Citrus Valley Health Partners

2013 Community Health Needs Assessment - Implementation Plan Period: 2014-2016

Priority Health Need # 1 - Evaluation of Strategies - YR 2015

PRIORITY	STRATEGY	OBJECTIVE/ACTIVITIES	OUTCOMES/EFFECTIVENESS
I **Increased Awareness of Mental Health Programs and Services.**	❖ Partnership with the Behavioral Health Committee (BHC) in the San Gabriel Valley.	• Mental Health/Substance Abuse providers and Health Plans with the purposes of having a joint dialogue and to strengthen the relationship between *Health Plans and Federally Qualified Health Centers* and to inform FQHCs of resources available to them from the Health Plans. • As a result of the 2014 Behavioral Health Committee's planning process, the following identified strategies will be addressed: 1. Improve coordination of services for residents who require treatment for mental health, substance abuse and physical health issues. 2. Promote the integration of primary care and behavioral health care service providers to impact existing gaps.	• CVHP continues to be an active member of the Behavioral Health Committee of the SGV Health Consortium. In 2015, the BHC, CVHP and community partners held a very successful *Behavioral Health Round Table* hosted at Citrus Valley Medical Center Inter-Community Hospital. As a result of this event, the following objectives were accomplished. 1) Educated 90 providers and stakeholders about primary health, mental health and substance use disorder services, including how they are organized and accessed.

			2) Roundtable participants built relationships among providers across the three service types. 3) The networking will improve referrals between the three service types. 4) Shared and promoted a list of primary care and behavioral health resources. This data was organized by the Azusa Pacific University. 5) 14 organizations hosted resource tables and shared information about their services as well as materials to give to clients/patients. Participant's evaluation results: The majority of the 64 participants who turned in the evaluation form marked a positive response to the proposed questions (Strongly Agree and Agree).
	Strategy I Construction of a Federally Qualified Health Center (FQHC) to meet community physical and mental health needs.	Finish construction of the new community health clinic across for the Inter-Community Hospital in the city of Covina in 2014. CVHP engaged in this partnership with East Valley Community Health Center (FQHC) to open and operate the clinic. The estimated date for the grand opening is March of 2015.	➢ This is a highly effective investment and strategy to increase service capacity in the outpatient setting. The new health center initiated the provision of medical and **behavioral health** services for children and adults in March of 2015. The services are also offered to the remaining uninsured.

	Strategy II Increase Access to physical and mental health services through access to free and/or affordable public health insurance programs.	❖ Facilitate access to physical and mental health services through, Community Outreach/Awareness and Enrollment in affordable health insurance coverage.	➢ CVHP's GEM (Get Enrollment Moving) Project staff conducted outreach throughout the various communities in the East San Gabriel Valley. GEM provided enrollment in Medi-Cal, Covered California, AIM, KPCHP and MediCal Expansion (MAGI). In YR 2015, A total of 3,987 applications for health insurance were completed and followed- up by telephone calls 1) to confirm enrollment, 2) provide assistance with access, advocacy, and troubleshooting, and 3) retention in coverage. A detailed table with detailed information is included in this annual report. These results were achieved as a result of cross-sector community partnerships with promotoras, dental clinics, schools, food banks, churches, businesses, Department of Public Health, CBOs, etc.

		❖ Engage in community partnerships to provide prevention and intervention behavioral health programs through clinical and education services. Support and partner with SPIRITT Family Services with the implementation of the Child Abuse Risk and Intervention Neighborhood Outreach (CARIŇO) Program. Its purpose is to strengthen the family unit by promoting mental health and well-being through proactive programs of education, prevention, intervention, treatment and recovery and to strengthen the individual's self-concept through personal development, taking into consideration the multicultural communities served.	➢ In 2015, CVHP engaged in a partnership with SPIRITT Family Services, a mental health provider agency. ➢ Through funding from the Department of Children and Family Services and Citrus Valley Health Partners, clinical and educational services were provided to 57 indigent and underinsured individuals residing in the El Monte and South El Monte communities. Face-to-face sessions assisted individuals with building coping skills to improve their emotional and behavioral well-being and address issues of addition, mental health, domestic violence, anger management or other unhealthy challenges. Clinical counseling services included individual, couple, family, or group therapy. The demographics on the population served are outlined in the 2015 full community benefit report update.

		Utilize the Five Protective Factors based on the foundation of the Strengthening Families: 1) parental resilience, 2) social connections, 3) concrete support in times of need, 4) knowledge of parenting and child development, and 5) social and emotional competence of children. Research studies support the notion that when these protective factors are well established in a family, the likelihood of child abuse and neglect diminishes.	➢ In 2015, sixty-one percent (61%) of participants completed outcome measures (pre and posttest). There were improvement in the following protective factors: 1. Social Support 2. Concrete Support 3. Parental Resilience ➢ The standards of Quality for Family Strengthening & Support Survey were provided to program participants in July 2015. Participants rated favorably.

Citrus Valley Health Partners

2013 Community Health Needs Assessment - Implementation Plan Period: 2014; 2015; and 2016.

Priority Health Need # 2 - Evaluation of Strategies - YR 2015

PRIORITY	STRATEGY	OBJECTIVE/ACTIVITIES	EFFECTIVENESS
II **Increased Awareness and Improve Access to Programs, Education and Services Focusing on the Reduction of Obesity and Overweight Conditions.**	**GOAL:** ❖ Increase awareness and access to *Lighten Up San Gabriel Valley (SGV)* Program, Resources and Services.	1. Education/Awareness In 2015 CVHP continued to implement its campaign to increase awareness about overweight and obesity in our communities and offer a comprehensive support program for community members in various communities.	CVHP's Lighten Up SGV initiative carefully planned and implemented has proven success in bringing awareness, resources and education on obesity reduction, physical activity and prevention practices throughout CVHP's service area. The services and activities implemented in conjunction with community partners, health educators, and professional topic expert presenters have been successful in bringing community members for a dialogue, active participation, and the sense of competitiveness as an incentive.
	Strategy I: Weigh-in Community Event.	1. CVHP offered the bi-annual weight loss contest to increase awareness and improve access to programs, education and services, focusing on the reduction of overweight and obesity as well as promoting life styles to the whole family and friends of participants.	Beyond the pilot stage, Lighten-Up-SGV is now integrated in CVHP's system of health promotion and disease prevention practices and is an integral strategy of CVHP's vision: "We are an Integral Partner in Elevating our Communities' Health."

		CVHP held two (2) Weigh-In-Events/Weight loss contests. Community residents were widely invited to register and attend the Weigh-In events. a. During health screening process, participants create a record of their individual results of weight, blood pressure, and body fat and measurements. b. Nutritionists offered one-on-one consultation and formal presentations. i.e. "Basic things that you need to know to start losing weight." c. Expert presenters offered participants eight education presentations in 2015. The detail on topics and dates are outlined on the website www.lightenupsgv.com. List attached in the 2015 annual Community Benefit Report. d. The event had fifteen (14) partner agencies/programs in attendance. Jointly, they provided resources, education and information on nutrition, exercise and healthy life style opportunities. Participant	Weight-In events/Weight loss contests. This strategy continues to succeed in bringing together individual residents and families around a common theme. Multiple community wellness partners and community participants have actively engaged in a fun and enriching environment. Outcomes: ➢ The event was able to engage 298 attendees. ➢ 14 partner agencies/programs offered resources, education and information on nutrition, exercise and healthy life style opportunities. ➢ Contest participants lost a total of 624 pounds jointly. ➢ Program participants continue to enjoyed discounts from community partners for memberships in LA Fitness, Yoga and Zumba classes.

		partners are Big Bang Crossfit; Cooking For Health; Costco; Elements Natural Foods; Fit Body Boot camp; Fitness Life Studio; Fitness 19; LA Fitness; Latin Steps; Nutrishop Glendora; Summit Fitness; Take Shape For Life; Yoganettee and 24-Hour Fitness. Community partners offered discounted prices for program participants for memberships in LA Fitness, Yoga and Zumba classes. e. In a special ceremony, CVHP acknowledged each participant's accomplishments and gave special prizes to the individuals who lost the most weight. For example: 1. Highest Percentage of *Individual Weight Loss* Participant $250. Second Prize $100 and Third Place $50 in cash. *2.* Highest Percentage of *Weight Loss Individual.* CVHP Employees $250. Second Prize $100 and Third Place $50 in cash *3.* Highest Percentage of *Weight Loss in a Team.* Grand Prize community members $250**.** *4.* Highest Percentage of *Weight Loss in a Team*. Grand Prize CVHP Employee Team $250 in cash.	➢ The LPSGV Events continue to motivate and engage community residents to go through the six (6) month program to learn, lose weight and become more active. ➢ CVHP's the cash prize strategy has also served as an effective stimulation strategy for participation.

	Strategy II Free Education Opportunities provided by CVHP experts and community partners	a. Expert presenters offered participants eight education presentations in 2015. The detail on topics and dates are outlined on the website www.lightenupsgv.com. The Topics Include: Heart Health; Exercise do's and don'ts; Building a Weigh Loss Support Community; Stroke Awareness; How to eat healthy on a budget; Overcoming a summer slump; Don't eat your feelings; and Getting ready to face the holidays.	➢ The eight (8) free education presentations were provided by CVHP experts and community partners. ➢ The presentations were extremely successful and had significant attendance. RSVPs and Sign-In Sheets are kept on file.
	Strategy III Dedicated Website	The Lighten Up SGV includes Social Networking features to encourage discussion on the topic. ➢ It contains social networking features that encourage discussion. I.e. Message boards (Weight Watchers, Seniors and New Moms). ➢ Free user profile page, regular blog posts on weight loss and fitness tips. ➢ Access to over numerous health and weight loss articles. ➢ Links to Healthy Partners - groups and businesses providing health services.	➢ The website is functioning and available to the community. It accounts for a high number of hits. This report contains website sample pages. ➢ The url to access the website is www.lightenupsgv.com ➢ Dedicated FACEBOOK Page.

Citrus Valley Health Partners (CVHP)

2013 Community Health Needs Assessment - Implementation Plan Period: 2014-2016

Priority Health Need # 3 - Evaluation of Strategies - YR 2015

PRIORITY/AREA OF FOCUS	STRATEGY	OBJECTIVE/ACTIVITIES	OUTCOMES/UPDATE
Increase diabetes prevention strategies and disease management *Best Practices.*	**GOAL** Address Access, Inpatient Care Best Practices, and Chronic Disease Management including education, self-management, community input and resources.		
	Strategy I Preventable hospital admissions and access to care. CVHP in partnership with East Valley Community Health Center will build and open a new Federally Qualified Health Center (FQHC) early January of 2015.	1. Provide health services to uninsured and underinsured residents with diabetes and/or pre-diabetes. 2. Establish the clinic as a medical home. 3. Bilingual bicultural staff (English/Spanish). 4. Supply medications at low to no cost. 5. Provide diabetes and nutrition education at the three CVHP hospitals and at the FQHC.	➢ The design and construction of the clinic was implemented in the city of Covina in 2014. ➢ Provision of health services will initiate approximately in March of 2015. ➢ CVHP provided free support groups to help participants with concerns, achievements and challenges in managing their Diabetes. They are offered at the three hospital locations in West Covina, CA; Glendora, CA; and Covina, CA. Promotional flyer is attached in this annual report. ➢

	Strategy II A) Seek grant funding to establish an out-patient diabetes clinic at the Queen of the Valley Hospital location in West Covina.	1. Seek grant funding for the Diabetes Management Clinic.	➢ The MDC and the Citrus Valley Health Foundation submitted a grant proposal to the California Community Foundation to support the Diabetes Initiative and it was accepted. Received funding to support part of the initial funding support.
	B) Formalize a Multidisciplinary Diabetes Committee **(MDC)** to conduct a formal evaluation and gap analysis on diabetes metrics for all three hospitals to establish a baseline and opportunities for improvement.	1. Initiate meetings and planning with the MDC. 2. Poll and include input from the Community Diabetes Collaborative partners. 3. Include information from CVHP's 2013 Community Health Needs Assessment.	➢ CVHP's MDC was formed and developed *Phase I* of the Diabetes Initiative plan and implementation strategies. ➢ Identified grant funding opportunity. ➢ Identified Medical Director and an Endocrinologist for the Diabetes initiative. ➢ Initiated Medical Staff Education (CME) and partnership with our hospital group to improve diabetes outcomes. ➢ Initiated specialized education for Nursing on Diabetes and Diabetes Management.
		Strategy II - Phase 1: Create three sub-initiatives. 1. Insulin Drip Protocol for patients in Critical Care.	➢ Initiated computerized Insulin Drip Technology for Critical Care patients. Contract approved and will launch in the summer of 2015.

		2. Basal Nutrition Protocol for Non-Critical Care Inpatients.	➢ Established a Multi-Disciplinary Inpatient Nutrition Insulin Protocol with significant improvement in blood glucose control vs. baseline. Over 75% of blood glucose values vs. American Diabetes Association baseline at 45%. Hypoglycemia improved from 2-4% to now 1%. ➢ This pilot program is scheduled to expand to CVMC Inter-Community Hospital and Foothill Presbyterian Hospital in 2015.
		3. Diabetes Management Center for Ambulatory Patients.	➢ The MDC and the Citrus Valley Health Foundation submitted a grant proposal to the California Community Foundation to support the Diabetes Initiative and it was accepted. Received funding to support part of the initial funding support.
		4. Launch a pre-surgical diabetes protocol for participants in June of 2015. The purpose/benefit is to insure that patient's blood glucose is optimized to decrease risk for morbidity and mortality, per	➢ The Multidisciplinary Community Diabetes Management Center started accepting referrals from community agencies. ➢ Participants are receiving services at the center regardless

		literature.	of ability to pay. ➢ Memorandum of Understanding in process.
	C) Capitalize on the synergy between CVHP and the new FQHC clinic on Chronic Disease Management and Population Health.	1. In the summer of 2015, develop the formal partnership with the FQHC. 2. First, focus on anticoagulation and diabetes protocols. 3. Address provider shortage through a multidisciplinary approach to support complex care and chronic disease management to: **a.** Improve provider efficiency. **b.** Improve access and education. **c.** decrease inappropriate use of the Emergency Room as first level of care. Organize and implement a Diabetes Health Fair in partnership with the Federally Qualified Health Center in the fall of 2015.	➢ Protocols for anticoagulation and diabetes have been reviewed by medical staff.
	D) Continue to engage and join efforts with La Puente Community Diabetes Collaborative developed by CVHP in 2013. The Greater La	➢ Schedule and lead the monthly meetings with the collaborative to share ideas, coordinate strategies and receive recommendations from the group. (composed of community stakeholders and community residents.	➢ In 2014, the collaborative partners served as advisors to the CVHP Diabetes Initiative Team.

	Puente area has the highest incidence of severe diabetes and highest incidence of amputations. Data shows that, in addition of being at higher risk for developing diabetes, poorer patients are disproportionately affected by the complications associated with diabetes.		➢ The community collaborative met once a month. Partners include La Puente City Council members; pharmacies; school representatives; community-based organizations, faith communities and other. ➢ The collaborative explored strategies, resources and opportunities to address the major behavioral health and care management challenges for diabetic residents. Recommendations included the creation of individualized health improvement goals and advance their well-being. ➢ The collaborative now has on board an Executive Medical Director, Jorge Reyno, MD, committed to co-leading the collaborative. Dr. Reyno is a physician champion with expertise in diabetes care and treatment modalities and has passion for community health improvement.

	E. Amputation prevention screenings.	➢ CVHP's Outpatient Wound Center at Inter-Community Hospital provides *free diabetic foot screenings* every month.	➢ Free foot screenings were provided on hospital site every third Wednesday of the month. ➢ Free screenings were also provided at community events. ➢ Supplementary educational booklets on *Self Care* for the diabetic foot were distributed in community events and physician's offices.