Citrus Valley Health Partners

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

Priority Health Need # 1 - Evaluation of Strategies - YR 2014

PRIORITY	STRATEGY	OBJECTIVE/ACTIVITIES	OUTCOMES
I **Increased Awareness of Mental Health Programs and Services.**	❖ Partnership with the Behavioral Health Committee (BHC) in the San Gabriel Valley.	• CVHP is an active member of the BHC in the San Gabriel Valley. The Committee went through a process of identifying the service needs in the area. • The BHC brought together mental health and 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.	The community assessment of needs was a very effective strategy towards identifying specific priorities for the committee to focus on. Key Findings: 1. There is a need to improve coordination of services for residents who require treatment for mental health, substance abuse and physical health issues. 2. The integration of primary care and behavioral health care service providers is seen as a key strategy to positively impact existing service gaps.

	Strategy I Construction of a Federally Qualified Health Center (FQHC) to meet community physical and mental health needs.	In the winter of 2014, CVHP finished construction of a new community health clinic across for the Inter-Community Hospital in the city of Covina. CVHP engaged in this partnership with the 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 for needed services in the outpatient setting. The new health center will provide medical and **behavioral health** care for children and adults. It will also provide services for the remaining uninsured.
	Strategy II Increase Access to physical and mental health services through access to free and/or affordable public health insurance programs.	❖ Community Outreach and Enrollment Services.	➢ CVHP's GEM (Get Enrollment Moving) Project staff and promotoras conducted outreach in the community and provided enrollment in Medi-Cal, Covered California, Healthy Kids, AIM, KPCHP and MediCal Expansion (MAGI). With the onset of the Affordable Care Act, opportunities for free and/or low-cost insurance with **behavioral health coverage** have increased. The outcomes show that a total of 3,535 applications for health insurance were completed in 2014 and followed- up with enrollment verification, troubleshooting and retention services. These results were achieved as a result of community partnerships with promotoras, schools, food banks, churches, CBOs, etc.

Citrus Valley Health Partners

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

Priority Health Need # 2 - Evaluation of Strategies - YR 2014

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 2014 CVHP continued to solidify and implement its campaign to increase awareness in the various communities.	CVHP's Lighten Up SGV initiative was successful in bringing awareness and education on obesity reduction and prevention practices throughout CVHP's service area. The multiple services and activities were accessed by many program participants as described below.
	Strategy I: Weigh-in Community Event.	1. Implemented the bi-annual (2) weigh in events and weight loss contests to increase awareness and improve access to programs, education and services focusing on the reduction of the obesity and overweight conditions as well as promoting healthy life styles. a. Community residents were widely invited to attend and register at the Weigh-In events. b. During health screening process participants create a record of their individual results of weight, blood pressure, and body fat and body measurements.	CVHP held two Weight-In events/Weight loss contests. This strategy was very successful in bringing together individual residents and families around a common theme. Multiple community wellness partners actively engaged attendees in the various exercise activities and health information. Outcomes: ➢ The event was able to engage 301 attendees. ➢ 19 partner agencies/programs offered resources, education and

		c. Nutritionists offered one-on-one consultation and formal presentations. . d. Description of topics and dates are outlined on the website attachment. e. The event had fifteen (15) partner agencies/programs in attendance. The names of the partners are included in the full report. f. 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 in a Team.* Grand Prize community members **$250.** Grand Prize CVHP Employees **$250** in cash.	information on nutrition, exercise and healthy life style opportunities. ➢ Contest participants lost a total of 496.8 pounds jointly. ➢ Community residents benefited from discounted prizes from community partners for memberships in LA Fitness, Yoga, Zumba classes and Supermarket tours. ➢ Community residents were motivated to go through the 6 month program to lose as much weight as possible.

	Strategy II Free Education Opportunities provided by CVHP experts and community partners	Throughout the year, expert presenters offered topic related presentations. The Topics Include: Basic things that you need to know to start losing weight; Four tips to get you started on a fit 2014! 5 Things weight losers know; Let's talk diets: the good, the bad and what really works; Eating healthy on a budget; All you have to do is care; Roughage and why it is important; Jennifer Hudson weights in how she lost 80 lbs. and keeps them off!; Diabesity and Veggies.	➢ The ten (10) 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 100 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 2014

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.