Citrus Valley Health Partners

Inter-Community Hospital • Queen of the Valley Hospital
Foothill Presbyterian Hospital • Citrus Valley Hospice • Citrus Valley Home Health

www.cvhp.org

Citrus Valley Medical Center, Inc.
Inter-Community Campus – 210 W. San Bernardino Road, Covina, CA 91723-1515
License # 930000131

Queen of the Valley Campus – 1115 S. Sunset Ave., West Covina, CA 91790-3940
License # 930000131

Foothill Presbyterian Hospital – Morris Johnston Memorial
250 S. Grand Ave., Glendora, CA 91741-4218
License # 930000052

2016 Community Benefit Needs Assessment

Implementation Strategy
2017-2019

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CITRUS VALLEY HEALTH PARTNERS

2016 Community Health Needs Assessment (CHNA)
Implementation Strategy Report - Period: 2017-2019

I General Information

Contact Person: Maria Peacock, Director, Community Benefit
Written Plan Effective Date: **March 22, 2017**

Date Plan was Authorized and Adopted by
Authorized Governing Body: **March 22, 2017**

Written Plan adopted and approved by: CVHP, CVMC, CVH, FPH BOARDS OF DIRECTORS

Was the written plan written and Adopted by the Authorized

Governing Body by End of Tax Year in Which CHNA was made available to the Public?

Yes No X The new regulations indicate:

(5) When the implementation strategy must be adopted--(i) In general.
For purposes of paragraph (a)(2) of this section, **an authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month** after the end of the taxable year in which the hospital facility completes the final step for the CHNA described in paragraph (b)(1) of this section, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.

Date Facility's Prior Written Plan Was Adopted by Organization's Governing Body: March 2, 2014.
Name and EIN of Hospital Organization Operating Hospital Facility:

Citrus Valley Health Partners, Inc.
Citrus Valley Health Partners - EIN # 95-3885523

Address of Hospital Organization: 140 W. College Street, Covina, CA 9172

II Citrus Valley Health Partners (CVHP)

As the largest, nonprofit health care provider for the residents of the East San Gabriel Valley, CVHP serves the community through the work of its four facilities: Citrus Valley Medical Center – Inter-Community Campus in Covina, Citrus Valley Medical Center – Queen of the Valley Campus in West Covina, Foothill Presbyterian Hospital in Glendora, Citrus Valley Hospice and Citrus Valley Home Health in West Covina. Nearly one million residents in the East San Gabriel Valley rely on CVHP for their health care needs.

While CVHP is focused on healing the sick, we are also dedicated to reaching out to improve the health of our community. Our community outreach efforts allow us to reach beyond our hospital walls to help educate our community members, to help manage their health and to give them options in resources and health screenings. We offer a variety of health programs, services and support groups and partner with a variety of community organizations, cities and school districts with the common goal of improving health and well-being.

III Citrus Valley Health Partners Community Benefit

CVHP is an organization recognized for its outstanding community outreach efforts and accomplishments. An organization dedicated to creating innovative partnerships among the numerous health and social service organizations in our valley, with multiple participating agencies and diverse collaborative relationships devoted to promoting community health and well-being. In addition, CVHP has a charity care policy in place to respond to the needs of low-income, uninsured and underinsured populations.

CVHP's vision is to be an integral partner in elevating communities' health through collaboration and partnerships. This is the principle that guides all community health improvement and community benefit initiatives. Some highlights include CVHP's Get Enrollment Moving program, also known as GEM, enrollment specialists work in collaboration with community-wide partners to recruit eligible families and enroll them in the different Medi-Cal programs and other health access programs for low-income uninsured and underinsured populations to access health care services. Enrollment is followed by three separate calls to ensure confirmation of coverage, utilization of services, advocacy, problem solving and assistance with renewal. Since conception, Every Child's Healthy Option (ECHO) has been a collaborative effort coordinated and lead by local school districts. The program offers free urgent care services in various specialties regardless of income level and provides enrollment for the child in the adequate health insurance program. CVHP actively engages in community planning in partnership with the Health Consortium of the Greater San Gabriel Valley

CVHP's Diabetes and Lighten-Up San Gabriel Valley programs offer culturally competent disease prevention approaches as well as best practices to chronic disease management with the support of CVHP's clinical and nutrition professionals including community multidisciplinary partnerships. CVHP in partnership with First 5 LA, offer a health and psychosocial maternal/child program through home visitation during the prenatal and postpartum stages. CVHP has been diligent and responsive to the health coverage changes by offering outreach and education in the community on the Affordable Care Act/MediCal Expansion, Covered California market place, and other free and low-cost access programs.

IV Rationale for Implementation Strategy

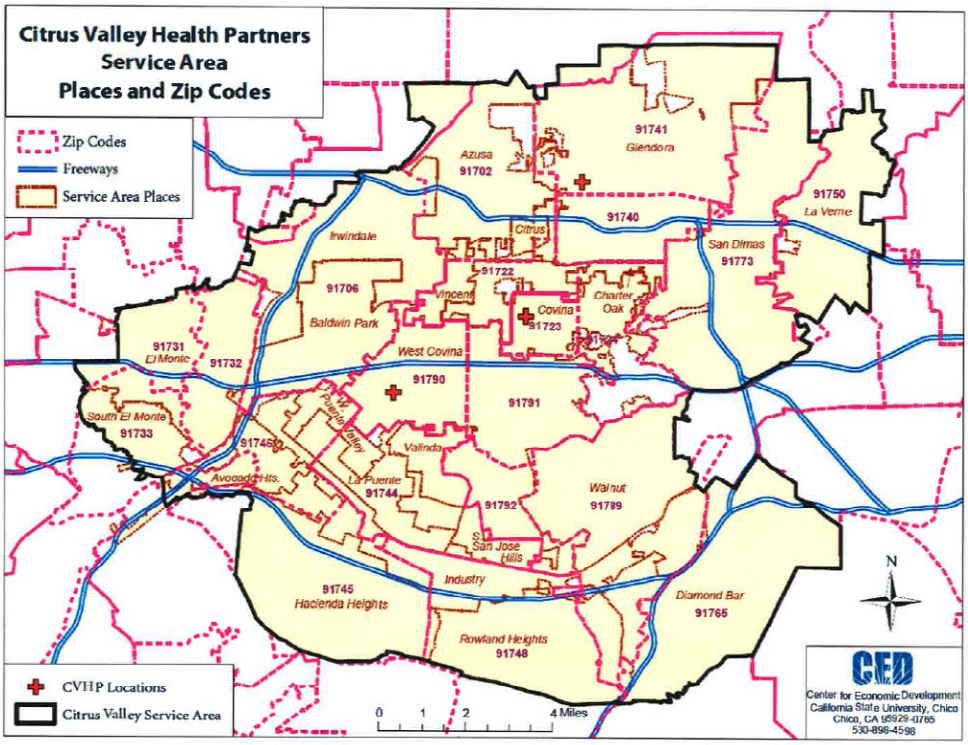
CVHP's Community Needs Implementation Strategy is being adopted to comply with federal tax law requirements set forth in Internal Revenue Code section 501r requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community health needs identified through the community health needs assessment.

CVHP's implementation strategy is the means to satisfy all applicable requirements outlined in the proposed regulations released in April of 2013. This implementation strategy focuses on the highest needs identified in the 2016 Community Health Needs Assessment.

V Citrus Valley Health Partners Service Area

CVHP's Service Area is characterized by significant disparities in income. One in five people in the SPA 3 - San Gabriel Valley service area population lives below 100% of the Federal Poverty Level (23% overall and 20% of children), while a larger percentage (47%) lives below 200% of the Federal Poverty Level. There are 2,612 homeless people in SPA 3 - San Gabriel Valley, most of who are mentally ill (30%), suffer from substance abuse problems (25%), or are physically disabled (22%).

The Citrus Valley Health Partners hospital generally serves residents surrounding the hospital in theEast San Gabriel Valley region and does not exclude low-income or underserved populations. The cities/communities in CVHP's service area are Azusa, Irwindale, Baldwin Park, Covina, Diamond Bar, El Monte, Glendora, Hacienda Heights, City of Industry, La Puente, Bassett, Valinda, La Verne, Rowland Heights, San Dimas, South El Monte, Walnut and West Covina. CVHP's service area is part of the SPA 3 (Service Planning Area 3 of Los Angeles County).



POPULATION - CVHP

The CVHP service area has a total population of 905,984 representing 8.8% of the total population in Los Angeles County (10,237,502) and 2.3% of the total population in California (39,356,473). The total population in the CVHP service area is projected to increase at a slower rate of 3.2% by 2021 than Los Angeles County (4.1%) and California (4.8%).

In 2010, the total population within CVHP service area was 880,220, making up 7.1% of the population in Los Angeles County (U.S. Census, 2010) (U.S. Census Bureau Decennial Census, 2010).

Since the 2013 report, the ratio of females to males has remained steady, and in 2016 nearly divided in half by females (50.9%) and males (49.1%). CVHP age distribution is consistent with that of the county and state. Youth between the ages of 0 and 17 comprise 23.0% of the population in the CVHP service area, adults between the age of 18 and 64 comprise 63.7%, and senior adults 65 years and older comprise 13.2% of the population. By ethnicity, over half (55.7%) of the population is Hispanic/ Latino. The second largest ethnic group is Asian/Pacific Islander making up over a quarter (22.5%) of the population. The third largest ethnic group is Caucasian with 18.0% of the population. and 2.1% are African American. Over a quarter (26.9%) of the population has less than a 9th grade education, another 20.1% in the CVHP service have a high school diploma. The service area has lower rates of four year college and graduate degrees in Los Angeles County. By language spoken, a larger portion of the population speaks Spanish (41.3%) at home another third speak English only (37.2%) at home; another significant portion of the population speaks an Asian/Pacific Island language (18.9%) at home. While the service area's income distribution is skewed slightly higher than the county and state, a significant number of households have lower income levels. Almost 20 percent of households (18.4%) had household incomes between $50,000 and $74,999, followed by household incomes between $35,000 and $49,999 (12.6%) and $75,000 and $99,999 (14.0%). A slightly higher percentage of the opulation in the SPA 3 – San Gabriel Valley (22.2%) lives in households below 100% of the Federal Poverty Levels (FPL). CHNAs show that the rate has risen sharply over time going from 12% in 2010 to 22.2% in 2014.

VI List of Identified Community Health Needs

Below is the summary list in alphabetical order of the identified health needs in the CVHP's 2016 Community Health Needs Assessment:

1. Access to health care
2. Access to healthy foods
3. Alcohol abuse, substance abuse and tobacco use
4. Alzheimer's disease
5. Cancer
6. Cardiovascular disease
7. Cultural and Linguistic Barriers
8. Diabetes
9. Economic Security
10. Healthy Behaviors
11. Housing
12. Hypertension
13. Mental Health
14. Oral Health
15. Overweight and obesity
15. Physical Environment
16. Preventive Healthcare
17. Respiratory disease
18. Violence and injury prevention

VII Individuals Involved in the Development of the Implementation Strategy

Tracy Dallarda, Chief Communications and Advocacy Officer
Maria Peacock, Director, Community Benefit Programs

VIII Availability of the 2016 Community Health Needs Assessment (CHNA) to the Public

CVHP has implemented several strategies to make the report widely available to the general public within the service area:

1) CVHP's website http://www.cvhp.org/Patient_Resources/Community_Needs_Assessment.aspx

2) On November 4th of 2016, Citrus Valley Health Partners and Kaiser Permanente Baldwin Park presented the joint tri-annual community health needs assessment at a community breakfast for state and local government representatives, non-profits, community-based organizations, faith communities, school districts, community colleges, public and private agencies, residents, institutions of higher education, public health department, department of health services, mental health department and agencies, etc. It is estimated that 100 community representatives attended this event and were provided with a hard copy and digital copy of the full report. This year, Senator Ed Hernandez, 22nd Senate District provided special remarks at the community presentation.

3) The report findings and hospital priorities are shared with the Health Consortium of the Greater San Gabriel Valley. The group conducts community planning and a coalition of local safety net organizations serving the lower-income populations of the Greater San Gabriel Valley (SGV).

4) The report is available upon request to CVHP's Community Benefit Department. Call (626) 814-2450.

IX Health Needs that Citrus Valley Health Partners will address in years 2017-2019

Process and Criteria Utilized in the Selection

Citrus Valley Health Partners Chief Communications and Advocacy Officer and the Director of Community Benefit engaged in an examination and analysis process of the broader list of community health needs identified in the 2016 CHNA. The comprehensive review process was designed with the purpose of identifying the community needs that can best be addressed by the hospital organization taking in consideration assets and expertise and community partnerships. The core factors that drove the process were: 1) High Community Need and 2) Feasibility to create an impact.

The methodology used for the selection included a scale of 1 to 5 from least to most for each of the health needs listed in section VI. The resulting scores were translated to a four section grid (vertical and horizontal axes from Low to High) according to High Need and Feasibility for review by the Implementation Strategy Team. The health needs receiving the highest scores for Need and Feasibility were selected as needs that Citrus Valley Health Partners will address as outlined and described in the Priority Areas listed below.

Following is the conceptual criteria utilized for this process:

High Need:

- Magnitude/Scale of the Problem: the health need affects a large number of people within the community
- Severity of Problem: the health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected
- Disparities: the health need disproportionately impacts the health status of one or more vulnerable population groups

Feasibility:

- Consider CVHP's relevant capacities and initiatives within the integrated health system.
- Ability to leverage: opportunities to collaborate with existing and new community partners working to address the need, to build on current programs and efforts, identify and support emerging innovative opportunities, and other assets.

X CITRUS VALLEY HEALTH PARTNERS IMPLEMENTATION STRATEGIES

SELECTED COMMUNITY NEEDS TO BE ADDRESSED

Health outcomes and drivers were taken into account because of their interconnection with community needs considering that they can negatively or positively impact individual health.

CVHP PRIORITY HEALTH FOCUS AREAS

Area of Focus I:

Increase Diabetes Prevention Strategies and Disease Management Best Practices.

Area of Focus II:

Increase access to Mental Health and Behavioral Health services and enhance service capacity through provider collaboration.

Area of Focus III:

Increase Awareness and Improve Access to health education and resources focusing on the reduction of Obesity and Overweight.

Area of Focus IV:

Improve Access to Health Care.

Area of Focus I: Increase Diabetes Prevention Strategies and Disease Management Best Practices

Diabetes decreases life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness. A diabetes diagnosis can indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity. In addition to heart disease, diabetes is also associated with other co-morbidities, including cognitive impairment, incontinence, fracture risk, and cancer risk and prognosis. Gestational (developing diabetes during pregnancy) diabetes occurs more frequently among Black/African-Americans, Hispanic/Latino Americans, American Indians, and people with a family history of diabetes. Women who have had gestational diabetes have a 35% to 60% chance of developing diabetes in the next 10 to 20 years.

Prevalence: In the CVHP service area, 12.0% of the population 20 years and older were diagnosed with diabetes, which is higher than in Los Angeles County (10.0%) and California (8.9%). **Hospitalizations**: More adults in the CVHP service area were hospitalized for diabetes (200.5 per 100,000 population) when compared to Los Angeles County and California. Nearly three times the number of adults in the CVHP service area were hospitalized for uncontrolled diabetes (13.5 per 100,000 population) than in Los Angeles County (4.5), and more than four times the number than in California overall (2.8).

Goal: Increase awareness of diabetes education and services and create greater access points for better chronic disease management.

Strategy I: DECREASE INADEQUATE HEALTHCARE ACCESS

Partners: CVHP physicians & staff; community physicians, local pharmacies, Welcome Baby program, educators and others.

Objective	Activities	Tracking Method
Provide Ambulatory Care Services Plan is to see 8 patients per day—Monday through Thursday	1) Preventative education by ADA-recognized educators 2) Pharmacist-driven medication management for chronic disease states (diabetes, hypertension, hyperlipidemia) and function as a resource to the patient and multidisciplinary team. o Improve patient satisfaction—pts are already verbalizing they can reach the team, easier and appreciate the extra time spent with them. o Achieve measurable outcomes to	1. A1c reduction 2. Hospital re-admission rate 3. Participant satisfaction 4. Medication adherence 5. Continue ADA-required data collection, including behaviour modification

	enhancing patient's quality of life. o Reduce re-admissions to the hospital and utilization of EDs. Patient can call the team with questions, rather than go to Urgent Care/EDs.. o Utilize Pharmacist as "middle man" between Retail Pharmacist/Patient and Physician/Patient. Physicians can focus more on other concerns, rather than the chronic diseases. o Accessibility and availability of pharmacists help patients to feel less alone in new diagnosis of chronic disease state, provides great deal of emotional support. o Educate patient so that they identify problems early and receive expedited treatment rather than wait before a problem becomes more severe. For example, how to recognize early signs of eye and foot disease so that they seek additional preventative services. o Improved access to medications. Turn-around time for refills is high. The Pharmacist can help obtain the medications they need or offer appropriate substitutions. o Identify women in our Sweet Success program that want to prepare for the next pregnancy and get them medically cleared for pregnancy. o Bridge gap between medication efficacy/safety and medication adherence. Meds will not work if patients decide not to take it. o Provide continuous DM management in ambulatory care setting, deterring high-risk patients from "falling through the cracks" upon d/c or upon new diagnosis post-PCP visit. 3) Monitor medication side-effects/adverse effects associated with chronic disease	state management.

Strategy II: DISPARITIES FOR WOMEN OF CHILDBEARING AGE

Objectives and Activities

Partners: **CVHP Medical Staff, East Valley Community Health Center (FQHC).**

Objective	Activities	Tracking Method
1. Support optimal health and planning for the next pregnancy 2. Reduce the risk of miscarriage and malformations	• Utilize existing outpatient diabetes services to help women achieve their pre-pregnancy goals . • Partnership with East Valley Community Health Center (FQHC) to provide a medical home so that the women are screened and provided preventative health maintenance to assure optimal health for the woman planning the next pregnancy.	• Evaluate all Sweet Success patients for pre-conception care • Evaluate outcomes for those women who received pre-conception care

Area of Focus II: Increase access to Mental Health and Behavioral Health services

The CVHP service area is experiencing mental health–related issues with youth and adults. Mental Health disparities were observed among youth, the elderly, the low income, the middle class, the uneducated, the homeless, and communities mostly located in the western and central parts of the CVHP service area.

Prevalence. In the CVHP service area, the population experienced an average of four mentally unhealthy days per month, similar to that reported in Los Angeles County.
Hospitalizations. In the CVHP service area, the mental health hospitalization rate per 100,000 adults was higher (616.8) when compared to California (540.9), and less than the county (677.0). The mental health hospitalization rate per 100,000 youth was much higher (451.6) than Los Angeles County's (377.1) and twice California's (294.8).

Goal: Expansion of Mental Health Services and Provider Coordination

Strategy I: BUILD PROVIDER CAPACITY THROUGH COLLABORATION

Build capacity among the local physical health, mental health and substance use disorder (SUD) providers to better serve patients and community, including primarily the lower-income, vulnerable and immigrant populations residing in Citrus Valley Health Partners service area. Community Partner: Greater San Gabriel Valley Physical & Behavioral Health Integration Committee.

Objectives & Activities

Objective	Activities	Tracking Method
1. Convene the network on a regular basis to facilitate implementation of purpose.	• Plan meeting schedule and agendas. • Submit meeting notices. • Complete meeting notes to document discussion items and decisions.	• Meeting agendas will document the plan/focus of each meeting. • Meeting notes documenting discussion. • Presentation slides and/or hand outs. • Evidence of sharing mental health assessment tools
2. Facilitate and support shared learning, capacity building and coordination of care with focus on 3 topics: [1] Emerging best practices; [2] Shared assessments & screening tools; and 3) accessing Los Angeles County mental health services.	• Hold meetings and/or forums focused on the three topics including expert speakers/presenters.	• Meeting agendas will document the plan/focus of each meeting. • Meeting notes documenting discussion. • Presentation slides and/or hand outs

Strategy II: ASSESS THE NEEDS FOR COMMUNITY-BASED FOLLOW-UP SUPPORT.

Support would be provided by a professional Psychiatric Pharmacist that will focus on this specific condition.

Objectives and Activities

Objective	Activities	Tracking Method
1. Partner with Western University to bring on board a qualified psychiatric pharmacist on a part-time base. 2. Conduct needs assessment. 3. Determine priorities to design a psychiatric specific pharmacy program to respond to needs.	• Develop MOU with Western University • Bring on a psychiatric pharmacist 3 times a week. • Develop and conduct assessment • Review findings and determine priority needs • Research resources to respond to the findings/needs.	• Partnership documentation • Psychiatric Pharmacist on board. • Assessment tool. • Determine priority needs • Proposal and budget • Implementation

Strategy III: ADDRESS BEHAVIORAL HEALTH DRIVES FOR OBESITY AND OVERWEIGHT.

Objectives and Activities

Objective	Activities	Tracking Method
1. Collaborate with other mental health programs on improving the individual overall health by addressing “drivers” (i.e. obesity, overweight, diabetes, cardiovascular disease, etc.).	1. Weigh-In Events 2. Inclusion in community education and presentations. 3. Welcome Baby/maternal depression component. 4. Diabetes programs	1. Included mental health education and resources in all activities.

Strategy IV: INCREASE ACCESS TO OUTPATIENT MENTAL HEALTH SERVICES.

Objectives and Activities

Objective	Activities	Tracking Method
Partner with East Valley Community Health Center, an FQHC clinic, to enhance access to outpatient mental health services by a Psychiatric Nurse Practitioner and Licensed Social Workers.	Work collaboratively with the Clinic to support improving access to outpatient mental health services to low-income uninsured and underinsured individuals and children.	• Number of mental health professionals providing services • Decrease in the wait time for appointments

Strategy V:

DEPRESSION AND RISK ASSESSMENTS FOR PRENATAL AND POST PARTUM WOMEN.

Partners: Welcome Baby Program, Los Angeles Best Babies Collaborative; Perinatal Mental Health Program and Health Consortium of the San Gabriel Valley's Behavioral Health Committee.

Objective	Activities	Tracking Method
Partner with the San Gabriel Valley area Welcome Baby Program to conduct assessments to pregnant and post partum women. Referrals for mental health services.	• Administer the PHQ9 Assessment. • Administer the Bridges for Newborns Assessment. • Provide meaningful referrals for mental health services. • Follow-up to ensure that the participant successfully receives services.	• Number of mental health professionals providing services • Decrease in the wait time for appointments

Area of Focus III: Increase Awareness and Improve Access to education and resources focusing on the reduction of Obesity and Overweight.

Associated health needs consist of hypertension, diabetes, cardiovascular disease, obesity and overweight. The CVHP service area has a greater portion of population classified as overweight and obese when compared to Los Angeles County and California. The issue has become increasingly prevalent among children and youth. **Prevalence.** In the CVHP service area, a greater percentage of teens between the ages of 12 and 17 (22.8%) were obese when compared to Los Angeles County (14.9%).
Greater percentages of Hispanic/Latino (22.5%) as well as Black/African American (21.6%) children in grades 5, 7, and 9 in the CVHP service area are obese relative to other races/ethnic groups.

Goal: Increase awareness and access to the Lighten-Up SGV program, resources and services.

CVHP's innovative weight loss support program Lighten-Up SGV will continue in years 2017-2019. This is a free program which offers the community and 3,000 CVHP employees monthly workshops in a wide variety of health improvement, healthy life styles, prevention, meal preparation, and wellness topics as well as resources to help participants lose weight through awareness and by using any plan they choose. For more information, please see the attached flier. A cadre of community partners is an intricate part of this program from design.

Strategy I: BI-ANNUAL COMMUNITY WEIGHT LOSS CHALLENGE

Objective	Activities	Tracking Method
1. Weight loss challenge.	• Conduct community "weigh-in" events annually. • Professional health providers and volunteers conduct health screenings including weight, blood pressure, etc. The information is documented to compare at the subsequent weigh-in event in June. • Special event includes information tables of a variety of community partners who offer nutrition and fitness information. Including exercise modalities such as Yoga, Zumba, etc. • L.A. Fitness offers discounted registration prices for interested participants. • Monthly series of FREE classes featuring presentations by CVHP experts and community partners • Topics include: weight loss myths, ideas for shopping and cooking healthier, tips to start a fitness routine, how to deal with emotional eating and more	• Personal and/or team screening results are shared with participant. • Record of Educational Workshops and Presentations. • Records of participants • 6-month evaluation of improvement. • Number of participants • Number of pounds lost by individuals and teams. • Record of Awards and Recognition provided. • Anecdotal stories

	• CVHP will award cash prizes to community and CVHP employee winners. The first place for indivual and team categories will receive $250 cash. • Participant will receive a design bag with information and resources to help them continue to lose weight and be entered into a drawing for a door prize.	
2. Dedicated Lighten Up San Gabriel Valley website at www.lightenupsgv.com	• Provides social networking features to encourage discussion. Message boards such as Weight Watchers, seniors and new moms. • Access to a significant number of health, weight loss and wellness articles. • Links to Healthy Partners groups and businesses providing health services.	• Number of hits and interactive participation.
3. Dedicated Facebook Page	• Facebook page with a focus on youth. • Free profile page, regular blog posts on weight loss and fitness tips. • Seek partnerships with school districts and/or youth organizations.	• Will monitor friends of the facebook page and interactions. • Partnerships with youth organizations.
4. Focus on becoming more active and health educated vs. Weight loss.	• Focus messaging and promotion on resources and education to maintain healthy lives.	• Flyers, social media messaging, Elevations publication, etc.

Area of Focus IV: IMPROVE ACCESS TO HEALTH CARE.

Access to health care is a driving factor that affects various aspects of maintaining good health, including: people's overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy. Financial instability creates barriers to access, including insurance coverage and health services. Furthermore, cultural and linguistic barriers can create inequities.

In the CVHP service area, 21.3% of the population does not have health insurance and 16.7% does not have a usual place to go for medical advice or to receive treatment when sick. Further, a greater percentage (27.7%) could not afford to see a doctor than in Los Angeles County (16.0%). The southeast portion of the CVHP service area seemed most affected by a lack of health coverage according to U.S. Census statistics. In particular, 20.7% of Hispanic/Latino populations lack a consistent source of primary care, and 21.8% non-Hispanic white populations needed access to mental health care.

Goal: Outreach, Screen, Enroll and Follow-up Assistance for the uninsured and/or underinsured in CVHP's service area.

Strategy I: CONDUCT COMMUNITY OUTREACH

Objectives and Activities

Objective	Activities	Tracking Method
1. Conduct outreach, education, presentations, promotion and information in target areas working in partnership with community agencies, school districts, WIC, etc.	1. Identify data of service areas with higher number of uninsured. 2. Schedule outreach activities including community events. 3. Conduct phone outreach to respond to referrals and inquiries. 4. Analyze outcomes to strategize as needed.	1. Enter outreach reports in the data entry system. 2. Identify trends and results.

Strategy II: ENROLLMENT ASSISTANCE

Objectives and Activities

Objective	Activities	Tracking Method
1. Provide health insurance enrollment assistance to uninsured individuals and families for Medi-Cal, Covered California, and any other low cost health access programs.	1. Enrollment counsellors screen and complete application for free and/or low-cost health insurance.	1. Number of applications completed. 2. Compare statistics of uninsured with the 2019 CHNA data.

Strategy III: ENROLLMENT VERIFICATION

Objectives and Activities

Objectives	Activities	Tracking Method
1. Conduct follow-up contact to confirm successful enrollment with at least 80% of applications assisted.	1, Call participants to ask if they have received their insurance card/approval. If unable to reach client, check the Meds system to verify enrolment outcomes.	1. Enrollment verification reports. .

Strategy IV: ASSISTANCE WITH PROBLEM SOLVING AND SYSTEM NAVIGATION

Objectives and Activities

Objectives	Activities	Tracking Method
1. Provide ongoing assistance to people experiencing problems with enrollment, utilizing benefits, or retention of health insurance. 2. Offer system navigation support.	1. Conduct troubleshooting/problem solving and advocacy services. 2. Offer utilization of services assistance to ensure that the person is accessing health, dental and vision services. 3. Educate participants on how to navigate the health system. 4. Assist with completing the Medi-Cal packet including plan and physician selection.	1. Completed forms with assistance documented. 2. CHOI Data system records of number of people contacted and assisted.

Strategy V: INSURANCE RETENTION ASSISTANCE

Objectives and Activities

Objectives	Activities	Tracking Method
1. Offer assistance with redetermination and/or renewal of health insurance. 2. Achieve rate of retention at least 80%.	1. Contact participants by telephone to determine if they have completed the redetermination forms or if they need assistance. 2. Provide determination assistance as needed.	1. Completed retention verification forms. 2. Completed renewal assistance forms. 3. CHOI Data system report.

Strategy VI: INCREASE ACCESSIBLITY TO OUTPATIENT SERVICES AT COMMUNITY SITES.

Goal: Increase access to health care services at community-based locations.

Objectives	Activities	Tracking Method
1. Increase accessibility to needed outpatient services through expansion of community-based service capacity.	• Seek community partnerships to increase accessibility to outpatient services in CVHP's service area. • Focus partnerships in specialty care services to increase access at the community level rather that travelling to the hospital.	1. Number of Partnerships. 2. List of specialties available at community locations. 3. Other outcomes
2. Increase and enhance access to emergency services to meet community needs.	• Expansion of the Inter-Community Hospital emergency room services. • InQuicker online appointment scheduling for non-emergencies.	• Report on additional capacity of services as a result of the expansion.
3. Increase capacity of hospital physician services to the community through a Partnership with East Valley Community Health Center (FQHC) and University of Southern California Keck School of Medicine to add a Family Residency Program.	• Complete administrative processes. • Interview candidates • Start residency program	• Completed administrative and contractual activities. • # of Candidates Interviewed • # of Residents selected • Start Date.

Strategy VII: INFORMATION DISSEMINATION ON GOVERNMENT CHANGES FOR ACCESSING HEALTH INSURANCE

Objectives	Activities	Tracking Method
1. Information campaign on repeal and replace the Affordable Care Act.	• Information dissemination on updates and health access changes as a result of the new federal government mandate. • GEM Project staff will communicate changes and will support community members in maintaining health coverage and accessing health services. • CVHP's Elevations publication will provide • information and updates.	• Report on strategies and information disseminated. • Report on barriers and challenges experienced by the community.

XI CITUS VALLEY HEALTH PARTNERS EVALUATION PLANS

1. CVHP will collaborate with non-for profit hospital local and regional networks to share and identify best practices to effectively measure community impact.

2. Citrus Valley Health Partners will monitor and evaluate the strategies listed above for the purpose of tracking their implementation as well as to document the anticipated impact.

3. Monitoring activities will include the collection and documentation of tracking measures, such as the number of grants made, accounting of financial resources spent and number of people reached and assisted.

4. The 2016 CHNA Implementation Plan programmatic and financial updates will be submitted to OSHPD via the annual SB-697 Community Benefit Report.