Emanate Health™

Formerly Citrus Valley Health Partners

2020-2022
Community Health Needs Implementation Plan

Emanate Health – Formerly Citrus Valley Health Partners

2019 Community Benefit Needs Assessment

Implementation Strategy

2020-2022

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Emanate Health

2019 Community Health Needs Assessment (CHNA)

Implementation Strategy Report - Period: 2020-2022

I GENERAL INFORMATION

Contact Person: Maria Peacock, Director, Community Benefits

Written Plan Effective Date: **March 25, 2020**

Date Plan was Authorized and Adopted by Authorized Governing Body: **March 25, 2020**

Written Plan adopted and approved by:

Emanate Health Medical Center (Queen of the Valley Hospital and Inter-Community Hospital) and Foothill Presbyterian Hospital 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 22, 2017.

Name and EIN of Hospital Organization Operating Hospital Facility:

Emanate Health - EIN # 95-3885523

Address of Hospital Organization: 140 W. College Street, Covina, CA 91723.

II EMANATE HEALTH

As the largest, nonprofit health care provider for the residents of the East San Gabriel Valley, Emanate Health serves the community through the work of its four facilities: Emanate Health Medical Center Inter-Community Hospital in Covina, Emanate Health Medical Center Queen of the Valley Hospital 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 Emanate Health for their health care needs.

While Emanate Health 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 preventative health screenings. We offer a variety of health programs, services and support groups. In addition, Emanate Health has extensive partnerships with a variety of stakeholders such as community based organizations; cities; public and personal health departments; community planning groups; safety net clinics; school districts; other surrounding hospitals; etc., with the common goal of improving the health and well-being of our residents. Due to the dichotomy and diversity in our service area, joining efforts with community coalitions and partners is an effective strategy to continue to address health disparities.

III EMANATE HEALTH

Emanate Health 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.

Emanate Health'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 Emanate Health's Get Enrollment Moving (GEM) program outreach and enrollment navigators who work in collaboration with community-wide partners to recruit eligible families for screening and free enrollment in the different insurance coverage programs such as Medi-Cal and Covered California 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. Furthermore, GEM has expanded its scope by providing referrals to much needed services such as food, housing, mental health, etc. Since conception, Every Child's Healthy Option (ECHO) has been a collaborative effort coordinated and lead by local school districts. The program has offered free urgent care services in various specialties regardless of income level and provides enrollment for the child in the adequate health insurance program. Emanate Health engages in community planning in partnership with the Health Consortium of the Greater San Gabriel Valley

Emanate Health'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 Emanate Health's clinical and nutrition professionals including community multidisciplinary partnerships. Emanate Health, in partnership with First 5 L.A., offer a health and psychosocial maternal/child program through home visitation during the prenatal and postpartum stages. Emanate Health has been diligent and responsive to the health coverage changes by providing 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. With the onset of new regulation proposed by the federal government on Public Charge, Emanate Health adopted additional outreach and education strategies to support immigrant communities during these difficult times.

IV Rationale for Implementation Strategy

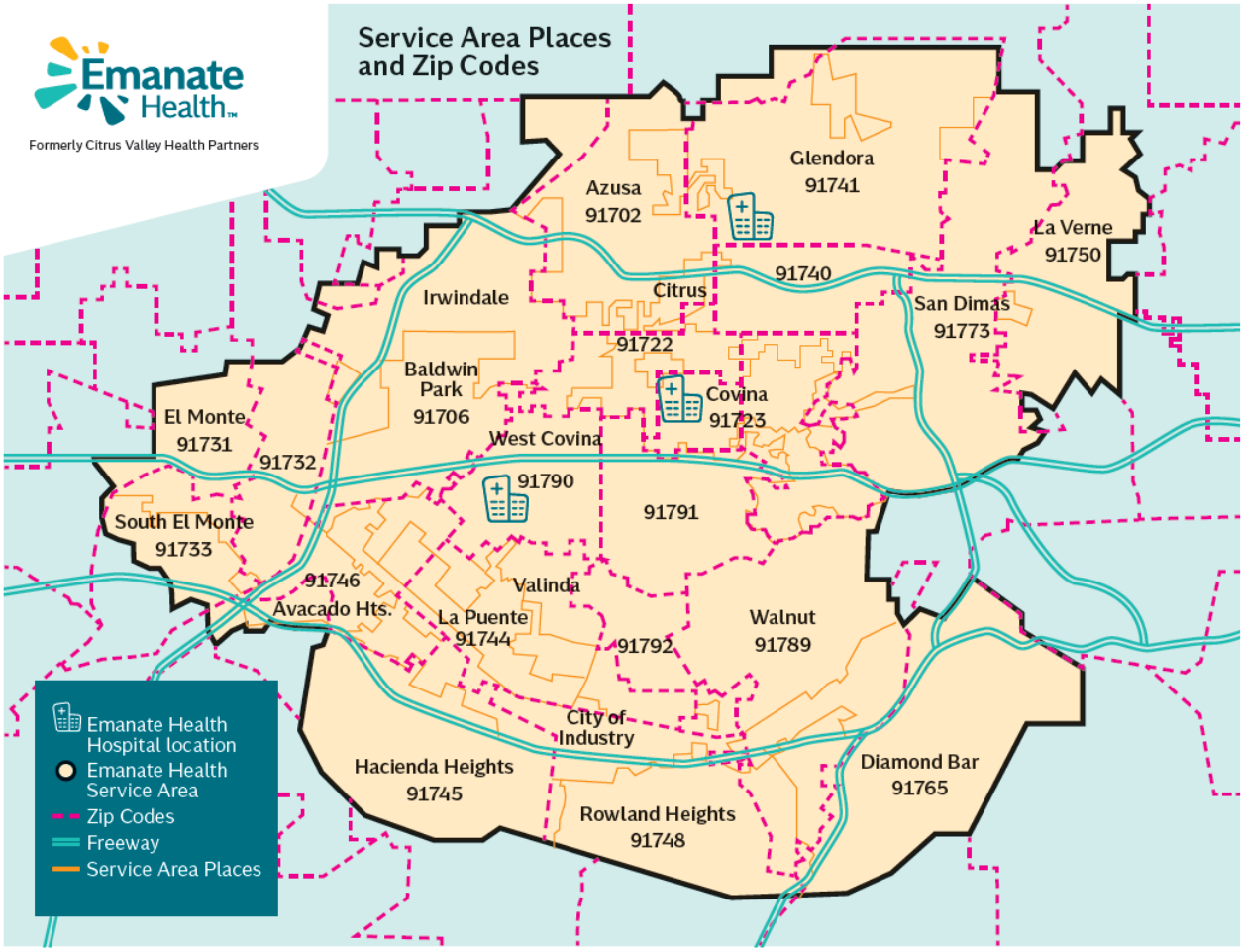
Emanate Health's *Community Needs Implementation Strategy* is being adopted to comply with federal tax law requirements set forth in Internal Revenue Code section 501r, requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health 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.

Emanate Health'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 2019 Community Health Needs Assessment.

V Emanate Health's Service Area

The Emanate Health (EH) hospital generally serves residents surrounding the hospital in the East San Gabriel Valley region and does not exclude low-income or underserved populations. The service area is described in the table below by city/community, ZIP Code and Service Planning Area (SPA).

City/Community	ZIP Code	Service Planning Area (SPA)
Azusa, Irwindale	91702	SPA 3 – San Gabriel Valley
Baldwin Park, Irwindale	91706	SPA 3 – San Gabriel Valley
Covina	91722, 91723, 91724	SPA 3 – San Gabriel Valley
Diamond Bar	91765	SPA 3 – San Gabriel Valley
El Monte (including City of Industry)	91731, 91732	SPA 3 – San Gabriel Valley
Glendora	91740, 91741	SPA 3 – San Gabriel Valley
Hacienda Heights (including City of Industry, La Puente)	91745	SPA 3 – San Gabriel Valley
La Puente (including Bassett, City of Industry and Valinda)	91744, 91746	SPA 3 – San Gabriel Valley
La Verne	91750	SPA 3 – San Gabriel Valley
Rowland Heights (including City of Industry, La Puente)	91748	SPA 3 – San Gabriel Valley
San Dimas	91773	SPA 3 – San Gabriel Valley
South El Monte	91733	SPA 3 – San Gabriel Valley
Walnut (including City of Industry)	91789	SPA 3 – San Gabriel Valley
West Covina	91790, 91791, 91792	SPA 3 – San Gabriel Valley



The EH service area has a total population of 903,864 representing 8.8% of the total population in Los Angeles County (10,231,037) and 2.3% of the total population in California (39,557,045). The total population in the EH service area is projected to increase at a slower rate of 2.4% by 2023 than Los Angeles County (3.3%).

Since the 2016 report, the ratio of females to males has remained steady, and nearly divided in half by females (51.0%) and males (49.0%). This is consistent with Los Angeles County (50.7% females and 49.3% males, respectively) and California (50.3% and 49.7%, respectively).

EH age distribution is consistent with that of the county and state. Youth between the ages of 0 and 17 comprise 22.2% of the population in the EH service area, adults between the age of 18 and 64 comprise 64.3%, and senior adults 65 years and older comprise 13.5% of the population. Similar percentages were noted in Los Angeles County (22.4%, 64.2%, and 13.4%, respectively) and California (22.7%, 63.0%, and 14.3%, respectively).

The EH service area is more heavily Hispanic/Latino and Asian, and less Caucasian/White (as a percentage of the total population), than either Los Angeles County or the state of California. In the EH service area in 2018, more than half the population identified as Hispanic/Latino (54.9%), followed by Asian/Pacific Islanders (25.2%), and Caucasian/White (15.8%). Hispanics/Latinos represent 48.4% of the population in Los Angeles County and 38.8% in California. Caucasians/Whites are the second-largest ethnic group in Los Angeles County (26.5%) and California (37.9%) followed by Asians/Pacific Islanders (14.3% and 13.9%, respectively).

As in 2016, nearly two-thirds (63.1%) of the population over the age of 5 years in the EH service area primarily speaks a language other than English in the home. This is significantly higher than in the county and state. The largest percentage of the population 5 years and older in the EH service area speak primarily Spanish in the home (40.1%), closely followed by English (36.9%) and an Asian language (20.9%). However, in Los Angeles County and California, English is most often spoken in the home (42.8% and 56.0%, respectively) followed by Spanish (39.7% and 28.7%, respectively). Asian languages represent the third language most often spoken in the home for Los Angeles County and California (11.0% and 9.9%, respectively). There has been a slight increase (1.4%) in the number of Asian speaking households since 2016, and a very slight decrease of 0.9% for primarily Spanish speaking households and 0.3% for English speaking households in the EH service area.

High Need Populations

Emanate Health's Service Area is characterized by many pockets of high concentrations of very low-income households and high economic insecurity. Just over one in eight people (13/3%) in the SPA 3 - San Gabriel Valley service area population lives below 100% of the Federal Poverty Level (FPL), and nearly one in five (18.6%) children live below 100% FPL. In many cities, including El Monte, Baldwin Park and Rowland Heights, over 60% of renting households spend more than 30% of their income on rent.

There are 4,489 homeless residents in SPA 3, an increase of 70% from the number of 2,612 homeless in 2016. Only 27% of these are chronically homeless, the remainder are newly homeless individuals and families. Only a quarter of the homeless in 2019 were mentally ill, and less than one in five (14.3%) suffer with substance use disorders. Importantly, just over one in five (20.6%) are physically disabled.

The Emanate Health's hospitals generally serve residents surrounding the hospitals in the East San Gabriel Valley region and does not exclude low-income or underserved populations. The cities/communities in the 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. Emanate Health's service area is part of the SPA 3 (Service Planning Area 3 of Los Angeles County).

VI List of Identified Community Health Needs

Below is the summary list in alphabetical order of the identified health needs in the Emanate Health's 2019 Community Health Needs Assessment:

- Access to Care
- Cancer
- Chronic Diseases (Heart Disease & Stroke, Diabetes)
- Economic and Food Insecurity
- Exercise, Nutrition, and Weight (Obesity)
- Homelessness and Housing Instability
- Mental Health
- Oral Health
- Senior Services and
- Substance Abuse/Tobacco Use

VII Individuals Involved in the Development of the Implementation Strategy

Mary Kirchen, IHM, Chair of the Strategic Planning, Marketing and Community Benefit Board Committee

Diane Martin, Chief Marketing and Communications Officer

Maria Peacock, Director, Community Benefit Programs

VIII Availability of the 2019 Community Health Needs Assessment (CHNA) to the Public

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

1) Emanate Health's website https://www.emanatehealth.org/about-us/community-health-needs/

2) On February 6, 2020, the San Gabriel Valley Non-Profit Hospital Collaborative united to make an unprecedented region-wide presentation of the CHNA findings and health trends in the San Gabriel Valley of Los Angeles County. The event was hosted at City of Hope Conference Center and had an attendance of 165 cross-sector community representative agencies such as 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. The collaborative partner, Center for Non-Profit Management, presented an overview of the 2019 CHNAs findings including health trends, demographic diversity, emerging needs, health and income inequalities, etc..

The event featured a hospital leadership panel facilitated by the Department of Public Health Area Health Officer. Each hospital representative had the opportunity to make comments about the 2019 CHNA findings and their role in responding to the emerging community needs.

The event was appreciated and well received by community participants.

3) The 2019 CHNA report is broadly shared throughout the Greater San Gabriel Valley. Electronic and printed copies of the report are available upon request by calling Emanate Health's Community Benefit Department at (626) 814-2450.

IX Health Needs that Emanate Health will address in years 2020-2022

Process and Criteria Utilized in the Selection

On February 26, 2020, ten key Emanate Health stakeholders came together to review and discuss the significant community health needs and social determinants of health that emerged through the CHNA process. Following this review and discussion, stakeholders participated in a prioritization process to produce a recommendation around the significant health needs to be prioritized by Emanate Health over the next three years.

First, stakeholders were asked to rate each identified health need and social determinant according to: severity, magnitude, degree to which the severity and magnitude are disproportionately distributed across racial/ethnic/age group or other social category (disparity), change over time, and availability of community resources.

Stakeholders then participated in a dot-voting exercise to indicate which needs rose to the top during the dialogue as needs or social determinants that Emanate health should focus on in the next three years.

The average rating of each health need and social determinant was combined with the number of dot votes assigned to each by the prioritization session participants. The total score determined the four priority health needs to be addressed by Emanate Health during the 2020-2022 period.

- ☐ Chronic Diseases
- ☐ Mental Health
- ☐ Homelessness
- ☐ Access to Care

X IMPLEMENTATION STRATEGIES

PRIORITY FOCUS AREAS

AREA OF FOCUS I: CHRONIC DISEASES / HEALTHY BEHAVIORS

Cardiovascular Disease

Cardiovascular disease—also called heart disease and coronary heart disease—includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis. As plaque builds up, the arteries narrow, restricting blood flow and creating the risk of heart attack. Currently, more than one in three adults (81.1 million) in the United States live with one or more types of cardiovascular/heart disease. In addition to being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. Cardiovascular health is significantly influenced by physical, social and economic factors including maternal and child health, access to educational opportunities, availability of and access to healthy foods, physical activity, access to safe and walkable communities, and access to affordable, quality health care.

Prevalence and Management: In SPA 3 in 2017, 7.1% of the population was diagnosed with heart disease, which is higher than Los Angeles County (6.6%) and California (6.6%). Among diagnosed adults managing their condition, more than half in the State (57.4%) appeared confident to control their condition. However, 13.2% in SPA 3 do not feel confident in managing their heart disease diagnosis compared to 9% of 512,000 adults in Los Angeles County. This rate is significant given that there is estimated to be approximately 512,000 adults in the Los Angeles County. More adults in Los Angeles county (3.2%) and SPA 3 (9%) have no confidence in controlling their condition than in the State (5.8%).

Hypertension

Hypertension, defined as a blood pressure reading of 140/90 mmHg or higher, affects one in three adults in the United States. With no symptoms or warning signs and the ability to cause serious damage to the body, the condition has been called a silent killer. If untreated, high blood pressure can lead to blood vessel aneurysms, chronic kidney disease which may lead to kidney failure, cognitive changes including memory loss, difficulty finding words, and losing focus during conversations, eye damage, heart attack, heart failure, peripheral arterial disease, and stroke. High blood pressure can be controlled through medication and lifestyle changes; however, patient adherence to treatment regimens is a significant barrier to controlling the condition.

Prevalence: In 2017 SPA 3, close to a third (30.2%) of the population were diagnosed with hypertension, a trend similar to that in Los Angeles County (30.0%) and California (29.0%), all higher than the Healthy People 2020 goal of <=26.9%. Stakeholders indicated that hypertension has become common among young adults between 20 and 30 years old.

Emanate Health CHNA Implementation Strategies 2020: Chronic Disease Management

Heart Disease

The following strategies and activities are intended to address our Community Access Needs for heart disease:

1. **Heart Center Expansion -** Intercommunity Hospital is a certified STEMI receiving center (ST-elevation myocardial infarction) where serious heart attack patients receive care from our entire Primary Service Area.

    - **Cath Lab # 3 Expansion –** Cardiac catheterization is way of examining the inside of the heart to see how well it is working, identify problems and possibly open blocked arteries. We complete over 2k cath lab procedures annually. To support the increasing patient needs for Cath Lab diagnostic an intervention procedures, a 3rd Cath Lab is being constructed by end of 2022 and will be adjacent to the Emergency Department to minimize transport time.
    - **Structural Heart Programs** - Intercommunity Hospital has added several complex structural heart procedures in the past few years including TAVR and MitraClip. We plan to add additional complex structural heart procedures as the technology advances and evolves as well as increase the volume of the existing non-invasive structural heart procedures.
    - **Open Heart and Valve Repair Procedures -** Intercommunity Hospital performs 200 annual open heart and valve repair procedures annually. With full time cardio-thoracic surgeons provided through a partnership agreement by USC Keck, we have been able to meet the need for patients in the Primary Service Area and not have their cases migrate outside. We plan to add an additional cardio-thoracic surgeon to address the growing open heart and valve repair procedure needs by end of 2022.

2. **Primary Care**

    - **Family Medicine Faculty** - will provide primary care services and continuity of care for patients discharged from the hospital that don't have a primary care physician assignment
    - **Family Medicine Residents** - Dr. Luis Garcia-Ayala a graduate from our Residency program will be working full time for the Family Practice in the 1206d**.**

3. **Specialty Care**

    - **Cardiology Clinic** - In May of 2020 cardiologist will see patients in the 1206d clinic that otherwise wouldn't have access to care due to being underinsured.

4. **Heart Disease Education & Awareness**

    - **Heart Month -** Every February, Emanate Health provides heart disease education and awareness events for our community. These include education talks by our physicians and special events such as heart healthy cooking and diet sessions. We plan to continue to expand the frequency of these education events, bring them to the community locations outside of our health system walls (such as Plaza West Covina shopping mall), and provide them in the preferred language of our community demographics.
    - **Women's Health Subgroup -** Women's Heart specific education and awareness sessions starting in 2020 will be launched.

Stroke Disease

The following strategies and activities are intended to address our Community Access Needs for stroke and neuroscience care:

1. **Stroke Center Expansion –** Queen of the Valley Hospital is a certified Primary Stroke Center where stroke and neuroscience patients receive care. We are looking to enhance the accreditation level and services for

patients so they can remain in our Primary Service Area and not have to be diverted to other outer lying hospitals by EMS.

- **PSC+** Pursuing the DNV PSC+ Stroke Center designation
- **RAPID Software Tool –** Launched in February 2020 the Rapid platform that brings cerebrovascular imaging software for identifying treatment options for stroke patients to Queen of the Valley.

2. Specialty Care

- **Neurology Clinic** - In January 2020 we added a full time Neurologist in the 1206d clinic seeing patients that otherwise wouldn't have access to care due to being underinsured.

3. Dedicated Ambulance Transport Service

- In May 2020 an ambulance service provider will be contracted to provided dedicated ambulances to transport stroke and neuroscience patients to Queen of the Valley Hospital.

AREA OF FOCUS II: MENTAL HEALTH

The Emanate Health 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 Emanate service area.

Prevalence. More than one in six (17.0%) of the population in SPA 3 reported needing help for emotional/mental or alcohol/drug problem in past 12 months, which was slightly lower than Los Angeles County (21.1%). The rate of teens likely to have serious psychological distress in SPA 3 - San Gabriel Valley and Los Angeles County is more than twice than the respective adult rate. In SPA 3, 9.6% of adults reported having thoughts of suicide at one point in their life, which was the same percentage as in Los Angeles County (9.6%), but a lower percentage than California (11.6%).

Goals:

Improve access to and utilization of mental health care services and address inequity in access to mental health care.

Strategy 1:

Build Community Capacity and Increase Accessibility and Equity in Access to Mental Health Care.

Activities: Partnership with GSGV Health Consortium and Hospital Collaborative

Activities	Outcomes	Impact
Engage in network building activities at each of the Greater San Gabriel Valley (GSGV) Health Consortium meetings.	Create opportunities for participants to get to know each other and to learn about the services offered at organizations they represent.	Improve client referrals to mental health providers that are best able to serve client needs and facilitate warm hand-offs between providers who know each other.
Invite keynote speakers to provide expert information about mental health-related initiatives, services	Build cross-sector provider knowledge and awareness of mental health services,	Same as above.

Activities	Outcomes	Impact
and resources available in the San Gabriel Valley. Including associated social determinants of health.	resources and initiatives that impact their service delivery options available for their clients.	
Plan and implement four Webinars through our GSGV Health Integration Training Program that will be geared to reach a larger population of physical health, mental health and SUD providers to enhance their capacity to effectively deliver integrated services. Four (4) educational topics have been identified 1) Trauma-informed care; 2) Diabetes & mental health; 3) Increasing access and effectiveness to mental health and SUD services; and 4) Reducing and addressing stigma related to mental health and SUD among service providers and among specific ethnic/cultural groups.	The cross-training webinars in 2020 will result in increased behavioural and mental health integration among safety-net organizations, including community-based organizations; community clinics; hospitals and county departments; and non-profit health, mental health and SUD providers.	Improve inter-agency knowledge and systems to improve patient referrals among providers that are best able to serve client needs in a timelier manner.
As a member of the Greater SGV Hospital Collaborative, Emanate Health will participate in the selection of mental health issues among youth including the stigma associated with accessing mental health services. The six non-profit hospitals in the SGV will potentially work jointly to develop a region-wide strategy around stigma. Specific strategy still to be determined, but potential topics areas are mental health concerns among youth; homelessness and mental health; and/or addressing social determinants of health such as food insecurity among youth.	A coordinated strategy across the six non-profit hospitals in the SGV to address a mental health issue.	TBD, based on selected strategies. Goal is to select strategies that will have an impact on the target population.

Strategy # 2

Address Behavioral Health Drivers for Obesity and Overweight

Activity: Education Module "Diet and Mental Health:" The Connection between Sugar, Anxiety & Depression

Activities	Outcomes	Impact
Emanate Health will sponsor and participate in the planning and implementation of the ***Diet and Mental Health*** training for youth in partnership with Azusa Pacific University Counseling Canter. Additional partners will include interested high need school districts and community members. • Workshop schedules • Printed materials • Videos • Healthy food demonstration and samples Conduct Pre and Post Surveys on Eating Habits	Participants will learn how processed sugar is wreaking havoc on the mind and body. Participants will identify 2 common intake habits that contribute to anxiety and/or depression. Participants will identify at least 2 healthy food substitutes for processed sugar and carbohydrates. Participants will identify 2 benefits to physical health when eliminating processed sugars Participants will learn about how to handle potential stigma related to accessing mental health services.	Physical and mental wellbeing; education; positive messaging. Impact will be measured based in the results of the pre and post-surveys.

Strategy # 3

Provide Depression and Risk Assessments for Prenatal and Postpartum Women -

Activities: Partnership with First 5 LA Welcome Baby Program and LABBN

Activities	Outcomes	Impact
Partner with the San Gabriel Valley area Welcome Baby (WB) Program and Los Angeles Best Babies Collaborative to conduct assessments to pregnant and postpartum women. Warm hand-off referrals for mental health services. • Administer the PHQ9 Assessment. • Administer the Bridges for	Identification of pregnant women who have depression. Identification of risk levels in three main areas: 1) basic needs, 2) physical health, and 3) psychosocial needs. Women receive assistance and support from Emanate Health Welcome Baby Mental Health Professional. Confirmation of appointment to consult with mental health	Increased risk screenings and assessments. Increase referrals to access needed mental health services. Decrease in the wait time for appointments.

New born Assessment. • Client Support and assistance from WB Licensed Clinical Social Worker. • Provide meaningful referrals for mental health services. • Follow-up to ensure that participant successfully receives services • Administer the Generalized Anxiety Disorder Assessment (GAD-7) tool at specific timeframes during the postpartum period.	provider.	

Strategy # 4

Emanate Health Faculty and Residents Training: Use of Alcohol and Opioid Use Disorder

Activities

Activity	Outcome	Impact
Train faculty of the Family Residency Program on treatment practices in the use of alcohol and opioid use disorder. Partner with other community health centers to arrange for the training. Engage in language and cultural appropriate community outreach to identify and refer clients for services at our partner clinic, East Valley Community Health Center. Engage with the community about the problem of addiction, providing brief presentations and distributing treatment brochures.	Complete Faculty Training. Ongoing training for Family Practice Residents. Ability to assist patients with their health care needs and their alcohol and opioid use needs. Information disseminated in the community. Meeting with community agencies, providers and places of worship will have ripple effects in terms of a sense of shared purpose and another resource for help. Appointments resulted from the outreach activities.	Increased capacity to train multiple Family Practice to begin to treat patients in the continuity clinic and in-patient settings using new attitudes, knowledge and skills. Increased capacity for physician residents to integrate treatment of health and substance abuse treatments. Impact on faculty and resident attitudes regarding substance use disorders by increasing understanding of how and why addictions develop and substance abuse issues.

AREA OF FOCUS III: HOMELESSNESS

As of 2019, there are 4,489 homeless residents in SPA 3, an increase of 70% from the number of 2,612 homeless in 2016. Only 27% of these are chronically homeless, the remainder are newly homeless individuals and families.

Approximately a quarter of the homeless in 2019 had been diagnosed with a mental illness, and less than one in five (14.3%) suffer with substance use disorders. Importantly, just over one in five (20.6%) are physically disabled.

Strategy # 1

Partnership with United Way of Greater Los Angeles and L.A. County Union Station to initiate a Patient Navigator Pilot Program.

The Patient Navigator Pilot Program is a system integration model designed to reduce Emergency Department and/or inpatient readmission for people experiencing homelessness or at-risk for homelessness identified as "high utilizers" of emergency services. The program is designed to follow them and work with them post-discharge to effectively link them with homeless services and other needed health and related services (e.g., recuperative services, medical homes, mental health, oral health, substance use, etc.).

Activities	Outcomes	Impact
Determine program goals and metrics. Create consistent/standardized processes for referrals and communication/information sharing with local clinics and other hospital partners.	The goals and procedures will guide successful implementation of the program.	The metrics will assist with capturing the impact of the program for evaluation purpose.
Finalize MOU with Union Station.	Formalize partnership and scope of work i.e., number of cases, etc.	N/A
Coordinate with other neighbouring SGV hospitals to collaborate and share the patient navigator.	Shared knowledge and shared resources with other hospitals.	The pilot program will benefit several communities in the San Gabriel Valley and will strengthen collaboration between hospitals.
Initiate the pilot program by the 2nd quarter of 2020.	Patient navigator will be integrated in the hospital Social Services/Discharge team	A smooth start with the patient navigator coordinate and work together with the hospital's team.
Participate in pilot evaluation and in periodic meetings to share progress, challenges, lessons learned, etc.	Monitor performance, challenges and lessons learned.	

Strategy # 2

Engage in a partnership with Los Angeles Homeless Services Authority (LAHSA) and Union Station to initiate a new pilot of "Hospital Liaisons."

Hospital liaisons will serve as "air traffic controllers," helping to connect homeless patients in hospital settings to services and resources in the L.A. Count Coordinated Entry System (CES).

Activities	Outcomes	Evaluation
Hospital Liaison launch event. Designation of Hospital staff to work with the Hospital Liaison. Designation of Hospital Liaison that will work with the hospital. Introductions to hospital staff and orientation to hospital setting. Develop procedures and schedule.	Will facilitate better coordination between hospitals and CES. Lessons learned. Successes and challenges. Hospital staff assigned to implement the program. Development of Procedures.	LAHSA and Emanate Health (and San Gabriel Valley participating hospitals) look forward to learning how this pilot of Hospital Liaisons can help ensure better coordination between hospitals and CES, and how it can help ensure high-needs homeless patients are connected to the services needed to end their homelessness.

Note: The Patient Navigator and the Hospital Liaison initiatives are under the auspice of the Health Consortium's SGV Hospital Collaborative.

Strategy # 3

Collaborate and support the San Gabriel Valley Consortium on Homelessness

Activities: *The consortium facilitates partnerships and regional linkages to more effectively and efficiently provide housing and homeless services; educates the community and member agencies, and advocates for appropriate* ***housing*** *and services. The Consortium membership encompasses mental health and substance abuse providers; leadership from Los Angeles County Homeless Services Authority; Police Departments; LA County Whole Person Care; advocacy agencies; FQHACs; public health; mental health; city officials, hospitals, health plan representatives, etc.*

Activities	Outcome	Impact
Secure conference room for all twelve (12) monthly meetings each year along with refreshments free of charge. Provide room set up services and audio-visual equipment assistance. The San Gabriel Valley has a	Emanate Health is well known as the "hub" in the San Gabriel Valley for the consortium on homelessness. Furthermore, Emanate Health was a founding partner in 2001. Emanate Health's staff from social services and community	Collaboration among providers. Improved services program coordination. Improved knowledge and use of available shelter and housing services. Improved access to mental health and substance abuse

vibrant and effective group of homeless advocates who engage in the annual homeless count; cross-sharing of resources and information; service coordination; legislation updates, grant funding opportunities to respond to the needs of our homeless individuals and families, etc. Support consortium initiatives.	benefit department leaders collaborate with consortium members and identify opportunities to partner to secure warm hand-off referral opportunities to best serve ER homeless patients upon discharge. Additional programs and resources brought to the San Gabriel Valley.	provider services.

Strategy # 4

Community Partnerships for Homelessness Prevention.

Activities	Outcomes	Impact
Emanate Health is seeking proposals from community agencies who work with fragile low-income families and individuals at-risk for becoming homeless.	Identification of community-based trusted agencies that work with at-risk populations. Development of program service delivery and assignment of financial and/or in-kind support to the agency to help prevent additional homelessness in the service area.	Make a difference in the lives of people who are touched by this program and who, otherwise, would have become homeless. Quantification not available at this time.

AREA OF FOCUS IV: IMPROVE ACCESS TO HEALTH CARE

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life. The lack of access to health services can lead to unmet health needs, delays in receiving appropriate care, inability to benefit from preventive services, and preventable hospitalizations.[1]

In the EH service area, a slightly smaller percentage (12.3%) of the population does not have health coverage when compared to Los Angeles County (13.3%) though lack of health coverage is slightly higher when compared to California (10.5%).[2]

In terms of accessing primary care, in SPA 3, 4.8% of the population reported having a difficult time, which is lower compared to Los Angeles County (5.0%) and California (5.7%).

In terms of specialty care, in SPA 3 approximately a third of the population (33.5%) needed to see a medical specialist, which was lower than that reported in Los Angeles County (37.4%) and California (38.8%). Access to specialty care is important and may be affected by cost or lack of health coverage for such services. Another factor is the lack of availability of appointments within a reasonable period of time. Also, specialists that are cultural and linguistic adequate for the patient. A small percentage (10.5%) of the population in SPA 3 reported having difficulty accessing a medical specialist when compared to Los Angeles County (11.5%) and California (11.5%).

One of the barriers to accessing necessary health care services can be lack of health insurance or coverage. In SPA 3, 6.2% of the population reported that their primary care doctor did not accept their insurance in the past year, which is higher when compared to Los Angeles County (5.6%) and California (5.1%). Additionally, 11.8% of those needing to see a medical specialist were not able to because their insurance was not accepted which is a higher percentage when compared to Los Angeles County (11.0%) but lower than for Improve California (10%).

Access to Health Care

***Strategy #1*:**

Conduct Community Outreach

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

Objectives and Activities

Objective	Activities	Tracking Method
Conduct strategic outreach activities to target low-income uninsured.	Identify data of service areas with higher number of uninsured. Continue fostering partnerships with school districts, CBO's, resource centers, etc. Schedule outreach activities	Enter outreach reports in the data entry system. Identify trends Evaluate results and the need for new strategies to reach the target community.

[1] Office of Disease Prevention and Health Promotion, (2014). *Access to Health Services*. Washington, DC. Available at [http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services]. Accessed [December 1, 2015].

[2] See Map 1 in Appendix D for rates of children under 18 underinsured.

	including community events and other effective tactics. Conduct phone outreach to respond to referrals and inquiries. Analyse results and adapt innovative strategies.	

***Strategy #2*:**

Enrollment Assistance

Objectives and Activities

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

Strategy #3:

Enrollment Verification

Objectives and Activities

Objectives	Activities	Tracking Method
Conduct follow-up phone contact to confirm successful enrolment with at least 80% of applications assisted.	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.	Enrolment verification data reports.

Strategy #4

Assistance and Advocacy

Objectives and Activities

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

Strategy #5

Insurance Retention Assistance

Objectives and Activities

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

Strategy #6:

Increase Accessibility to Ambulatory services at community sites

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

Objectives	Activities	Tracking Method
Increase accessibility to needed outpatient services through expansion of community-based service capacity.	Continue fostering community partnerships to increase accessibility to outpatient services in on a timely manner. Continue to foster partnerships to improve access to specialty care services.	Number of Partnerships. List of specialties available at community locations. Other outcomes
Increase capacity of hospital physician services to the community through partnerships with FQHCs, Clinics and Emanate Health's Family Residency Program.	Strategize to increase recruitment of specialty services physicians.	Additional specialty services available to the community.

Strategy #7:

Information Dissemination on Public Insurance program changes with focus on Public Charge

Objectives	Activities	Tracking Method
Information campaign to bring reliable information to the community related to the new federal legislation on public charge. Train the enrolment navigators on Public Charge. Provide the tools on how to educate residents. Promote the Medi-Cal programs that do not count for public charge.	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 making informed decisions related to Public Charge. If unable to apply for Medi-Cal, offer information on access to free and/or low-cost ambulatory care services. Share the hospital's community assistance program information.	• Report on strategies and information disseminated. • Report on barriers and challenges experienced. • Report on number of referrals to My Health L.A. program as well as to FQHCs.

XI EMANATE HEALTH EVALUATION PLAN

1. Collaborate with the San Gabriel Valley Non-for-Profit Hospital Collaborative and the Department of Public Health Area Health Officer to develop joint initiatives to address community needs and identify best practices to effectively measure community impact.
2. Monitor and evaluate the strategies listed above for the purpose of tracking their implementation as well as to document the anticipated impact including new developments and barriers.
3. Monitoring activities will include the data collection and documentation of tracking measures.
4. The 2019 Emanate Health Implementation Plan programmatic and financial updates will be submitted to OSHPD via the annual SB-697 Community Benefit Report.