Ventura County Community Health Needs Assessment Collaborative

2019 Community Health Implementation Strategy

Adopted November 2019

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At-a-Glance Summary

Community Served

Located in southern California, Ventura County includes 10 cities, 13 census-designated places, and 15 other unincorporated communities. Geographically diverse, Ventura County covers agricultural fields, mountain communities, coastal plains and an active naval base. The farmlands of Ventura County attract thousands of farm and migrant workers and their families. Total population was 850,967 in 2018.

Significant Community Health Needs Being Addressed

The significant community health needs were identified in the Ventura County Community Health Assessment Collaborative's (VCCHNAC) most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs in this report are:

- **Improve Access to Health Services**
- **Address Social Needs**
- **Improve Health and Wellness for Older Adults**

Strategies and Programs to Address Needs

VCCHNA member organizations intend to take several actions to address the above prioritized needs, including:

- Providing leadership to implement community-wide strategies to improve population health outcomes.
- Leveraging data to identify high need/high cost clients and address their unmet social needs, including food insecurity.
- Reducing hospitalizations and readmissions among older adults by providing them and their caregivers with tools and resources to improve quality of care and care transitions between hospital and community settings.
- Creating a sustainable governance structure to resource and fund community health improvement activities.

Anticipated Impact

It is anticipated that these efforts will improve quality of care by increasing care coordination among health systems and community based social need organizations, decrease the burden of care for families of clients, reduce cost of care and enhance client satisfaction. Further, by connecting clients from the most vulnerable populations to community-based resources for their unmet social needs like food, housing, and transportation, a reduction in the social and economic factors that act as barriers to health and wellness and exacerbate health outcomes is expected. Given the partnerships that are being created and strengthened by VCCHNAC, disparities in access to care and health outcomes are expected to decrease.

Planned Collaboration	VCCHNAC is a charter bound structure of seven health agencies and hospitals that are committed to addressing health disparities and serving communities with impactful solutions that leverage shared resources and coordinate care. While the primary motive of the collaboration was to complete the 2019 Community Health Needs Assessment, the VCCHNAC has since developed a multi-sectoral partnership with the objective of breaking down siloes between health systems and identifying issues that impact the most vulnerable populations. The strategies and programs outlined in this report will be addressed jointly by all the partners of VCCHNAC. Further, an active search of more community stakeholders - including media, business, academic, legal, health plans, advocacy, faith and social organizations - who might be able to participate in VCCHNAC's growing mandate is currently underway and will be regularly updated on the website of the collaborative: Health Matters in Ventura County.

This document is publicly available online at www.healthmattersinvc.org and https://www.dignityhealth.org/central-coast/locations/stjohnsregional.

VCCHNAC 2019 – 2021 Implementation Strategy Plan

Introduction

The Ventura County Community Health Needs Assessment Collaborative (VCCHNAC) is pleased to share their joint Community Health Implementation Strategy (CHIS) plan, which follows the development of the joint 2019 Community Health Needs Assessment (CHNA) for Ventura County, California. The following agencies constitute the VCCHNAC:

- Adventist Health Simi Valley
- Camarillo Health Care District
- Clinicas Del Camino Real, Inc.
- Community Memorial Hospital
- Ojai Valley Community Hospital
- St. John's Regional Medical Center, Dignity Health
- St. John's Pleasant Valley Hospital, Dignity Health
- Ventura County Health Care Agency Community Health Center
- Ventura County Public Health

The mission of the VCCHNAC is to enhance partnerships between Ventura County Public Health, area hospitals, healthcare providers, special health care districts, and health systems to improve population health outcomes in Ventura County. These partnerships are necessary to accomplish the shared vision of a single, comprehensive CHIS so resources may be focused on collaboratively developing strategies for improvement of the identified health priorities to address population health and benefit the communities being served. After a thorough review of the health status in Ventura County through their joint 2019 Community Health Needs Assessment (CHNA), VCCHNAC identified areas that they could address with their resources, expertise, and community partners. This CHIS summarizes the plans for VCCHNAC to develop and/or collaborate on community benefit programs that address the prioritized health needs identified in the CHNA.

The CHIS has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r). It requires hospital facilities owned and operated by an organization, described in Code section 501(c) (3), to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community

health needs identified through the CHNA. This CHIS is intended to satisfy each of the applicable requirements set forth in final regulations released in December 2014 and also meet community health improvement plan requirements for Public Health Accreditation.

This CHIS describes the planned response by the Hospitals listed below to the needs identified in the 2019 joint CHNA. The CHIS was approved by each board of directors and applies to tax years 2020 through 2022.

Names of the participating hospitals:

- Adventist Health Simi Valley
- Community Memorial Hospital
- Ojai Valley Community Hospital
- St. John's Regional Medical Center, Dignity Health, which is a part of CommonSpirit Health
- St. John's Pleasant Valley Hospital, Dignity Health, which is a part of CommonSpirit Health

Prioritized Health Needs – Planning to Address

The following are the prioritized health needs that will be addressed:

- **Improve Access to Health Services**
- **Address Social Needs**
- **Improve Health and Wellness for Older Adults**

Written comments on this report can be submitted at www.healthmattersinvc.org or by e-mail to erin.slack@ventura.org.

As a collaboration comprised of diverse organizations serving diverse communities VCCHNAC will need to pursue an additional organizational priority in order to strengthen the three year old charter-based partnership into a backbone organization that will have long term oversight of all the strategies and corresponding implementation plans. The priority is given below:

- **Aligning cross-sectoral partnerships for population health impact in order to develop a sustainable collaborative structure for collective implementation of population health strategies**

An implementation plan for this organizational priority is also included in this document.

Description of the Community Served

Community is defined as the resident population within the hospital's service area. Committed to addressing health disparities and serving communities with impactful solutions that leverage shared resources and coordinate care, the seven health agencies that make up the VCCHNAC have come together in defining their service area as the County of Ventura.

In 2018, Ventura County's population had a median age of 37.5 and a median household income of $81,972. Among county residents, 42,012 have veteran status, 38.6% of the people in Ventura County speak a non-English language, and 22.5% are foreign born. The median property value in Ventura County is $520,300 and the homeownership rate is 63.2%. The percent of households with a computer is 90.9% and with a broadband internet subscription is 85.1% (United States Census Bureau, 2018).

Community Demographics
(Source: United States Census Bureau, 2018; Health Matters in Ventura County)

- Total Population: the population estimate for Ventura County is 850,967 on July 1, 2018.
- Age Groups: 22.9% of the population is under the age of 18 with 15.6% over the age of 65.
- Gender Diversity: 50.5% of the population is female, 49.5% male.
- Race/Ethnic Diversity: 45% are White alone, not Hispanic or Latino, 43% of the population is Hispanic or Latino, 7.9% Asian, 2.4% African American or Black, 0.3% are Native Hawaiian and Other Pacific Islander alone and all others comprise 1.4%.
- High School Graduate or Higher, percent of persons 25 years +: 16.0 % do not have a High School Diploma
- Persons in Poverty: the poverty rate for county is 9.5%.
- Unemployment: the unemployment rate is 3.6% in June 2019
- Primary Language and Linguistic Isolation – English and Spanish are the primary languages. 15.3% of population 5 years and above speak English 'less than very well.'
- Insurance status – 9.3% of the population under 65 years are uninsured.

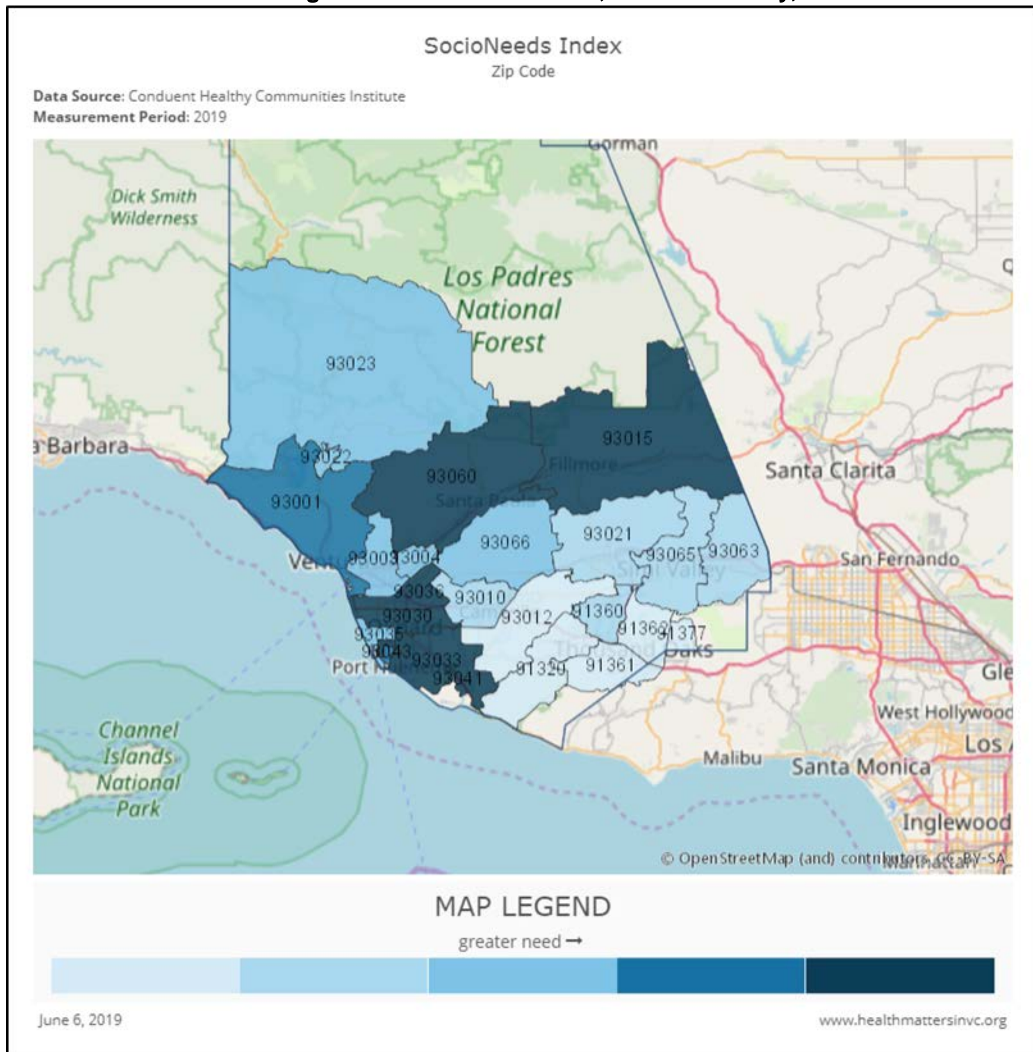
The Medi-Cal Managed Care Gold Coast Health Plan serves nearly 200,000 Medi-Cal beneficiaries in Ventura County. There are 8 hospitals within Ventura County. Ventura County is served by: Adventist Simi Valley Hospital and Santa Paula Hospital to the north, Los Robles Regional Medical Center and Thousand Oaks Surgery Hospital to the east, and Community Memorial Hospital, Ojai Valley Community Hospital, and Ventura County Medical Center to the west. St. John's Regional Medical Center (SJRMC) serves an area federally designated as a Medically Unserved Area (MUA). The hospital is in the 93030 zip code of the service area. Dignity Health St. John's Pleasant Valley Hospital (SJPVH) is the City of Camarillo. Despite this, there are several barriers to accessing healthcare within the county including lack of transportation, inadequate or no insurance coverage, lack of culturally competent care, low English proficiency, and limited availability of appointments after work.

SocioNeeds Index

All communities can be described by various social and economic factors that are well known to be strong determinants of health outcomes. Healthy Communities Institute developed the SocioNeeds Index to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for six different social and economic determinants of health — income, poverty, unemployment, occupation, educational attainment, and linguistic barriers — that are associated with poor health outcomes including preventable hospitalizations and premature death. Within Ventura County, zip codes are ranked based on their index value to identify the relative levels of need. Those geographic areas with the highest values (from 0-100) are estimated to have the highest socioeconomic need which can be correlated with preventable hospitalizations and premature death (Healthy Communities Institute, 2019).

Figure 1 shows that Oxnard (93030, 93033 and 93036), Santa Paula (93060), Fillmore (93015), and Port Hueneme (93041) are the areas within the county that have the highest socioeconomic needs. In general, the areas of the county with higher socioeconomic needs have a lower average life expectancy than the average of 82.0 years for Ventura County residents. Conversely, those areas with lower socioeconomic needs such as Oak Park (93777) and Thousand Oaks/Westlake (91361 and 91362) both have life expectancies of 85+ years.

Figure 1: SocioNeeds Index, Ventura County, 2019



Source: Health Matters in Ventura County

Community Assessment and Significant Needs

The participating VCCHNAC organizations and hospitals seek to engage in multiple activities to conduct their community health improvement planning process. In the next three years, the joint Community Health Implementation Strategy (CHIS) activities will include identifying potential partnering community based organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The priority health issues that form the basis of the joint CHIS were identified in the most recent CHNA report, which was adopted in June, 2019.

The joint 2019 CHNA provides an overview of significant health needs in the Ventura County Service Area. VCCHNAC partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the Ventura County Service Area and to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 240 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data is the Health Matters in Ventura County platform, a public data platform made available by Ventura County Public Health. That platform can be found here: http://www.healthmattersinvc.org/.

The CHNA contains several key elements, including:

- Description of the assessed community served by the Collaborative;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at http://www.healthmattersinvc.org/content/sites/ventura/chnas/Ventura_CHNA_2019.pdf or upon request at each hospital's community benefit office.

Significant Health Needs

On April 23, 2019, 25 stakeholders of the VCCHNAC convened in an all-day exercise to review the findings from the primary data and the secondary data collection efforts to prioritize the significant health issues that arose through this analysis. Through this exercise, five priority health areas were defined for subsequent implementation planning by the VCCHNAC. These five health priorities are:

- ✓ Improve **Access to Health Services**
- ✓ Reduce the Impact of **Behavioral Health Issues**
- ✓ Improve **Health and Wellness for Older Adults**
- ✓ Reduce the Burden of **Chronic Disease**
- ✓ Address **Social Needs**

Significant Needs the Hospital Does Not Intend to Address

Of the five identified priorities, the organizations participating in this joint Community Health Implementation Strategy have chosen not to address two of the prioritized health needs identified by VCCHNAC.

Prioritized Health Needs – NOT Planning to Address
• Reduce the Impact of **Behavioral Health Issues** • Reduce the Burden of **Chronic Disease**

These prioritized health needs were not selected because VCCHNAC has identified other community stakeholders that are currently leading interventions to address these health needs in the county. Further, the prioritized strategies that have been chosen are upstream strategies that target root causes of the poor health outcomes that affect vulnerable populations in the county such as food insecurity. These strategies need to be implemented county-wide through collaborative and collateral action and require all the partners to engage in extensive sharing of technology and data in a HIPAA compliant manner. Given the wide scope of the selected strategies, the VCCHNAC partnership will need to focus its resources and expertise on the selected priorities to demonstrate impact. That focus will require concerted efforts and time and leave VCCHNAC with no resources to take on the remaining priorities in this iteration of the joint CHIS.

However, VCCHNAC is committed to serving the community by adhering to VCCHNAC's stated mission as well as the missions of the participating organizations and hospitals. The VCCHNAC partners will use their combined skills, expertise and resources to provide a range of community benefit programs aligned to the chosen prioritized health needs. VCCHNAC will provide support to stakeholders in the county already working on the priorities not selected and find appropriate opportunities to share resources and collaborate when required.

St. John's Hospitals currently offer programs that address Chronic Diseases. St. John's plans to continue to offer those programs, and if possible expand them.

2019-2022 Implementation Strategy

This section presents strategies and program activities VCCHNAC intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration.

The participating hospitals each provide additional support for community benefit activities in their service area that lay outside the scope of the programs and activities outlined in this joint CHIS. However, those additional activities will not be explored in detail in this CHIS. Further, the hospitals may amend the outlined plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospitals' limited resources to best serve the community.

Creating the Implementation Strategy

VCCHNAC is dedicated to improving community health and delivering community benefit with the engagement of its participating hospitals' management team, board, clinicians and staff, and in collaboration with community partners.

Conduent HCI Consulting Services were engaged to facilitate the Implementation Planning Process. They created and fielded surveys to elicit the readiness and capacity of participating organizations to take on specific components of the proposed strategies. Additionally, Conduent HCI reviewed the literature for evidence-based interventions, best practices and success stories for those most applicable for community benefit. In September 2019, Conduent HCI facilitated the Implementation Strategy process with VCCHNAC partners in Camarillo, Ventura County through an onsite planning workshop.

Table 1: Participants at the Implementation Strategy Planning Workshop

Name	Organization
Allison Nackel	Ventura County Health Care Agency
Blair Craddock	Camarillo Health Care District
Bonnie Subira	Community Memorial Health System
Christina Navarro	Vista Del Mar
Diana Jaquez	Community Memorial Health System
Ed Pulido	Community Memorial Health System
Erik Cho	Ventura County Health Care Agency
Erin Slack	Ventura County Public Health
George West	Dignity Health System
Lydia Kreil	St. John's Hospitals, Dignity health
Jennifer Claros	Gold Coast Health Plan
Jennifer Tougas	Community Memorial Health System
John Cortes	Community Memorial Health System
Karen Ochoa	Communities Lifting Communities
Kathryn Stiles	Simi Valley Hospital (Adventist)
Kathy Neel	Gold Coast Health Plan
Kristine Supple	Community Memorial Health System
Laura Cabrera	Child Development Resources
Lucy Marrero	Ventura County Health Care Agency
Lynette Harvey	Camarillo Health Care District
Maya Lazos	Vista Del Mar

Nancy Espinoza	Clinicas Del Camino Real
Nancy Wharfield	Gold Coast Health Plan
Nilesh Hingarh	Gold Coast Health Plan
Pauline Preciado	Gold Coast Health Plan
Phylene Wiggins	Ventura County Community Foundation
Rachel Cox	Clinicas Del Camino Real
Rachel Lambert	Gold Coast Health Plan
Selfa Saucedo	Ventura County Public Health
Sue Tatangelo	Camarillo Health Care District
Susan Harrington	Communities Lifting Communities
Tony Alatorre	Clinicas Del Camino Real
Will Garand	Community Memorial Health System

Strategy by Health Need

The tables below present strategies and program activities VCCHNAC and the participating hospitals intend to deliver to help address prioritized health needs identified in the CHNA report. These are organized by health need and include: 1) actions VCCHNA partners intend to take to address the prioritized health needs identified in the CHNA, 2) the resources VCCHNA partners plan to commit to each strategy, 3) statements of the strategies' anticipated impact in the goal statement and as reflected in the short-term and intermediate outcomes measures for each activity and/or strategy, and 4) any planned collaboration with other organizations in the county. These strategy maps will serve as a menu of metrics that will be reported based upon the organizations participating.

Prioritized Health Need: Improve Access to Health Services							
Goal: To improve access to health services by addressing social needs of high risk/high need clients to reduce preventable emergency room and hospital utilization.							
Objective: From 2019 to 2022, VCCHNAC will build a Countywide Community Resource and Referral Network/Platform which can be adopted by participating hospitals and other community based organizations to increase intra- and inter-agency referrals and tracking of high risk/high need clients.							
Resources	**Key Activities**	**Process Measures – Year 1**	**Source of Data**	**Short Term Outcome Measures – Year 2**	**Source of Data**	**Intermediate Outcome Measures – Year 3**	**Source of Data**
Asset Mapping Tools and Exempt Organizations Database	**1.1** Identify non-traditional partners through asset mapping exercise	# partners; # populations covered; # census tracts covered	Database of organizations	Interested and committed partners	Asset Mapping Questionnaire	Network of strategic and diverse partners with aligned goals	Coalition membership assessment
VCCHNAC Providers and Health Plans, FQHCs, Health Care Agency	**1.2** Identification of appropriate SDoH Tool	# PDSA cycles; time and duration of screening; assessment of line-staff and patient satisfaction/uptake	Screening protocols; clinic/Provider workflows	County-wide adoption of single screening tool	Partner reports/ protocols	Reduced client barriers to health; increased linkages to social need agencies and services	Hospital/ clinic rescreening data of high need/high risk clients
SDoH screening tool	**1.3** Screening high risk/high need clients	# and % clients screened; # clients referred to social and community based	Follow-up and referral tracking data	Increased appropriate referrals	Uptake and adherence data from CBO	Improved health outcomes; stabilized clients	Hospital data of clients' clinical outcomes and healthcare utilization

		organizations (CBO)					
Partner Workflows Workflow Mapping and Social Network Analysis Tools	**1.4** Workflow modification at Provider Practice and CBO to receive and make referrals	# workflow and service maps between Providers and CBOs	Follow-up and referral tracking data	CBO network of organizations providing social or related services to same population	Social Network Analysis	Closed loop referrals	Hospital/ clinic rescreening data of high need/high risk clients
Train the trainer Modules	**1.5** Staff training on screening and services	# core implementation team trainings/activities	Core implementation guide	Increased Provider staff knowledge of CBO services	EHR workflows and referrals	Increased referrals for social needs and care coordination	Hospital/ clinic rescreening data of high need/high risk clients
2-1-1; Facilitated Community Resource and Referral Platform funding	**1.6** Meet with existing contractor 2-1-1; Referral network selection and development/ installation	# Meetings with platform technology firms; internal meetings and decision points	Meeting notes	Deployment of curated community resource directory and facilitated referral network	Partner reports/ protocols	Increased # of clients with needs met; shared services; better allocation of existing resources	Return of investment/ cost savings data and improved population health outcome indicators

Planned Collaboration: VCCHNAC member organizations, as well as those organizations that participated in the implementation planning exercise, will commit staff time and resources to support these activities to create a centralized, close-looped referral platform for addressing social needs. A Social Needs Network Committee will be established to develop work plans for each of the activities outlined above. This committee will also continue to follow the **Kaiser/Unite Us collaboration for creating a New Social Health Network** to identify opportunities to collaborate with Kaiser on the Ventura County implementation.

Hospitals' Role and Responsibilities: St. John's will continue to expand its resources and leverage relationships with organization and providers to improve access to care. Current examples include St. John's Regional Medical Center current Emergency Department expansion and the expansion of its Labor-Delivery, Mother Infant and neonatal Intensive Care Units.

Prioritized Health Need: Address Social Needs through a Food Access Intervention							
Goal: To address food insecurity and reduce hospitalizations and health care costs in medically-complex populations by increasing access to adequate nutrition.							
Objective: From 2019 to 2022, VCCHNAC will reduce food insecurity by 2% from baseline (7.6% to 7.4% for county and 15.4% to 15.1% of children in 2017) by screening for food insecurity at provider practices and hospitals to connect high need/high risk clients to federal/state/local food access programs and food resources for their unmet needs.							
Resources	**Key Activities**	**Process Measures – Year 1**	**Source of Data**	**Short Term Outcome Measures – Year 2**	**Source of Data**	**Intermediate Outcome Measures – Year 3**	**Source of Data**
Hunger Vital Signs screening tool	**1.1** Uniform screening of clients at all Provider Practices/ hospitals	# food insecure clients identified; # referrals to food access CBOs; % utilization of referrals (uptake)	EHR data	Reduced stigma; Increased connections to food access resources	Partner records/ reports; clinic rescreening data	Reduced readmission and healthcare utilization	Patient healthcare utilization data
Business Agreement Template	**1.2** Develop Business Agreements with food access organizations	# identified partners; # Partner Business Agreements; # patient authorizations to share PII	Internal documentation /reports; curated database of organizations	Patient data sharing with HIPAA compliance	Closed loop referral data	Value Based Payment Billing & Contracting	Managed Care and Provider System Contracts
HIPAA Guidance (Food Banks as Partners in Health	**1.3** Refer clients with vouchers and/or food	# vouchers; # prescriptions	EHR data	Reduced financial trade-offs through	Partner reports;	Increased patient	Patient re-screening data

Promotion); 2-1-1 directory; curated resource directory of food access organizations with agreements	prescriptions to food access organizations			increased utilization of food access facilities	closed loop referral data	financial stability	
Nutrition counselor or dietician; Chronic Disease Self-Management and other such classes	**1.4** Refer to dietary and nutrition counseling and provide preventive health screenings	# classes; # and % clients that completed course; # completed immunizations and preventive screenings; cost of course per client	Internal provider documents; EHR and reimbursement data	Improved knowledge and skills on dietary management; improved diet	Pre-Post tests	Improved pre-diabetes and other clinical outcomes	Cost savings per client on readmissions and healthcare utilization
Clinical Care Plan Template	**1.5** Develop tailored care plan based on food security status and financial stability; connect to medically tailored meals	# tailored care plans; # medical tailored meals provided	EHR and reimbursement data	Improved diet; lowered pre-diabetes metrics	Patient clinical data	Chronic care management ; lowered risk of co-morbidities	County prevalence of pre-diabetes and diabetes
DHHS Eligibility/ Screening Forms	**1.6** Connect to federal and state food assistance programs (SNAP, WIC, TANF, SFSP, TEFAP, Congregate Meal Program, National School Lunch Program etc.). based on availability	# administrative linkages with public programs; # clients eligible; # eligible clients referred: # clients receiving aid	Case Manager/ social worker follow – up reports; rescreening data	Increased food assistance; case management	Case Manager/ social worker follow – up reports; rescreening data	Stabilized clients	State and county level indicators; case manager reports

Planned Collaboration: VCCHNAC member organizations, as well as those organizations that participated in the implementation planning exercise, will commit staff time and resources to support these activities to reduce food insecurity among clients in the clinical environment. This is a continuation of a Communities Lifting Communities (CLC) initiative that provided VCCHNAC with technical assistance to implement food insecurity screening with a focus on the pre-diabetic population. CLC is a community health improvement initiative sponsored by the Hospital Association of California. CLC will continue to partner with VCCHNAC to identify funding opportunities to further this work. A Food Insecurity CLC Committee will be established to develop work plans for each of the activities outlined above. VCCHNAC member collaboration will also extend into the Waste-Free Ventura coalition which works to eliminate food waste, while improving nutrition in food insecure communities.

Hospitals' Role and Responsibility: VCCHNAC member St. Johns will continue its Health Ministry Programs that address the social determinants of health, including its Community Food Pantry and its Basic Needs Program that assist vulnerable populations with food, medication, transportation, clothing, utilities and emergency shelter.

Prioritized Health Need:
Improve the Health and Wellbeing of Older Adults

Goal:
To implement a multiple hospital-based intervention with the assistance of CBOs that will establish a continuum of care and reduce readmissions for high-risk Medicare beneficiaries.

Objective:
From 2019-2022, VCCHNAC will implement a Community Based Care Transition Program per Section 3026 of the Affordable Care Act to support medically fragile 65+ year adults and their caregivers after an acute care hospitalization to reduce hospital re-admissions and improve the provision of value-based services.

Resources	Key Activities	Process Measures – Y1	Source of Data	Short Term Outcome Measures – Y2	Source of Data	Intermediate Outcome Measures –Y3	Source of Data
Caregiver Patient Navigator (CGPN) •Powerful Tools for Caregivers class	**1.1** Caregiver Assessments and Care Planning	•# caregivers who had initial visit with patient navigator •# caregivers with completed care plan	Caregiver Patient Navigator Program Database	•Increased confidence, skills, coping for CG •Ability to provide higher quality care to care recipient	Zarit Burden scale and other tools	Caregiver and Care Recipient: • Supported and able to manage complex medical care at home • Improved health/well-being/quality of life	Healthcare utilization records or other surveys

•Care Plan Templates •Assessment Tools •Program records •Funding •Family Caregiver Resource Centers (FCRC)	**1.2** Community Partner Identification	•# referrals made to the caregiver navigator program (FQHC) •# referrals made by CGPN to community resources	Caregiver Patient Navigator Program Database	• Develop feedback mechanism for completed referrals • Develop a referral process to FCRC once caregiver completes program	Caregiver Patient Navigator Program Database		
	1.3 Education for Caregivers	•# CG attendance at Powerful Tools for Caregivers class	Caregiver Patient Navigator Program Database	•# CG attendance at Powerful Tools for Caregivers class	Caregiver Patient Navigator Program Database		
	1.4 Integration into Health Systems	•# Healthcare providers educated on the CGPN program	Caregiver Patient Navigator Program Database	• Increase # referrals made to the caregiver navigator program	Caregiver Patient Navigator Program Database		

Planned Collaboration: VCCHNAC member organizations, as well as those organizations that participated in the implementation planning exercise, will commit staff time and resources to support these activities to implement a caregiver navigation program at area hospitals. Funding from the Ventura County Community Foundation (VCCF) will be provided to area hospitals who have submitted a successful proposal to support year 1 implementation; opportunities for additional funding may be available in the future. VCCHNAC will also work with a VCCF supported consultant, Evaluation Specialists, for the evaluation component of this strategy. A Caregiver Navigation Committee will be established to develop work plans for each of the activities outlined above. The County of Ventura will be developing a Ventura County Master Plan on Aging by early 2020; VCCHNAC members will participate in its development and align implementation efforts if appropriate.

Hospitals' Roles and Responsibilities: In addition to its Senior Wellness program, St. John's is seeking to create a grant funded Caregiver Navigator Program (as described above).

Organizational Priority:
Aligning cross-sectoral partnerships for population health impact

Goal:
To develop a sustainable Collaborative Structure of hospital and community partnerships for long term implementation of chosen community health and population health strategies.

Objective:
From 2019 to 2022, VCCHNAC will evolve into a backbone organization with equal partnership from hospitals, local health department and community based organizations (CBOs) which supports cross-sectoral operations and aligned funding streams.

Strategy 1: Build Governance Structure

Resources	Key Activities	Process Measures – Year 1	Source of Data	Short Term Outcome Measures – Year 2	Source of Data	Intermediate Outcome Measures – Year 3	Source of Data
Templates for Data Sharing Agreements, Contracts, Memorandum of Understanding Wilder Collaboration Factors Inventory and other Assessments; Social Network Analysis Tools	**1.1** Develop common priorities and objectives	Written Mission, Vision and Goals Statement	Charter	Buy-in from partners and their leadership	Memoranda of Understanding (MOU)/ Agreements	County wide planning and oversight	County Action Plans
	1.2 Coordinate overarching goals and efforts	Written shared goals; # Committees; # Committee actions	Implementation Plan; Committee Meeting Notes	Cross-sectoral collaboration and activities	Collaboration Meeting Notes	Increased alignment and efficiency	Coalition membership assessments
	1.3 Define stakeholders; roles and responsibilities	# active/ contributing partners; # paid positions/assigned roles to manage interventions	Roster of partners; Organization Chart	Succession Plan; dedicated time and leadership	MOU/ Agreements and update to hospital community health board charters	Increased partner participation, working relationships and satisfaction	Coalition membership assessments; Social Network Analysis

Collaboration Building Toolkit	**1.4** Formalize project scope and structure	Statement of work; Laws and by-laws	Charter	Integrated operations and structure	Charter	Inclusive and sustainable partnership	Coalition membership assessments
Strategy 2: Cross Sector Prevention Model							
Resources	**Key Activities**	**Process Measures – Year 1**	**Source of Data**	**Short Term Outcome Measures – Year 2**	**Source of Data**	**Intermediate Outcome Measures – Year 3**	**Source of Data**
Mobilizing for Action through Planning and Partnerships (MAPP) Assessments, IRS Form 990 Guidance	**2.1** Combined Community Health Assessments	County CHA/CHNA; Implementation Plan/ Community Health Improvement Plan	County Reports	Root causes/ primary drivers of adverse outcomes; evidence based interventions and best practices	Priority specific Action Plans for cross sector collaboration	County wide community engagement and collective impact	Federal/State surveillance data
Strategy 3: Develop Financing Plan							
Resources	**Key Activities**	**Process Measures – Year 1**	**Source of Data**	**Short Term Outcome Measures – Year 2**	**Source of Data**	**Intermediate Outcome Measures – Year 3**	**Source of Data**
Federal and State Legislation for Population Health Funding; Population Health Contracts; CBISA guidance and/or funds; partner funding	**3.1** Identify initial capital and innovative long-term funding streams	# and types of funding sources; funding amount; partner contributions; # fund raising activities/meetings; # funded cross-sectoral activities	Joint grants, proposals, Ventura County Foundation report	Secured demonstration phase funding	Community benefit and other reports	Long-term sustained financing	Community benefit reports, state and federal grants, managed care and healthcare system contracts

Strategy 4: Explore Data Sharing Strategy							
Resources	**Key Activities**	**Process Measures – Year 1**	**Source of Data**	**Short Term Outcome Measures – Year 2**	**Source of Data**	**Intermediate Outcome Measures – Year 3**	**Source of Data**
Data Sharing Readiness Assessment Tool; Clinic/Provider Workflows	**4.1** Consider data availability and explore methods of health information exchange	Types of patient data collected by each partner; types and functionality of HIE of each data sharing agency	Data Sharing Readiness Assessment Tool; Report on current initiatives already in progress	Aligned technology platform	EHR Workflows	HIPAA compliant patient data sharing or interoperability; coordinated care among VCCHNAC partners	Data-Sharing Agreements
Strategy 5: Develop Performance Management and Evaluation							
Resources	**Key Activities**	**Process Measures – Year 1**	**Source of Data**	**Short Term Outcome Measures – Year 2**	**Source of Data**	**Intermediate Outcome Measures – Year 3**	**Source of Data**
Coalition membership assessments	**5.1** Create performance feedback loops	Plan-Do-Study-Act (PDSA) cycles (through periodic assessments)	Documentation of PDSA activities	Increased and outcome focused alignment with partner operations	VCCHNAC records	Transparency and accountability	Coalition membership assessments

Planned Collaboration: VCCHNAC member organizations, as well as those organizations that participated in the implementation planning exercise, will commit staff time and resources to support these five strategies to create a sustainable governance structure. A Governance Committee will be established to develop work plans for each of the strategies outlined above. Many of the strategies and activities require participation from Information Technology (IT) staff from each of the organizations; member organizations will begin to engage their IT staff. This committee will also engage more community stakeholders - including media, business, academic, health plans, legal, advocacy, faith and social organizations - who might be able to participate in VCCHNAC's growing mandate to improve population health outcomes. Gold Coast Health Plan and Vista Del Mar, while not current signatories to the charter, have expressed interest becoming signatories with the next update of the charter to be completed by December 2019.

Hospital Community Board and Committee Rosters

Name	Committee(s)
Sr. Amy Bayley, RSM Sister of Mercy	
Dr. Chirag Dalsania Hematologist	Strategic Planning Committee
Dr. Jeffery Davies, *Chief of Medical Staff* Emergency Medicine Physician	
Kristin Decas Port of Port Hueneme	Healthy Communities Committee
Dr. Gary Deutsch Identitity Medical Group	Strategic Planning Committee
Dr. Neal Dixon Surgeon	Strategic Planning Committee
Gloria Forgea Livingston Visiting Nurse Association	Quality Improvement Committee
Greg Glover, *Foundation Board Chair*	Quality Improvement Committee
Ted Grether Grether Farms	Strategic Planning Committee
Steve Huber, *Vice-Chair* S.H. Huber & Associates	Board Executive Committee Board Development Committee Healthy Communities Committee
Tom Laubacher, *Community Board Chair* Hub International	Board Executive Committee Board Development Committee
Darren Lee Hospital President & CEO	Board Executive Committee Board Development Committee Strategic Planning Committee Quality Improvement Committee
Travis Mack Saalex Corp.	Strategic Planning Committee
Sonia Robles Quest Staffing	Healthy Communities Committee
Billie Jo Rodriguez, *Board Secretary* Soares, Sandall, Bernacchi & Petrovich	Board Executive Committee Quality Improvement Committee
Tony Trembley Esq. Attorney	
Dr. George Yu Pulmonologist	Quality Improvement Committee
Jerry Zins LPL Investments	Board Development Committee

“Collaboration – Working together with people who support common values and vision to achieve shared goals”

Dignity Health Core Value