Adventist Health Simi Valley
2022 Community Health Plan

The following Implementation Strategy serves as the 2020 ς 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 rchedule H r1r Afffffordabl(e)n r3&CH ren-USda4n B

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

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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

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

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

https://www.healthmattersinvc.org/

Implementation Strategy ς 2019-2022

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COVID 19 Considerations

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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 ς 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
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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
  -

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 ς suspended due to Covid-19

Adventist Health

Strategy Results 2022:

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

GOAL STATEMENT (P)-9 (O)92-4.7 0.5 0.5 r N NSNB BT 1 gRATI/4oORSHp /AROIMP2-4.7 5 rN (P)-9 (O)9AN-4.7 D4GOAL

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 servicers 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

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 asccess to appropriate nutrition.
Mission Alignment: Well-being of People Strategy 1:

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 Acto 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 readmissions; 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 referrals76.3 re W*n B			

Collaboration Partners: [illegible]; 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)

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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 ς to live God[illegible] ς 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 ς treating people once they are ill ς to transformative well-being- changing the way communities live, work and play. [illegible] states to a global mission practice.