MAPP2Health 2025 - 2028

Community Health Improvement Plan *(CHIP)*

ALBEMARLE • CHARLOTTESVILLE • FLUVANNA
GREENE • LOUISA • NELSON

Chronic Conditions

Obesity • Mental Health

Healthcare Access

Social Drivers

Economic Stability • Transportation • Healthy Food Access

BRHD Blue Ridge Health District · Sentara · UVA Health · VDH Virginia Department of Health

Table of Contents

Message from the Core Group

Since 2009, the Blue Ridge Health District, UVA Health, and Sentara Martha Jefferson Hospital have worked together through the MAPP2Health process, forming Virginia's longest-standing community health improvement partnership. Grounded in trust and shared learning, we believe meaningful community health planning begins with the people we serve.

The **2025-2028 Community Health Improvement Plan** reflects the voices and experiences of more than 1,100 residents across Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson. Through interviews, surveys, focus groups, and neighborhood-level analysis, we combined quantitative data with lived experience to ensure our priorities are based in evidence and rooted in community.

We recognize large systems and institutions carry their own pressures and constraints, and remain committed to the hard work of coordinating efforts across sectors. Our goal is to be strong allies to those who are on the front lines every day making it possible for individuals and families to access food, care, connection, safety, and opportunity.

This plan is both a roadmap and a commitment to transparency, collaboration, and action. Together, we are building a healthier future for all who call the Blue Ridge region home. We are grateful to every resident and partner who contributed their time, insight, and expertise to this process, and we look forward to turning our shared vision into progress that endures in perpetuity.

Warmly,

The MAPP2Health Core Group

BRHD Blue Ridge Health District · Sentara · UVA Health · UVA SCHOOL of MEDICINE Public Health Sciences

Blue Ridge Health District

Kathryn Goodman, MPH, CHES
Director of Population Health & Communications

Ryan McKay, MPA
Director

Sarah King, MPP, CPRS-T
Population Health & MAPP2Health Project Manager

Sentara Martha Jefferson Hospital

Tameka Irving, MPH
Community Benefits Manager

UVA Health

Jackie Martin, MPH, CDM
Director of Community Partnerships & Health Outcomes

UVA Department of Public Health Sciences

Aaron Pannone, PhD, MS
Associate Professor

Antoinette McFarlane, PhD
Research Scientist

Glossary of Lead Partners

BRHAC - Blue Ridge Hunger Action Coalition
BRHD - Blue Ridge Health District
    IPO - Improving Pregnancy Outcomes Workgroup
BRMC - Blue Ridge Medical Center
CFC - Charlottesville Free Clinic
CHP - Child Health Partnership
Fluvanna Rotary Club
Feeding Greene Food Pantry
IRC - International Rescue Committee
L&F - Loaves & Fishes
MACAA - Monticello Area Community Action Agency
M2HE - Move2Health Equity Coalition
MoW - Meals on Wheels
NAMI - National Alliance on Mental Illness
Network2Work
PATH - Partnership for Accessible Transportation Help
RBSI - Reparative Birth Systems Initiative
Region Ten CSB - Region Ten Community Services Board
    BRC - Blue Ridge Center
    CMHWC - Community Mental Health and Wellness Coalition
SMJH - Sentara Martha Jefferson Hospital
The Center - The Center at Belvedere
The GOOD Foundation
UVA - University of Virginia
    Center for Community Partnerships
    SOM- School of Medicine Medical Sciences Outreach
    Pipelines & Pathways
UVA Health - University of Virginia Health System
    CCC - Comprehensive Cancer Center
    Emergency Department
    Global Health
    CEHO - Office of Community Engagement & Health Outcomes
    Pediatric Psychology
VCE - Virginia Cooperative Extension
    Nelson County Office
    Northwest Region

Executive Summary

Across the Blue Ridge region, residents identified several barriers to good health: difficulty accessing timely and affordable healthcare, rising mental health needs, increasing costs of living, and challenges related to transportation, childcare, and nutritious food. The **2025-2028 Community Health Improvement Plan (CHIP)** is the region's shared response to those challenges.

Building on the **2025 Community Health Assessment (CHA)**, this plan integrates quantitative health, demographic, and community data to identify where needs are greatest and how partners can respond. Clinical and population-level data revealed persistent disparities in health outcomes among rural, low-income, African American and Black, and Hispanic/Latinx residents. The Area Deprivation Index further identified census tracts experiencing the greatest socioeconomic disadvantage, guiding neighborhood-level assessment and engagement.

The MAPP2Health partnership used these findings, along with community feedback and partner planning meetings, to identify strategies organized around three integrated goals rather than separate health issues. This structure reflects how residents experience health challenges and how partners can work together to improve multiple outcomes at once.

2025-2028 CHIP Goals

- 🎯 **Goal 1**: Improve Access to High-Quality, Affordable, and Responsive Health Services
- 🎯 **Goal 2**: Integrate the Regional Mental Health Ecosystem
- 🎯 **Goal 3**: Strengthen Community Supports for Well-Being, Nutrition, and Financial Security

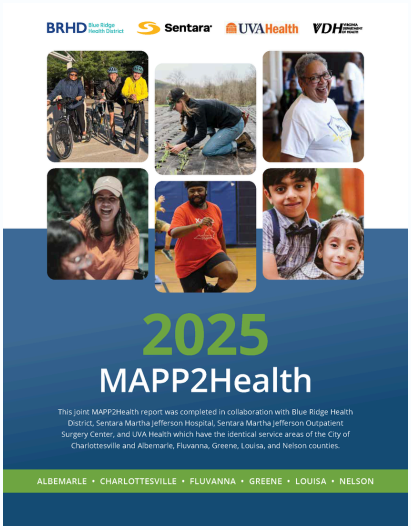
A Shared Roadmap for Action

This CHIP provides a shared framework for residents, healthcare systems, community organizations, educators, businesses, and local governments working to improve health outcomes across Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson. Implementation begins immediately, with quarterly updates and annual progress reports shared publicly to track milestones, report on outcomes, and keep partners and residents informed throughout the CHIP cycle.

Background

History of the MAPP2Health Partnership

For nearly two decades, the Blue Ridge Health District (BRHD), UVA Health, and Sentara Martha Jefferson Hospital have partnered through the MAPP2Health process to assess community health needs and coordinate regional action across Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson. The partnership began with the region's first Community Health Assessment in 2007 and expanded district-wide in 2011, resulting in the first regional Community Health Improvement Plan in 2012. Since then, successive assessment and planning cycles in 2016, 2019, 2022, and 2025 have strengthened collaboration among healthcare systems, public health agencies, local governments, and community organizations.



Community Health/Needs Assessment

A Community Health Assessment (CHA) is a systematic process for identifying the conditions that influence health, the barriers residents experience, and opportunities to improve well-being across a community. In the nonprofit hospital sector, this process is commonly referred to as a Community Health Needs Assessment (CHNA) and is conducted to satisfy federal Internal Revenue Service (IRS) requirements under the Affordable Care Act. Public health agencies and local governments, by contrast, typically use the term Community Health Assessment (CHA) as part of ongoing community health planning and improvement efforts.

Through the MAPP2Health partnership, these complementary requirements are fulfilled through a single, shared regional assessment. Throughout this document, the term CHA is used to refer to that collaborative process. The 2025 CHA followed the updated MAPP 2.0 framework, emphasizing collaboration, community engagement, trust-building, and the integration of quantitative data with lived experience.

The 2025 assessment was the most comprehensive conducted by the MAPP2Health partnership, incorporating more than 1,100 community inputs through multiple complementary methods. These included a randomized door-to-door household survey in rural Nelson County, 347 individual interviews across all localities, focus groups, community and stakeholder surveys, and a youth-led Photovoice project. Together, these methods provided a detailed understanding of health needs across diverse communities throughout the district.

Background

Key Findings

Across communities, residents consistently identified affordability, transportation, access to healthcare, mental health, and other social and economic conditions as interconnected factors influencing health and well-being. While the specific barriers varied by community, common themes emerged across urban and rural areas and among priority populations, including low-income households, Black residents, Hispanic/Latinx residents, older adults, and people with disabilities.

From Assessment to Priorities

The MAPP2Health Steering Committee reviewed findings across all data sources to identify areas where coordinated regional action could produce measurable progress during the three-year CHIP cycle.

The Committee reaffirmed **four priority populations**:

- Rural
- Low income
- Black + African American residents
- Hispanic + Latinx residents

and identified **three priorirty areas across six topics**:

Social Drivers of Health

Economic Stability

Healthy Food Access

Transportation

Chronic Conditions

Obesity

Mental Health

These priorities build on findings from previous MAPP2Health assessments while reflecting current community needs and opportunities for regional collaboration.

Healthcare Access

Background

Community Health Improvement Plan

A Community Health Improvement Plan (CHIP) translates assessment findings into coordinated action. It establishes shared goals, implementation strategies, and accountability measures that guide collaboration among public health, healthcare systems, community organizations, local governments, and residents over a three-year period.

Following completion of the 2025 CHA, BRHD convened the MAPP2Health Core Group and community partners throughout winter and spring 2026 to develop the 2025–2028 CHIP. Through a series of planning meetings, participants:

- **Refined priorities**
- **Aligned organizational commitments**
- **Assessed feasibility**
- **Identified shared strategies and outcomes**

The June 10, 2026, partnership meeting provided an opportunity for partners across the district to review and finalize the plan before publication.

Geographic Focus and Area Deprivation Index (ADI)

The 2025 MAPP2Health Community Health Assessment marked a deliberate shift toward focusing data collection and planning on neighborhoods experiencing the highest levels of socioeconomic disadvantage.

To guide this work, the MAPP2Health Core Group used the Area Deprivation Index (ADI), a nationally validated measure developed by the University of Wisconsin that ranks neighborhoods based on indicators such as:

- **Income**
- **Employment**
- **Education**
- **Housing Quality**

Using the ADI allowed the partnership to look beyond locality-wide averages and identify the census tracts where residents face the greatest structural barriers to health.

Background

Understanding Place-Based Health Needs

The Blue Ridge Health District includes five counties and the City of Charlottesville, encompassing communities with distinct assets, challenges, and healthcare environments. These differences shape how residents experience barriers to health.

In Charlottesville and Albemarle County, residents described:

Long wait times • **Overburdened providers** • **Administrative barriers**

Inaccessible insurance coverage • **Lack of housing support**

Limited access to culturally responsive mental health and specialty care *(despite the concentration of healthcare services)*

In Fluvanna, Greene, Louisa, and Nelson Counties, residents identified:

Transportation • **Travel distance** • **Fuel costs** • **Limited public transport**

Provider shortages *(telehealth was not always a practical alternative because of broadband limitations and digital literacy challenges)*

These findings underscore an important conclusion of the 2025 CHA: **place matters**. Similar challenges often have different underlying causes depending on where residents live. Difficulty accessing mental health care, for example, reflects provider shortages, transportation barriers, and broadband gaps in many rural communities. In Charlottesville, on the other hand, it more often stems from high demand, long waitlists, and administrative complexity.

By highlighting these neighborhood-level differences, the ADI helped reveal patterns that county-level data alone would not have captured.

Background

The CHA's neighborhood-level approach ensured that the assessment prioritized communities most affected by socioeconomic disadvantage and produced more localized data to inform planning.

The assessment identified six priority census tracts across the Blue Ridge Health District with ADI scores at or above the 53rd percentile, indicating greater socioeconomic disadvantage than more than half of U.S. neighborhoods.

Figure: Map of the Blue Ridge Health District

Census Tracts Prioritized Based on ADI Ranking

- **Albemarle County**: Branchlands/Squire Hill
- **Charlottesville**: Fifeville
- **Fluvanna County**: Columbia/Fork Union
- **Greene County**: Stanardsville
- **Louisa County**: Town of Louisa
- **Nelson County**: Arrington-Wingina

Although Fifeville had the district's highest ADI score, it was intentionally excluded from the randomized household survey because residents were already participating in numerous community engagement efforts and research initiatives. To minimize additional burden, the survey focused on the remaining five census tracts.

Among those, Arrington–Wingina in southwestern Nelson County had the highest ADI score and was selected for the district's first randomized door-to-door household survey. This choice was a direct reflection of the area's geographic isolation, transportation challenges, economic hardship, and limited access to healthcare.

Background

Why These Communities Were Prioritized

Prioritizing high-ADI neighborhoods strengthened both the assessment and the resulting Community Health Improvement Plan by:

Focusing engagement where need is greatest.

Neighborhood-level data ensured that residents facing the greatest structural barriers to health were centered throughout the assessment and planning process.

Generating more actionable data.

Localized information revealed community-specific challenges that would have been obscured by district-wide averages.

Informing targeted strategies.

Assessment findings directly shaped strategies addressing transportation, food access, behavioral health, economic stability, and other factors influencing health.

Supporting an integrated CHIP structure.

Residents consistently described transportation, healthcare access, food security, economic stability, and mental health as interconnected challenges. These findings reinforced the decision to organize the CHIP around three integrated goals rather than multiple standalone issue areas.

The 2025-2028 Plan Structure

CHIP Goals

Goal 1: Improve Access to High-Quality, Affordable, and Responsive Health Services

Addresses healthcare access, transportation barriers, and prevention and management of chronic conditions, including obesity and mental health.

Goal 2: Integrate the Regional Mental Health Ecosystem

Advances coordination across prevention, crisis response, treatment, recovery, transportation, and the social factors that influence mental well-being.

Goal 3: Strengthen Community Supports for Well-Being, Nutrition, and Financial Security

Addresses healthy food access, economic stability, chronic stress, community resilience, and other social conditions that influence health.

Guiding Principles

Coordinate across systems.

The CHIP is designed to align healthcare, public health, and community organizations around shared goals rather than isolated initiatives.

Champion community voices.

Planning was grounded in resident interviews, surveys, focus groups, and other community engagement activities, with particular attention to neighborhoods experiencing the greatest socioeconomic disadvantage.

Strengthen community partnership.

Residents, community-based organizations, healthcare providers, and public agencies contributed to shaping priorities, strategies, and implementation.

Promote transparency and accountability.

Progress will be communicated through shared indicators, regular public updates, and ongoing collaboration among Lead Partners.

Reduce community burden.

The planning process sought to minimize duplicative engagement while recognizing the time, expertise, and lived experience contributed by residents and community partners.

The 2025-2028 Plan Structure

Implementation, Governance, and Accountability

The 2025–2028 Community Health Improvement Plan is a living document. Following publication on July 1, 2026, the MAPP2Health partnership will immediately begin implementation, with regional workgroups convening to refine strategies, confirm organizational roles, and finalize performance measures. Each outcome identifies one or more Lead Partners responsible for:

- Coordinating implementation
- Convening collaborators
- Monitoring progress
- Maintaining communication across participating organizations

The Blue Ridge Health District, UVA Health, Sentara Martha Jefferson Hospital, and the UVA School of Medicine's Department of Public Health Sciences will continue serving as the MAPP2Health Core Group, providing overall coordination and ensuring alignment with the Community Health Assessment and Virginia's Plan for Well-Being.

To maintain implementation momentum, performance indicators will be finalized during the first phase of the CHIP cycle and published as an addendum in October 2026. Progress will be tracked through quarterly public updates highlighting implementation milestones, emerging initiatives, and partnership accomplishments, while an Annual CHIP Progress Report published each July will summarize district-wide outcomes, report on performance measures, and document substantive revisions to the plan.

The 2025-2028 Plan Structure

Community Participation

Successful implementation depends on sustained participation from residents, community organizations, healthcare providers, local governments, and other partners across the district. Community members are encouraged to get involved and can do so in several ways:

- **Attend meetings**
- **Contribute expertise and lived experience**
- **Participate in workgroups**
- **Help guide implementation through the CHIP cycle**

Through transparent communication, shared accountability, and ongoing collaboration, the MAPP2Health partnership will continue working to improve health and well-being across Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson.

Stay Connected

Quarterly progress reports, meeting schedules, and implementation updates will be available through the MAPP2Health newsletter and BRHD website. CHIP news will also be shared on our Facebook and Instagram profiles.

Organizations whose work aligns with CHIP priorities are encouraged to participate in implementation efforts. To learn more about partnership opportunities or share an initiative that supports CHIP goals, contact **Sarah King**, **Blue Ridge Health District Population Health & MAPP2Health Program Manager**, at **sarah.king@vdh.virginia.gov**.

Sign up for the newsletter

Visit the CHIP webpage

The 2025-2028 Plan Structure

2025-2028 CHIP Timeline

MAY - JUNE 2026

PHASE 1

Meet with community partners to conduct feasibility of proposed goals and objectives; Convene CHIP ReLaunch meeting (6/10/2026)

JULY 2026

PHASE 2

Publish CHIP; All Community Partners Virtual Meeting (7/15/2026)

AUGUST 2026

PHASE 3

Strategy groups define meeting cadence and begin convening, sourcing data and deliberating metrics

FALL 2026 - 2028

PHASE 4

Quarterly updates and annual reports published with ongoing support and coordination from the Core Group

Timeframe	Milestone
July - September 2026	Lead Partners convene workgroups and finalize implementation plans
October 2026	Publish implementation addendum with indicators, target dates, and action plans
Quarterly	Progress reporting and partner convenings
Annually	Public progress update and CHIP review
2028	Final evaluation and next CHA/CHIP cycle begins

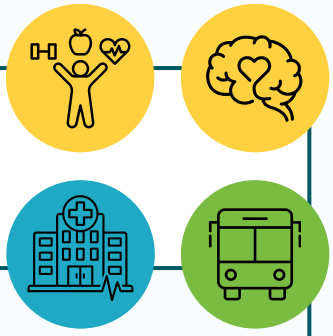
2028 Community Health/Needs Assessment Timeline

Timeframe	Milestone
August - Nov. 2027	Community survey planning
Nov. 2027 - Jan. 2028	Deploy community survey
Jan. - March 2028	Focus group planning & implementation
April - July 2028	Data analysis & report writing
August 2028	Publish Community Health/Needs Assessment

2025 – 2028

Priority Targets

Priority Areas	***Chronic Conditions*** *(obesity, mental health);* ***Healthcare Access****;* ***Social Drivers*** *(transportation)*
Goal 1:	**Improve Access to High-Quality, Affordable, and Responsive Health Services**



Issue statement: Residents across the Blue Ridge Health District consistently described healthcare access as one of the greatest barriers to achieving and maintaining good health. While the region is home to nationally recognized healthcare institutions, many residents continue to face significant obstacles in obtaining timely, affordable, and responsive care. Long wait times, provider shortages, transportation challenges, high out-of-pocket costs, language barriers, complex eligibility requirements, and limited appointment availability all contribute to delayed or forgone care.

These barriers are not experienced equally. Rural residents often travel long distances for specialty services. Low-income households may postpone care because of cost or competing financial priorities. Black and Hispanic/Latinx residents described challenges related to language access, trust, cultural responsiveness, and navigating complex healthcare systems. Individuals living with chronic conditions frequently encounter fragmented care across multiple providers, increasing both the burden on patients and the likelihood of poorer health outcomes.

Improving access therefore requires more than increasing healthcare capacity. It requires coordinated systems that are affordable, person-centered, culturally responsive, and connected to the community resources that support health long before and long after a clinical encounter. Goal 1 advances strategies to:

- Expand mobile and flexible healthcare delivery
- Strengthen Medicaid navigation and enrollment support
- Align social drivers of health screening practices
- Improve transportation options for medical and essential services

Objective 1.1: Expand mobile & flexible healthcare delivery

Outcome	Strategy
1.1.1. Expanded mobile health services and outreach in rural communities	**1.1.1a:** Establish a rural health outreach collaborative to expand access to free health services in high-need communities through coordinated primary care, referrals, health education, and wrap-around support. ***Lead Agencies**: BRHD, M2HE, UVA Health Emergency Department/Global Health volunteers, CFC*
1.1.2. Increased access to cancer screening and navigation services in rural communities	**1.1.2a:** Expand community-based cancer screening outreach and navigation services in rural communities and strengthen partnerships that increase access through the mobile mammography coach and other community-based initiatives. ***Lead Agency**: UVA CCC*
	1.1.2b: Integrate cancer screening outreach and navigation into BRHD's Community Health Worker model to increase awareness of recommended screenings, reduce barriers to care, and connect residents with navigation and support services. ***Lead Agency**: UVA CCC*
	1.1.2d: Increase access to prostate cancer education and screenings in rural communities by providing outreach, education, and screening opportunities that help reduce barriers to care and support early detection. ***Lead Agencies**: UVA CCC, SMJH*

Objective 1.2: Increase Medicaid Navigation and Enrollment Support

Outcome	Strategy
1.2.1. Expanded Medicaid navigation workforce and outreach capacity	**1.2.1a:** Develop and deploy a regional network of Medicaid Assisters and community advocates to support Medicaid enrollment and renewal, reduce administrative disenrollment, and improve access to healthcare coverage. ***Lead Agency***: *M2HE, The GOOD Foundation*
	1.2.1b: Hire and deploy three full-time Community Health Workers to strengthen care coordination, connect residents with healthcare and community resources, and improve access to preventive and ongoing care across the district. ***Lead Agency***: *BRHD*
1.2.2. Established regional Medicaid referral and enrollment network	**1.2.2a:** Develop and implement a coordinated Medicaid referral and enrollment assistance network connecting healthcare providers, community organizations, and public resources (including housing agencies, food pantries, shelters, after-school programs, and faith communities) to improve enrollment, renewal, and access to ongoing care. ***Lead Agency***: *M2HE, The GOOD Foundation, UVA Health CEHO, SMJH*

Objective 1.3: Align Social Drivers of Health (SDoH) Screening Tools Regionally

Outcome	Strategy
1.3.1. Standardized regional SDoH screening and referral practices	**1.3.1a:** Standardize SDoH screening questions, workflows, and referral processes across BRHD health departments and local healthcare providers ***Lead Agency***: *BRHD*

Objective 1.4: Improve Transportation Access for Healthcare and Essential Services

Outcome	Strategy
1.4.1. Expanded volunteer driver networks and rural non-emergency medical transportation	**1.4.1a:** Expand volunteer driver programs and strengthen partnerships with transportation providers to increase access to medical appointments and other essential services in underserved rural communities through technical assistance, volunteer recruitment, driver training, mileage reimbursement, and funding support. ***Lead Agency***: *PATH*
1.4.2. Improved coordination of transportation scheduling and discharge rides	**1.4.2a:** Develop a coordinated transportation referral and scheduling network connecting healthcare providers, transportation agencies, and community organizations to improve access to medical appointments, hospital discharge transportation, and other essential healthcare services. ***Lead Agencies***: *PATH, BRMC*

Priority Areas	***Chronic Conditions*** *(mental health);* ***Social Drivers*** *(transportation)*
Goal 2:	**Integrate the Regional Mental Health Ecosystems**

Issue statement: Mental health emerged throughout the Community Health Assessment as a cross-cutting issue shaped by economic stress, housing instability, transportation barriers, social isolation, and other conditions that influence well-being. These challenges affect emotional health while also contributing to substance use, chronic disease, and increased healthcare utilization.

Although the region offers a broad network of behavioral health, crisis, prevention, recovery, and community support services, residents often experience those resources as difficult to navigate or disconnected. Long wait times, workforce shortages, fragmented referral pathways, transportation barriers, stigma, and limited access to culturally responsive care continue to delay treatment, particularly for rural and historically underserved populations.

Goal 2 strengthens the regional mental health ecosystem by improving coordination across healthcare providers, community organizations, schools, and other partners. Strategies focus on expanding prevention, treatment, recovery, and community-based supports while exploring shared regional infrastructure that provides residents with a more connected, accessible, and navigable behavioral health system.

Objective 2.1: Coordinate a behavioral health continuum of care across health systems

Outcome	Strategy
2.1.1. Expanded access to coordinated outpatient, crisis, and recovery services	**2.1.1a**: Develop a sustainable regional behavioral health coordination platform that improves navigation of clinical and community-based mental health resources across the Blue Ridge Health District. Evaluate existing platforms, including 211Virginia and Bridge2Resource, assess long-term fiscal and operational sustainability, identify required data elements, and begin coordinated data collection with community partners. ***Lead Agencies***: *CMHWC, UVA Center for Community Partnerships*
	2.1.1b: Establish a regional evidence-based psychotherapy consultation network to support licensed clinicians and clinical trainees through regular case consultation, continuing education, and peer learning. Develop the infrastructure needed to support statewide participation, including scheduling, confidentiality protocols, and continuing education units. ***Lead Agency***: *UVA Pediatric Psychology*
	2.1.1c: Develop a regional network of community wellness providers to improve awareness of prevention programs and non-clinical ("soft support") services, strengthen communication across public and private sectors, and enhance coordination throughout the regional mental health ecosystem. ***Lead Agency***: *UVA Health CEHO*

Objective 2.2: Increase wellness promotion, prevention, and community-based support

Outcome	Strategy
2.2.1. Increased availability and participation in social-connection programs	**2.2.1a:** Expand access to community-based programs that promote social connection, reduce isolation, and foster belonging by connecting residents with opportunities that strengthen relationships, purpose, and overall wellbeing. ***Lead Agencies**: The Center, UVA Health CEHO, BRC, M2HE, NAMI Charlottesville*
	2.2.1b: Develop and offer community-based mental health education programs that incorporate art, music, and other forms of creative expression to promote emotional wellbeing and social connection. Schedule programming during late fall and early winter to provide additional support for individuals experiencing seasonal affective disorder and other seasonal mental health challenges associated with reduced daylight. ***Lead Agencies**: VCE*
2.2.2. Expanded community wellness resource distribution and stigma-reduction initiatives	**2.2.2a:** Expand naloxone distribution and Lock & Talk suicide prevention programming to increase awareness, strengthen community safety, and reduce the risk of overdose and suicide. ***Lead Agency**: Region Ten CSB*
	2.2.2b: Expand Mental Health First Aid training for students, educators, and community partners to increase mental health literacy, reduce stigma, and strengthen the community's capacity to recognize and respond to mental health concerns. ***Lead Agency**: Region Ten CSB, SMJH, UVA Health CEHO*
	2.2.2b: Provide "Care for the Caregiver" education and support initiatives to reduce secondary traumatic stress, strengthen trauma stewardship, and promote resilience among behavioral health and healthcare professionals. ***Lead Agency**: UVA Health CEHO*

Priority Areas	***Chronic Conditions*** *(obesity);* ***Social Drivers*** *(healthy food access, economic stability)*
Goal 3:	**Strengthen Community Supports for Well-Being, Nutrition, & Economic Opportunity**

Issue statement: Residents consistently identified the conditions in which people live, work, learn, and age as fundamental drivers of health. Throughout the Community Health Assessment, community members described the growing impact of financial strain, transportation challenges, limited childcare options, and barriers to accessing healthy foods. Improving outcomes requires stronger partnerships between healthcare systems and the community organizations that provide food assistance, workforce development, education, transportation, recreation, and other essential supports.

Goal 3 integrates multiple interconnected priority topics, including obesity, healthy food access, and economic stability, into coordinated strategies that:

- Expand nutrition security and food-as-medicine initiatives
- Strengthen prevention and health education for youth + families
- Increase workforce and career opportunities
- Advance community-informed solutions to housing stability for residents in the perinatal period

Together, these efforts recognize that access to nutritious food, education, economic opportunity, and stable housing are foundational to preventing chronic disease, improving well-being, and building healthier, more resilient communities.

Objective 3.1: Expand nutrition security and food-as-medicine pathways

Outcome	Strategy
3.1.1. Expanded food delivery and community food distribution	**3.1.1a**: Expand access to fresh, healthy food through no-cost community farm stands operating across the Blue Ridge Health District during the growing season, increasing the availability of nutritious foods in rural and underserved communities. ***Lead Agencies**: SMJH*
	3.1.1b: Expand neighborhood food access by installing and sustaining up to 10 Little Food Pantries throughout Fluvanna County through community partnerships and ongoing food drives. ***Lead Agency**: Fluvanna Rotary, MACAA*
	3.1.1c: Establish demonstration community gardens throughout Nelson County that showcase container gardening and small-space food production. Pair garden sites with nutrition and gardening education to increase community knowledge, participation, and access to locally grown food. Expand to additional garden models as community interest and local capacity grow. ***Lead Agency**: VCE*
	3.1.1d: Implement a volunteer-based Personal Shopper Program to help older adults, individuals with disabilities, and residents facing transportation barriers access nutritious foods that meet their dietary needs. ***Lead Agency**: Feeding Greene Inc.*
	3.1.1e: Expand community-based food access programs in the Fifeville neighborhood to increase participation among residents experiencing food insecurity and improve access to fresh, healthy food. ***Lead Agencies**: UVA CEHO*

Objective 3.1: Expand nutrition security and food-as-medicine pathways

Outcome	Strategy
3.1.2. Expanded community free-fridge network and nutritious meal distribution	**3.1.2a**: Strengthen coordination among community free-fridge sites and expand the regional network, prioritizing neighborhoods experiencing food insecurity and limited food access across Charlottesville and surrounding rural communities. ***Lead Agencies***: *BRHAC*
	3.1.2b: Strengthen Cville Feeding 500 as a regional hub connecting food producers, gleaners, nutrition education, workforce development, and community meal distribution. Expand collaborative preparation and distribution of nutritious meals to improve food access across the region. ***Lead Agency***: *BRHAC, L&F*
3.1.3: Increased perinatal nutrition support	**3.1.3a:** Strengthen outreach and referral pathways for postpartum families by coordinating education, marketing, and referral efforts that increase awareness of Meals on Wheels, WIC, and other nutrition support resources. ***Lead Agency***: *BRHD, MOW*
	3.1.3b: Expand education and nutrition support services that promote healthy perinatal and newborn outcomes through WIC enrollment assistance, nutrition education, food resource referrals, healthy food incentives, and produce distribution. ***Lead Agency***: *BRHD, Child Health Partnership*



Objective 3.2: Empower youth and families through education and outreach

Outcome	Strategy
3.2.1. Expanded culturally responsive nutrition and health education	**3.2.1a**: Sustain culturally responsive nutrition education programs tailored to the needs of Afghan community members to promote healthy eating, food security, and long-term well-being. ***Lead Agencies***: *CHP, IRC, L&F*
	3.2.1b: Pilot a culturally responsive nutrition education program for students in grades 5–8 at Abundant Life Ministries in Charlottesville's Fifeville neighborhood, with the goal of expanding the program to additional community sites across the district. ***Lead Agencies***: *UVA Health CEHO*
3.2.2. Expanded evidence-based healthy aging programming	**3.2.2a:** Implement evidence-based strength-training programs that increase physical activity, promote healthy aging, and improve mobility, balance, strength, and overall well-being among older adults. ***Lead Agency***: *SMJH, VCE*
3.2.3. Increased access to social-emotional learning supports in schools	**3.2.3a:** Expand a student-led social-emotional learning program developed by UVA School of Medicine students by strengthening partnerships with organizations such as the YMCA and increasing opportunities for youth participation in school and community settings. ***Lead Agency***: *UVA Health CEHO*
	3.2.3b: Expand implementation of the Botvin LifeSkills and Parent Program curricula across schools and community organizations to strengthen self-management, social skills, and substance use prevention among youth and families. ***Lead Agency***: *VCE*

Objective 3.2: Empower youth and families through education and outreach

Outcome	Strategy
3.2.4. Established regional dashboard for monitoring school wellness policies	**3.2.4a:** Assess school wellness policies using standardized evaluation tools to identify strengths, prioritize opportunities for improvement, and support healthy school environments that promote nutrition, physical activity, and obesity prevention. ***Lead Agency**: UVA CCC, UVA Health CEHO*

Objective 3.3: Strengthen economic and housing security

Outcome	Strategy
3.3.1. Increased participation in healthcare education and workforce development initiatives	**3.3.1a**: Expand employment readiness training, skills development, supportive services, and career navigation to increase access to healthcare education and career opportunities. ***Lead Agencies**: UVA Pipelines and Pathways*
	3.3.1b: Promote healthcare career pathways by providing youth with hands-on learning experiences, guided hospital tours, and opportunities to explore health professions through school career fairs and community events. ***Lead Agencies**: SMJH, UVA SOM*
3.3.2. Increased access to family-sustaining employment	**3.3.2a**: Expand the Network2Work platform to connect more residents with family-sustaining employment by strengthening partnerships among employers, community organizations, and workforce development providers. Increase access to quality employment opportunities, resource navigation, and coordinated services that support long-term employment success. ***Lead Agencies**: Network2Work*

Objective 3.3: Strengthen economic and housing security	
Outcome	**Strategy**
3.3.3. Established community-governed evidence base to inform maternal housing stability policy	**3.3.3a**: Conduct a community-governed assessment documenting how housing instability affects pregnant and postpartum residents in Charlottesville and Albemarle County. Through story circles, interviews, photovoice, community surveys, and provider engagement, generate community-owned findings that inform policy recommendations to prevent pregnancy- and postpartum-related housing displacement. ***Lead Agencies**: RBSI*

Alignment with the Virginia Plan for Well-Being

The Blue Ridge Health District Community Health Improvement Plan supports Virginia's Plan for Well-Being (2025-2029) by translating statewide priorities into coordinated regional action. Virginia's plan identifies six priority areas: infant mortality, firearm-related deaths, obesity, mental health, substance use and drug overdose, and housing, transportation, and economic stability. Each is shaped by overlapping social, economic, and environmental conditions.

The 2025-2028 CHIP reflects the same understanding. By strengthening healthcare access, integrating the regional mental health ecosystem, and improving the community conditions that support well-being, the CHIP advances multiple statewide priorities at once while tailoring strategies to the needs, strengths, and lived experiences of Blue Ridge residents.

One Regional Strategy Advances Multiple State Priorities

Virginia Plan for Well-Being Priority	Blue Ridge CHIP Alignment
Obesity	**Goal 1**: Improve Access to High-Quality, Affordable, and Responsive Health Services; **Goal 3**: Strengthen Community Supports for Well-Being, Nutrition, and Financial Security
Mental Health	**Goal 2**: Integrate the Regional Mental Health Ecosystem
Substance Use & Drug Overdose	**Goal 2** through integrated behavioral health, prevention, recovery, and community partnerships
Housing, Transportation & Economic Stability	**Goal 3**: Strengthen Community Supports for Well-Being, Nutrition, and Financial Security
Infant Mortality	Addressed through maternal and child health partnerships, improved healthcare access, and community supports across **Goals 1 and 3**
Firearm-Related Deaths	Advanced through **Goal 2**'s emphasis on prevention, community well-being, cross-sector collaboration, and strengthening protective factors

Appendix A: Record of Adoptions & Changes

Summary of Change	Organizational Representative	Date