Citrus Valley Health Partners

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

Priority Health Need # 1 - Evaluation of Strategies - YR 2016

PRIORITY	STRATEGY	OBJECTIVE/ACTIVITIES	OUTCOMES/EFFECTIVENESS
I **Increased Awareness of Mental Health Programs and Services.**	**Strategy 1** 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 (BHC) 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 is a strategic partner of the SGV Health Consortium Behavioral Health Committee. In 2016 the BHC developed a shared vision and response with specific strategies for collaboration between physical and behavioral health care organizations in the Greater San Gabriel Valley. 1. Conducted assessment of behavioral health resources, gaps and best practices relative to enhancing collaboration. 2. Maintained the Behavioral Health Committee as a group of physical health, mental health and substance use disorder (SUD) providers who work together to share resources and expertise as well as planning. The meetings provided a forum for providers to make presentations, share tools, network and share best practices among the group.

	Strategy II 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 which has increased service capacity in the outpatient setting. In 2015, the new health center initiated the provision of medical and **behavioral health** services for children and adults since March of 2015. The services are also provided to the uninsured.
	Strategy III 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. Children, families and individuals were enrolled in MediCal; Covered California; AIM; KPCHP; and MediCal Expansion (MAGI). In YR 2016, a total of 2,785 applications for health insurance coverage were submitted. Applicants received follow-up calls to confirm enrollment, utilization of services, finding a provider, advocacy, troubleshooting, and retention of coverage.

			In addition, information was also provided to uninsured individuals to access mental health services through the LA County Department of Mental Health via three programs: 1) Ability to pay; 2) Indigent funds; 3) Sliding Scale programs. These results are achieved as a result of cross-sector partnerships with public and private community partners such as schools, food banks, churches, birthing centers, CBO's, etc., and particularly with the LA County DMH.
		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	In Partnership with the Welcome Baby program; SPIRITT Family Services and Foothill Family Service, CVHP was able to identify post partum women who suffer of depression. Welcome Baby is a psychosocial universal home visitation program. In 2016, 1,269 women who received the PHQ (Parental Health Questionnaire) at each engagement point before, during and after giving birth. This tool is used to identify maternal depression. In addition,

		self-concept through personal development, taking into consideration the multicultural communities served. 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.	mothers received a full assessment to identify psychosocial risk level of the participant at the hospital after giving birth. The tool used is the Bridge for Newborn Screening Tool which identifies risk in three main areas: basic needs; physical and psychosocial health. The tool was administered to approximately to 1,250 moms and 87% scored 50 and above, which is considered high risk. These women receive support and are linked to one of the two mental health partner agencies for specialized higher level of services.

Citrus Valley Health Partners

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

Priority Health Need # 2 - Evaluation of Strategies - YR 2016

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.	Lighten Up SGV has a proven success in bringing awareness, resources and education on obesity reduction, physical activity and prevention practices for the community. The services and activities were 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. CVHP held two (2) Weigh-In-Events/Weight loss contests.	The bi-annual Weight-In events/Weight loss contests have become well known and widely anticipated every six months. These program activities align with CVHP's Vision of: "Being an Integral Partner in Elevating our Communities' Health."

		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 partners are Big Bang Crossfit; Cooking For Health; Costco;	Once again, this successful program brings together individual residents and families around a common theme of improving health and quality of life. Multiple community wellness partners and community participants continue to engage in an atmosphere of fun and enrichment. Outcomes: ➢ The event was able to engage 276 attendees. ➢ 15 partner agencies & programs offered resources, education and information on nutrition, exercise and healthy life style opportunities. ➢ Contest participants lost a total of 505.6 pounds jointly. ➢ Program participants received discounts from community partners for memberships in LA Fitness, Yoga, Zumba classes, etc.

		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 a very effective incentive for participation. ➢ After 6 months of enrollment, the program participants come back to be evaluated on their individual results in, weight, blood pressure, body fat and measurements (BMI). CVHP has followed through with the commitment to address obesity reduction and prevention as key components.

	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 eight (8) free education presentations were provided by CVHP experts and community partners. The Topics in 2016 Include: Emotional Eating; Label Reading; Hydration; Keeping a Food Diary; Fiber-Why is Roughage Important; Detoxing - Facts and Fiction; Psytoestrogen. ➢ 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 remains active.

Citrus Valley Health Partners (CVHP)

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

Priority Health Need # 3 - Evaluation of Strategies - YR 2016

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.	➢ The design and construction of the clinic was implemented in the city of Covina in 2014. ➢ Provision of health services was initiated in 2015. ➢ The Diabetes program has bi-lingual, bi-cultural professional staff providing services and education.

		5. Provide diabetes and nutrition education at the three CVHP hospitals and at the FQHC.	➢ 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 received a grant from the California Community Foundation to support and enhance the Diabetes Initiative.
	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.	➢ CVHP's Diabetes Management Clinic was formed and developed *Phase I* of the Diabetes Initiative plan and implementation strategies. ➢ At this time the Collaborative is being restructured. Input from patient evaluations has been utilized to ensure feedback from the very community we serve.

		3. Include information from CVHP's 2013 Community Health Needs Assessment.	➢ The Diabetes team is constantly consulting with CVHP's CHNA. It is a valuable tool as the multidisciplinary team consults to remain focused on the community needs and areas of health disparities.
		Strategy II - Phase 1: Create three sub-initiatives. 1. Insulin Drip Protocol for patients in Critical Care.	➢ This pilot program expanded to CVMC Inter-Community Hospital in August of 2015 and continued through 2016. The implementation has unfolded successes and challenges that will positively affect the implementation at Foothill Presbyterian Hospital.
		2. Basal Nutrition Protocol for Non-Critical Care Inpatients.	➢ Established a Multi-Disciplinary Inpatient Basal 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%.

	C) Capitalize on the synergy between CVHP and the new FQHC clinic on Chronic Disease Management and Population Health.	3. Diabetes Management Center for Ambulatory Patients.	➢ During the three years of addressing diabetes as a priority need, CVHP has managed 1200 patients have been successfully transitioned to our community integrated diabetes management services. These vulnerable individuals all have received diabetes and dietary education as well as direct medication therapy management as needed. ➢ The Multidisciplinary Community Diabetes Management Center (MDC) continues to reach out and accept referrals from community agencies. ➢ Participants are receiving services at the center regardless of ability to pay. ➢ In 2016, CVHP's efforts to impact diabetes care throughout our community have continued and successfully advanced. By using evidence- based medicine, the diabetes program initiates the recovery process

			while patient still at the hospital and empowers patients to transition into disease self-management. Through this program, CVHP has screened approximately 3500 people with diabetes and converted 1200 patients to a team-based insulin management program which includes: initial diabetes education, tight glycemic control through basal-bolus insulin therapy and review of the medication and therapy appropriateness.
		4. Launch a pre-surgical diabetes protocol for participants. The purpose/benefit is to insure that patient's blood glucose is optimized to decrease risk for morbidity and mortality, per literature. 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.	Many individuals were ideal candidates for continued transition to an out-patient team-based management mode; emphasis was made to enroll patients with advanced disease that have poor access to care. ➢ The pre-surgical diabetes protocol has been successfully implemented since 2015. ➢ CVHP and East Valley

		b. Improve access and education. **c.** decrease inappropriate use of the Emergency Room as first level of care.	Community Health center have formalized a joint partnership. ➢ Protocols for anticoagulation and diabetes have been reviewed by medical staff and have been approved. ➢ To expand capacity, CVHP developed a partnership with Keck Graduate Institute from the Claremont Colleges to provide a faculty member 3 days/week. This additional clinician the diabetes program can increase capacity with accepting additional patients from the hospital to ensure a safe transition after discharge. ➢ A full-time Pharmacist was added in mid-December of 2016 as part of the expended Ambulatory Care Center. ➢ Furthermore, there are plans to add a full time Spanish speaking MSW in the spring of 2017 to further address the determinants of health

			beyond the clinical model. ➢ In addition, 600 pregnant women with diabetes or nutritional needs have been served over the last three years. Of those women, 73% were able to achieve blood sugar control through diet and exercise only; 91% of the women delivered babies of normal weight. ➢ CVHP and East Valley Community Health Center have joined forces to address provider shortage. One significant strategy is for both organizations to initiate a physician residency program. The expected date to implement this important and strategic residency program is 2017.
	A) Continue to engage and join efforts with La Puente Community Diabetes Collaborative developed by CVHP in 2013. The Greater La Puente area has the highest incidence of severe diabetes and highest incidence of amputations. Data shows that, in addition of being at	➢ Plan and implement a Diabetes Health Fair in partnership with the Federally Qualified Health Center in the fall of 2015.	➢ CVHP holds an annual Diabetes Health Fair in partnership with the FQHC and other strategic providers and partners. ➢ Supplementary educational booklets on *Self Care* for the diabetic foot are distributed in

	higher risk for developing diabetes, poorer patients are disproportionately affected by the complications associated with diabetes.	➢ Schedule and lead the monthly meetings with the collaborative to share ideas, coordinate strategies and receive recommendations from the group. (comprised of community stakeholders and community residents). ➢ CVHP's Outpatient Wound Center at Inter-Community Hospital provides *free diabetic foot screenings* every month.	community events and physician's offices. ➢ The members of the Diabetes community collaborative continue to be open and available to provide advice and support. However, at this time, the community collaborative is in the process of revamping the collaborative by recruiting new participants. The monthly meetings were put on hold for a short period of time. ➢ Free foot screenings were provided at the hospital site every third Wednesday of the month. ➢ Free foot screenings were offered at community events.