HEALTHY MEMPHIS INITIATIVE
CHURCH HEALTH CENTER/UNIVERSITY OF MEMPHIS PARTNERSHIP
13 February 2015

Opening Remarks
Karen Weddle-West welcomed everyone and reminded us to avoid collaboration fatigue

Introductions

Review of the minutes from 16 January 2015

Goals: This partnership should make this area an exemplar and a destination for activity and information on race-poverty-health initiatives
Consider these intersections from an ecological, systemic perspective
Many very good ideas discussed at the last meeting

Identify existing collaborations

Today’s Agenda:
• Review some of these existing arrangements (see spreadsheets from CHC and UofM)
• Prioritize current partnerships
• Create subcommittees
• Roll out something more formal at our next meeting and create a tentative plan

1. Review existing arrangements
   a. **Healthy Homes Partnership** – launched last month and is highly valued by the City of Memphis and Mayor AC Wharton
      i. See MOU handout
      ii. Kate Schaffzin provided details about this project: HHP was created with the CHC and the Health Law Institute (Amy Campbell is the director). Its primary goal is to improve physical conditions of children’s homes that affect their health (esp. asthma). The Law School is also working with Le Bonheur to have a lawyer housed in the hospital to help navigate health/legal overlap (ex. lack of income from an absentee parent). They are also interested in developing a law clinic in the future that would use law students to do the leg-work for the in-house attorney
      iii. KWW: Let’s develop and bolster our current projects instead of starting brand-new projects (ex. have KB Turner/criminology join the Law School’s projects; ex. how could the health science students help develop these projects?; health resources in the libraries?—websites? papers?; Mapping information?; Community health?—home visits to help the law school make assessments)
      iv. Joy Clay added that juvenile data has become available from the lead abatement program that Shelby County and SPH worked together on. They added nurses to the mix to explain the ramifications to the families and the importance of environment on health. We need to take advantage of this info while it is still available.
v. Everyone agreed to prioritize this project and volunteered ways they could contribute—Criminology, Nursing, Libraries (offer information, organize the outcomes), Graduate School (for social sciences, education, etc. —use this as a potential topic list as a resource for students looking for thesis/diss topics—both quantitative and qualitative), School of Urban Affairs and Public Policy

vi. ACA has components of community/public health; develop new models so people STAY healthy, so they never have to go to the hospital

b. **Poverty Simulation Program**—it is a 4 hour module that simulates what it is to live in poverty for four weeks; develops trust and communication between nurses and community members; develop nursing priorities based on the client’s priorities

i. Would the CHC like to participate even more in this program?

ii. Alan Swistak: We are developing a program for medical students to work with the underserved—Serving the Underserved (a six week program)—it is still in prototype form, but would like to expand it beyond just UT

c. **Learning Community at the CrossTown Center**

i. Expand our engaged scholarship by housing students and scholars at the CrossTown Center to work and do research with the CHC and other CT residents

ii. The CT Center will house the Hive (a multidisciplinary high-end innovation center)

iii. Lots of research opportunities at the CHC

iv. CHC has another “hive” at the CHC (Jasbir is involved)

d. **Collaboration on best practices to deal HIV/AIDS and intersections of race, class, gender, and poverty**—we have several smaller-scale projects that address HIV/AIDS that could be merged to have a higher impact (see pages 5 and 6 on the UofM spreadsheet)

i. HIV is spreading very rapidly in the area

ii. Bring in ministers and other ambassador-types to educate and test everyone that is at risk

iii. There has been some advances using App technology in conjunction with devices that attach to smartphones to test for various blood markers (ex. glucose testing, etc.), but we need to proceed cautiously because there are drawbacks to these and they do not always function quite as advertised—the results are usually pretty general when scanning for viruses

iv. Expand our efforts in this area and incorporate existing projects at UofM, the CHC, and St. Jude

v. St. Jude would make a great partner because of their grant money

vi. CHC has several projects in place: representatives go all over the city and train people in each church to carry on the education work—CHAMPIONS and ANGELS
vii. It is important to use people in each church and/or neighborhood community for the greatest impact—some communities are very suspicious of outsiders. Promotoras are health workers in the Hispanic tradition—we need to use people that the community will accept and talk to, instead of sending in outsiders.

viii. The SISTERS program would be a good model. It is a CDC program that is evidence-based.

ix. KB Turner suggested using the Drug Use Forecast to test inmates for drug use—1980s program that went into prisons—this model might be helpful.

e. Breast Cancer—ran out of time to discuss this during the meeting but seems very important.

2. Need co-chairs to head up this committee
   a. One from CHC and one from the UofM
   b. Would be the primary point of contact for and resource for information and internet presences about this partnership
   c. Expand our social media presence
   d. Create a communication plan and multi-modal map
   e. Alan will ask the CHC members, KWW will ask Marian Levy and Don Wagner