Message from President & CEO, Jennifer Swenson

I am pleased to present our Community Health Implementation Strategy for 2022-2025. Adventist Health Simi Valley (AHSV) works collaboratively in Ventura County to create a Community Health Needs Assessment (CHNA) every three years and subsequently, a Community Health Implementation Strategy (CHIS). Together, the CHNA and CHIS form a foundation on which we build programs, services and interventions targeted to meet the needs of the most vulnerable in our community. This aligns perfectly with our mission, Living God’s love by inspiring health, wholeness and hope.

AHSV is a chartered member of the Ventura County Community Health Improvement Collaboration (VCCHIC) which includes Camarillo Health Care District, Clinicas del Camino Real, Community Memorial Health System, Dignity Health St. John’s Camarillo & Regional Medical Center, Gold Coast Health Plan, Ventura County Health Care Agency and Ventura County Public Health. This collaboration broadens our vision of community health and helps us identify specific populations and needs. Working together, we will achieve significant outcomes by improving community well-being in the coming decade.

Included below are descriptions of a fully operational CHIS which combines the joint work of the collaborative and AHSVs independent initiatives. Our collaborative work, the CHNA and our CHIS, may be viewed online at www.healthmattersinvc.org. Printed copies are also available upon request. For Adventist Health Simi Valley, community health and well-being is our mission and we are proud of the the work we are doing to bring hope, healing and wholeness to the families we serve.

Sincerely,

Jennifer L. Swenson
President and CEO
Adventist Health Simi Valley

Adventist Health Simi Valley was founded in 1965 by a group of dedicated community members who had a vision to build a hospital in the towns of Santa Susana and Simi Valley. Today, all of us at Adventist Health Simi Valley share that same vision of progress and growth as well as a passion to provide excellent care and service.

As a faith-based hospital founded on the health and wellness principles of the Seventh-day Adventist Church, we are committed to providing Simi Valley, Moorpark and surrounding communities with the finest medical care. We believe that our Christian-based mission to treat the whole person—mind, body and spirit—makes the difference.

Today, Adventist Health Simi Valley offers a wide range of patient care services including:

- Cancer Navigation Program
- Care Transitions and Caregiver Support Program
- Center of Excellence in Robotic Surgery
- Childhood Development Center
- Emergency Department Care
- Level 2 NICU / Mother-Baby Care
- Moorpark Urgent Care Center and Specialty Clinic
- Nancy Reagan Breast Center
- Spine and Orthopedic
- STEMI Receiving Center
- Stroke Center of Excellence
- Substance Use Navigation Program (CA Bridge)
## 2022 CHNA
Top 15 Identified Health Needs

Prioritized Health needs – planning to address
- Mental Health
- Health Conditions
- Access to Care

What we are not directly addressing in the 2022-2025 CHIS:
Although we address aspects of the fifteen identified areas through our service lines and community outreach, we have chosen to apply targeted funding and efforts to our top three areas, identified above. The purpose of not targeting additional areas (Figure 2., page 8) are due to a combination of factors that include capacity, expertise and the way these concerns can be addressed by other agencies and organization.

### Community Health Implementation Strategy 2022-2025

In addition to the work identified in the Ventura County Community Health Improvement Collaborative (VCCHIC) contained in this report, Adventist Health Simi Valley is actively engaged in other projects which directly impact our community well-being that we implement, measure outcomes and report to the Mission Sub-Committee. These include: Community Presence through grants, events and sponsorships.

<table>
<thead>
<tr>
<th>Youth</th>
<th>Heart Health</th>
<th>Substance Abuse and Mental Health</th>
<th>Cancer</th>
<th>Community Presence Grants, Events and Sponsorships</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Athletic trainers and clinical oversight at five local high schools</td>
<td>3. Heart Disease Prevention</td>
<td>3. Community outreach and education events</td>
<td>3. Education and Prevention Classes</td>
<td></td>
</tr>
<tr>
<td>4. Create education and support network for students and families to navigate issues</td>
<td>4. 2-Step Hands Only CPR Education and Training</td>
<td>4. Distribution of Narcan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Opportunity to incorporate social work support</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>6. Healthy Kids Fun Zones at community events</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Every 15 Minutes and Not One More education events; hosting, funding, facilitating</td>
<td></td>
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</tr>
<tr>
<td>8. Foster Youth – Aging out of the foster system puts teens at higher risk of being trafficked, using drugs and alcohol, criminal behavior, homelessness and suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Human trafficking awareness, events and prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Aging Adults
1. Caregiver support program and care navigation
2. Senior Center collaborations
   a. Expand financial planning and counselling resources
   b. Senior Wellness Expo
   c. Fall Prevention
3. Senior Concerns collaborations
   a. Caregiver support events and groups
4. Parks and Recreation collaborations
   for senior health and well-being

### Community Presence
Grants, Events and Sponsorships
- 20+ events each year
VENTURA COUNTY COMMUNITY HEALTH IMPLEMENTATION STRATEGY 2022
<table>
<thead>
<tr>
<th>ADDRESSING MENTAL HEALTH AND SUBSTANCE USE ACROSS THE LIFESPAN</th>
<th>PREVENTION OF CHRONIC CONDITIONS BY PROMOTING HEALTHY LIFESTYLES</th>
<th>ADVANCING EQUITABLE ACCESS TO HEALTHCARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL:</strong> Increase access to mental health and substance use related services in Ventura County</td>
<td><strong>GOAL:</strong> Address some of the social determinants of health (SDOH) that contribute to chronic conditions and inhibit healthy lifestyles in Ventura County</td>
<td><strong>GOAL:</strong> Expand access to preventative care services to reduce the need for emergency visits in Ventura County</td>
</tr>
<tr>
<td><strong>STRATEGY:</strong> Expand reach of mental health and substance use prevention programs and measures</td>
<td><strong>STRATEGY:</strong> Promote and environment conducive to both physical exercise and increased access to healthy foods.</td>
<td><strong>STRATEGY:</strong> Develop and implement health equity conscious policies and programs to expand preventative care service availability and accessibility in Ventura County.</td>
</tr>
<tr>
<td><strong>OBJECTIVE:</strong> Improve mental health access through education, leveraging existing behavioral health resources, building organization-based networks and sharing lessons learned.</td>
<td><strong>OBJECTIVE:</strong> Identify policies and programs, evaluated through a health equity lens, that promote healthy behaviors and increase access to physical activities and healthy foods in Ventura County.</td>
<td><strong>OBJECTIVE:</strong> Implement policies and programs aimed at expanding and promoting access to culturally appropriate preventative care services among underserved populations in Ventura County.</td>
</tr>
</tbody>
</table>
INTRODUCTION

The Ventura County Community Health Improvement Collaborative (VCCHIC) is pleased to present its 2022 Community Health Implementation Strategy (CHIS). This plan follows the development of the VCCHIC 2022 Community Health Needs Assessment (CHNA). The CHNA report can be accessed on the Health Matters in Ventura County website at healthmattersinvc.org.

VCCHIC is a formal, charter-bound partnership of health agencies that came together in June 2018 to participate in the development of a joint CHNA exercise and report. VCCHIC continued to collaborate on the 2022 CHNA report. The agencies that constitute VCCHIC are:

- Adventist Health Simi Valley
- Camarillo Health Care District
- Clinicas Del Camino Real, Inc.
- Community Memorial Health System
- Gold Coast Health Plan
- St. John’s Regional Medical Center, Dignity Health System
- Ventura County Health Care Agency Community Health Center
- Ventura County Public Health

The mission of VCCHIC is to build partnerships to improve population health outcomes in Ventura County. These partnerships are necessary to accomplish the shared vision of working collaboratively to develop strategies based upon the identified health priorities from the community health needs assessment. This will result in a collective approach to addressing population health and benefit the communities in which we serve.
Community Health Implementation Strategy (CHIS) Purpose

The purpose of this CHIS report is to identify the goals, objectives and strategies that VCCHIC will use to address the three health priorities identified in the most recent CHNA: (1) Addressing Mental Health and Substance Use Across the Lifespan; (2) Prevention of Chronic Conditions by Promoting Healthy Lifestyles; and (3) Advancing Equitable Access to Healthcare.

The VCCHIC 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 report 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 VCCHIC partner hospitals (listed above) to the needs identified in the 2022 joint CHNA. The CHIS was approved by each board of directors and applies to tax years December 2022 through December 2025.
Developing Strategic Implementation Plans

VCCHIC’s action plans for 2022 include both policy and programmatic strategies that are designed to make a difference in the three priority areas. Recognizing that the social determinants of health (SDOH) have a major impact on people’s health, wellbeing, and quality of life, the implementation plan includes actionable items that address social and economic factors such as access in low-income areas.

The 2022 implementation plans for VCCHIC were thoughtfully developed to leverage current community resources, while also working collaboratively across multiple sectors to engage new community partners. A series of virtual meetings and workshops were conducted to identify the goals, objectives and strategies documented in this plan. An overarching, goal was developed for each health need, ensuring alignment and consistency across collaborative partner organizations. These plans will guide VCCHIC and member organization health improvement efforts from 2023 to 2025.

Prioritized Significant Health Needs

**Addressing Mental Health and Substance Use Across the Lifespan**
Goal: Increase access to mental health and substance use related services in Ventura County.

**Prevention of Chronic Diseases by Promoting Healthy Lifestyles**
Goal: Address some of the social determinants of health (SDOH) that contribute to chronic conditions and inhibit healthy lifestyles in Ventura County.

**Advancing Equitable Access to Healthcare**
Goal: Expand access to preventative care services to reduce the need for emergency visits in Ventura County.

Acknowledgments and Comments

VCCHIC commissioned Conduent Healthy Communities Institute (HCI) to support report development of the 2022 CHIS. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. This report was authored by Sharri Morley, MPH, Public Health Consultant at HCI. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/claims-and-administration/community-health-solutions/. Written comments on this report can be submitted at www.healthmattersinvvc.org.
**DESCRIPTION OF THE COMMUNITY SERVED**

**Community Definition and Description**

In this document, 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 health agencies that make up the VCCHIC have come together in defining their service area as the County of Ventura.

Located in Southern California, Ventura County has a land area of 1,843.1 square miles which encompasses 10 cities, 23 census-designated places, and 15 other unincorporated communities. According to 2022 Claritas Pop-Facts, Ventura County has a population of 842,465 and is the 13th largest county in terms of population. Figure 1 illustrates the population size in Ventura County by zip code. The most populated zip codes are 93033 (Oxnard), 93065 (Simi Valley), 93030 (Oxnard), and 93063 (Simi Valley) with population totals of 82,273; 74,289; 60,815; and 55,685 respectively. Additional details describing the community in Ventura County, including demographics and social and economic determinants of health, can be found in the CHNA report on the Health Matters in Ventura County website at https://www.healthmattersinvc.org/.

**FIGURE 1. POPULATION OF VENTURA COUNTY BY ZIP CODE**

*Data Source: Claritas*
FINDINGS FROM THE 2022 CHNA

VCCHIC conducted its 2022 Community Health Needs Assessment (CHNA) between January and June 2022. The purpose of the CHNA was to identify and prioritize the significant health needs of the community.

Methods for Identifying Community Needs
Secondary data used in the assessment consisted of community health indicators, while primary data consisted of focus group discussions and an online community survey. Findings from all these data sources were analyzed to identify the significant health needs for Ventura County.

Summary of Findings
Health needs were determined to be significant if they met the following criteria:

- Secondary data analysis: top 10 health needs as ranked by HCI’s Data Scoring Tool
- Survey analysis: identified by 25% or more of respondents as a priority issue
- Qualitative analysis: frequency topic was discussed within/across focus groups
- Life expectancy data: analysis of leading causes of death, leading causes of premature death and all-cause mortality

Through this criteria, fifteen needs emerged as significant. Figure 2 illustrates the final 15 significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all forms of data collected for the VCCHIC 2022 CHNA.

VCCHIC convened a group of community leaders to participate in a presentation of data on the 15 significant health needs. Following the presentation, participants engaged in a discussion and were asked to complete an online prioritization activity.
Process and Criteria

The online prioritization activity included two criteria for prioritization:
- Magnitude of the Issue
- Ability to Impact

Participants assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. Numerical scores for the two criteria were then combined and averaged to produce an aggregate score and ranking for each health topic.

Prioritization Results

After discussing the results of the prioritization process, the VCCHIC founding members agreed to include each of the 15 significant health needs as subtopics to three prioritized significant health needs. The three priority health needs are shown in Table 1.

Prioritized Significant Health Needs

The first prioritized significant health need, Addressing Mental Health and Substance Use Across the Lifespan included Adverse Childhood Experiences (encompassing Adolescent Health, Substance Use, Housing Overcrowding and Education) and Health and Wellness for Older Adults. The second prioritized significant health need, Prevention of Chronic Conditions by Promoting Healthy Lifestyles, includes chronic disease related sub-topics like Diabetes, Cancer, Weight Status, Physical Activity, Heart Disease and Stroke and Nutrition and Healthy Eating. The third and final prioritized significant health need is Advancing Equitable Access to Healthcare.

<table>
<thead>
<tr>
<th>TABLE 1. PRIORITIZED SIGNIFICANT HEALTH NEEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing Mental Health and Substance Use Across the Lifespan</td>
</tr>
<tr>
<td>Prevention of Chronic Conditions by Promoting Healthy Lifestyles</td>
</tr>
<tr>
<td>Advancing Equitable Access to Healthcare</td>
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</tbody>
</table>
This section presents strategies and program activities that VCCHIC intends to deliver, support, and/or collaborate on to address significant prioritized community health needs over the next three years, including resources for and anticipated impacts of these activities. Planned activities are consistent with current needs and VCCHIC mission and capabilities. VCCHIC may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Following the identification of the three priority health needs, VCCHIC founding members began subsequent work on implementation planning with the following goals:

- Plan aligns with VCCHIC strategy
- Plan includes measurable outcomes
- Plan outlines clear accountability and responsibility
- Plan is built into a framework designed to support monitoring, evaluation and reporting

**Overview**

Following these initial planning meetings, Conduent HCI hosted a series of virtual meetings and workshops as shown in Figure 3.

**FIGURE 3. CHIS WORKSHOP SERIES**

**Kickoff Meeting**

VCCHIC founding members were invited to participate in a CHIS kickoff meeting on July 5, 2022. A separate kick-off meeting was held on July 15 for all collaborative members. During each virtual meeting, participants reviewed the three health needs that emerged from the most recent CHNA and were introduced to the CHIS planning process (including logic models, process measures and outcome measures). During the founding members’ meeting, participants were also asked to provide feedback on a draft framework that was proposed for developing the new implementation plan and were informed about worksheets that they would be asked to complete prior to attending the upcoming workshop series.
Pre-Workshop Worksheets

Conduent HCI developed three **Pre-Workshop Worksheets** (one per health need) to prepare participants for group discussion in the upcoming workshops. Participants were asked to consider root causes for each of the priority health issues, complete a sample logic model, and identify existing programs or interventions that address the relevant priority health need. Each worksheet also included an appendix of resources, with links to national, state, and local goals and objectives, a list of evidence-based resources, and relevant indicators from the secondary data analysis. Each worksheet was emailed to participants several days prior to the respective workshop.

CHIS Workshops

Following the kickoff meeting, VCCHIC founding members were invited to two workshops on each significant prioritized health need. The first workshop was designed to discuss and define goals, strategies, objectives and associated activities to support the CHIS framework for the health topic. During the second workshop, participants refined activities and process measures within the context of the CHIS framework while identifying resources to lead the initiative and baseline measures for monitoring and evaluating activity progress over the next three years. Table 2 shows the timeline for each of the workshops.

### TABLE 2. VCCHIC FOUNDING MEMBERS WORKSHOPS

<table>
<thead>
<tr>
<th>Significant Prioritized Health Need</th>
<th>Session 1: Brainstorm and Discussion</th>
<th>Session 2: Refine and Finalize the Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing Mental Health and Substance Use Across the Lifespan</td>
<td>July 16, 2022</td>
<td>August 2, 2022</td>
</tr>
<tr>
<td>Prevention of Chronic Conditions by Promoting Healthy Lifestyles</td>
<td>August 23, 2022</td>
<td>August 30, 2022</td>
</tr>
<tr>
<td>Advancing Equitable Access to Healthcare</td>
<td>September 6, 2022</td>
<td>September 13, 2022</td>
</tr>
</tbody>
</table>

### Pre-Workshop Worksheets

**ALCOHOL, TOBACCO & DRUG USE**

Background: The purpose of this worksheet is to prepare for an upcoming workshop on March 26, 2022 (7:30 am-7:30 pm) where we will build a system-level implementation strategy for the priority area of Alcohol, Tobacco & Drug Use.

Based on your knowledge and experiences, please note your responses to the following questions:

1. Why do you think Alcohol Use, Tobacco Use and Drug Use are significant health needs in your community? Try to identify root causes for these issues.

2. Imagine this scenario: a local Kentucky community is implementing a school-based campaign to educate youth and raise awareness about the harmful effects of vaping. Help the local community health leaders understand the relationship among program inputs, activities and outcomes by completing the logic model in Appendix A.

3. Think of a program or intervention that addresses Alcohol Use, Tobacco Use and Drug Use in your community (this can be a hospital or community-led initiative). Complete the table in Appendix B by providing a response to the questions below:
   a. What is the name and/or goal of this program or intervention?
   b. What resources or inputs are available to support this program or intervention? (e.g., staff, material, funding, equipment, etc.)
   c. What activities take place within this program? (e.g., develop a curriculum, main educators, build a coalition, change program elements, develop implementation, evaluate the policy change, etc.)
   d. What are the process measures or outputs that the activities produce? (e.g., attendance, rate of training, number of participants, publications, etc.)
   e. What are the outcomes of this intervention? (Try to think of short, medium and long-term outcomes, e.g., increased knowledge, changes in behavior, changes in health outcomes, etc.)
Prior to the first workshop for each health topic, participants were encouraged to review relevant initiatives within their organizations as well as best practices outlined in the pre-workshop worksheet. Then, HCI facilitated a group brainstorming session using Jamboard, a collaborative digital whiteboard, to begin building various elements of a logic model to support a strategic framework for the health need. Results of the session are shown in Figure 4. The group discussion initially focused on root causes of the prioritized significant health need as a means of identifying framework goals. Once identified, participants moved to discuss the strategic approach VCCHIC might take to reaching the identified goal. Strategies were categorized as policy, programmatic or educational approaches to increase general knowledge or change attitudes and practices. The group also identified the population they intended to impact most. Finally, specific activities were outlined to facilitate the selected strategy.

After conducting the workshop, HCI utilized the information gathered during the group brainstorming activity to create an implementation framework that was shared with VCCHIC founding members for review and approval. The group developed a separate framework for each strategy.
**Action Plans**

The action plans presented on the following pages outline the individual strategies and activities VCCHIC will implement to address the three prioritized health needs. The following components are outlined in detail in the frameworks that follow: (1) actions VCCHIC intends to take to address the health needs identified in the CHNA, (2) the anticipated impact of these actions as reflected in the process and outcome measures, (3) the resources VCCHIC plans to commit to each strategy, and (4) any planned collaboration to support the work outlined.

**Contributors to Framework Development**

VCCHIC is the decision-making entity for the 2022 Community Health Needs Assessment and is chaired by the Epidemiologist at Ventura County Public Health. Primary representatives for the founding members of the collaborative include:

- Mohnisha Jit, MPH, Ventura County Public Health — *Epidemiologist*, Maternal, Child, and Adolescent Health Programs
- Aruni Ganewatte, MS, Ventura County Public Health — *Community Service Coordinator*
- George West, JD, St. John’s Regional Medical Center and St. John’s Pleasant Valley Hospital, Dignity Health System — *Service Area Vice President, Mission Integration*
- Kathryn Stiles, Adventist Health Simi Valley — *Director of Community Integration*
- Lizeth Barretto, Ventura County Health Care Agency Community Health Center — *Ambulatory Care Administrator*
- Lynette Harvey, Camarillo Health Care District — *Clinical Services Director*
- Erin Slack, MPH, Gold Coast Health Plan — *Senior Manager of Population Health*
- Rachel Cox, MPH, Clinicas Del Camino Real, Inc. — *Operations Manager*
- Will Garand, Community Memorial Health System — *Vice President, Planning & Managed Care*
- Jamie Rotnofsky, PhD, Ventura County Behavioral Health — *Senior Behavioral Health Manager*
Community Health Implementation Strategy 2022

**Objective:** Improve mental health access through education, leveraging existing behavioral health resources, building organization-based networks and sharing lessons learned.

**Intended Population:** Children and Older Adults (0-75) in Ventura County

**Resources:** Ventura County Community Health Improvement Collaborative (VCCHIC) founding member organizations

**Collaboration Partners:** Ventura County Behavioral Health

### Programs/Activities

<table>
<thead>
<tr>
<th>Programs/Activities</th>
<th>Lead Person / Organization</th>
<th>Process Measure Y1</th>
<th>Process Measure Y2</th>
<th>Process Measure Y3</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity 1: Expanding Substance Use Navigators (SUN) to all hospitals within Ventura County</td>
<td>VCCHIC Founding Members, Community Memorial Health System, Ventura County Public Health with the Ventura Department of Education as partner</td>
<td>• Leverage Continuing Medical Education (CME) program for providers to introduce substance use navigators and address stigma</td>
<td>Identify opportunities to leverage diversion from the emergency department to the sobering center or other substance use treatment centers within the county</td>
<td>Engage the Ventura County Sheriff’s Office and other associated organizations for jail diversion through sobering centers</td>
<td>California (CA) Bridge</td>
<td>Number of medical assisted therapy orders written in the emergency room prior to discharge</td>
</tr>
<tr>
<td>Activity 2: Leveraging lessons learned from Medi-Cal integrated behavioral health programs to expand access to behavioral health services</td>
<td>VCCHIC Founding Members, Gold Coast Health Plan</td>
<td>• Establish relationship and communication with commercial plans (via California Hospital Association, Hospital Association of Southern California, Veterans Affairs, etc.)</td>
<td>Leverage Medi-Cal Behavioral Health Integration and Student Behavioral Health Integration Program pilots as a starting point for expanding integrated programs to more Medi-Cal providers and in working with commercial plans to expand Behavioral Health and Substance Use resources in Ventura County through the school-linked Behavioral Health statewide fee schedule and provider network mandates</td>
<td>Identify funding opportunities via existing programs to maximize county resources</td>
<td>Gold Coast Health Plan</td>
<td>Data from BHIIP partners</td>
</tr>
<tr>
<td>Activity 3: Leverage the Community Information Exchange (CIE) as a resource for providers connecting patients in the primary care setting with existing and future community behavioral health support programs and services</td>
<td>VCCHIC CIE Governance Board Member Organizations</td>
<td>Assess and categorize available community resources</td>
<td>Collaborate with providers and community-based organizations to develop a common referral approach/mechanism and determine how best to communicate results and troubleshoot challenges regularly</td>
<td>Coordinate with providers and community-based organizations to develop and distribute materials to communicate and strengthen the connection between primary care providers and community-based behavioral health support programs including school-based programs</td>
<td>CIE</td>
<td>Collect at CIE launch</td>
</tr>
</tbody>
</table>

### Anticipated Outcomes

<table>
<thead>
<tr>
<th>Anticipated Outcomes</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term: Number of providers and community members educated to address mental health related stigma</td>
<td>VCHIC</td>
<td>Collect at program implementation</td>
</tr>
<tr>
<td>Medium-Term: Percentage of patients identified receiving mental health care through hospital or community-based services for depression, anxiety, suicide or substance use</td>
<td>Hospital records, CIE</td>
<td>Collect at program implementation</td>
</tr>
<tr>
<td>Long-Term: Reduced ER visits due to mental illness and/or substance use, by diverting those with mental health/substance use needs to mental health/substance use care specific centers</td>
<td>Department of Health Care Access and Information (HCAI)</td>
<td>Hospitalization Data (2021)</td>
</tr>
</tbody>
</table>
### Community Health Implementation Strategy 2022

#### Goal: Address some of the social determinants of health (SDOH) that contribute to chronic conditions and inhibit healthy lifestyles in Ventura County

**Strategy:** Promote an environment conducive to both physical exercise and increased access to healthy foods

**Objective:** Identify policies and programs, evaluated through a health equity lens, that promote healthy behaviors and increase access to physical activities and healthy foods in Ventura County.

**Intended Population:** All age, race and ethnic groups in Ventura County

**Resources:** Ventura County Community Health Improvement Collaborative (VCCHIC) partner organizations, state and county health departments, local businesses and non-profit organizations

**Collaboration Partners:** VCCHIC partner organizations

<table>
<thead>
<tr>
<th>Programs/Activities</th>
<th>Lead Person / Organization</th>
<th>Process Measure Y1</th>
<th>Process Measure Y2</th>
<th>Process Measure Y3</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity 1:</strong> Increase access to healthy foods by connecting community members to available resources</td>
<td>VCCHIC Founding Members with Ventura County Public Health and Gold Coast Health Plan as lead organizations</td>
<td>- Leverage existing data to identify produce providers and philanthropy partners in and around communities at highest risk for food insecurity • Locate a Farmer’s Market with free produce in the neighborhood</td>
<td>Provide on-site CalFRESH enrollment and healthy food education into the Farmer’s Market location</td>
<td>Leverage existing programs to increase produce consumption in the homeless population and older adults</td>
<td>Ventura County Public Health and Gold Coast Health Plan</td>
<td>Collect at activity implementation</td>
</tr>
<tr>
<td><strong>Activity 2:</strong> Promote physical activity as a key component of a healthy lifestyle</td>
<td>VCCHIC Founding Members with Camarillo Health Care District, Community Memorial Health System, Gold Coast Health Plan as lead organizations</td>
<td>Identify community-based programs and resources including green spaces, community centers and recreational clubs (walking, biking, running, sport, etc.) providing access to physical activities at low or no cost.</td>
<td>Identify and engage providers and other community partners to promote physical activity through physical activity prescriptions, family wellness workshops, recreational clubs and other community-based programs previously identified in Y1</td>
<td>Seek grant funding to improve access to recreational opportunities in areas with less access to open space including expanding walking paths, sports and club programs to include more age categories, etc.</td>
<td>VCCHIC Founding Member organizations</td>
<td>Collect at activity implementation</td>
</tr>
<tr>
<td><strong>Activity 3:</strong> Facilitate coordination of hospital and health system cancer prevention programs</td>
<td>VCCHIC Founding Members with Cancer Support Community with Dignity Health as lead organization</td>
<td>Brand VCCHIC health education materials for partner and community-based organizations to support cancer prevention activities</td>
<td>Expand screening and prevention initiatives by leveraging partner resources and VCCHIC education materials developed in Y1</td>
<td>Develop a strategic plan for all cancer programs in Ventura County</td>
<td>Dignity Health</td>
<td>Collect at activity implementation</td>
</tr>
<tr>
<td><strong>Activity 4:</strong> Coordinate referrals for strategic programs and promote events via the Community Information Exchange (CIE)</td>
<td>VCCHIC Founding Members with CIE Governance Board as lead organization</td>
<td>Assess and categorize available community resources</td>
<td>Onboard community resources identified in Y1 to the CIE</td>
<td>Utilize the referral data from the CIE to evaluate the needs and determine which programs VCCHIC wants to invest to increase availability of resources</td>
<td>CIE Governance Board</td>
<td>Collect at activity implementation</td>
</tr>
</tbody>
</table>

### Anticipated Outcomes

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Outcome</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term:</strong></td>
<td>Number of community-based programs (CalFRESH, recreational clubs and screening events) that invest in a community activity to promote physical activity, healthy eating and/or cancer screening</td>
<td>CIE, community partners</td>
<td>Collect at program implementation</td>
</tr>
<tr>
<td><strong>Medium-Term:</strong></td>
<td>Number of community members utilizing CalFRESH benefits at Farmer’s Markets. • Number of community members enrolled in physical activity programs • Planned cancer prevention coordination activities</td>
<td>Human Services Agency</td>
<td>Collect at program implementation</td>
</tr>
<tr>
<td><strong>Long-Term:</strong></td>
<td>Reduction in emergency room and hospital utilization from uncontrolled diabetes • Reduction in morbidity from all cancers • Reduction in mortality from all cancers</td>
<td>Department of Health Care Access and Information (HCAI)</td>
<td>Hospitalization Data (2021)</td>
</tr>
</tbody>
</table>
### Strategy: Develop and implement health equity conscious policies and programs to expand preventative care service availability and accessibility in Ventura County

**Objective:** Implement policies and programs aimed at expanding and promoting access to culturally appropriate preventative care services among underserved populations in Ventura County

**Intended Population:** Underserved populations including low-income, immigrant, migrant, refugee, LGBTQIA+, Latinx and Black/African American

**Resources:** Ventura County Community Health Improvement Collaborative (VCCHIC) partner organizations, American Hospital Association Institute for Diversity and Health Equity (AHA IFDHE)

**Collaboration Partners:** VCCHIC partner organizations

<table>
<thead>
<tr>
<th>Programs/Activities</th>
<th>Lead Person / Organization</th>
<th>Process Measure Y1</th>
<th>Process Measure Y2</th>
<th>Process Measure Y3</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity 1:</strong> Develop a collaborative Population Health Management (PHM) strategy as the framework for CalAIM implementation (high-level, data-driven, risk-stratified strategy for intended populations across the collaborative)</td>
<td>VCCHIC Founding Members with Gold Coast Health Plan as lead organization and First5 Ventura County and Westminster Clinic as partner organization</td>
<td>Develop a PHM strategy aimed at enhancing access to primary care and prenatal/postnatal care services</td>
<td>Restructure health plan financial model(s) and/or programs to incentivize both patients and providers toward expanded opportunities to access primary care and prenatal/postnatal visits and preventative screenings</td>
<td>Gold Coast Health Plan</td>
<td>Collect at program start</td>
<td></td>
</tr>
<tr>
<td><strong>Activity 2:</strong> Expand Sexual Orientation and Gender Identity (SOGI) knowledge and awareness in the community</td>
<td>VCCHIC Founding Members with Dignity Health as lead organization and Ventura County Diversity Equity and Inclusion (DEI) program as partner</td>
<td>Lead organization (Dignity Health) to facilitate Healthcare Equality Index (HEI) certification for other collaborative health systems</td>
<td>Support expansion of residency programs to include SOGI training</td>
<td>VCCCHIC Founding Member organizations</td>
<td>Collect at program start</td>
<td></td>
</tr>
<tr>
<td><strong>Activity 3:</strong> Assess the Diversity &amp; Inclusion in Leadership and Governance state of VCCHIC founding member organizations and action plan based on those findings</td>
<td>VCCHIC Founding Members with Communities Lifting Communities as partner</td>
<td>Select assessment tool and Conduct Assessments</td>
<td>Develop and implement individual organization action plans and VCCHIC action plan based on assessment findings</td>
<td>AHA IFDHE</td>
<td>Collect at program start</td>
<td></td>
</tr>
<tr>
<td><strong>Activity 4:</strong> Ensure Community Information Exchange (CIE) is integrated with Ventura County Health System electronic health records (EHR)</td>
<td>VCCHIC Founding Members with the CIE Governance Board as lead organization</td>
<td>Evaluate potential technology vendors for capability to connect with health systems’ EHR</td>
<td>Ensure ability of health systems to make social needs referrals to the CIE and close the loop from their EHR</td>
<td>CIE</td>
<td>Collect at baseline</td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Outcomes**

<table>
<thead>
<tr>
<th>Short-Term: Number of organizations that participate in SOGI and/or DEI assessments</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of organizations participating in the PHM strategy</td>
<td>American Hospital Association, Dignity Health, Gold Coast Health Plans and any state-level accreditation organization</td>
<td>Collect at program implementation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium-Term: Number of collaborative wellness and prevention programs that were developed because of the PHM strategy</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCCHIC Founders</td>
<td>Gold Coast Health Plan, VCCHIC health care partners, Department of Health Care Access and Information (HCAI)</td>
<td>Collect at program implementation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-Term: Increase primary care visits including screenings</th>
<th>Data Source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in infant, child, and adolescent well-child visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in childhood and adolescent vaccinations</td>
<td></td>
<td></td>
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<tr>
<td>Reduce emergency room visits</td>
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</table>

**Goal:** Expand access to preventative care services to reduce the need for emergency visits in Ventura County
CONCLUSION

This Community Health Implementation Strategy (CHIS) for Ventura County Community Health Improvement Collaborative (VCCHIC) meets the federal requirement for charitable hospital organizations to develop a three-year written plan describing how the hospital facility plans to address the significant health needs identified in the most recent Community Health Needs Assessment (CHNA) [IRS Section 501(r) (3)]. This CHIS also meets community health improvement plan requirements for Public Health Accreditation. VCCHIC partnered with Conduent Healthy Communities Institute to develop this 2022 CHIS.

A series of virtual meetings and workshops were conducted to identify the goals, objectives and strategies documented in this plan. The goals, objectives and strategies outlined in this report will guide VCCHIC in their collaborative efforts to address each of the three prioritized health needs. Periodic evaluation of process measures and outcome measures will be conducted to ensure that strategies are on track to be completed as described.

Please use this online form to send any comments or feedback about this report: Ventura County Public Health: Contact Us (healthmattersinvc.org). Feedback received will be incorporated into the next assessment and CHIS development process.
In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/West Board of Directors.

The final report was made widely available on May 31, 2023.

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