospital Corporation of America (HCA), Bon Secours Health System, and the VCU Health System, all located in the City of Richmond were profiled in his discussion.

Using the Herfindahl-Hirschman Index, a measure of the size of firms in relationship to the industry and an indicator of the amount of competition among them, Dr. Luke discussed the impact of market concentration in urban environments and showed the impact of such regionalization on market share for the City of
Richmond. In addition to the impact of regionalization on the city, Dr. Luke also discussed the distribution of payer sources across hospital systems and showed the concentration of low-income residents in three zip codes and their distribution across the available hospitals in the city.

**Community Doctors and their Role**

Mr. Chris Darling led a discussion about the importance of community doctors and their role in providing care to City of Richmond residents. His presentation highlighted that community physicians served a disproportionate share of low-income patients than their counterparts in suburban counties. Many of these physicians had been in the City of Richmond providing care for more than a decade and were located in areas containing the lowest income residents.

The value these physicians bring to the City of Richmond cannot be overlooked. As pointed out, these physicians are employers, provide access to critical primary and preventive care services, serve as the medical home for their patients, and interface with all facets of the health care delivery system in the city. Despite their value, the independent community providers are challenged because of the disparity in reimbursement rates paid by Medicaid. The Commission was encouraged to:

- Acknowledge the historic importance of the independent physician and their practices;
- Recognize the current and future value of access to physician care for Richmond residents;
• Recognize the increased costs that could be borne by the City if the independent physicians were to limit access to their service;
• Recognize the role of the independent physician as a core component of the City of Richmond healthcare delivery system;
• Recognize that the current system is on the brink of collapse; and
• Demand creation of appropriately funded systems to care for all Richmond residents, particularly those that are underserved.

Unnatural Causes (Place Matters)

Unnatural Causes is a four-hour documentary series that examines the link between social factors and disparity in health. The series consists of seven videos that examine the issue of health equity from different vantage points. Dr. Michael Royster led the Commission in an educational session about the Social Determinants of Health (SDOH), and introduced the Commission to the series episode “Place Matters.”

“Place Matters” examines location as a predictor of population health. It tells the story of recent immigrants who move into predominantly neglected urban neighborhoods without access to nutritious foods, safe and affordable housing, and employment opportunities. The individual who is the focus of this story suffers a major heart attack, which may be related to the stress of living in poverty and exposure to pollutants. As the narrators discuss the various aspects the environment may have on health, they leave the viewer with the understanding that health and health policy should be a major consideration in any policy discussion.
A description of each episode in the series can be found through the following link:
http://www.unnaturalcauses.org/media_and_documents_about_the_series.php

COMMUNITY ENGAGEMENT

During the Commission’s first meeting, members were asked to identify the most significant health concerns for the City of Richmond. During the discussion, several themes were identified including health equity and the impact of social determinants of health; resource availability (human, financial, facility) and system sustainability; the integrity of the health care safety net, including the maintenance of community physicians; the integration and coordination of physical health with other health services including behavioral health, oral health, pharmacy and specialty services; the impact of health care reform on the City of Richmond; cultural competency and the ability to reduce disparity in health outcomes across the City of Richmond; the need for health promotion activities linked to health education and the alignment of resources to health outcomes; and the ability to impact traditional health challenges, including but not limited to birth and termination rates, chronic disease rates and the resultant morbidity and mortality rates from preventable diseases; and the economics and financing of health care in the City of Richmond. While the list captured what Commission members felt were the concerns for the City of Richmond, the members felt it wise to hear directly from the Citizens and allow those most affected by health disparity to be heard.

In response to the desire of Commission members to hear directly from the individuals most impacted by the health care services in the City of Richmond,
focus groups were held with the community. Working with City Council members, the Commission reached out to the community and held three adult focus group meetings in their areas of the city, and a one-day focus group session with youth who were participating in the Mayor’s Youth Academy – Summer Works Initiative. Where possible, City Council member districts were combined.

While the gathering districts varied in size, each focus group was no more than 12 to 15 participants. A trained facilitator led the group and a note taker and a tape recorder were available to capture the conversations, which were later summarized. Facilitators were provided with a standard set of 15 questions and were trained on prompts to use to encourage active participation from the group as well as solicit more definitive information and to clarify responses given.

**Council Member Doug Conner, District 9**

**May 18, 2010**

This focus group took place at Council member Conner’s regularly scheduled district meeting. There were approximately 40 participants in attendance. The majority of the attendees was over 50 years of age and retired. Attendees expressed their concerns with the time it took to get appointments with physicians and specialists; long wait times in doctor offices; and transportation, since most of the attendees’ physicians were outside city limits.

Mental illness, followed by teen pregnancy, low self-esteem, diabetes, and lack of insurance (in that order), were identified as the most important health concerns for the City of Richmond.
This group wanted more options for fresh foods (fruits and vegetables), education, wellness programs, and expanded access to Virginia Commonwealth University’s insurance program.

**Council Members Cynthia Newbille and Ellen Robertson, Districts 6 and 7**

**Saturday, May 22, 2010**

Twenty-four persons attended this community gathering at Martin Luther King, Jr. Middle School. The attendees were working, middle class individuals, ranging in age from early twenties to mid fifties.

While the majority of the individuals had health insurance, some still made the decision to not go to their doctors until they were very, very sick. Reasons for this choice included a distrust of the system, cultural barriers, and the attitudes of doctors. Many felt that doctors were not empathetic and did not listen to their patients, but instead provided prescriptions and sent their patients away. Within the city, the consensus was that the VCU Medical Center was the best, with the only issue being the emergency room. However, most felt that the surrounding counties provided faster service, and that the personalities and attitudes of those in the healthcare industry there were better.

The attendees acknowledged that those without insurance had limited options, including difficulty seeing a doctor and non-preferential treatment options. Because of this, the group felt that the uninsured were more prone to self-diagnosis and treatment. To address the problem of the uninsured, the attendees recommended the creation of a proactive, collaborative, citywide approach to impact health;
public/partnerships and programs to provide primary care treatment to those who are uninsured and Medicaid ineligible; job opportunities so those without insurance will have the ability to purchase it; alternatives to COBRA due to its high costs; and educational programs for children that focus on health.

The attendees felt the most significant health challenges facing Richmond were mistreatment based on racial, cultural, disability, and insurance status; the length of time it takes to get a doctor’s appointment; poor communication on the part of physicians; heart disease; cancer; obesity; lack of exercise; and poor women’s health.

To improve health disparities amongst city residents, the attendees recommended the addition and improvement of grocery stores in poor communities; free clinics on each side of town; increased educational opportunities related to nutrition and food preparation; the removal of the stigma associated with mental health; and respect for all people, especially the poor, who are often treated without dignity and viewed as only wanting handouts.

Council Member Chris Hilbert, District 3
Wednesday, May 26, 2010

Rather than facilitated focus groups, attendees at Council member Hilbert’s District meeting were asked to complete a paper survey. There were a total of 18 respondents, predominantly female, and between the ages of 30 and 50.

Ninety four percent of the respondents had health insurance. One hundred percent reported that they had a primary care physician, with 55 percent indicating
that their primary care physician was located within the City of Richmond. Even though 100 percent of this population had a primary care physician, 55 percent had used an emergency room within the past year and 23 percent chose not to receive care when ill.

This group identified the top five health concerns facing the City of Richmond as lack of insurance, affordability of care, lack of health education, substance abuse, and diet and nutrition.

YOUTH MEETINGS

Focus groups were also conducted on June 5, 2010 with youth ages 16-19 who were enrolled in the Mayor’s Youth Academy – Summer Work Initiative. Approximately 65 youth from across the city participated in a focus groups where they were asked their opinions about health care issues. The youth were broken into groups of no more than 10 and asked a series of 25 questions. Youth provided candid responses to the questions posed to them.

The health issues they felt that were most important to their age group included unprotected sex, marijuana use, diabetes, cancer, lack of exercise, sexually transmitted diseases, alcoholism, high blood pressure, high cholesterol, and unhealthy diet. Most had seen a doctor and a dentist within the past year and for those who had not the reasons given were lack of insurance and no transportation.

Many of the youth had been affected by violence in some way—including verbal and physical abuse; robbery; school fights; gunshots; and even the Virginia
Tech shooting, which had altered their college decisions. Most, if not all youth knew someone who had been in an abusive relationship and most had friends who were sexually active. Some had friends who had contracted sexually transmitted diseases.

**WORKGROUPS**

The work of the Commission was conducted over a period of five months. After the first meeting, where the members were introduced and provided with background information, Commission members were divided into workgroups to develop the recommendations needed to comply with the Mayor’s order. The workgroups were children, youth, adults, and elders and special populations, a structure consistent with the goals of the Office of the Deputy Chief Administrative Officer for Human Services.

<table>
<thead>
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<th>Children</th>
<th>Youth</th>
<th>Adults</th>
<th>Elders</th>
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<tbody>
<tr>
<td>Dr. Joseph Boatwright</td>
<td>Dr. Donald Stern</td>
<td>Dr. Damian Covington</td>
<td>Ms. Marilyn West</td>
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<tr>
<td>Mr. Chris Accashian</td>
<td>Dr. Carolyn Graham</td>
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<td>Ms. Sheryl Garland</td>
<td>Mr. Jeff Cribbs</td>
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<tr>
<td>Mr. Chris Darling</td>
<td>Mr. Tracy Causey</td>
<td>Mr. Terone Green</td>
<td>Dr. Leonard Edloe</td>
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<td>Dr. Monroe Harris</td>
<td>Dr. Robert Cohen</td>
<td>Dr. Jack Lanier</td>
<td>Dr. Lerla Joseph</td>
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<td>Ms. Deborah Oswalt</td>
<td>Mr. Reggie Gordon</td>
<td>Hon. Cynthia Newbille</td>
<td>Dr. Horace Jackson</td>
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<td>Dr. Michael Royster</td>
<td>Dr. Daniel M. Jannuzzi</td>
<td>Dr. Robert Stroube</td>
<td>Dr. Roice Luke</td>
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<td>Mr. Wayne Turnage</td>
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<td>Mr. Michael Robinson</td>
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Once the workgroups were formed, Commission members were asked to:

1. Identify characteristics of a healthy community;
2. Address as part of their work the social, behavioral, environmental, and economic influences impacting or creating barriers to healthy communities;
3. Develop specific recommendations including recommendations for incorporating Electronic Health Records, funding resources to support initiatives, human capital needs to support initiatives recommended;

4. Identify best practices and innovative approaches to reaching the goal of a healthy community;

5. Consider best practices and innovative strategies that can/will be used to reach the goal of a healthy community; and,

6. Identify funding needs and economic challenges and sources of funding to help meet the goal of a healthy community (think strategically and consider where cross agency (organizational) funds may be used to meet the goal.)
POLICY RECOMMENDATIONS

Each workgroup developed recommendations based on their identification of the needs of the residents of the City of Richmond. There were a total of 45 recommendations presented. The Commission members were asked to prioritize the recommendations from all workgroups and the six recommendations that were identified as top priorities by the majority of Commission members are presented below. While members emphasized that all of the recommendations are important, they were realistic in looking for those recommendations that could build off of initiatives that were currently underway in the City of Richmond and that could be implemented or initiated within the next two years. In recognition of the work done by the workgroups we have included all of the recommendations in Appendix 2.

1. Develop public policy to mitigate against social factors that give rise to poor health outcomes.
   A. Include health and health equity as a primary consideration in decision-making.
   B. Provide tax incentives for healthcare professionals to work and practice in underserved areas and neighborhoods (particularly OB/GYNs, primary care physicians, pediatricians, child psychologists/psychiatrists, and dentists).
   C. Provide financial incentives for corner stores to sell healthy food options.
   D. Provide financial incentives to place grocery stores in food deserts.
   E. Require the inclusion of green spaces, trails, bike and walking paths and lanes in all new and revitalized community plans.
F. Create a “Mayor’s Healthy Richmond” initiative using social marketing.

2. Develop a responsive infrastructure that will facilitate the provision of a wide range of prevention and intervention services for at-risk youth and families in an efficient and effective manner following all of the well-documented principles and evidence-based practices in this domain, including but not limited to pursuing and making an application for a SAMHSA Systems of Care Grant and conducting a study of the system of Mental and Behavioral Health In-home Services and Day Treatment Services.

A. Ensure that all children receive an independent comprehensive diagnostic evaluation completed by a licensed mental health professional prior to the start of Intensive In-Home (IIH) or Therapeutic Day Treatment (TDT) services. The services will not be authorized unless the diagnostic evaluations indicate that the respective service and the related level of care is the least restrictive most clinically appropriate service option available.

B. Maintain a comprehensive list of providers authorized to deliver IIH and/or TDT services within the city limits. The providers will be selected based on a number of qualitative factors, including credentialing of staff and documented efficacy of clinical approaches.

C. Assist the guardians/parents of the targeted children in selecting a provider from a list of public and private providers authorized by the city.

D. Create utilization review (UR) and quality assurance (QA) processes that ensure that the targeted Richmond children receive quality services from members of the provider network. In addition, the City will utilize the UR and QA data and processes to ensure that the services are effectively
coordinated across all public and private child serving systems, which in turn will eliminate duplication of effort.

E. Implement a comprehensive consumer education program to include the following:

1. Training and education of school personnel who are instrumental in interfacing with these providers in the public school settings
2. Ongoing consumer education and communication through local civic organizations, churches, city agencies to include speaking engagements, brochures, bulletins, website, etc. to support and empower the parents/guardians as they access services on behalf of their children.

3. Reorganize the work of local government to focus on health and health equity.

A. Create a City of Richmond interdepartmental council designed to build bridges across all aspects of city government and the public/private health sector to work collaboratively developing policies that support equitable access to and distribution of social determinants of health across populations and neighborhoods. Include school system and private health care provider representatives on council in addition to government officials. Initiatives recommended for interdisciplinary council to address include but are not limited to:

1. Develop and use health impact assessment tools within city government and the City Council to assess the potential impact of policies on health and health equity and to identify policy options that most consistently promote health and health equity.
2. Re-activate the Richmond Public School’s School Health Advisory Board; develop guidelines for foods served at school (including vending machines); require physical activity for grades K-12; implement the Center for Disease Control’s Coordinated School Health Program.

3. Within each department of city government review and revise policies, practices, and procedures to ensure they promote health and social equity.

   B. Create a comprehensive workplace health promotion program for city employees, particularly public school employees, whose involvement serve as guidance for children and their families.

4. Identify models that work including but not limited to investigating the merits of establishing “medical homes” for the uninsured and reviewing models such as the East End Partnership for Families, and the Northside Partnership—collaborations between community groups and human service organizations working together to improve the lives of families.

5. Sponsor an annual health fair as an introductory initiative focused on health education and health screenings to residents.
CONCLUSION

The Mayor’s Health Commission on Health Policy was established to develop policy recommendations to guide the Mayor and the City of Richmond in decreasing the health inequity caused by the number of residents who are uninsured in the City of Richmond. An integral part of the discussion centered on the relationship between social and economic factors and health outcomes that greatly influence health outcomes and the ability to achieve a healthy Richmond City.

As the Commission worked through the complicated issues of health inequity and discussed potential solutions to these problems, Commission members were often reminded that significant work is already occurring in the city. Rather than trying to recreate programs that already exist the Commission recognizes the value of working collaboratively with existing programs and building off of programs and services that exist and are working.

The recommendations developed by the Commission include some new and innovative ideas and some ideas that build off of existing programs and initiatives. Each one has great merit in reducing the disparity in health outcomes in the city of Richmond. There are some additional recommendations that should also be considered. These low hanging fruit initiatives are easy to accomplish with a small funding investment. Because it is important to show that the Commission is serious about getting something done and not just doing another study, the Mayor may want to consider implementing one or more of these “quick start” recommendations immediately. In doing so, he can take a little time to identify funding and other
resources he needs to begin implementing the major initiatives that were identified by the Commission members. These quick start recommendations are:

- Develop a catalogue of providers (all providers, not just physicians) who provide services to the target population and identify where they located, the services they provide, and their availability in relationship to where the greatest need and service gaps are;
- Identify the unhealthiest communities of the city and focus current resources on those communities;
- Continue to explore and compete for grant funds and funds from private foundations to be used to fund some of the initiatives identified by the Commission; and,
- Examine the Affordable Care Act; evaluate its impact on the City of Richmond and coordinate/implement policies and programs that are consistent with the recommendations of the Commission and congruent with the law.

Community physicians are sharing the responsibility of caring for those without insurance and without options for seeking care; however, the escalating cost of providing care, including the rising cost of malpractice insurance for certain specialties, threatens the ability of the city to retain community based physician care. Providing tax and housing incentives should be seriously considered to maintain the integrity of the community based physician practices.

The responsibility for establishing health priorities and policies must reside with the City of Richmond. The current responsibility for the city’s health policies does not reside with the City of Richmond, but with the Commonwealth of Virginia.
As such, the ability of the city to identify its own policies and priorities and drive its own initiatives is limited. The City of Richmond must regain responsibility for its own health priorities consistent with the needs of its citizens and not continue to be driven by the priorities and needs as identified and set by the Commonwealth of Virginia.

The next steps for the Commission include working with the Mayor in further prioritizing the recommendations consistent with available resources and greatest need. Also, an implementation plan should be developed that identifies critical resource needs, actual time lines with deliverables and due dates and accountabilities to assure that the plan is carried out.

Considering the criticality of the recommendations made, it may be advisable as a first step to put in place the mechanisms needed to continue the work of the Commission. One such mechanism could be the proposed interdepartmental council. This council could be charged with the responsibility of overseeing the implementation of the recommendations and revising the plan as needed. As the Commission closes out this phase of its work, it may be prudent to identify some of the Commission members to sit on the interdepartmental council as a means of encouraging continuity between the Commission and the implementation of the final plan.

As the Commission closes out its work, a valuable service has been provided, and the work begun by the Commission is instrumental in addressing the problems of the uninsured in the City of Richmond. While the debate of health reform continues and the uncertainty of whether the Commonwealth of Virginia will be
successful in its lawsuit challenging the mandates of the Affordable Care Act, the initial work of the Commission will be in the forefront of addressing the health care inequity that exists within the City of Richmond.
APPENDICES
BIOGRAPHIES

Christopher S. Accashian

Chris Accashian is the Chief Operating Officer of Retreat Doctors’ Hospital. As a campus of Henrico Doctors’ Hospital and part of HCA Virginia, this 227 bed facility is Richmond’s oldest hospital and is located in the historic Fan District. Under Chris’ leadership, Retreat Doctors’ Hospital has been ranked in the top 1% of the country for their Wound Healing Center and Hyperbaric Oxygen Unit, was awarded Cycle III Chest Pain Accreditation and achieved certification by the Joint Commission in Total Joint Replacement and Stroke. Chris began his career with HCA at their corporate headquarters in Nashville where he served as the Director of Operations and Financial Planning.

Prior to joining HCA in 2001, Chris completed his Administrative Residence, with a focus on strategic planning, at Wake Forest – Baptist Medical Center. He received his Masters of Health Administration from Virginia Commonwealth University where he was a member of the Phi Kappa Phi Honor Society, a Medline Scholar and VCU Chapter President of the American College of Healthcare Executives. Chris completed his undergraduate studies with a Bachelor’s degree from the University of Virginia.

Chris currently serves on the Board of Directors and as Treasurer for Family Lifeline, a local non-profit supporting the health and development of at-risk families in the Richmond metro area. He is also a member of the VCU Department of Health Administration Admissions Committee and is an active member of American College of Healthcare Executives.
**John J. Baumann**

John Baumann is the Executive Director of Fan Free Clinic, Virginia’s first free clinic now in its 40th consecutive year of service. John holds a Ph.D. in Public Policy and Administration from the Center for Public Policy at Virginia Commonwealth University. He served as Executive Director of Richmond AIDS Ministry in the early 1990s, at a time when effective treatments for people with AIDS were scarce, and life expectancies were relatively short. John served as a community volunteer for a number of organizations while earning his doctorate in the late 1990s. From 2005-2008, he served as President of the Board of the Central Virginia Chapter of NAMI (National Alliance on Mental Illness), after having served as Deputy Director at the State NAMI office. During that same period, he also served on the board of REACH, a Richmond-area coalition of free clinics and community health centers.

**Dr. Richard Bennett**

Dr. Richard Bennett is a second generation pediatrician who has practiced in Richmond since 2002. He received his Bachelor of Science in Biology from the University of North Carolina, Chapel Hill and his Doctor of Medicine from Virginia Commonwealth University, Medical College of Virginia. He completed his residency in Pediatrics at Maimonides Medical Center. Dr. Bennett is a member of the American Academy of Pediatrics, the Richmond Academy of Medicine, the National Medical Association, and the Richmond Medical Society.
Joseph W. Boatwright, III, M.D.

Born at Richmond Community Hospital, Dr. Boatwright attended the former St. Joseph's Catholic Church on 1st Street and graduated from the former Maggie L. Walker High School. He received his B.S. at Davis and Elkins College and his M.D. at the University of Virginia. He trained in pediatrics at MCV and has practiced for in Jackson Ward for 32 years. He is a member of Richmond Community Hospital’s Credential Committee, the Community Health Associates Physician Organization, the Richmond Medical Society’s Managed Care Committee, the Carver Promise Male Reader, the Richmond Head Start Advisory Committee, the Jackson Ward Business Association, the History Jackson Ward Association, and the Richmond Public Schools Health Advisory Board.

Tracy Causey

Tracy Causey received his Masters of Science in Public Health from Meharry Medical College in 1997. After receiving a second Master’s, an MBA from Belmont University in 1999, he became the Director of Community Health at Ascension Health in St. Louis, Missouri, the largest non-profit Catholic hospital management system in the country. After three years at Ascension Health, he moved to Richmond in 2003 and became the Executive Director of Vernon J. Harris Medical Center. He is currently the Chief Executive Officer of the Capital Area Health Network (CAHN) where he oversees the 5 Federally Qualified Community Health Centers.

Mr. Causey is a member of the Medical Group Management Association and is a candidate for a fellowship from the Academy of Certified Medical Professional Executives. Mr. Causey is a former active duty officer in the United States Air
Force who currently serves his country in the reserves. He is also a member of the Alpha Phi Alpha Fraternity, Inc.

**Robert Cohen, Ph.D.**

Robert Cohen, Ph.D. is Professor of Psychiatry and Pediatrics and Vice Chair of the Department of Psychiatry at Virginia Commonwealth University (VCU). He serves as Director of the Virginia Treatment Center for Children, a comprehensive psychiatric hospital for children and adolescents. He was Principal Investigator and Co-Director of the VCU Academic Center of Excellence for the Prevention of Youth Violence, funded by the Centers for Disease Control and Prevention. In addition he is Director of the Commonwealth Institute for Child and Family Studies and the Autism Center of Virginia at VCU. He has previously served as Associate commissioner for planning, program development and policy analysis of the New York State Office of Mental Health. He has published seven books, including “Chiseled in Sand: Perspectives on Change in Human Service Organizations (Brook/Cole 2000).” He served as chair of the NIMH workgroup on developing an action plan for implementing services research for child and adolescent mental health disorders and directed a statewide assessment of Virginia’s Comprehensive Service Act for At-Risk Youth and Families.

**Damian L. Covington, MD**

Damian L. Covington, MD is a board certified family practitioner who joined Dominion Medical Associates, Inc. in 2004. Dr. Covington completed his residency at Hanover Family Physicians in Virginia after completion of a year long internship at the Medical College of Virginia. He received his medical degree from Wake
Forest University School of Medicine in 1999. He graduated magna cum laude with a bachelor’s degree in mathematics from Hampton University in 1991.

Dr. Covington is a professional affiliate of the American Academy of Family Physicians and the National Health Service Corps. Currently, Dr. Covington serves as Vice-President of the Medical Executive Community of Bon Secour Richmond Community Hospital.

**Jeffrey S. Cribbs, Sr.**

In 1998, Mr. Cribbs was appointed the founding Executive Director of the Richmond Memorial Health Foundation (RMHF) and in 2008 he was named President and Chief Executive Officer. RMHF is a private, regional health care foundation whose mission is to promote the health and well-being of the residents of Richmond and Central Virginia by providing financial and intellectual investments in region’s nonprofit health and health-care related organizations. Currently, the Foundation focuses its work in four primary areas of emphasis: Aging & Alzheimer’s; Women’s & Children’s Health; Nursing & Other Health Education; and the Bon Secours Memorial Regional Medical Center – the legacy hospital to the Richmond Memorial Hospital from which the RMHF takes its roots.

Mr. Cribbs is a graduate of Chaminade University of Honolulu (philosophy and religious studies) and the University of Richmond (economics and finance) with post master’s work in higher education administration and finance at the College of William and Mary. Cribbs also completed post-graduate studies at Yale University in institutional investment management.
Mr. Cribbs professional career has focused on higher education, government and philanthropy. From 1970 to 1976, Cribbs served in policy and planning positions in Virginia state government including the Governor’s Office, the State Department of Planning and Budget, the Virginia House Appropriations Committee and the State Council of Higher Education for Virginia. From 1976 to 1995, Cribbs was an associate professor of economics and vice president at Virginia Commonwealth University. Administrative responsibilities included university and hospital program planning and evaluation; operating and capital budgeting; real estate development; facilities planning, design and construction; physical plant operations; information systems and services administration; and liaison with community and legislative groups. From 1995 to 1998, Cribbs was president of Jeffrey S. Cribbs and Associates, a strategic planning, financial planning and facilities management consulting firm.

Mr. Cribbs served to two terms on the Chesterfield County School Board, serving as the Board’s vice chair or chair four years. Cribbs was a founding member of the Richmond Regional Math-Science Center, the Chesterfield Public Education Foundation, Chesterfield Community In Schools Board and the Pace Center for Campus and Community Ministries at Virginia Commonwealth University. Cribbs was selected to the inaugural class of Lead Virginia, a statewide leadership organization founded in 2005, and served on Lead Virginia’s planning and programming committee. Cribbs presently serves as a member of the Membership Committee of the Southeastern Council on Foundations (SECF) and is active with SECF’s Health Legacy Foundations. Cribbs is a founding member of the Board of Directors of the Older Dominion Partnership, an age wave planning collaborative of business, government, philanthropy and higher education. Other community service
activities include serving on the Executive Committee of the Partnership for Nonprofit Excellence, a regional partnership of business and philanthropic leaders working to improve organizational and executive leadership capacities of the region’s nonprofit sector. Cribbs serves on the Investment and Finance Committees of the Richmond District of the Virginia Conference of United Methodist Church and is a frequent guest lecturer on philanthropy and strategic planning at colleges and universities.

Mr. Cribbs is married to the former Peggy Lynn Judy, has three grown children and three grandchildren.

**R. Chris Darling, MHA**

Mr. Darling has been involved in health care management since receiving his Masters of Health Administration degree from Duke University in 1984. Mr. Darling was initially employed with for-profit and not-for-profit health systems in positions of increasing responsibility managing both revenue and overhead departments with multi-million dollar operating and capital budgets. He has spent the last 12+ years working as a practice administrator and business consultant with medical and dental practices.

Mr. Darling focuses on practice operations management (efficiency and profitability optimization), human resources management, professional relations/compensation and strategic planning. He enjoys working with his client’s team of professional advisors, (i.e., accountant, investment consultant and attorney) to optimize the value of these key client relationships.
Mr. Darling also brings specific knowledge associated with medical practices serving a disproportionate share of indigent and underserved patients. Mr. Darling currently serves as the Executive Director of Community Health Associates Physician Organization, an independent physician organization and certified minority business enterprise based in Richmond, VA.

Mr. Darling was raised in Williamsburg, VA. He received a Bachelor of Arts Degree in Psychology from Randolph-Macon College in Ashland, VA. At Randolph-Macon, Mr. Darling lettered on the varsity soccer and tennis teams and was a member of Theta Chi fraternity.

Professional memberships include the Medical Group Management Association (MGMA) and Virginia Medical Group Management Association (VMGMA).

Mr. Darling resides in Hanover County, Virginia with his wife Susan. His son Scott attends Virginia Tech and daughter Christy attends Clemson University.

Mr. Darling is a certified soccer referee and volunteers his time to the Church of the Redeemer in Mechanicsville, VA.

**Dr. Leonard L. Edloe**

Dr. Leonard L. Edloe is a pharmacist and Chief Executive Officer of Edloe's Professional Pharmacies, one of America’s largest chain of black owned pharmacies located in Richmond, Virginia, and Pastor of the Antioch Baptist Church, Susan, Virginia. He is a native of Richmond and a graduate of Armstrong High School. He earned a Bachelor of Science in Pharmacy from the Howard University School of Pharmacy, a Master of Divinity from the Samuel Dewitt Proctor School of
Theology at Virginia Union University, and a Doctor of Pharmacy degree from the University of Florida, School of Pharmacy. He serves as an Assistant Clinical Professor of Pharmacy at the Hampton University School of Pharmacy, an Associate Clinical Professor of Policy and Research at the MCV-VCU School of Pharmacy, and a Clinical Instructor of Pharmacy at the Howard University School of Pharmacy. He also was the Executive-In-Residence at the Longwood University College of Business and Economics for the school year 2004-2005.

Dr. Edloe has been active in many community and national organizations. He has served as President of the Church Hill Model Cities Program, President of the Richmond Urban League, Chairman of the Metro Convention and Visitors Bureau, Chairman of Main St 25 Inc., Chairman of the Board of Health for the City of Richmond and he was the first black chairman of the board of the Retail Merchants Association of Greater Richmond. Having a passion for better health, he serves on the board of the Richmond Memorial Health Foundation, the Mid-Atlantic Affiliate of the American Heart Association where he is immediate past chairman and also led their Power to End Stroke Initiative, the VCU Health System Authority, Virginia Premier and the Virginia Stroke System Task Force. He has the distinction of being one the youngest pharmacist every elected to the Board of Trustees of the American Pharmacists Association. He is a 33rd Degree Mason and served as the Worshipful Grand Chaplain of the M.W. Prince Hall Grand Lodge of the State of Virginia.

Rev. Edloe is the recipient of many awards, Who’s Who in America, Who’s Who in Medicine and Health Care, Distinguished Retail of the Year, Virginia’s Retailer of the Year, Dominion’s Strong Men, the Cure, Care, Commitment Award of the
American Diabetic Association, African American Trailblazer, The Bowl of Hygeia; just to list a few. He is the author of numerous articles and has made numerous presentations on health and economic development. He resides in Mechanicsville with his wife Serita. He also host a weekly talk show on WCLM 1450 AM.

**Sheryl Garland**

Sheryl Garland is currently the Vice President for the Department of Community Outreach for the Virginia Commonwealth University Health System and Administrative Director of the VCU Center on Health Disparities. She is a native Richmonder who received an undergraduate degree from Wake Forest University and a Masters in Health Administration from Virginia Commonwealth University. After completing a residency at the Virginia Commonwealth University Health System, she went on to hold several positions including Director of Planning, Associate Director of Strategic and Facilities Planning, and Vice President for Ambulatory Care.

During her 10 year tenure in Ambulatory Care position, Ms. Garland had responsibility for overseeing clinic operations and developing of community partnerships. Some of her accomplishments included the establishment of the Hayes E. Willis Health Center, a community-based primary care center to provide care to uninsured and underinsured patients, the development of a partnership with the Richmond City Department of Public Health (RCDPH) to integrate traditional public health services into primary care sites, and the creation of the Virginia Coordinated Care for the Uninsured program (VCC) - a partnership with community
providers to coordinate health care services and establish medical homes for uninsured patients in Central Virginia.

In October 2002, Ms. Garland became the VCU Health System’s first Vice President of the Department of Community Outreach. In this role she has been tasked with creating innovative partnerships with community providers and social services agencies. One of her primary tasks is to identify funding initiatives to support the health system’s mission of caring for underserved populations. She has received grants from HRSA, the Jesse Ball duPont Fund and the Jenkins Foundation. In 2004, she became the Director of Community Outreach for the VCU Institute for Women’s Health, a national Center of Excellence. In December 2005, her duties were expanded to include administrative director of the VCU Center on Health Disparities. Finally, Ms. Garland has served in key roles in the drafting of Theme V of VCU’s 2020 Strategic Plan related to enhancing the university’s commitment to building community relationships. Subsequently, she was appointed to serve as co-chair of the University’s Council on Community Engagement.

Ms. Garland has been the recipient of numerous awards acknowledging her efforts to enhance outreach services. These include the American College of Health Care Executives Regent’s Early Career Healthcare Executive Award (1994), the Virginia Commonwealth University’s Presidential Award for Community Multicultural Enrichment (Administrator Award – 1996), VCU/MCV School of Medicine Dean’s Award for Community Service (1999) and the YWCA’s Outstanding Woman of the Year Award in the field of Health/Science in 2000. In 2002 she completed an ambulatory care fellows program with the National Association for Public Hospital and Health Systems. Ms. Garland has also participated in several leadership
programs including Leadership Metro Richmond (1992), the Grace E. Harris Leadership Institute (2004), and LEAD Virginia (2005). She has served on the board of the Richmond AIDS Ministry, Vernon J. Harris Community Health Center, the YWCA of Greater Richmond and REACH (Richmond Enhancing Access to Community Healthcare). She currently serves on the boards of the Richmond Memorial Health Foundation, LEAD Virginia, the Capital Region Workforce Investment Board, Access Now and Virginia Premier Health Plan. Ms. Garland serves as the VCU Health System representative on the membership board of the National Association of Public Hospitals and Health Systems and the Executive Committee of the Richmond Health Start Initiative. She is also the VCU representative on the Urban Serving Universities’ (USU) Health Strand Steering Committee.

**Dr. Sandy Gibson**

**Reginald E. Gordon**

Reggie is a native of Richmond, Virginia. He attended public schools in Richmond. He began his volunteer experience with the Greater Richmond Chapter of the American Red Cross, while he was a student at Thomas Jefferson High School.

Reggie received his undergraduate degree in Public Policy from Duke University. He received his juris doctorate from Howard University School of Law.

He began his professional career as an attorney for Central Virginia Legal Aid in Emporia, Virginia. After that he was employed by the national Red Cross in Washington, D.C. and eventually became a Senior Associate General Counsel and
Ethics Officer. He returned home to Richmond in 1997 and worked as a fund developer with the United Way of Greater Richmond and Petersburg. He was selected as the first executive director of Homeward in 1998, the coordinating organization for homeless services in the Richmond Region. After seven years with Homeward, he became the executive director of William Byrd Community House, a multi-service poverty prevention agency, addressing the needs of low income children, families, seniors and single adults in the city of Richmond.

In July of 2007, his career came full circle, when he became the Chief Executive Officer of the Greater Richmond Chapter of the American Red Cross. He is delighted that his professional career path has led right back to the chapter that opened doors for him as a youth.

He is a past chair of the board for Leadership Metro Richmond. He is also on the board of Bon Secours Healthsource, James River Writers, and the Institute of Philanthropy at the University of Richmond. He is a Community Trustee for the Junior League of Richmond. He supports other organizations in his community like the Center for Civic Engagement at the University of Richmond, the Homeward Board of Advocates and Boaz and Ruth.


Dr. Carolyn N. Graham is a public administrator with over 25 years of experience in leading complex organizations. She was recently appointed by Mayor Dwight Jones as the Deputy Chief Administrative Office for Human Services, Richmond, VA. She is the Founder/President of the Elizabeth Ministry, Inc., a 501(c) 3 organization that works to empower teen mothers in the foster care system such that they are able
to live healthy, spiritually-centered, economically self-sufficient, successful, loving lives.

She served as Vice President for External Affairs for Greater Southeast Community Hospital; Vice President of the DC Board of Education, and Deputy Mayor for Children, Youth, Families, and Elders for the District of Columbia. In this latter capacity, she was responsible for the health and human services cluster of agencies in the District government, with budgets in excess of $2.6 billion.

Dr. Graham holds a Master of Education (M.Ed.) from Antioch College; a Master of Public Administration (M.P.A.) from City University of New York; a Master of Divinity (M.Div.) from the New York Theological Seminary; and a Doctorate of Ministry (D.Min.) from the United Theological Seminary, Dayton, OH. She has done post-graduate studies at Regents Park College, Oxford University, Oxford, England and the Catholic University of America in Spirituality and Social Ethics; and she is the recipient of a number of awards and honorable citations.

Dr. Graham founded a $7 million initiative to support teen mothers in the child welfare system. Her goal is to provide the support necessary for teen mothers to become women of charter and influence, with an economic stake in their communities. She has received support from the District of Columbia’s Child and Family Service Agency, the Department of Housing and Community Development, M & T Bank, the Local Initiatives Support Corporation (LISC), W. K. Kellogg Foundation and PNC Bank. The project has been designed to provide affordable housing and comprehensive supports to the teen mothers and their children. The
housing project will consist of 27 housing units, and an onsite infant/toddler care center designed specifically for the children of the teen mothers.

Terone Green

Dr. Monroe Harris

Dr. Horace Jackson
Dr. Jackson is an internist/gastroenterologist who has been practicing in Richmond for over 25 years. He received his M.D. from Howard University College of Medicine and is a member of the National Medical Association, the Richmond Medical Society, Old Dominion Medical Society, and the Virginia Premiere Medical Management Committee.

Daniel M. Jannuzzi, M.D.
Daniel Jannuzzi is Medical Director, at Cross-Over Health Centers, a network of 3 free clinics, operating in Richmond City, Henrico and Chesterfied. The health centers are sponsored by The Cross-Over Ministry, a faith-based, Christian ministry emphasizing health care and health education for low-income and uninsured individuals.

Dr. Lerla Joseph
Dr. Jack Lanier

Dr. Lanier currently serves as the Chief Executive Officer of the Richmond Behavioral Health Authority. Additionally, he serves as professor emeritus at Virginia Commonwealth University/Medical College of Virginia School of Medicine (VCU/MCV), Department of Epidemiology and Community Health. Dr. Lanier also holds a faculty appointment in VCU’s Department of Health Administration. In 1992, Dr. Lanier was recruited to VCU with the primary goal of directing the development and accreditation of the University’s newly-created Master of Public Health Program, a goal fully met within three years of his arrival. Prior to joining VCU, Dr. Lanier served for three years as the principal deputy assistant secretary of defense for health affairs, with responsibility for oversight and management of the Defense Department’s health services-related budget of approximately $15 billion at the time.

In 2001, Dr. Lanier was appointed by the governor to a four-year term on the Virginia State Board of Health. The following year, he was elected by board members to serve as Chairman. In 2005, he was reappointed by the governor to a second four-year term and, until 2009, served five consecutive years as Board Chair.

Dr. Lanier is a retired Colonel with more than 22 years of service with the U.S. Army Medical Department. Some of his key assignments include service at the U.S. Military Academy Hospital, West Point, NY, and the U.S. Army Academy of Health Sciences, Fort Sam Houston, Texas. Other military professional assignments have included commanding officer of the 93rd Evacuation Hospital, Republic of South Viet Nam; health policy staff officer at the U.S. Army Surgeon General’s
Office; and professor and director of the U.S. Army-Baylor University Graduate Program in Health Administration.

Dr. Lanier received his Doctorate in Public Health from The University of Texas Health Sciences Center School of Public Health, Houston, Texas, a Master of Health Administration, Baylor University, Waco, Texas, and a Bachelor of Science Degree in business administration from North Carolina Agricultural and Technical State University, Greensboro, North Carolina. He is a Fellow of the American College of Health Care Executives (FACHE), having recertified subsequent to receiving the initial credential.

Dr. Lanier serves on several corporate health system boards to include Catholic Health East, a multi-institutional Catholic health system co-sponsored by 10 religious congregations and Hope Ministries, based in Newtown Square, Pa. Catholic Health East provides the means to ensure the continuation of the Catholic identity and operational strength of the Sponsors’ health ministries, which are located in 11 eastern states from Maine to Florida. The system includes 33 acute-care hospitals, four long-term acute-care hospitals, 36 freestanding and hospital-based long-term care facilities, 12 assisted-living facilities, five continuing-care retirement communities, seven behavioral-health and rehabilitation facilities, 25 home health/hospice agencies and numerous ambulatory and community-based health services. For the past 12 years, he has served on the Board of the Wheaton Franciscan Healthcare Inc., Wheaton, Illinois. Another key appointment includes serving on the Education Board of the American Public Health Association.
Roice D. Luke, Ph.D.
Dr. Luke is a specialist in strategic management and health care policy and studies local health care systems and markets both nationally and internationally. He has authored numerous publications and has been an active speaker on a wide range of topics focused on the restructuring health care industry.

Aside from his professional life, Dr. Luke has a deep interest in post-civil war history and genealogy. He has been actively involved in the historically significant and just completed “Virginia Freedmen Project” and the current “Finding the Freedmen Marriage Records Project,” both undertaken by the Black History Museum and Cultural Center of Virginia, in collaboration with both local and national partners. Dr. Luke serves on the Board of Directors of the Black History Museum and Cultural Center of Virginia (located in Richmond).

William Murray, Ph.D.
Bill Murray is the Managing Director, Corporate Public Policy for Dominion Resources. Dr. Murray previously worked in policy for Governors Warner and Kaine, as Vice President for policy at the Virginia Hospital and Healthcare Association, and as a senior health policy analyst for the Virginia General Assembly. Dr. Murray holds a Ph.D. in public policy from Virginia Tech and B.A. from the University of Virginia.

The Honorable Cynthia Newbille
Ms. Newbille was elected to Richmond City Council as the Councilperson for the East End 7th District in a Special Election held on November 3, 2009. She serves as a member of the Richmond City Council Public Safety Standing Committee, the
Richmond Behavioral Health Authority Board of Directors the Richmond City Council Organizational Development Standing Committee and the Richmond Community Criminal Justice Board. Councilwoman Newbille received her MA in Psychology and her BA in Psychology and Linguistics from the State University of New York (SUNY) at Stony Brook. She is expected to receive her Ph.D. in Public Policy and Administration this year from Virginia Commonwealth University.

Deborah D. Oswalt
Since graduating from Rutgers University School of Law in 1979, Debbie Oswalt has worked on issues related to health and human resources. Her Richmond work began at the Virginia Poverty Law Center, where she worked as a staff attorney for four years. She then served as Deputy Secretary of Health and Human Resources in the Cabinets of Governors Baliles and Wilder. For seven years she worked closely with state agencies that regulate, deliver and monitor health services, including the Departments of Health, Health Professions, Medical Assistance Services (Medicaid), and Mental Health, Mental Retardation and Substance Abuse Services; as well as the Health Services Cost Review Council.

In 1992, she became the founding Director of the Virginia Health Care Foundation (VHCF). Created as a public-private partnership by the Virginia General Assembly and its Joint Commission on Health Care, VHCF’s mission is to increase access to primary and preventive health care for uninsured and medically underserved Virginians. Under Ms. Oswalt’s leadership, VHCF has been instrumental in significantly expanding the number of Virginia’s health safety net providers; obtaining health insurance coverage for over 50,000 children; and generating over $750,000,000 in free chronic disease medicines for uninsured Virginians.
Ms. Oswalt is a graduate of Leadership Metro Richmond (1983) and the Virginia Executive Institute (1989). She received the Outstanding Woman in Health & Science Award from the Richmond YWCA in 2002 and the Child Health Advocate Award from the American Academy of Pediatrics - Virginia Chapter in 1992.

**Michael Robinson**

**Michael O. Royster, MD, MPH**

Michael O. Royster, MD, MPH is the Director of the Virginia Department of Health, Office of Minority Health and Public Health Policy (OMHPHP). OMHPHP’s mission is to advance health equity by identifying health inequities, assessing their root causes, and addressing them by promoting social justice, influencing policy, establishing partnerships, providing resources, and educating the public. OMHPHP serves as Virginia’s state office of minority health, rural health, and primary care. The Office focuses on advancing health equity by designating medically underserved areas, improving access to quality health care, addressing barriers to rural health, focusing on community-based participatory efforts to promote health equity, and facilitating strategies to target the social determinants of health and advance social justice.

Prior to this position, Dr. Royster was the Director of the Crater Health District headquartered in Petersburg, Virginia. The Health District serves 5 rural counties and 3 small cities with a combined population of 150,000. In that capacity, he led the health department in its efforts to assure the health of the citizens within the district. Much of his work focused on developing and sustaining diverse
community partnerships in order to maintain and improve the health of the community and eliminate health inequities. Among other initiatives, he implemented outcome-based program evaluations for all health department programs and led the expansion of efforts to promote cardiovascular health, eliminate childhood lead poisoning, and reduce teen pregnancy. In addition, he worked with local university faculty to develop community-based participatory research partnerships. He was a member of the National Association of County and City Health Officials, Chronic Disease and Tobacco Workgroup.

Dr. Royster completed his undergraduate training at the University of Virginia with a degree in Biology. He obtained his medical degree from Duke University School of Medicine and completed a residency in Public Health and General Preventive Medicine at Johns Hopkins Bloomberg School of Public Health. Immediately following his residency, he worked as an environmental epidemiologist with the U.S. Environmental Protection Agency. In addition, he completed the 2 year W.K. Kellogg Community Health Scholars Program at the University of North Carolina, Chapel Hill School of Public Health. He is board certified in Public Health and General Preventive Medicine and he is a fellow of the American College of Preventive Medicine.

Donald Stern, M.D., M.P.H.
Dr. Stern is the Director of the Richmond City Health District. He is licensed with the Virginia State Board of Medicine and certified in Public Health and General Preventive Medicine through The American Board of Preventive Medicine. He has a B.S. in Biology from the University of New Mexico; a Masters in Public Health from the University of North Carolina, School of Public Health, Department of
Maternal and Child Health; and an M.D. from the University of New Mexico School of Medicine.

**Robert B. Stroube, MD**

Robert B. Stroube, MD has a BS from the College of William and Mary, a Masters of Public Health from the Johns Hopkins School of Hygiene and Public Health, and an MD from the Medical College of Virginia. Dr. Stroube completed his residency in Preventive Medicine at the Medical College of Virginia/Virginia Department of Health. He is Board Certified in Preventive Medicine and Public Health.

Dr. Stroube served 33 years with the Virginia Department of Health including 9 as the State Health Commissioner. He also served as State Epidemiologist, Deputy State Health Commissioner and Assistant State Health Commissioner and was health officer for Prince William Health District, Chesterfield Health District and Fairfax Health District.

Dr. Stroube retired in 2008 from the Virginia Dept of Health. He served as president of the Association of State and Territorial Health Officials in 2007.

**Wayne Turnage**

Wayne M. Turnage serves as a member of President Michael Rao’s senior leadership team. He also manages the president’s office staff and assists university leaders with implementation of VCU’s strategic initiatives.

Turnage has spent most of his career in Virginia state government. Prior to serving as chief of staff and deputy chief of staff to Virginia Gov. Tim Kaine, he served as
deputy secretary of Health and Human Resources and later special adviser in health policy under Gov. Mark Warner, and director of policy and research for the Virginia Department of Medical Assistance Services. He also served for 15 years as chief legislative analyst for the Joint Legislative Audit and Review Commission, the General Assembly’s evaluation agency.

Turnage received a bachelor’s degree in social science from North Carolina Agricultural and Technical State University in Greensboro, N.C., and a Master of Public Administration degree from Ohio State.

**Marilyn West**
Marilyn West holds a master’s degree from the University of Pittsburgh, Graduate School of Public Health (Pennsylvania) and a bachelor’s degree in Mathematics from Waynesburg University (Pennsylvania). She has post graduate work in Biostatistics and is a graduate of many leadership programs such as Leadership Metro Richmond and the Virginia Executive Institute.

Ms. West is the owner and Chairman/CEO of M. H. West & Co., Inc., which is a Virginia-based consulting firm that specializes in management, planning and education services. Through a talented team of professionals, WEST has developed solutions that help clients build and maintain a qualified and satisfied workforce, strengthen internal and external customer relationships, align the organizational structure with the strategic plan, reduce costs, assure the delivery of quality products and services, meet financial and other performance goals, keep pace with the factors that impact their market share and monitor outcomes from resources expended. A
broad cross-section of industries, governments, non-profit organizations and trade associations have engaged WEST.
WORKGROUP RECOMMENDATIONS

CHILDREN

1. Reorganize the work of local government to focus on health and health equity
   o Create a Richmond City interdepartmental council designed to build bridges across all aspects of city government and public/private health sector to work collaboratively developing policies that support equitable access to and distribution of social determinants of health across populations and neighborhoods → VDH OMHPHP created a similar proposal for state government, which is currently unfunded. Include school system and private healthcare provider representatives on council in addition to government officials.
   o Invite the Joint Center for Political and Economic Studies to present their “Place Matters” (http://www.jointcenter.org/hpi/pages/place-matters) initiative and highlight successful and promising practices among participating localities around the country to address the social determinants of health (Seattle-King County is one of the participating localities, which is becoming a best practice because of the innovative work they’re doing- http://www.kingcounty.gov/exec/equity.aspx). Present to recommended council (noted above) in addition to city council, mayor, and other gov’t and private leaders.
   o Initiatives recommended for interdisciplinary council to address include but are not limited to:
     ▪ Develop and use health impact assessment tools within city government and city council to assess the potential impact of
policies on health and health equity and to identify policy options that most consistently promote health and health equity. HIA is “a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (1999 Gothenburg consensus statement) -- http://www.cdc.gov/healthyplaces/hia.htm

- Re-activate the school system’s School Health Advisory Board; develop guidelines for foods served at school (including vending machines); require physical activity K-12; implement the CDC’s Coordinated School Health Program - http://www.cdc.gov/HealthyYouth/CSHP/

- Within each department of city government review and revise policies, practices, and procedures to ensure they promote health and social equity for children
  - Create comprehensive workplace health promotion program for City employees, particularly public school employees whose involvement serve as guidance for children and their families -- http://www.cdc.gov/nccdphp/dnpao/hwi/index.htm

2. City Council and Mayor develop public policy to promote equitable access to Social Determinants of Health (SDOH)

  A. City’s comprehensive development plan to include health and health equity as a primary consideration in decision-making require all zoning decisions to assess impact on health and health equity (already required
for certain projects through US EPA Environmental Impact Assessment legislation)

B. Tax incentives for healthcare professionals to work and practice in underserved areas, neighborhoods (particularly OB/GYNs, PCPs, Pediatricians, and Dentists)

- Financial incentives for **corner stores to sell healthy options**-
  http://www.thefoodtrust.org/php/programs/corner.store.campaign.php
- Financial incentives to **place grocery stores in food deserts**-
- Require the **inclusion of green spaces, trails, bike and walking paths and lanes** in all new and revitalized community plans
- Create a “Mayor’s Healthy Richmond” initiative using social marketing

3. **Target intensive efforts to high priority target areas (HPTA) within the city** defined by concentrated poverty and child poverty; risk for infant mortality/prematurity/LBW; shortened life expectancy; unemployment; high drop out rate; crime; homicide; and other critical determinants of community health.

- Richmond City’s interdepartmental council, in collaboration with public, private, and non-profit partners, **identify policies and programs to promote health and health equity in HPTAs. Program and policy examples include:**
  - Home visitation program for all expectant mothers children
  - Comprehensive, high quality early childhood education
  - Expand mentoring programs for children
Develop **community organizing initiatives** within disadvantaged neighborhoods to build community capacity and civic engagement

- Address **transportation** barriers
- Maximize health insurance and public support (e.g. TANF, FAMIS) for eligible participants (i.e. pregnant mothers & children) through outreach, education and support in HPTA’s.

**YOUTH**

From the Commission on Children at Risk report (2003), *Hardwired to Connect* (see original document for references):

- **Concerning all community members**
  1. We recommend that all adults examine the degree to which they are positively influencing the lives of children through participating in authoritative communities and try where possible to do a better job.
  2. We recommend that all families with children and youth-included organizations and initiatives examine the degree to which they meet the 10 basic criteria for authoritative communities and try where possible to strengthen themselves in accordance with those criteria.

- **Concerning Families, Neighborhoods, and Workplaces**
  3. A child’s first and typically most authoritative community is his or her family. We recommend that we reevaluate our behavior and our dominant cultural values, and consider a range of changes in our laws and public policies, in order to increase substantially the proportion of
U.S. children growing up with their two married parents who are actively and supportively involved in their lives.

4. We recommend that some U.S. “work-family” advocates change their priorities, putting less emphasis on policies that free up parents to be better workers and more emphasis on policies that free up workers to be better parents and better guides for the next generation. Examples of the latter include flexible and reduced work hours, teleworking, job-sharing, part-time work, compressed work weeks, career breaks, job protection and other benefits for short-term (up to 6 months) parental leave, and job preferences and other benefits, such as graduated reentry and educational and training benefits, for long-term (up to 5 years) parental leave. We suspect that, if more leading advocates and analysts were to reconsider their priorities, at least some corporate decision makers might follow suit. Perhaps the new emphasis could be conveyed by a new label, “family-work.” This shift would benefit not only families but neighborhoods and civic life generally.

5. We recommend that large employers reduce the practice of continually uprooting and relocating married couples with children.

- Concerning Adolescents

6. We recommend a creative society-wide effort to respond more effectively to adolescents’ needs for risk taking, novelty seeking, and peer affiliation. The goal is to provide healthy opportunities for young people to meet these needs in the context of significantly greater adult support, participation, and supervision. “Integral to these efforts,” as Michael Resnick of the University of Minnesota reiterates, “is a
philosophical commitment that young people are resources to be developed, not problems to be solved.”

7. We recommend that authoritative communities attend more purposively to the gendered needs of adolescents. Equal opportunity and equal rights do not mean that boys and girls have identical patterns of development. The goal is to address their needs for meaning and sexual identity in prosocial ways, including mentoring, rites of passage, opportunities for adventure, exploration and service, discussions about the meaning of fertility, and guidance regarding the appropriate means of managing sexual and aggressive energies. Much more than it is today, adolescence should become a time for adult engagement with, not retreat from, young people.

• Concerning Moral and Spiritual Development

8. We recommend that youth-serving organizations purposively seek to promote the moral and spiritual development of children, recognizing that children’s moral and spiritual needs are as genuine, and as integral to their personhood, as their physical and intellectual needs. For organizations that include children from diverse religious backgrounds or no religious background, this task admittedly will be difficult. But it need not be impossible and should not be neglected. In a society in which pluralism is a fact and freedom a birthright, finding ways to strengthen, and not ignore or stunt, children’s moral and spiritual selves may be the single most important challenge facing youth-service professionals and youth-serving organizations in the United States today.
• Concerning Private and Public Resources

9. We recommend that a major funding priority for philanthropists who want to help children at risk should be the goal of empowering and extending the influence of authoritative communities.

10. We recommend that corporate foundations and charitable giving programs reconsider the practice of refusing even to consider giving grants to faith-based organizations whose mission is to improve the lives of children. There is nothing inherently improper about religiously informed efforts to help children, and these efforts, just like purely secular efforts, should be judged strictly by the (secular) results that they produce. The issue is understandably difficult and complex. In a pluralistic society such as ours, there are significant differences in viewpoints and values, and tolerance for these differences is essential. But religious and philosophical pluralism is a challenge to be embraced, not avoided by arbitrary exclusiveness.

11. We recommend that the U.S. Congress, as well as state legislators, shift their approach to providing social services for children, seeking wherever possible to use and empower authoritative communities to deliver services and meet human needs.

12. We recommend a special national commitment of both private and public energy and resources to rebuild authoritative communities in disadvantaged, low-income neighborhoods.

13. With Isabel V. Sawhill of the Brookings Institution and her colleagues, we recommend that, in order to improve the life prospects of children in low-income families and neighborhoods, the United States in the
near term allocate an additional 1% of its gross domestic product to children, and especially to the goal of strengthening those authoritative communities that affect the lives of children in low-income, troubled neighborhoods.

14. We recommend that the U.S. Congress create a new federal tax credit for individual contributions of up to $500 ($1,000 for married couples) to charitable organizations whose primary purpose is improving the lives of children and youth. The goals of this policy change are to increase charitable giving and volunteerism and to diversify and decentralize the financial supports for authoritative communities and other nonprofit youth-serving organizations.

- Concerning Scholars

15. We recommend more and stronger partnerships between scholars and youth-serving organizations. Access to relevant research findings, scholarly analysis, and evaluation tools can help youth leaders do a better job. Connectedness to front-line leaders and local communities and organizations can help scholars do a better job, both professionally and as individuals.

16. Building in part on Robert Putnam’s work showing correlations between high levels of social capital and good outcomes for children, we recommend that interested scholars develop scientific measures of the reach and effects of authoritative communities in the United States. Doing this work would permit scholars to examine correlations between authoritative communities and child outcomes. It would also permit scholars to develop data, including trend-line data, in the vitality
of U.S. authoritative communities and their precise effects on child well-being.

17. We recommend that scholars and others consider revising their methodology to include families in the definition of a civil society. This issue at first glance might appear to be of purely academic interest, but it is not. Conceptually separating families from civil society has many practical consequences – many of which, in our view, tend to be unhelpful and potentially harmful. For example, based in part on this conceptual exclusion of families from civil society, researchers and policy makers often simply assume that family structure in not a legitimate area for inclusion in policy recommendations. It is. More generally, as this report has tried to demonstrate, it is important for policy makers and society as a whole (not just scholars) to view the environment of childhood holistically, transcending the largely arbitrary intellectual dichotomy between family life and civic and public life.

- **Concerning Immediate Next Steps**

  18. We recommend that youth service and civic leaders across the country, drawing on this report as well as other resources, help to lead a new and sustained national conversation about the crisis of childhood in the United States and the most effective ways to meet that crisis.

- **Other recommendations of the Youth Work Group:**

  19. We recommend that the City develop a responsive infrastructure that will enable us to provide a wide range of prevention and intervention
services for at-risk youth and families in an efficient and effective manner following all of the well-documented principles and evidence-based practices in this domain

a. Action Step #1: Pursue and make an application for a SAMHSA Systems of Care Grant

b. Action Step #2: There is a need to study the system of Mental and Behavioral Health In-home Services and Day Treatment Services.

- There are approximately 173 In-home Service provider organizations and 40 Day Treatment provider organizations working in the City of Richmond. It is not uncommon for multiple organizations to be working in any one school and for multiple organizations to service any one family. The system to provide mental and behavioral health counseling and treatment for youth in Richmond is considered “out of control.”

20. We recommend that the City support the ongoing development of Health Resource Centers in the Richmond Redevelopment and Housing Authority (RRHA) facilities in partnership with the RRHA and Richmond City Health District (RCHD).

21. We recommend that the City of Richmond conduct the Youth Risk Behavior Survey and use it to direct its policies and planning.

22. We recommend that the City consider expanding the school health center model based on the work of the RCHD, Communities in Schools, Richmond Behavioral Health Authority and Richmond Public Schools at George Wythe High School.
23. We recommend that the City support and promote policies and programs that facilitate successful transition from youth to adulthood for those who have gone through the foster care system.

24. We recommend that the City take steps to remove impediments to returning males to the roles, responsibilities and rewards of fatherhood (for example, policies associated with status as a convicted felon).

**ADULTS**

1. Identify models that work
   - Investigate the merits of establishing “medical homes” for the uninsured with partners such as private practitioners, FQHC’s, Free clinics, health departments,
   - Review models such as the East End Partnership for Families, Northside Partnership, etc.

2. Identify resources
   - Human Services staff should conduct a “gap analysis”
   - Examine availability of existing resources throughout the City

3. Leverage IT/Systems
   - Identify data/connectivity needs
   - Review information systems that exist or are planned, including the Health Information Exchanges and Regional Health Information Organizations (RHIO’s) under review
   - Examine opportunities to interface existing systems
4. Identify roles for “non-traditional partners”
   • Examine opportunities to engage community based organizations, members of the faith-based community, foundations, etc.

5. Create navigation models
   • Examine models that enable adults to successfully access the services needed
   • Identify evidence-based models that improve hand-offs and communications between service providers

6. Incorporate the diverse components of a healthy community (safe neighborhoods, access to grocery stores, increase access to recreation, access to quality, emergent and non-emergent health care) into the model that is developed

7. Representatives from the partner City agencies (i.e., Parks & Recreation, Social Services, Police Department, Public Health, etc.) should work with the DCAO’s office to identify and leverage resources that can support the healthy community model

8. Identify national best practices (i.e., Richmond, California)
   • Incorporate ideas from best practices to expand/enhance local models (i.e., East End Partnership for Families, Northside Partnership, etc.)
   • Dedicate resources to focus on the development/expansion of innovative mental health models (i.e., Program for Assertive Community Treatment (PACT) teams, etc)
9. Designate City resources (staff and funding) to focus on the development of the healthy community model

10. Establish an annual health fair that is sponsored by the City as an introductory initiative focused on health education and health screenings to residents
    • Invite representatives from the community to participate to ensure that City residents have access to a diversity of services

11. The City should designate staff resources to identify funding opportunities to support the model

12. The City should identify personnel who are focused on the development of a Healthy Community model including the development of public/private partnerships

SENIORS AND SPECIAL POPULATIONS

Value Propositions
1. Elders and special populations should reside in environments that are conducive to healthy living
2. The community should embrace practices that improve its population’s social, health and behavioral well-being, education and safety
3. Access to a full range of high quality, affordable services should be available with priority attention given to eliminating services gaps in areas with greatest need
4. There should be public-private partnerships to help assure that human capital, financial and technological resources and other infrastructure are available and responsive to needs.

5. Health care reform and similar initiatives at the national, state and local levels should be taken into account in developing services options.

Goals

1. Create a vision for healthy neighborhoods that incorporates the views and needs of residents and other key stakeholders.

2. Cultivate and nurture relationships among key community partners (government agencies, academia, philanthropy, business, payors and providers) that demonstrate their commitment to translate a healthy neighborhoods’ vision into action.

3. Align financial and human resource availability with identified needs and priorities for healthy living.

4. Empower residents to invest in healthy lifestyles and practices that promote wellness, functional independence and economic self-sufficiency.

5. Embrace traditional and non-traditional approaches to create pathways and quicker entry to services that lead to healthy lifestyles.

6. Identify and use indicators that measure progress made in moving the community towards healthier living and that are captured in periodic reports.

Suggested Policies of the Mayor

1. Champions health care and healthy living and maintains it as a priority in the affairs of the City.
2. Prepares and updates annually a citywide Plan for Healthy Neighborhoods and reports on progress made in achieving goals in the state of the City address
3. Uses the citywide Plan for Healthy Neighborhoods to facilitate decision-making and generate/allocate resources that promote healthy living
4. Reviews and suggests changes to laws and regulations that serve as barriers to reaching goals of the citywide Plan for Healthy Neighborhoods
5. Maintains a Commission to provide oversight of efforts that support healthy neighborhoods and living
6. Promotes healthy lifestyles by declaring annually Healthy Neighborhoods Week and by issuing a proclamation that recognizes residents and public-private partnerships for their support of this initiative
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