VENTURA COUNTY

PUBLIC HEALTH

A Department of Ventura County Health Care Agency

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May 2, 2019

COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATION

Lessons Learned from Ventura County

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Presentation Overview

- Ventura County Health Needs Assessment Collaborative Development
- Public Health Accreditation Board (PHAB) and Internal Revenue Service (IRS) Requirements for the CHNA
- Lessons learned from the first collaborative CHNA cycle
- Opportunities to collaborate on implementation strategies to improve population health
- Communities Lifting Communities Pilot Project county to focus on upstream diabetes prevention

Ventura County Health Needs Assessment Collaborative - Development

Adventist Health

CLINICAS del Camino Real, Incorporated

Dignity Health

Camarillo Health Care District

Community Memorial Health System
Where Excellence Begins with Caring

Ventura County Health Care Agency

Ventura County Public Health

IRS Requirements = PHAB Requirements

1. Definition of the community served	**Measure 1.1.2.1.b.** - Description of the demographics of the population
2. Description of the process and methods	**Measure 1.1.1.3** - Process used to identify health issues and assets
3. Description of how the Hospital solicited input from the broad interests of the community	**Measure 1.1.1.1 – 2. -** Participation of representatives from a variety of sectors of the local community
4. Identify significant health needs and prioritize their needs	**Measure 1.1.2.1.c. -** Description of the health issues and inequities
5. Description of the resources available to meet the needs	**Measure 1.1.2.1.e.** - Description of existing community resources.
6. Evaluation of impact of actions taken by hospital to address the health issues from previous CHA	**Measure 1.1.2.1.d. -** Description of the factors that contribute to specific populations' health challenges.

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Example: PHAB Requirements for CHA – 2. Description of the Process and Methods

- **Measure 1.1.1.3** - Process used to identify health issues and assets

VCPH Resources

- Association for Community Health Improvement CHA Toolkit
- Healthy People 2020
- National Public Health Performance Standards
- County Health Rankings

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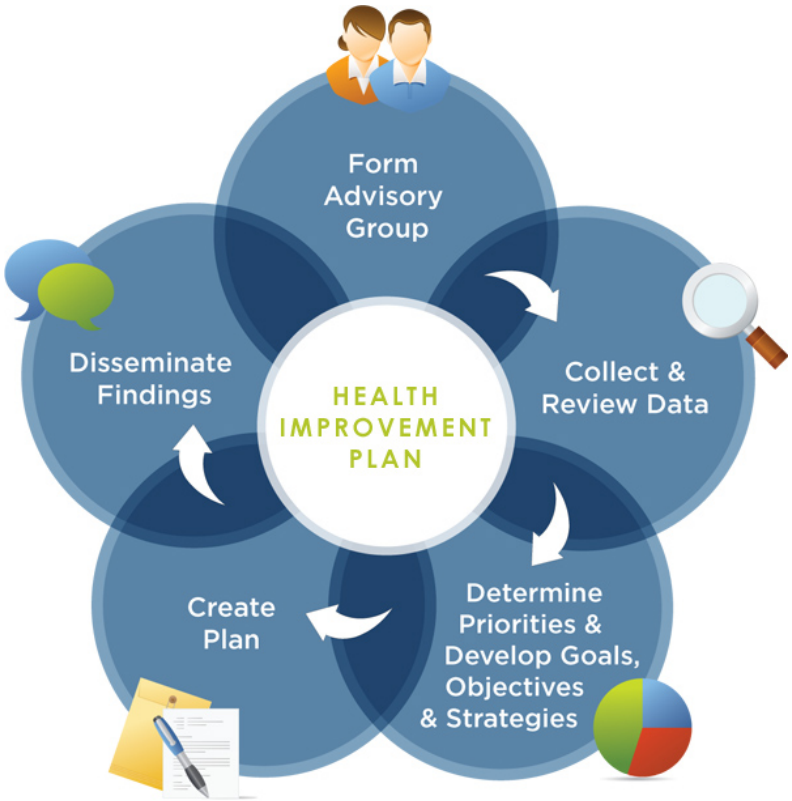
IRS Implementation Strategy = Community Health Improvement Plan



- Long-term, systematic effort to address public health problems
- Plan should:
  - Be used by health, human services, and other governmental agencies
  - Be made in collaboration with community partners
  - Set priorities
  - Coordinate and target resources

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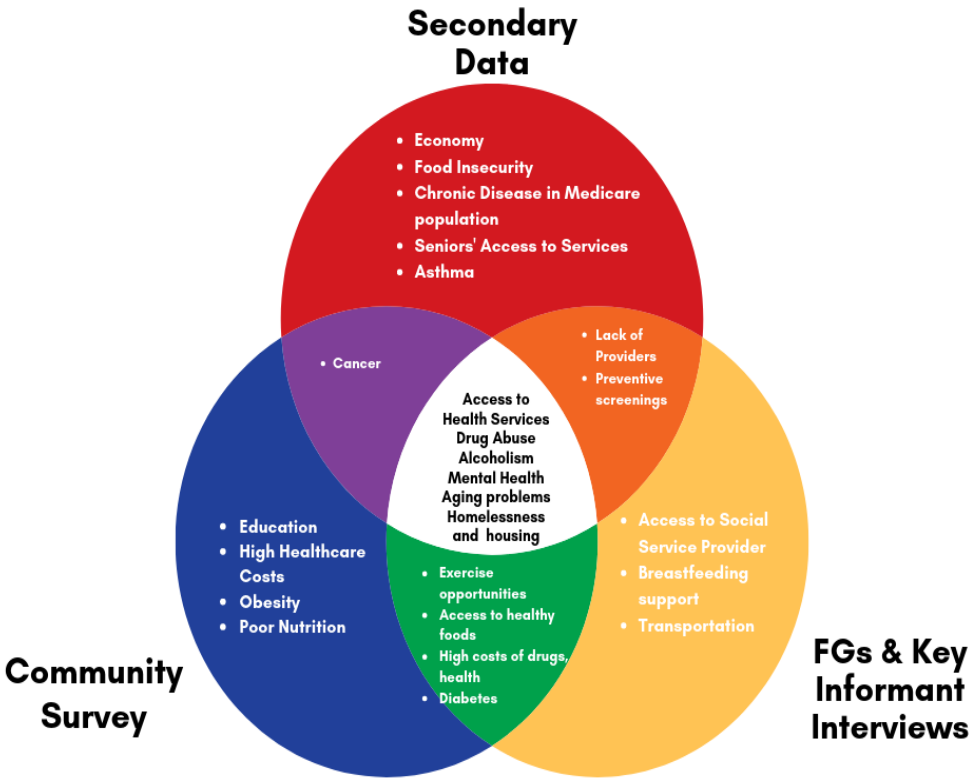
Lessons Learned from First Collaborative CHNA Cycle

- Health Department needs to take on a leadership role in the process because they have a wider net of partners
  - Enhanced relationship between VCPH and hospitals
- Development of charter was key to commitment to the process
- Continuously share information about the health assessment process – identifies partners
- Community benefit activities vary by hospital – no formal mechanism for assessing reach and overlap

Data Synthesis:
Exploring Significant Health Needs – Summary



Final Population Health Priorities:

- Access to Health Services
- Mental health
- Drug Abuse (including prescription drugs)
- Alcoholism
- Aging Problems

Final Vulnerable Population Health Priorities:

- Housing and homelessness
- Cancer
- Food Insecurity
- Poor nutrition
- Diabetes
- Asthma
- Lack of pre-natal care/breastfeeding support

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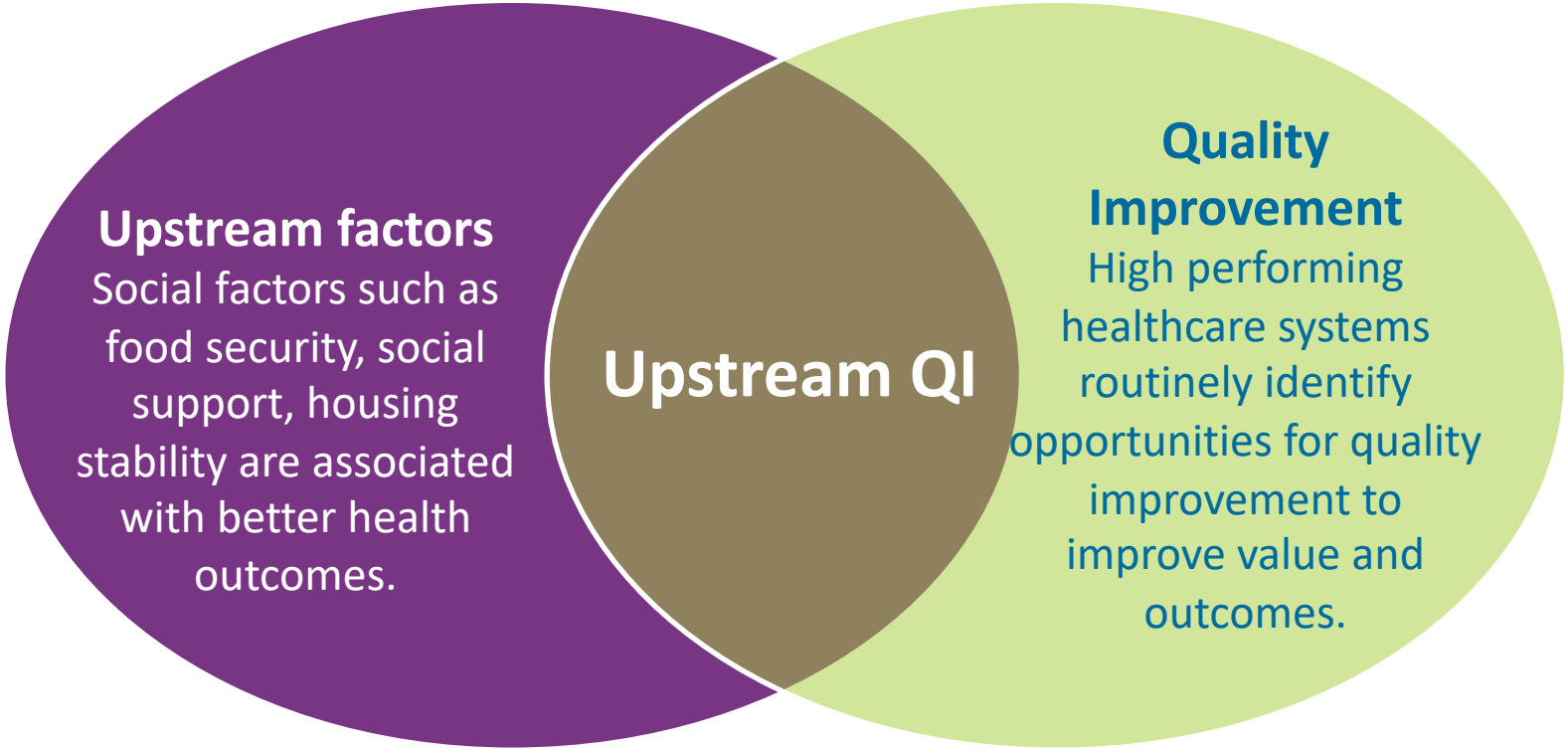
Opportunities to Collaborate on Implementation Strategies

- All day implementation strategy summit – 2 strategies will be developed as a collaborative
- Share the responsibility for addressing health priorities and attempt to eliminate overlap
- Opportunity to work with employers – especially those employers with populations experiencing disparities
- Develop policy action statements as a collaborative to advocate for policy, systems and environmental change based upon the priority areas

Communities Lifting Communities - Upstream Quality Improvement



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Academic Family Medicine Pilot

Selected Target Population:

Reproductive-age women between ages 18-49

Who are pre-diabetic/increased risk for diabetes (ADA 2011):

- Impaired fasting glucose >= 100mg/dL to 125mg/dL
- 2-hour post-load glucose on 75gm >= 140 to 199mg/dL
- HgbA1c 5.7 – 6.4%

Social Determinant of Health: Food Insecurity

Screening Process and Workflow

- **Within the past 12 months, we worried whether our food would run out before we got money to buy more. (Yes/No)**
- **Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. (Yes/No)**

Referral Sources: WIC, CalFresh, Health Care for All, Diabetes Prevention Program

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Questions??

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