



Adventist Health Simi Valley 2022 Community Health Plan



The following Implementation Strategy serves as the 2020 – 2022 Community Health Plan for Adventist Health Simi Valley and is respectfully submitted to the Office of Statewide Health Planning and Development on May 19th, 2023 reporting on 2022 results.

Executive Summary

Introduction & Purpose

Adventist Health Simi Valley is pleased to share our 2022 Annual Report on our 2019 CHNA and CHIS. This follows the development of its 2019 Community Health Needs Assessment (CHNA) in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements and approved by the Adventist Health Board of Directors on October 17, 2019.

Collaborative CHNA and CHIS 2019-2022

In 2019, AHSV became a chartered member of a collaboration in Ventura County, in order to create a robust CHNA. Chartered members include:

- Adventist Health Simi Valley
- Camarillo Health Care District
- Clinicas Del Camino Real, Inc.
- Community Memorial Hospital and Health System
- Gold Coast Health Plan (Medi-cal, CalAIM)
- 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 Ventura County Community Health Needs Assessment Collaboration (VCCHNA) produced a comprehensive CHNA in 2019. It references over 200 data sources and surveyed more than 5,000 Ventura County residents. The resulting CHNA is available here:

http://www.healthmattersinvc.org/content/sites/ventura/chnas/Ventura_CHNA_2019.pdf.

After completing the CHNA, the collaborative refreshed our charter, becoming the Ventura County Community Health Improvement Collaborative (VCCHIC). Together we published a joint CHIS which is published here:

http://www.healthmattersinvc.org/content/sites/ventura/Implementation_Strategies/PH_CHIS_Booklet_02-27-20_web.pdf

Although delayed by the unexpected challenges of 2020 and 2021, AHSV and our collaborative partners made significant strides on our goals. During 2020 and 2021 our resources were diverted to address the impacts of the global pandemic. However, VCCHIC remained focused and intact.

This Implementation Strategy summarizes plans for Adventist Health Simi Valley and where applicable, collaborative partners, to develop community benefit programs that address prioritized health needs identified in its 2019 CHNA.

VCCHIC Prioritized Health Needs – Planning to Address

- Health Priority #1: Aligning Cross-Sectoral Partnerships for Population Health Impact
- Health Priority #2: Improve Access to Health Services
- Health Priority #3: Address Social Needs through a Food Access Intervention
- Health Priority #4: Improve the Health and Wellbeing of Older Adults

Adventist Health Simi Valley – Planning to Address

- Population Health Impact
- Access to Health Services
- Social Needs Interventions
- Wellbeing of Older Adults
- Substance Use Disorder

About Adventist Health System

Adventist Health Simi Valley is an affiliate of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii.

Vision

Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

Mission Statement

Living God's love by inspiring health, wholeness and hope.

Adventist Health Includes:

- 23 hospitals with more than 3,393 beds
- 370 clinics (hospital-based, rural health and physician clinics)
- 14 home care agencies and eight hospice agencies
- 3 retirement centers & 1 continuing care retirement community
- A workforce of 37,000 including medical staff physicians, allied health professionals and support services

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths.

About Adventist Health Simi Valley

AHSV has 144 licensed acute inpatient beds, operates with a medical staff of 270 physicians, 1100 associates and 80 volunteers. Built in 1965 and led by dedicated community physicians, the hospital has grown with it's community over the past 58 years. The population of Simi Valley is 126,559 (July 1, 2021) but in 1965 it was closer to 30,000. To keep up with the growth, Adventist Health, AHSV and community donors have invested millions of dollars to expand the hospital. These expansions have resulted in more services and a variety of quality distinctions.

Ventura County Community Health Improvement Collaborative



VENTURA COUNTY COMMUNITY HEALTH IMPROVEMENT COLLABORATIVE

Implementation Strategy Design Process

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities that define the well-being of people.

The purpose of the CHNA was to offer a comprehensive understanding of the health needs in Ventura County at large and specifically in Adventist Health Simi Valley's service area. The findings guide our hospital's planning efforts to address those needs. The CHNA and CHIS are adopted at the executive level, leadership departments, community board, mission sub-committee and an internal multi-disciplinary committee. The goal of these activities is to place the CHNA and CHIS at the center of our strategic focus.

The significant health needs were identified through an analysis of secondary data and community input. These health needs were prioritized according to a set of criteria that included severity, change over time, resources available to address the need and community readiness to support action on behalf of any health need. Secondary sources include publicly available state and nationally recognized data sources available at the zip code, county and state level. Health indicators for social and economic factors, health system, public health and prevention, and physical environment are incorporated. The top leading causes of death as well as conditions of morbidity that illustrate the communicable and chronic disease burden across Los Angeles County is included.

Data for this assessment was collected through US Bureau of Census, Nielsen Claritas, California Disease Control and Prevention, California Department of Education, United States Department of Health and Human Services, California Office of Statewide Health Planning and Development, California Department of Public Health, County Health Rankings & Roadmaps, Los Angeles Homeless Service Authority, American Heart Association, National Cancer Institute, Centers for Disease Control, World Health Organization. When feasible, health metrics have been further compared to estimates for the state or national benchmarks, such as the Healthy People 2020 objectives.

Adventist Health Simi Valley worked, in collaboration, to identify relevant key informants and topical focus groups to gather more insightful data and aid in describing the community. Key informants and focus groups were purposefully chosen to represent medically under-served, low-income, or minority populations in our community, to better direct our investments and form partnerships. The criteria listed recognize the need for a combination of information types (e.g., health indicators and primary data) as well as consideration of issues such as practicality, feasibility, and mission alignment.

For further information about the process to identify and prioritize significant health needs, please refer to the Adventist Health Simi Valley CHNA report at the following link:

<https://www.adventisthealth.org/about-us/community-benefit/>

Adventist Health Simi Valley and the Ventura County Community Health Improvement Collaborative (VCCHIC)

<https://www.healthmattersinvc.org/>

Implementation Strategy – 2019-2022

The implementation strategy outlined below summarizes the strategies and activities by Adventist Health Simi Valley in collaboration with VCCHIC to directly address the prioritized health needs. They include:

- **Health Need : Aligning Cross-Sectoral Partnerships for Population Health Impact**
 - Governance Structure
 - Cross Sector Prevention Model
 - Develop Financing Plan
 - Explore Data Sharing
 - Develop Performance Management and Evaluation

- **Health Need : Improve Access to Health Services**
 - Asset Mapping
 - SDoH Screening Tool Selection
 - Screening High Risk/High Need Clients
 - Workflow Modification
 - Training on Screenings and Services
 - Facilitate Community Information Exchange and Referral Platform funding

- **Health Need : Address Social Needs through Food Access Intervention**
 - Select Uniform Screening Tool
 - Develop Business Agreements with Food Access Organizations
 - Referrals for Dietary and Nutritional Counseling
 - Preventative Health Screenings
 - Develop Tailored Care Plan
 - Connect to Federal and State Food Programs

- **Health Need : Improve the Health and Wellbeing of Older Adults**
 - Caregiver Assessments and Care Planning
 - Community Partner Identification
 - Education for Caregivers
 - Integration of Caregivers into Health Systems
 - Participate in the Master Plan on Aging

The Action Plan presented below outlines in detail the individual strategies and activities Adventist Health Simi Valley will implement to address the health needs identified through the CHNA process. The following components are outlined in detail in the tables below: 1) actions the hospital 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 Outcomes measures for each activity, 3) the resources the hospital plans to commit to each strategy, and 4) any planned collaboration to support the work outlined.

No hospital can address all the health needs identified in its community. Adventist Health Simi Valley is committed to serving the community by adhering to its mission, and using its skills, expertise and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific plan to address the following significant health needs identified in the 2019 CHNA.

Significant Health Needs – VCCHIC NOT Planning to Address

- Reduce the Impact of Behavioral Health Issues
- Reduce the Burden of Chronic Disease

These prioritized health needs per the findings of our 2019 CHNA were not selected to be addressed by the collaborative because the VCCHIC has identified other community stakeholders who actively leading programs to address these needs, including but not limited to Ventura County Behavioral Health. The VCCHIC is committed to working on building infrastructure that will help us formalize our ability to fundraise and expand the impact of working collectively. The VCCHIC is committed to building upstream programs that are known to prevent at-risk populations from succumbing to behavioral health conditions and drivers of chronic disease.

The VCCHIC is committed to serving our communities and the county at large through our mission statement and the mission statements of all participating members. The VCCHIC partners bring our strengths, resources and expertise to design interventions that will have long-term, measurable and beneficial results. The VCCHIC is also committed to providing support and connectivity to other community partners not included in the charter but identified as experts in their areas of operation.

COVID 19 Considerations

The COVID-19 global pandemic has caused extraordinary challenges for Adventist Health hospitals and health care systems across the world including keeping front line workers safe, shortages of protective equipment, limited ICU bed space and developing testing protocols. They have also focused on helping patients and families deal with the isolation needed to stop the spread of the virus, and more recently vaccine roll out efforts.

Adventist Health, like other health care systems, had to pivot its focus to meet the most urgent healthcare needs of its community during the pandemic, as well as reassess the ability to continue with some community health strategies due public health guidelines for social distancing. Adjustments have been made to continue community health improvement efforts as possible, while ensuring the health and safety of those participating. The Strategy Action Plan Grids on the following pages reflect updated activities for each strategy.

VCCHIC CHIS 2022

Prioritized Need #1: Aligning Cross-Sectoral Partnerships for Population Health Impact

Key Strategies

Strategy 1: Build Governance Structure

- 1.1 Develop common priorities and objectives
- 1.2 Coordinate Overarching goals and efforts
- 1.3 Define stakeholders, roles and responsibilities
- 1.4 Formalize project scope and structure

Accomplished in 2022

- Community Information Exchange governance established
- Health Information Exchange
 - Manifest MedEx utilization
- Renewal of founding members charter
- Added Gold Coast Health Plan to the founding members charter

Strategy 2: Cross Sector Prevention Model

2.1 Combined Community Health Assessments

Accomplished in 2022

- CHNA 2019 adoption and promotion – ongoing
- CHNA 2022 stakeholder asset mapping
- Began CHNA 2022 Planning
- Hired Conduent for CHNA 2022
- Survey construction for deployment in 2022
- Established timeline, process and roles

Strategy 3: Develop Financing Plan

3. 1 Identify initial capital and innovative long-term funding streams

Accomplished in 2022

- Secured funding through VCPH for a full-time associate to manage the VCCHIC
- Hired full-time associate
- Backbone organization exploratory meetings
- Created Backbone organization selection framework, criteria and governance
- Working with HASC, CLC and PHI on infrastructure and governance

Strategy 4: Explore Data Sharing Strategy

4.1 Consider data availability and explore methods for health information exchange (HIE)

Accomplished in 2022

- Gold Coast Health Plan Manifest MedEx Utilization
- Adventist Health submitting data to Manifest MedEx
- Other partners are in process

Strategy 5: Develop Performance Management Evaluation**5.1 Create performance feedback loops**

Accomplished in 2022

- Anticipated to occur in 2023 after CIE launch

Prioritized Need #2: Improve Access to Health Services**Key Activities**

- 1.1 Identify non-traditional partners through asset mapping exercises
- 1.2 Identification of appropriate SDoH screening tool
- 1.3 SDoH Screen tool deployment
- 1.4 Workflow modifications as needed per provider practices and CBOs needs
- 1.5 Staff training on screening and service referrals
- 1.6 Facilitate Community Information Exchange (CIE)

Accomplished in 2022

- Created CIE Governance
 - Created CIE Governing Board
 - Secured over 4 million dollars in funding for CIE
 - CIE Subcommittees established
 - CIE Newsletter creation and deployment
 - Hired technology consultant for CIE selection
 - Stakeholder identification process created
 - Performance evaluation criteria project initiated
- Identification of non-traditional partners
- SDoH tool selection
- Adventist Health Physicians Network utilization of SDoH screening questions

AHSV Access to Care for Underserved Populations

- The Free Clinic of Simi Valley
 - Lab and Radiology services provided to all Free Clinic referrals - \$153,665 value
 - 461 people served
 - Cash donations
- Westminster Free Clinic
 - Cash donations
 - PPE Supplies donated
 - 400+ people served
- Community Health and Wellness Programs
 - Provided services valued at \$805,588
 - Number of people served: 12,150+
- Medi-cal Enrollment Services \$118,260
- Homeless Discharge \$10,885
- Nurse Navigation \$210,238

AHSV Access to Care – Health Professions

- Nursing students clinical rotations
 - 159 students served
 - \$250,983
- Other health professions rotations
 - 75 students served
 - \$31,259
- Health Professions Scholarships
 - \$25,000
 - 20 students served

VCCHIC Prioritized Need #3: Address Social Needs through a Food Access Intervention

Key Activities

- 1.1 Select uniform screening tool for providers, practices and hospitals
- 1.2 Business agreement template for screening partnerships
- 1.3 Client referral program
- 1.4 Clinical dietary counseling referrals for chronic disease and prevention
- 1.5 Clinical care plan template for tailored care plans
- 1.6 Connect screening and referrals to federal and state food assistance programs, CBO resources

Accomplished in 2022

- Identified and selected Hunger Vital Signs screening tool
- Other activities postponed due to Covid-19

- Building screening tool into CIE structure

AHSV Population Health Interventions / Upstream Prevention

Focus on Youth:

- Moorpark College program
- Athletic Training and Medical Oversight Program
 - Sports medicine physician provides oversight
 - Athletic trainers funded by the hospital for 5 high schools
 - Creation of SDOH interventions and care navigation for student athletes
- Healthy Kids Fun Zones at 10 community events
 - Served over 20,000 visitors
- Every 15 Minutes Committee Planning for 2022 Event
- Family Education Classes: Childbirth, breastfeeding, siblings
- Simi Valley Education Foundation Enhancement Grant funding
- Moorpark Education Foundation program grant funding
- Boys & Girls Club of Simi Valley and Moorpark funding of food access program
- Funding for concussion prevention and education

Focus on Substance Use and Mental Health:

- Applied for a CalBridge grant and received the award for \$100,000 to begin a Substance Use Navigator program. Program begins in 2021.
- Participation in Ventura County Behavioral Health mental health task force – suspended due to Covid-19
- Sponsor and participant in concert and education event celebrating recovery
 - Over 250 persons served
- SUN provides community outreach specifically with high schools working with their guidance counselors to educate students about substance use disorder and how to get help.

VCCHIC Prioritized Need #4: Improve the Health and Well-being of Older Adults

Key Activities

- 1.1 Caregiver Assessments and Care Planning
- 1.2 Community Partner Identification
- 1.3 Education for Caregivers
- 1.4 Integration into Health Systems

Accomplished in 2022

- VCCF Caregiver Support Program Grant awardees include AHSV, Dignity Health St. John's and Community Memorial Hospital & Health System
- Awarded grant from UniHealth Foundation to augment the program
- California State University Channel Islands mid-term evaluation completed
- AHSV revived caregiver support program

- Participated in collaborative committee meetings
- Funded Powerful Tools for Caregivers within collaborative
- Program severely impacted by Covid-19

AHSV Focus on Seniors:

- Caregiver support program
- Senior Center collaborations
 - Senior Wellness Expo
 - 300+ seniors screened for blood pressure
 - 300+ seniors screened for advanced directives
- Senior Concerns collaboration
- Parks & Receptions collaboration
 - Funding for Senior Games
 - 500 seniors served

AHSV – Other CHIS Activities Carried Over from Previous CHNA/S

Focus on Heart Health

- American Heart & Stroke Association
 - Happiness In The Park / Heart Walk
- Blood pressure awareness education
- Heart disease prevention education
- Hands-Only CPR training

Focus on Cancer

- CSC Support groups virtualized during pandemic
- Genetic Testing Program
- Lung Cancer Screening
- Cancer care navigation program
 - Hired two navigators in late 2021
 - Rebuilding the program in 2022
- Festival of Trees – grants for local cancer patients
- Cancer Support Community

Adventist Health Simi Valley Implementation Strategy Action Plan

**PRIORITY HEALTH NEED:
ALIGNING CROSS-SECTORAL PARTNERSHIPS FOR POPULATION HEALTH IMPACT**

GOAL STATEMENT: TO DEVELOP A SUSTAINABLE COLLABORATIVE STRUCTURE OF HOSPITAL AND COMMUNITY PARTNERSHIP FOR LONG TERM IMPLEMENTATION OF CHOSEN COMMUNITY HEALTH AND POPULATIONS HEALTH STRATEGIES.

Mission Alignment: Well-being of People

Strategy 4: Health Information Exchange in Ventura County

Programs/Activities	Process Measures	Results: Year 1	Short Term Measures	Results: Year 2	Medium Term Measures	Results: Year 3
Data Sharing	Capacity Evaluate and recommend vendor for health information exchange (HIE) Operational criteria; IT security	Manifest MedEx selected; Adopted by AH, GCHP and VCPH	Adopted by Gold Coast Health plan and Adventist Health Simi Valley	Uni-directional data flow from AH	EHR workflows	See Narrative Below

Source of Data:

- Data sharing readiness assessment of partners; Report on current initiatives already in progress; EHR workflows; Data-sharing agreements

Target Population(s):

- Ventura County at large; high-risk hospital utilizers; complex case mixes

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)

- AHSV IT and CWB staff; AH IT and Cerner staff; Education and implementation teams

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- VCCHIC members

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

A – Community Health Improvement

Strategy Results 2022:

Despite the significant impact of Covid-19 on the efforts of the VCCHIC, we were able to accomplish getting Manifest MedEx selected as our Health Information Exchange (HIE) provider. Gold Coast Health Plan, Ventura County Public Health and Adventist Health all signed the agreement and are working independently to get their interoperability functionality established. Other VCCHIC partners are in the process of evaluating Manifest MedEX. The HIE has to go through each organizations IT/Security clearance process and also go through various executive approvals. We anticipate the functionality of the HIE to improve how the health care providers, including clinics and physician offices, can better manage the care of their shared patients. We appreciate the Hospital Association of Southern California for advocating for this project.

PRIORITY HEALTH NEED: ALIGNING CROSS-SECTORAL PARTNERSHIPS FOR POPULATION HEALTH IMPACT

GOAL STATEMENT: TO DEVELOP A SUSTAINABLE COLLABORATIVE STRUCTURE OF HOSPITAL AND COMMUNITY PARTNERSHIPS FOR LONG TERM IMPLEMENTATION OF CHOSEN COMMUNITY HEALTH AND POPULATION HEALTH STRATEGIES

Mission Alignment: Well-Being

Strategy 1: Build Governance Structure

Programs/Activities	Process Measures	Results: Year 1	Short Term Measures	Results: Year 2	Medium Term Measures	Results: Year 3
Develop common priorities and objectives	Written Mission, Vision and Goals statement	Revised and adopted Charter; CHIS goals	Support for the VCCHIC structure from each participating organization	Created new charter; Designated Gold Coast Health Plan as founding member	Charter; Memoranda of Understanding (MOU) agreements	See Narrative Below

Source of Data:

- Chartered partner reports; Meeting minutes; County action plans; VCPH

Target Population(s):

- Ventura County at large; high-risk populations; high utilizers

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)

- CWB director involvement; AHSV executive oversight; AH compliance reviews;

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- All VCCHIC partners

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

- A – Community Health Improvement**

Strategy Results 2022:

The VCCHIC had significant interruptions in our cadence of monthly group meetings and bi-monthly Sub-committee meetings due to Covid-19. VCPH and each hospital organization had to redirect staff and resources to address the impact of the pandemic on our local communities.

PRIORITY HEALTH NEED: IMPROVE ACCESS TO HEALTH SERVICES

GOAL STATEMENT: To improve access to health services by addressing social needs of high risk/high need clients to reduce presentable emergency room and hospital utilization.

Mission Alignment: Well-being of People

Strategy 1: From 2019 to 2022, VCCHIC will build a Community Information Exchange (CIE) which can be adopted by participated hospitals and other community-based organization to increase intra- and inter-agency referrals and tracking of high risk/high need clients.

Programs /Activities	Process Measures	Results: Year 1	Short Term Measures	Results: Year 2	Medium Term Measures	Results: Year 3
Identify non-traditional partners through assets mapping and exercises	Number of partners; number of populations covered; number of census tracts covered	Participated in numerous demonstrations of UniteUs; Exploring 211 options	Curate interested and committed partners; Create governance for CIE; Complete partnership agreements	Initial Funding secured; Technology advisor hired; Evaluation task force created; Governing Board	Governance structure finalized; funding sources identified; platform selected; contracts completed	See Narrative Below

Target Population(s):

- Ventura County at large; at-risk populations; high utilizers

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)
 AHSV CWB director time; AHSV executive and compliance time and reviews; AH oversight

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- All VCCHIC partners; non-chartered and non-traditional care partners

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

- A- Community Health Improvement

Strategy Results 2022:

Though delayed by impact of the pandemic, the VCCHIC was able to convene multiple virtual meetings in Q3 and Q4 of 2020 to evaluate the functionality of UniteUs as a CIE platform. The collaborative made significant progress in 2022:

- Established charter for membership of Ventura County Community Information Exchange board
- Established bylaws
- Secured over 4 million dollars in start up funding
- Hired technology assessment consultant
- Interviewed a variety of CIE leaders from countys and cities across the United States
- Established technology committee
- Established governance committee
- Established CBO outreach planning team

The collaborative has escalated this project due to a funding opportunity and expect to make significant progress in 2022.

PRIORITY HEALTH NEED: ADDRESS SOCIAL NEEDS THROUGH A FOOD ACCESS INTERVENTION

GOAL STATEMENT: To address food insecurity and reduce hospitalizations and health care costs in medically-complex populations by increasing access to appropriate nutrition.

Mission Alignment: Well-being of People

Strategy 1: From 2019 to 2022, the VCCHIC will reduce food insecurity by 2% from baseline (pre-Covid 19 data) by screening for food insecurity at provider practices and hospitals and referring high need/high risk clients to food and nutrition access programs, resources and professionals.

Programs/ Activities	Process Measures	Results: Year 1	Short Term Measures	Results: Year 2	Medium Term Measures	Results: Year 3
Select a uniform screening tool	Number of food insecure clients identified; Number of referrals	Hunger Vital Signs screening tool selected	Reduced stigma, increased connections to food resources	Integration of screening tool into CIE project	Reduced stigma, Increased connectivity to food and nutrition resources and education services	See Narrative Below
Develop Business Agreements with food access organization	Number of identified partners and agreements executed;	Food distribution organization listed; schedule of COVID-19 response drive through pantries	Number of partnerships signed on to the referral resources website and collateral pieces; Number of participating organizations	Previous report available upon request	Closed loop referrals and outcomes	See Narrative Below

Source of Data:

- VCCHIC partners

Target Population(s):

- Ventura County at large; high-risk populations; high-utilizers

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)

- AHSV CWB director time; AHSV clinical workflow; AHSV education

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- All VCCHIC partners

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

- Community Health Improvement

Strategy Results 2022:

This portion of our CHIS is delayed due to Covid-19 but we made progress on the selection of the screening tool and will address our need to adjust our metrics to include the new landscape and data points after Covid-19. We anticipate building this into our CIE project as it is built and deployed.

PRIORITY HEALTH NEED: IMPROVE THE HEALTH AND WELLBING OF OLDER ADULTS

GOAL STATEMENT: 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

Mission Alignment: Well-being of People

Strategy 1: From 2019-2022, VCCHIC will implement a Community Based Care Transition Program per Section 3026 of the Affordable Care Act to support medically fragile 65+ year old adults and their caregiver after an acute care hospitalization to reduce hospital re-admissions and improve the provision of value-based services.

Programs/Activities	Process Measures	Results: Year 1	Short Term Measures	Results: Year 2	Medium Term Measures	Results: Year 3
Caregiver and Patient Navigation	Caregiver Assessments	Number of caregivers contacted by navigator. Number of caregivers enrolled in the program	Increased confidence and score on Zarit Burden Scale; Improve care outcomes for patient	Participants saw reduction in readmission s; Mid-pilot report published; Sustainability committee Established	Caregiver integration into care continuum; caregivers equipped for medically complex care in the home; reduction in hospital overutilization	See Narrative Below
Caregiver Support Program	Community partners identified	Creation of network of community partners	Develop feedback loop for completed referrals; create committee for managing program creation, alignment and outcomes	Established growth plan to move the program to the community	Caregiver Navigator Program Database	See Narrative Below

Source of Data:
Partner hospitals navigation programs; CSUCI validator; Zarit Burden Scale survey results; other measures

Target Population(s): Medicare; High-risk caregiver burnout candidates

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)
AHSV CWB director time; Caregiver support program staff; education materials; enrollment supplies; caregiver gifts; funding of Powerful Tools for Caregivers

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

VCCHIC; HASC; VCCF; Dignity St. John's; Community Memorial Health System; California State University Channel Islands

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

- **A – Community Health Improvement**

Strategy Results 2022:

AHSV hired a care transition's nurse to build the care transitions team that includes the caregiver support navigator. AHSV has three staff who share the work of navigating caregivers and connecting them with appropriate resources. The program was severely impacted when Covid-19 caused the hospital to restrict all visitation and eliminate any non-clinically necessary in person visits with care management and care navigators. The dramatic impact of our response to the pandemic has delayed our program but we created a new workplan for 2022 with adjusted metrics based on the impact of the pandemic. This program is more needed than ever.

The Adventist Health + Blue Zones Solution

Our desire to improve community well-being grew out of not only our mission at Adventist Health – to live God’s love by inspiring health, wholeness and hope – but also by the sheer need as seen across our system of 23 hospitals. Overwhelmingly, we see diseases of despair including suicide, substance abuse, mental health and chronic illnesses plaguing the communities in which we have a significant presence in. That is why we have focused our work around addressing behavior and the systems keeping the most vulnerable people in cycles of poverty and high utilization.

In an effort to heal these communities, we have strategically invested in our communities by partnering with national leaders in community well-being. We believe the power of community transformation lies in the hands of the community. Our solution for transformation is to create a sustainable model of well-being that measurably impacts the well-being of people, well-being of places and equity.

2020 saw the acquisition of Blue Zones by Adventist Health as the first step toward reaching that goal. By partnering with Blue Zones, we are able to gain ground in shifting the balance from healthcare – treating people once they are ill – to transformative well-being- changing the way communities live, work and play. Blue Zones widens our impact from only reaching our hospitals’ communities in four states to a global mission practice.