

Imperial County 2017



Community Health Assessment & Community Health Improvement Plan 2017 – 2021

The Imperial County Community Health Assessment & Community Health Improvement Plan (CHA/CHIP) 2017-21 is the full version of the report.

Condensed summary of the Imperial County CHA/CHIP 2017-2021: **Taking Action 2017**

The Imperial County Community Health Assessment (CHA) & Community Health Improvement Plan (CHIP) 2017-2021 is the full report.

For a condensed summary of the Imperial County CHA/CHIP 2017-2021, reference the Taking Action 2017 document.

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EXECUTIVE SUMMARY

The *Imperial County Community Health Assessment (CHA) & Community Health Improvement Plan (CHIP) 2017-2021* report provides guidance to community members and stakeholders who wish to become involved in or continue to engage in health and wellness improvement. This report has two versions. The *Imperial County Community Health Assessment and Community Health Improvement Plan 2017–2021* version is the detailed, data-heavy report. The *Taking Action 2017* version is the condensed summary report with primary emphasis on the CHIP. **This is the Imperial County Community Health Assessment and Community Health Improvement Plan 2017–2021 report.**

The CHA/CHIP report in its two versions is the result of a robust and cooperative process that took 18 months and included stakeholders, community members, community forum attendees, workgroup members, and those who completed community surveys [2,334]. Imperial County has various capable programs and efforts already in place to address health from numerous perspectives – the CHA process confirmed this. The process also documented, however, that there are many gaps in services and ways to build on and strengthen efforts. Insights from the CHA led to the identification of three priority areas for Imperial County along with three impact targets within each priority area:

A) Healthy Eating, Active Living

- *Consumption of affordable, accessible, and nutritious foods*
- *Engagement in affordable and safe opportunities for physical activity*
- *Achieve and maintain healthy weight*

B) Community Prevention Linked with High Quality Healthcare

- *Asthma detection, management and education*
- *Prenatal Care – Early and Adequate*
- *Diabetes detection, management and education*

C) Healthy and Safe Communities and Living Environment

- *Engagement in improving air quality*
- *Prescription drug abuse prevention*
- *Linking family members, care givers and persons living with dementia across systems of care and support*

These three priority areas are the foundation of the goals and strategies outlined in the CHIP. While providing goals and strategies specific to each priority area, this report also proposes ways to move forward through collective impact work. Collective impact is the concept of sustained change in the way that we think about health and act to improve it. Such changes involve regular convening of diverse partners that work to align and build on one another's efforts by adopting a common agenda with shared goals and metrics to measure progress. Health is complex and affected by a variety of determinants such as access to healthcare, environment, culture, social support networks, literacy,

education, housing, and employment. No single organization or program can alone solve a health problem, but together, through coordination and communication, we can each play a part in effecting change that collectively helps resolve issues.

The principles of collective impact guided the development of the *Taking Action: The Year 1 Integrated Workplan - 2017* section of the report.

Strategies from the priority areas were aligned into four themes to leverage resources, reinforce efforts, and reduce duplication in work across health issues. These four themes are shown in Figure 1. Annual milestones were then created for each strategy to track progress and objectively assess what is effective and ineffective in our community. Finally, a lead organization or group was identified to convene community partners around the work to be done.

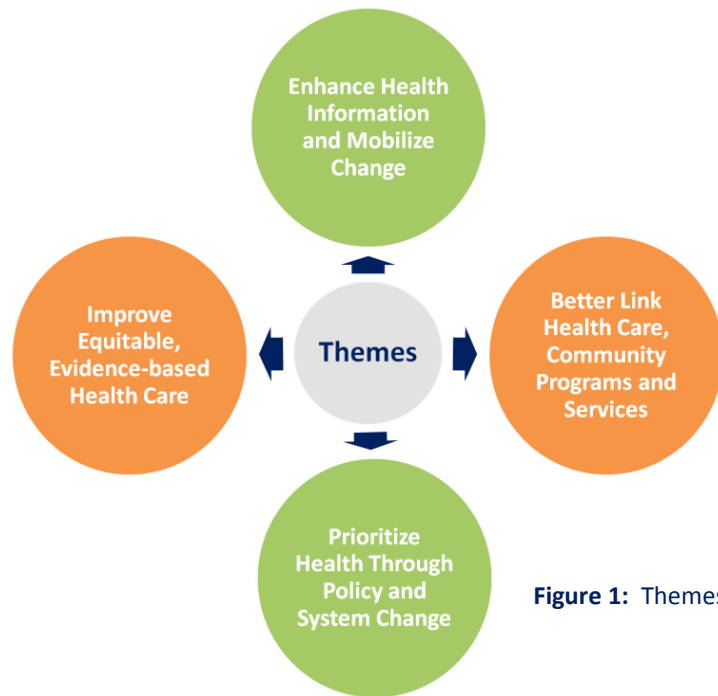


Figure 1: Themes

Our community has begun to align multiple infrastructures that will help collective impact to thrive. These infrastructures include: 1) Governance by the Local Health Authority (LHA) Commission; 2) Leadership by Steering Committee; 3) a Community Partnership composed of Community Health Improvement Partnership; and 4) a Backbone Organization led by the Imperial County Public Health Department. More detail about these **groups** and how to become involved in their work are found in the *Taking Action to Mobilize Change – How to Join* section of the Taking Action 2017 report.

The CHA/CHIP is a starting point for work with a focus in the priority areas over the next five years. The report's two versions are living documents, meaning that they will continue to be revisited, revised, and built upon as needed to assure progress in the priority areas. It is the hope of everyone involved in this process that interested stakeholders, community members, and all others will identify with the CHA/CHIP's findings, and support the action steps and direction proposed for our community. Each of us has a role in working to improve health and the quality of life in Imperial County. What's your role?

Inquiries regarding this plan may be directed to:
Collective Impact Initiative Manager
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(442) 265-1479 | deniseandrade@co.imperial.ca.us

ABOUT IMPERIAL COUNTY

The Imperial County, a unique rural community established in 1907, is located in the far southeastern corner of California bordered by Riverside and San Diego Counties, the State of Arizona, and Mexico. It is a beautiful desert region primarily made up of sand and rugged mountains with extreme climate ranging from high temperatures surpassing 120 degrees in the summer to freezing temperatures in the winter. There is also very little rainfall in Imperial County with an average of 3 inches of rain per year, compared to 23 inches in California and 37 inches in the United States.

The Imperial County is the 9th largest county in California and a leading world-wide producer and exporter of agricultural goods. It dedicates about 800 of its 4,597 square miles to irrigated farmland and produces over 100 different commodities, with the largest 2 commodities being cattle and alfalfa. The county is one of the top 5 producers of spinach, potatoes, cauliflower, sweet corn, broccoli and onions in California, and is one of the top sheep and lamb producers in the nation.

Besides farming, Imperial County's interest in renewable energy (geothermal, wind, and solar) development has evolved over the years. Currently, it is the second largest geothermal energy producing county in the nation: several new geothermal facilities are being designed and built. More recently, and due to an average of 360 days of annual sunshine and large amounts of land available for development, interest was placed in solar energy generation projects: several projects have been completed thus far and others are currently underway.

There is vast natural beauty in Imperial County. Bird-watching aficionados can find thousands of birds at a time in key areas of the county. Over 400 of the 800 bird species found in the United States have been spotted in the area. For off-road enthusiasts, over 40 miles of sand dunes cover the county. The Imperial Sand Dunes, widely known as "Glamis," are the largest dunes in the state and are highly frequented in the cooler months.

When it comes to population, Imperial County's make-up is also very distinctive. Its population of 180,000 is made up of over 80% Hispanic or Latino, 11% White (non-Hispanic or Latino), 3% African American, 2% Asian, Native Hawaiian or Pacific Islander or other, and 2% American Indian or Alaska Native. The two tribes located in the county are the Quechan Tribe of the Fort Yuma Indian Reservation and Torres Martinez Desert Cahuilla Indians. Sixty-five percent of the Imperial County population has a high school degree or higher, while 13% have a bachelor's degree or higher. Per capita family income is \$16,409, compared to \$29,906 statewide. (Will need to check CommunityCommons.com)

Imperial County is invested in protecting and improving the overall health of its community. Over the years, betterment has been seen in several areas since 2000; most notable, there have been lower death rates for certain cancers, cerebrovascular disease, and coronary heart disease. Improvements have also been seen in other areas including breastfeeding initiation, as well as vaccine rates, leading to a reduction in cases of certain diseases such as hepatitis A and B in recent years. However, opportunities for health improvement still exist. Imperial County continues to report high teen pregnancy rates. Asthma and tuberculosis rates continue to be among the highest in the state,

diabetes death rates are higher than statewide and nationally, and obesity prevalence (or rates) continue(s) to be a growing problem.

In June 2015, Imperial County stakeholders initiated a discussion to engage in a Community Health Assessment (CHA) and an ongoing, broader community health improvement process, with a final Community Health Improvement Plan (CHIP). The CHA would provide information that would assist with problem and asset identification, policy formulation, implementation, and evaluation, and serves as a tool to measure how well the public health system is fulfilling its core functions. CHA data were then used to identify priority areas, develop and implement interventions and establish measures, and all, is detailed in three documents:

1. Community Health Assessment & Community Health Improvement Plan 2017-2021
2. Taking Action 2017 document
3. Community Health Assessment & Community Health Improvement Plan 2017-2021 Appendices 1- 7.

The Community Health Assessment & Community Health Improvement Plan (CHA/CHIP) 2017-2021 is the primary CHIP document that provides a detailed discussion on the processes, findings, work plan activities, community spotlights, and more. The Taking Action 2017 document is a companion document to, and provides highlights and summaries of the larger comprehensive CHA/CHIP 2017-2021 Document. The Appendices capture information ranging from meeting minutes and handouts, Community Survey training presentation, administration protocol, Forces of Change results, Cause and Effect Diagrams, Environmental Scans, and more. The Appendices are meant to be used in coordination with, and referenced by the CHA/CHIP 2017-2021 document.

It is the hope of the stakeholders that local community members and others will use these documents to gain a better understanding of current topics and health issues in Imperial County and where efforts and resources are being focused over the next few years. Everyone is invited to visit the last section of both documents (Taking Action 2017 and CHA/CHIP 2017-2021), for detailed information on how to:

- a. become more involved in the process
- b. use the documents
- c. participate in the activities over the next few years.

ACKNOWLEDGEMENTS *Thank you to those who...*

Participated in the Stakeholder Process

| | |
|-----------------------------------------------|----------------------------------------------|
| 2-1-1 Imperial | Imperial County Public Administrator / Area |
| Alliance Healthcare Foundation | Agency on Aging |
| Calexico Neighborhood House | Imperial County Public Health Department |
| California Health & Wellness | Imperial County Veteran's Service Office |
| Calipatria State Prison | Imperial Valley Child Asthma Program |
| Cancer Resource Center of the Desert | Imperial Valley College |
| Centinela State Prison | Imperial Valley Food Bank |
| City of Brawley | Imperial Valley LGBT Resource Center |
| City of El Centro | Imperial Valley Regional Occupational |
| Clinicas de Salud del Pueblo, Inc. | Program |
| Comité Cívico del Valle, Inc. | Local Health Authority Commission |
| El Centro Regional Medical Center | March of Dimes |
| First 5 – Imperial | Molina Healthcare |
| Gentiva Health Services | Pioneers Memorial Healthcare District |
| Heffernan Memorial Healthcare District | San Diego State University - Imperial Valley |
| Imperial County Behavioral Health Services | Campus |
| Imperial County Department of Social Services | Sure Helpline Crisis Center |
| Imperial County Free Library | U.S. Customs and Border Protection |

Participated in the Community Survey

California Health & Wellness
Cancer Resource Center of the Desert
Clinicas de Salud del Pueblo, Inc. locations (West Shores, Calexico, Niland, Brawley, Winterhaven, and El Centro)
El Centro Regional Medical Center
El Centro Rotary Club
First 5 – Imperial
Imperial County Behavioral Health Services
Imperial County Free Library Satellite locations (Holtville, Calipatria, Heber, and Salton Sea)
Imperial County Public Administrator / Area Agency on Aging
Imperial County Public Health Department
Imperial County Veteran's Service Office
Imperial Valley Food Bank and local distribution sites (Our Lady of Guadalupe - Calexico, Niland, Westmorland, Salton City, and Heber)
Molina Healthcare
Pioneers Memorial Healthcare District and satellite locations (The Pioneers Health Center, Calexico Health Center, and Wound Clinic)
San Diego Regional Center (Imperial County)
Sure Helpline Crisis Center

Thank you City of El Centro Parks and Recreation Department for providing the facility for the Community Forum.

Participated in the Priority Areas Workgroup Activities

Priority Area: Healthy Eating, Active Living

| | |
|-------------------------------------|----------------------------------------------------|
| Calexico Neighborhood House | Clinicas de Salud del Pueblo, Inc. – WIC Program |
| Imperial County Office of Education | UC Cooperative Extension |
| Sodexo | Imperial Valley Food Bank |
| First 5 - Imperial | Imperial County Board of Supervisors Jack Terrazas |

Priority Area: Community Prevention Linked with High Quality Healthcare

| | |
|-----------------------------------------------------|--------------------------------------|
| Clinicas de Salud del Pueblo, Inc. | California Health & Wellness |
| El Centro Regional Medical Center | Imperial Valley Child Asthma Program |
| San Diego State University - Imperial Valley Campus | UCSD Rady Children's Hospital |
| American Diabetes Association | Comité Cívico del Valle, Inc. |

Priority Area: Healthy and Safe Communities and Living Environments

| | |
|---------------------------------------|-----------------------------------------------|
| Pioneers Memorial Healthcare District | Imperial County Department of Social Services |
| Calipatria State Prison | Molina Healthcare |
| El Centro Regional Medical Center | |

Organizing for Success



ORGANIZING FOR SUCCESS

Overview

During 2015 and 2016, local key stakeholders, community members, and advocates came together to participate in a Community Health Assessment and Community Health Improvement Planning (CHA/CHIP) process. This was the first time a comprehensive and collaborative process was completed in the community, and as such, received enthusiasm, broad commitment, and support. A five-member Public Health Department team was formed to begin conversations with local stakeholder agencies and community advocates to gauge interest in the process.

A kickoff event was organized to:

- a. identify current partners who were interested in participating in community planning and assessment activities,
- b. select a community health assessment model to guide the CHA/CHIP process,
- c. identify the decision-making process and meeting schedule for future meetings,
- d. determine if a smaller core Steering Committee was needed to help provide leadership and direction to the Community Partnership, and
- e. determine who else needed to be invited to participate in this process.

Community Partnership Agreements

- Use of evidence-based model to approach CHA/CHIP development
- Mobilizing for Action through Planning and Partnerships (MAPP) selected as the model
- Consensus decision-making
- Steering Committee model adopted and Steering Committee members selected
- Partnership meetings to be held 1st Thursday of each month

Steering Committee Members

The primary focus of the Steering Committee members was to facilitate discussion, focus ideas, strategies, and propose decision options to the Stakeholder Group. This approach helped with the forward movement of the CHA/CHIP process, decision-making, completion of activities, and milestones. The Steering Committee usually met prior to the Community Partnership meeting, with a total of eight (8) meetings.

- ❖ **Helina Hoyt, RN, MS, PHN; San Diego State University-IV Campus; RN-BS Program Coordinator; LHA Commissioner**
- ❖ **Afshan Baig, MD; Clinicas de Salud del Pueblo, Inc.; Chief Medical Officer; LHA Commissioner**
- ❖ **Kathleen Lang, DPA; California Health & Wellness; Vice President – Operations**
- ❖ **Julio Rodriguez; First Five-Imperial; Executive Director**
- ❖ **Amy Binggeli-Vallarta, DrPH, RD; Imperial County Public Health Department; Planning and Evaluation Specialist**

The MAPP Model

The MAPP (Mobilizing for Action through Planning and Partnerships) process was developed by the National Association of County and City Health Officials in collaboration with the Centers for Disease Control and Prevention. The MAPP process is centered on community organizing and partnership development and includes four assessments:

1. Community Themes and Strengths Assessment
2. Local Public Health System Assessment,
3. Community Health Status Assessment,
4. Forces of Change Assessment

MAPP also involves the identification of strategic issues, formulation of goals and strategies, and a continuous cycle of planning, implementation, and evaluation. A modified MAPP model, Figure 2, was developed to better illustrate the collective impact approach later described in this report.

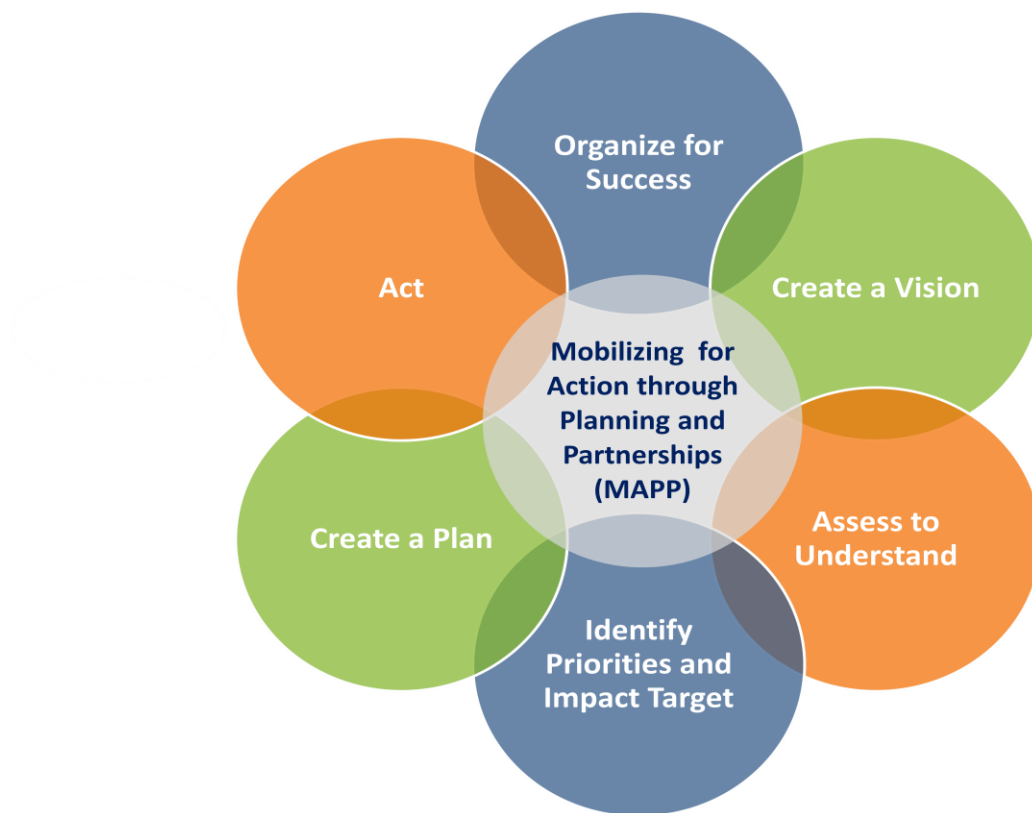


Figure 2: MAPP

Creating a Vision



CREATING A VISION

The Steering Committee, in concert with the Community Partnership, identified, refined and finalized a Shared Vision, Guiding Principles, and Shared Values. These were developed to serve as a framework, and provide context and visualization of the County's unique challenges and opportunities. The process of crafting these three elements occurred through multiple brainstorming sessions where the following questions (adapted from the MAPP User's Handbook) were discussed:

- ✓ What does a healthy Imperial County look like to you?
- ✓ What are the characteristics of a healthy community for all who live, work, and play?
- ✓ What kinds of resources are needed to create a healthy neighborhood?

The process resulted in a shared vision that reflected an ideal picture of health in Imperial County. Although the Community Partnership is a diverse group of individuals made up of various backgrounds, the members came together and united around guiding principles and values that reflect a roadmap to achieve a shared vision for a healthy community.

Shared Vision

“A community that supports and empowers all people to thrive and be healthy”

Guiding Principles

- ❖ Use a systems approach that incorporates evidence-based and best practices
- ❖ Open dialogue to ensure respect for diverse voices and perspectives
- ❖ Foster a proactive response to the issues and opportunities to promote wellness in our community
- ❖ Build on existing activities to “dove-tail” needs and resources

Shared Values

- ❖ **Fairness** – To focus efforts to create conditions where those in Imperial County have equal access to the opportunities that support their achievement of optimum health
- ❖ **Transparency** – To act openly and truthfully in all processes
- ❖ **Inclusiveness** – To respect and seek out diverse perspectives and encourage broad contribution in order to give a voice to individuals who may not be at the table
- ❖ **Commitment** – To effectively collaborate, share resources and coordinate efforts to continually assess and improve the health of Imperial County

Assessing to Understand



THE FOUR COMMUNITY HEALTH ASSESSMENTS

The Community Health Assessment (CHA) component of the CHA/CHIP report was completed from June 2015 – August 2016. As part of this component, the following four assessments were conducted:

- ✓ **Community Themes and Strengths Assessment (CTSA)** – solicited perceptions about quality of community life and issues affecting the community, both positive and negative;
- ✓ **Local Public Health System Assessment (LPHSA)** – worked to answer the questions, “What are the components, activities, capacities of our local public health system?” and “How are the Essential Services being provided to our community?”;
- ✓ **Community Health Status Assessment** – provided an in depth review of current health indicators and community demographics; identified data trends impacting health status and compared existing indicator levels with national benchmarks (i.e., HP2010 and HP2020); and
- ✓ **Forces of Change Assessment** – assessed both current and future forces that may affect the ability to improve health status.

The four assessments merge important information about the local public health system, the community’s health, and forces that may affect health now and in the future. Together, the assessments were designed to a) offer information on strengths and gaps between the community’s current landscape and the community’s vision, b) provide information on strategic issues that should be addressed, and c) serve as a platform in the formation of strategies and goals.

In the sections below, each assessment is discussed. Detailed reports for each of these can be found in Appendix 2.

Community Themes and Strengths Assessment

The Community Themes and Strength Assessment (CTSA) captured opinions and perceptions from the community members, using two means of data collection. The means identified by the Community Partnership group to collect community input were the Imperial County Community Survey (Community Survey) (Appendix 3), and a Community Forum (Appendix 3). The goal of the Community Survey was to maximize broad input from community members, and to use the Community Survey findings to inform the development of the Community Forum Event.

Community Survey: The Community Survey methodology was shaped to maximize community input from all areas of the County. Specifically, multiple mechanisms were used to encourage participation by utilizing existing networks across the community and local public health system. For example, the Survey was available in both English and Spanish and available to complete using one of the following: a) Survey Monkey link, b) self-administered drop-boxes, and c) facilitated processes.

This survey sought to answer the following questions:

- What is important to our community?
- How is quality of life perceived in our community?

- What are the most important health-related issues for the community?
- What assets do we have that can be used to improve community health?
- What would most improve the quality of life for the entire community?

Once the English Language Survey was developed, piloted, refined, and finalized, it was translated into Spanish. The same evaluative process occurred; the Spanish Language Survey was developed, piloted and refined before finalizing.

In total, 2,334 people responded to the survey between July 23rd 2015, and August 28th 2015. Responses represent both electronic and self-administered completion. For the self-administered component, drop boxes were in place throughout the community, totaling 17 agencies (28 sites). Additionally, the electronic link to the survey was shared with local public health partner agencies and others, and was posted on partner agency websites for individuals to easily access and complete. The Community Survey was also promoted as part of an Imperial County news release in August 2015.

It is important to note that the purpose of the data collection was to maximize opportunities for the community to provide input into the process, and for the findings to provide a snapshot of, and draw attention to, the broad areas of health-related issues and concerns, community assets and needs, and quality of life improvement opportunities. This process was not intended to be used to measure trends or to collect a representative sample, rather to provide a starting point for the other assessments.

Community Forum: A second component to the Community Themes and Strength Assessment was the completion of a Community Forum event. The decision to host a Community Forum was based on discussions at both the Steering Committee and Community Partnership meetings. It was also determined that the event would be held during the month of September 2015 at a local Youth Center. The Community Forum was held from 11:30 p.m. - 1:15 p.m. where more than 40 community members attended. The selected site (local Youth Center) was chosen because it was recently renovated and the Steering and Stakeholder Group members wanted to encourage the community to see the renovations and promote attendance. The coordination of resources allowed for the availability of a light lunch and healthy beverages to those in attendance, and met other program deliverables for the Public Health Department. Further, it was an opportunity to garner additional community input and present and discuss selected health indicators and recent Community Survey findings. Discussion topics included:

- Local health issues and major themes from the Community Health Survey findings;
- Top seven health priorities; and
- Strategies to improve our community's health.

Survey Response 10,000 Foot Level: Community members gave us a glance in to their prospective of health through the survey. The following are some of those response highlights.

Participants indicated that 90% of them had insurance.

When asked to rate the community's health participants rated as follows:

- Fair to Good (65%)
- Poor (26%)
- Very Good (6%)

The following stores were selected as places where grocery purchases are most often made:

- Grocery store / supermarket (83%)
- Wholesale (Costco, Smart N Final, etc,) (61%)
- Dollar store and/or 99 cent store (41%)
- Corner market/convenience store (24%)
- Fast food restaurant (21%)
- Run out of money (8%)

The following were identified to be within the participants household:

- High Blood Pressure (52%)
- Diabetes (42%)
- Stress/Depression (43%)
- Obesity (37%)
- Lack of exercise (39%)
- Cholesterol (38%)
- Asthma (32%)
- Arthritis (28%)
- Cancer (28%)
- Dental problems (28%)
- Tobacco Use (21%)
- Mental Health Issues (16%)

Participants were asked to indicate if they agreed or disagreed with a list of statements. The following statements received the highest approval rating:

- I feel we can make the community a better place to live (90%)
- My community is a safe place to live (73%)
- My community is a good place to raise children (68%)

▪ Their families will most often go to the following locations when sick:

- Doctor's Office in Imperial County (61%)
- Hospital/ED in Imperial County (29%)
- Doctor's office in Mexico (25%)
- Hospitals/ED in Mexico (13%)

When asked to select the items that they felt would most improve their lives. The following had a high endorsement:

- More Jobs (44%)
- Engage in more physical activity (40%)
- Health Care (36%)
- Access to healthier foods choices (28%)
- Educational opportunities (27%)
- Learn how to make healthier food choices (27%)
- Job training opportunities (25%)

Participants identified the following as being the most important health risks:

- Overweight/obesity in child (43%)
- Air Quality (37%)
- Overweight/obesity in adults (36%)
- Drug use in youth (34%)
- Drug use in adults (27%)
- Diabetes (27%)
- Inactive lifestyle (22%)
- Teen pregnancy (22%)
- Homelessness (20%)
- Poor nutrition (2%)

Local Public Health System Performance Assessment

The Local Public Health System Performance Assessment process provided an opportunity to review and gauge the extent to which the local public health system was meeting the ten Essential Public Health Services. The primary purpose for local jurisdictions to complete this assessment is to promote continuous improvement that will result in positive outcomes for local public health system performance. This assessment process was completed by local public health system stakeholders, including the Steering Committee, Imperial County Public Health Department staff and other community partners.

Ten Essential Public Health Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. The Local Public Health System Assessment asks questions about how a community provides each essential service using a series of “model standards” for each service. There are thirty model standards evaluated with a series of questions for each standard and represents the spectrum of activities to assure public health within a jurisdiction.

This assessment can assist the local public health system in identifying areas of strength and weakness in addressing public health needs. From this, health improvement plans can build on areas where the Local Public Health System (LPHS) is performing well, and enhance areas where services are weaker.

Depending on the essential service and corresponding model standards that were worked on, 3-5 meetings were needed and discussion lasted anywhere between 1-2 ½ hours for each meeting. During instances where the group was unable to come to an agreement on the scoring, differing sides were presented by the respective group member(s), and discussion and debate continued until all were in agreement.

In addition to the meetings being an opportunity to evaluate the performance of the public health system, the process also allowed the opportunity for group members to, many times, learn more about the vast and comprehensive roles and responsibilities of partner agencies that make up the public health care system.

In general, each workgroup reached consensus on the score for each measure. The scores were entered into the CDC system and a report generated for the county. Local public health system was strongest in diagnosing and investigating health problems and hazards (Essential Service #2) with 65.3 out of 100. The area with the greatest need for improvement was Essential Service #5: Develop Policies and Plans that Support Individual and Community Health Efforts (30.6 of 100). The full report is available in Appendix 4.

Health System Performance Survey

| | |
|-----------------------------|----------------------------------------------------------------------------------------------|
| Optimal Activity | Greater than 75% of the activity described within the question is met. |
| Significant Activity | Greater than 50% but no more than 75% of the activity described within the question is met |
| Moderate Activity | Greater than 25% but no more than 50% of the activity described within the question is met |
| Minimal Activity | Greater than zero but no more than 25% of the activity described within the question is met. |
| No Activity | 0% or absolutely no activity. |

Ten Essential Public Health Services: Imperial County Performance Assessment

1. **Monitor Health Status To Identify Community Health Problems (SCORE =40.3)**
2. **Diagnose and Investigate Health Problems and Health Hazards (SCORE = 65.3)**
3. **Inform, Educate, and Empower People about Health Issues (SCORE = 63.9)**
4. **Mobilize Community Partnerships to identify and Solve Health Problems (SCORE = 58.3)**
5. **Develop Policies and Plans that Support Individual and Community Health Efforts (SCORE = 30.6)**
6. **Enforce Laws and Regulations that Protect Health and Ensure Safety (SCORE = 50)**
7. **Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable (SCORE = 40.6)**
8. **Assure a Competent Public and Personal Health Care Workforce (SCORE = 44.3)**
9. **Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services (SCORE = 42.9)**
10. **Research for New Insights and Innovative Solutions to Health**

Community Health Status Assessment

The findings and data presented in the sections below are the result of the 2015 edition of the Health Status Report. Over the past decade, there have been significant areas of change, primarily for the better; however, our community continues to struggle with some important health issues. Analyses comparing local indicators to state and national rates were included when possible. Healthy People 2010 targets were presented when corresponding goals were available.

The categories examined as part of the Community Health Status process include:

- Demographic and Socioeconomic Indicators
- Maternal, Child and Adolescent Health
- Communicable Diseases
- Sexually Transmitted Diseases
- Chronic Diseases
- Injuries
- Environmental Health
- Emergency Preparedness
- Mortality Rates

An overview and major findings of the Community Health Status Assessment were presented to the Community Partnership group at the initial CHA/CHIP kickoff meeting in August 2015. Subsequent presentations on local health indicators occurred throughout the process. For the complete Imperial County Health Status Report, please refer to Appendix 5.

Community Health Status Assessment Highlights

| Leading Causes of Death Imperial County and California 2012-2014 | | |
|---------------------------------------------------------------------------------|-----------------------|---------------------|
| | <u>Average Number</u> | <u>Age-Adjusted</u> |
| Imperial County | <u>Deaths</u> | <u>Death Rate*</u> |
| All Cancers | 211 | 126.7 |
| Heart Disease | 175 | 107.3 |
| Accidents (Unintentional Injuries) | 71 | 40.7 |
| Cerebrovascular Disease (Stroke) | 50 | 30.4 |
| Diabetes | 45 | 27.6 |
| California | | |
| All Cancers | 57,763 | 146.5 |
| Heart Disease | 38,543 | 96.6 |
| Cerebrovascular Disease (Stroke) | 13,574 | 34.4 |
| Chronic Lower Respiratory Disease | 13,073 | 33.7 |
| Lung Cancer | 12,376 | 31.7 |

Leading Causes of Death: In 2012-2014, the leading cause of death for Imperial County and California was cancer (malignant neoplasms), accounting for nearly 25% of all deaths in California and 21% of all deaths in Imperial County. Heart disease, accidents (unintentional injuries), cerebrovascular disease, and diabetes were other leading causes of death.

Maternal, Child, and Adolescent Health:

Fertility Rates

Since 2002, Imperial County's general fertility rates have been higher than California overall, with the higher rates in all age groups except those aged 35 years and older.

Prenatal Care

In 2013, 14.9% of pregnant women in Imperial County began prenatal care late or did not receive any prenatal care, compared to 3.5% of women statewide.

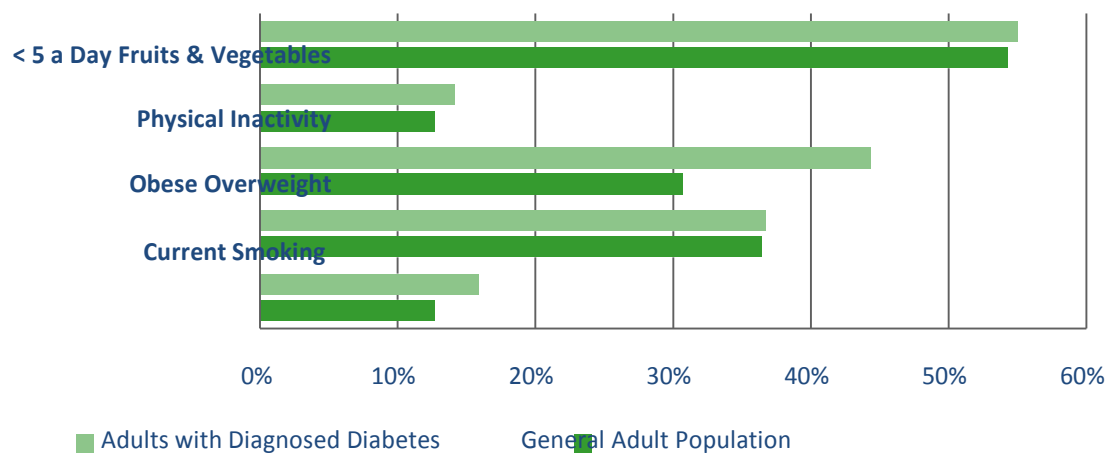
Breastfeeding Initiation

In-hospital exclusive breastfeeding in Imperial County was reported at 38% in 2015, significantly lower than California overall, which reported in-hospital exclusive breastfeeding at 68.8%, according to the Newborn Screening Test Form.

Diabetes:

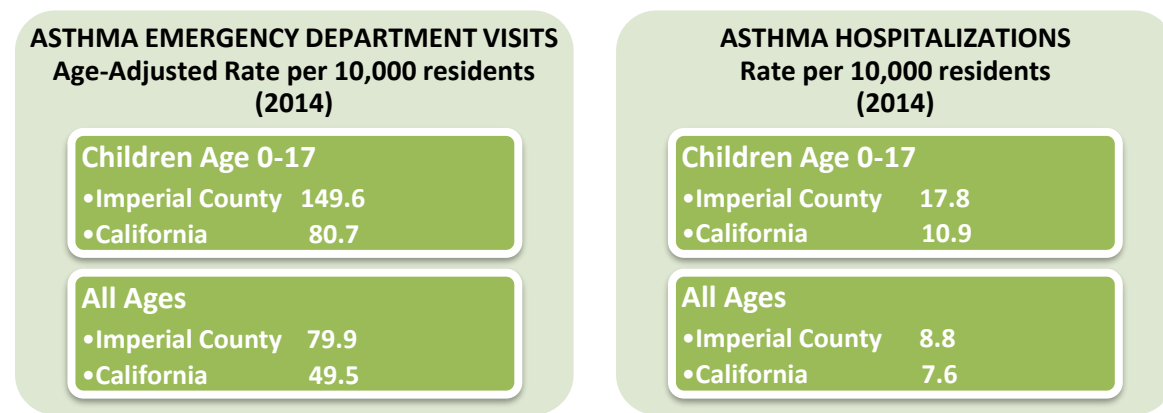
In the Imperial County adults that are diagnosed with Diabetes have a higher rate of obesity, smoking patterns, overweight, inactive living and fruit & vegetable intake than the general adult population.

Diabetes Risk Factors, Imperial County, 2009



Asthma:

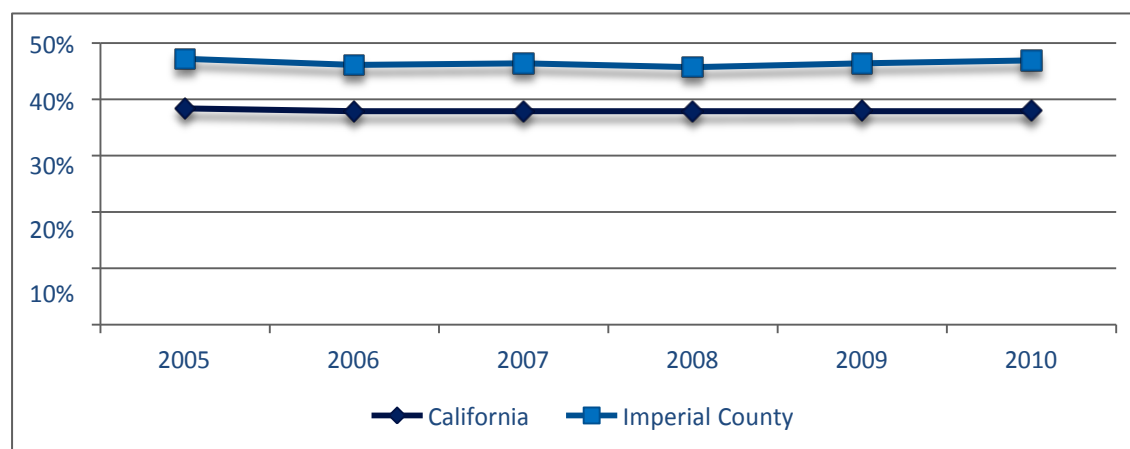
Although the Imperial County does not have a higher rate of Asthma cases than the California average, there are disparities in the amount of times that Asthma patients visit the Emergency Department.



Obesity:

Imperial County showed to have a higher number of overweight and obese students than the California average.

Overweight/Obese Students, Imperial County and California · 2005 – 2010



Source: California Department of Education, Physical Fitness Testing Research Files

Forces of change Assessment

The Forces of Change Assessment is one of the four assessments conducted as part of the MAPP framework. This assessment focused on identification of opportunities and threats that might impact the community and how the public health system operate and was designed to help community stakeholders answer the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

During the months of October and November 2015, the first step of business for the Steering Committee and Stakeholder Group was to identify local categories for the Forces of Change document. The Steering Committee took the lead on determining the categories, after reviewing and discussing selected tools from the MAPP handbook and a few existing Forces of Change documents. The following categories were created by the Steering Committee and accepted by the Stakeholder Group:

- Place – (environment, geographic location, climate)
- Technological & Scientific (social media, advances in diagnostics and treatment EMR/Health Information Exchange, medical home, prevention)
- Political/Legal/Ethical (elected officials, policy, regulations (making/implement) equity, transparency, governance, representation, judicial)
- People (education, culture, relationships, social associations, literacy, and language)
- Economics (those medically underserved, access to care, safe and healthy housing, education pathways/school systems, P-16 Council)

Following the selection of the category groups, the Steering Committee and Stakeholder Group used various mechanisms including fact-to-face meetings, brainstorming sessions, large and small group process techniques, and online document sharing and discussion strategies to conduct needed work and finalize the Forces of Change document. The complete, comprehensive matrix of key forces and their associated threats and opportunities can be found here (Appendix 6). Within the 5 categories that were identified, a total of 33 forces were agreed upon.

Forces of Change Highlights

Quality Initiatives:

Threats: Fragmented and/or divergent mandates and objectives; lack of coordination across local system; no forum for local discussion.

Opportunities: Increased opportunity to leverage existing programs (evidenced-based; best practices; and best practice models); increased opportunities to replicate models.

Patient Centered Medical Home/Universal Electronic Medical Records:

Threats: Lack of coordination across local system.

Opportunities: Improved medical home capability; health care testing – increased recovery and less cost; improved continuity of care – less invasive; real time data; access and increased timeliness to care and health education (patient and provider).

Local Health Policy:

Threats: Local resistance to health policy; inconsistent policy adoption and implementation across communities; limited communication about policy adoption; cost of implementing health policies; special interest groups.

Opportunities: Creation of the Local Health Authority; create a council of government to access regional funding opportunities; educate elected officials about health issues and opportunities.

Health Equity:

Threats: Lack of coordination, limited communication and linkage with efforts, initiatives and organizations.

Opportunities: Development of a system/clearing house to collect and disseminate information to maximize collaboration, leverage capability and implement initiatives.

Internet/Social Media:

Threats: Unreasonable patient expectations vs. appropriate provider intervention; increased threat for misinformation/self-diagnosis/confusion; sensationalism and conflicting information

Opportunities: Alerts for both patient and providers

Geographic Location:

Threats: Bi-national healthcare system; health threats from shrinking Salton Sea and insecure funding for restoration/mitigation.

Opportunities: Bi-national healthcare system; agricultural industry; international trade; access to regional healthcare system (San Diego, Yuma, Riverside, and Mexicali); tourism; large federal and state presence.

Identifying Priorities and Impact Targets



IDENTIFYING PRIORITIES AND IMPACT TARGETS

As each meeting was held and decisions were made, the Community Partnership group remained cognizant about the necessity to develop a Community Health Improvement Plan (CHIP) that was informed by the Community Health Assessment (CHA) process, and at the same time, practical, not over burdensome to implement, with a sufficient level of accountability for a 3-5 year CHIP. The sections below describe activities and efforts that occurred to try and complete this.

During the months of September and October 2015, Community Partnership meetings were held to discuss not only the progress of the health assessment processes, but also to gather information on local health indicators with the purpose of using the information to help inform the development of health priorities.

During the September 2015 Imperial County Health Improvement Partnership Meeting, attendees were provided with list of 25 health indicators to review. This initial listing included not only health indicators as discussed in the Health Status Report, but also additional health indicators that were identified by the Steering Committee and Community Partnership members. The health indicators, along with resources and supplemental information describing relevant data sources for each, key attributes, as well as contextual information and examples that could be used for each one were provided to the Community Partnership members. As part of the first phase of prioritizing and selecting the top health indicators, meeting participants were provided with note cards and asked to list the top 3 local health issues that were of most concern to them. Upon completion, the cards were collected by Public Health Department staff for grouping and display. Once the selected health issues/priorities were transcribed and summarized, they were posted throughout the meeting room for a second voting process. Each meeting participant was provided with 3 voting dots and again asked to vote for the top three health priorities that resonated for Imperial County. The votes were tabulated and the top 7 health priorities were identified as follows:

Top 7 Health Priorities

Obesity – Air Quality – Mental Health Access – Diabetes - Poor Nutrition – Inactive Lifestyle – Teen Pregnancy

Following the September 2015 Community Partnership meeting, it was determined that the health priorities needed to be further refined, and go through an additional iteration process. During the October 2015 meeting, the Community Partnership reviewed the top 7 health priorities previously selected with the goal of narrowing the list to the top 5 health priorities. An updated list of the of the health indicators, including examples of evidence based practices related to each, was provided to each Community Partnership member. The participants convened into 2 separate working groups, consisting of 7 members each. The workgroups were asked to review the 7 health priorities, discuss the list of evidence based interventions, the most important health risks identified from the survey results, and feedback from the community survey and community forum regarding what residents feel was working or not working well in our community. They were also asked to discuss and answer the following three questions when thinking about which health priorities should remain on the list:

- Do the 8 identified health risks (from survey and community forum) resonate with the 7 health priorities identified by the stakeholders?
- Given the challenges and successes that have been discussed, does the health priority have evidence-based practices that would be successful?
- Does this priority have the ability to leverage opportunities for broad stakeholder involvement?

Top 5 Health Priorities

Following the small group discussion, participants came back together and shared their identified priorities. By consensus the following five health priorities were adopted by the group:

1. Obesity
2. Food Environment
3. Asthma
4. Inactive Lifestyle
5. Drug Use

Transitioning to 3 Priority Areas

At this point in the community health assessment process, the Community Partnership group was completing the different assessments as outlined in the MAPP process. Priority areas were refined one more time during the December 2015 Community Partnership meeting taking into consideration the outcomes and reports from the Community Partnership and Steering Committee meetings, discussions around selected health priorities, results from the four assessments that were conducted during 2015, and the concept of collaboration versus collective impact.

Collaboration vs. Collective Impact

Collaboration and collective impact are both terms that describe the convening of people and organizations to work together. Such convenings, however, vary greatly in terms of their purpose, outcomes, and longevity. Collaboration typically comes together for a short, defined amount of time to work on a grant or special project. The individual grant or project guides the group and the group then works to gather data to prove certain assumptions right or wrong. In a project-driven collaboration, organizations may advocate to bring new ideas and concepts into the community that they believe will help to achieve the project's desired outcomes. The impact of collaboration is project-specific and does not typically translate to changes in the every-day function of collaborating organizations.

In comparison to collaboration, collective impact is the concept of convening organizations around a common agenda, acknowledging that successful work requires active engagement from a variety of sectors that together affect outcomes. This common agenda is set by having stakeholders assess outcomes, set priorities, find solutions, and create shared metrics to improve outcomes and measure progress.

Importantly, collective impact moves beyond creating a short-term partnership to changing the way that organizations work. Such changes are evidenced by continuous and active engagement of partners that guides organizations' thought, work, and communication in a coordinated and reinforcing

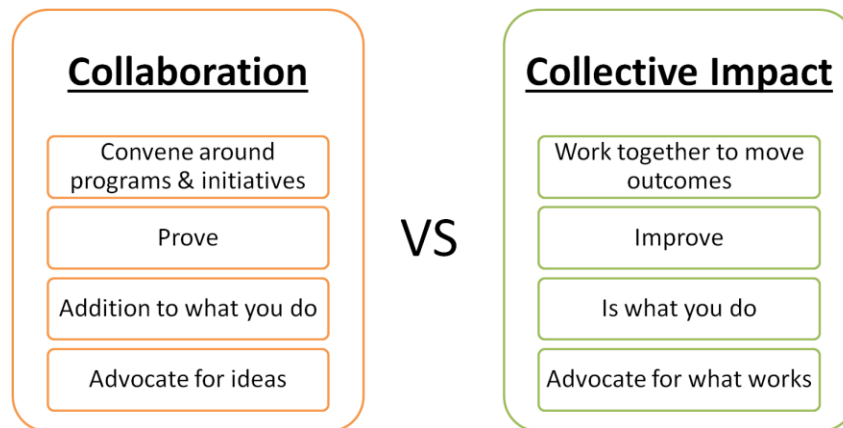


Figure 3

manner to achieve impact on the common agenda. The comparison between collaboration vs collective Impact is shown in Figure 3.

The collaboration versus collective impact discussion and restructuring of the final priority areas were critical steps in minimizing agency worry of being overburdened with additional workplans and activities, overlapping efforts and activities, and disjointed projects and efforts.

The discussions about further refining priorities and collaboration versus collective impact were well received by those who attended the meeting. The collaboration versus collective impact discussion was critical in minimizing agency worry of being overburdened with additional work plans and activities, overlapping efforts and activities, and disjointed projects and efforts.

Final 3 Priority Areas

This collective impact discussion ultimately led to the identification of three final priority areas that were less focused on individual health indicators and more focused on opportunities for collective impact. The final priority areas identified by consensus were:

1. Healthy Eating and Active Living
2. Community Prevention Linked with High Quality Healthcare
3. Healthy and Safe Communities and Living Environments.

Formulate Goals and Strategies



FORMULATE GOALS AND STRATEGIES

Following the finalization of the 3 health priorities with corresponding focus areas, the stakeholder group led a discussion on creating a focused workgroup for each health priority (3 workgroups), one for each of the three priority areas selected. The workgroups were designed to help inform and develop strategies and goals for the CHIP. Each workgroup had 2 chairpersons who were responsible for assembling a workgroup comprised of interested community members and subject matter experts for the purpose of identifying interventions, strategies and lead agencies for each of the health issues contained in the priority areas.

Impact Targets

Each workgroup was also charged with identifying potential measures for the respective strategies, conducting an environmental scan, and working on Cause and Effect Diagrams for each focus area. The environmental scan activities allowed each workgroup to explore and understand the assets and gaps in the community, the existing activities, programs, policies, and efforts in the communities, as well as the gaps. Additionally, this information provides a snapshot of existing partnerships, and coordinated efforts. The Cause and Effect diagram activities provided the work groups a structure to identify and discuss the problem statements, and information for the next MAPP step, formulating goals and strategies.

Three impact targets were also identified for each priority area. Impact targets were developed by considering the following: a) identification of evidence-based interventions; b) the most important health risks identified from the survey results; and c) feedback from the community forum regarding what residents felt was working or not working well in our community. Figure 4 depicts the vision, final priority areas and their respective impact targets.

| |
|---------------------------------------------------------------------------------------------------------|
| A community that supports and empowers all people to thrive and be healthy. |
| Priority Areas and Impact Targets |
| <u>Healthy Eating and Active Living</u> |
| Consumption of affordable, accessible and nutritious foods |
| Engagement in affordable and safe opportunities for physical activity |
| Achieve and maintain healthy weight |
| <u>Community Prevention Linked with High Quality Healthcare</u> |
| Asthma detection, management and education |
| Prenatal care - Early and Adequate |
| Diabetes detection, management and education |
| <u>Healthy and Safe Communities and Living Environment</u> |
| Engagement in improving air quality |
| Prescription drug abuse prevention |
| Linking family members, care givers and persons living with dementia across systems of care and support |

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

The definition of a Community Health Improvement Plan (CHIP) is:

A long-term systematic effort to address community health problems used by health organizations and community partners to set priorities and coordinate and target resources. It is critical in developing policies and defining actions that promote health. A CHIP is created through a collaborative process and should address the gamut of strengths, weaknesses, challenges and opportunities that exist in the community.

The development of the CHIP

The development of the CHIP was accomplished through a three step process.

Step1: Better Understand the Impact Targets Identified through the Community Assessment

Each of the three Priority Area Workgroups invested a considerable amount of time and effort to better understand the impact targets of their respective Priority Area by identifying:

- The work that is already happening in our community to improve the health issue;
- The factors in our community that have led to the increased burden of each of the Impact Targets;
- The evidence-based and best-practice strategies that are either already in place or could be put in place to improve the health of our community.

Step 2: Develop a Measurable, Five-Year Work Plan for Impact Targets in Each Priority Area

The Priority Area Workgroups benefited from the insight of various subject matter experts that joined the effort to develop a meaningful work plan, rooted in the realities of our community and the organizations that provide health and community services. Based on an in-depth understanding of the Impact Targets and with the guidance of the subject matter experts each workgroup:

- Identified high priority strategies to reduce the burden of the impact targets and improve the health of our community. These high priority strategies leverage existing efforts and integrate several new strategies.
- Created a Work Plan spanning 2017 through 2021, to guide our work and gauge our progress. The Work Plan includes: a goal for each impact target; how the goal will be measured; the timeframe and indicators to measure milestones of progress; and the partners that will lead the efforts.

Step 3: Develop an Integrated Work Plan that Supports Collective Impact

Effective solutions benefit when work is not performed in silos and in recognizing that activities in one sector can be mutually reinforced by- and connected to activities in another sector. Collective impact requires that organizations objectively assess what does and does not work in the community, share lessons learned, and then improve implementation of effective practices in different settings. In developing an Integrated Work Plan the principles of collective impact will be further developed in an Introduction to the Integrated Work Plan.

Healthy Eating, Active Living



PRIORITY AREA: HEALTHY EATING, ACTIVE LIVING

This priority area supports our vision by facilitating change in multiple venues to create environments that lead to increased access to healthy food and beverage choices and safe places to be active. Good nutrition, combined with physical activity, is essential for reducing the risk of certain chronic diseases and is associated with positive health outcomes. While there is work currently being performed around this priority area, creating community environments that support healthy lifestyle options requires additional multi-sector and place-based efforts. Therefore, the focus of our community health improvement plan will be placed on working collectively on strategies that maximize resources and outcomes to help improve the overall health status of our community.

Supporting Assessment Data

- High overweight and obesity rates (*Community Health Status Assessment*)
- Diabetes identified as one of the most important health risks (*Community Themes and Strengths Assessment*)
- Low satisfaction with opportunities to be physically active and physical activity identified among the top things to improve life (*Community Health Status Assessment*)
- Weather identified as a major barrier to being physically active (*Community Health Status Assessment*)
- Access to healthy and affordable foods identified as a major theme (*Community Themes and Strengths Assessment*)
- High food insecurity rates (*Community Health Status Assessment*)
- Creation of Local Health Authority to focus on community health issues of concern (*Forces of Change Assessment*)
- Lack of formal healthy eating and active living policies (*Cause and Effect Diagrams*)
- Good communication and collaboration across agencies and good job of establishing local partnerships and alliances (*Local Public Health System Assessment*)

Impact Targets

- ❖ Consumption of affordable, accessible, and nutritious foods (healthy eating, food security)
- ❖ Engagement in affordable and safe opportunities for physical activity (active living)
- ❖ Achieve and maintain healthy weight (healthy eating, active living)

Strategies

Increase availability of healthier, affordable food and beverage choices

- Impact Targets: healthy eating, food security

Increase food recovery systems

- Impact Targets: healthy eating, food security

Increase opportunities for indoor and outdoor physical activity

- Impact Target: active living

Increase community resource coordination and access to health information

- Impact Targets: healthy eating, food security, active living

Enhance health information and mobilize change

- Impact Targets: healthy eating, food security, active living

Healthy Eating, Active Living Workplan 2017-2021

| Impact Targets | Indicators | Measures | Goals | Timeframe | Responsible Partners |
|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Consumption of affordable, accessible, and nutritious foods (healthy eating, food security) | <ul style="list-style-type: none"> ➤ Wellness policies ➤ Health retail strategies | % of children living in food secure households ¹ | 5% reduction ¹ from baseline | December 2021 | <ul style="list-style-type: none"> ➤ Imperial Valley Food Bank ➤ Public Health ➤ Childhood Obesity Prevention Alliance (COPA) |
| Engagement in affordable and safe opportunities for physical activity (active living) | <ul style="list-style-type: none"> ➤ Food recovery ➤ Creating & enhancement of physical activity opportunities | % of children meeting fitness standards ² | 10% increase ² from baseline | December 2021 | |
| Achieve and maintain healthy weight (healthy eating, active living) | <ul style="list-style-type: none"> ➤ Community education ➤ Resource coordination | Adults with BMI >30 ³ | 5% reduction ³ from baseline | December 2021 | |

| Data Source for Health Improvement Plan Measures | Baseline for Goals |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| ¹ California Food Policy Advocates (CFPA) 2014 | 31% of low income households in Imperial County are food insecure |
| ² Kidsdata.org 2015 data | 13.9% of 5 th graders, 23.6% of 7 th graders and 30.3% of 9 th graders in Imperial County meet all fitness standards |
| ³ California Health Interview Survey (CHIS) 2014 | 41.9% of adults in Imperial County with a Body Mass Index (BMI) greater than 30 |

Data Source for Health Improvement Plan Measures

¹California Food Policy Advocates (CFPA) 2014 – CFPA is a 501(c)3 non-profit organization exclusively focused on food policy and increasing low-income Californians access to healthy food. The data source is the California Health Interview Survey (CHIS) 2014. Interview questions regarding food security are asked of adults who report household income below 200% of poverty. Results lag about 2 years after the survey.

²Kidsdata.org 2015 data – Percentage of public school students in grades 5, 7, and 9 meeting 6 of 6 fitness standards. The data source is the California Dept. of Education, Physical Fitness Testing Research Files (Dec. 2015). In order to meet fitness standards, children must score in the "Healthy Fitness Zone" on 6 out of 6 fitness tests. Years presented are the final year of a school year (e.g., 2014-2015 is shown as 2015).

³California Health Interview Survey (CHIS) 2014 – CHIS is an on-going health survey conducted by the UCLA Center for Health Policy Research throughout California. It allows for comparison of Imperial County results and statewide results. The survey includes a broad range of health and demographic questions including self-reported Body Mass Index. Because of the time it takes to analyze the information collected, release of survey results can lag about 2 years (e.g., 2016 survey results may be released in late 2017 or 2018).

Community Spotlight

Child Obesity Prevention Alliance (COPA)

The Childhood Obesity Prevention Alliance (COPA), established in 2009, has worked to improve and maintain the health of Imperial County children and their families through the implementation of an array of childhood obesity prevention strategies. Over the last few years, it has served as a forum for organizations to stay engaged and informed about obesity prevention issues and practices, as well as a training platform, venue to build and strengthen partnerships, and has been a central resource that advocates for healthy community changes. Its membership is made up of over 40 traditional and non-traditional partners including those representing the child care, school, law enforcement, healthcare, and the community sectors.

The core focuses of COPA's current workgroups include improving access to and consumption of healthy food and beverage choices and increasing opportunities for physical activity in the community in which we live, learn, play, shop, and work. COPA members and partners collaborate with schools and community members in annual events such as International Walk to School Day and Bike to School Month, where walking and biking to and from school is promoted and highly encouraged. Trainings and workshops are also made available to partners, child care providers and others around the implementation of healthy food and beverage and physical activity standards, and gardens at child care and other sites. More recently, COPA has worked on making social media training, tools and resources available to its members and community partners to enhance health education messages and expand local networking opportunities.

If interested in making healthy change happen in our community or to learn more about COPA, visit www.iccopa.org or call (442) 265-1367.



Imperial Valley Food Bank (IVFB)

The Imperial Valley Food Bank (IVFB), recognized as the 2016 California Nonprofit of the Year, has been serving Imperial County since 1991 with a mission to 'bring health and hope to the Imperial Valley.' The IVFB currently collaborates with over 100 agencies in the county to serve individuals and families

in the region. Its primary function is to resource, allocate and distribute nutritious foods through churches, schools, shelters and soup kitchens.

Imperial County is among the top counties in California that lacks reliable access to a sufficient quantity of affordable, nutritious food. Through programs such as the Weekend Backpack Program, Mobile Food Pantry, USDA Commodities and Fresh Rescue, the IVFB helps fill some of the food security gaps and tries to meet the continual needs of over 20,000 community residents. In 2015, and through their Fresh Rescue Program, the IVFB rescued 250,000 pounds of food and is on target to exceed the previous year in 2016. Fresh Rescue Program staff and volunteers pick up, in a refrigerated truck, edible but non-saleable foods that would otherwise be disposed from local grocery stores. The food that is 'rescued' is then provided to shelters and soup kitchens, which in turn use the food items to prepare and distribute meals for individuals in need.



Providing local hunger relief to residents in need requires a lot of time, resources and effort. The IVFB's ability to distribute food across the county relies on individuals from our local community and across the globe.

If interested in supporting or learning more about the Imperial Valley Food Bank and its programs, please visit <http://www.ivfoodbank.org> or call (760)370-0966.

Providing local hunger relief to residents in need requires a lot of time, resources and effort!

Enhancing Community Environments to Support Active Play!

Physical activity has an abundant mix of physical, health, and emotional benefits. In Imperial County, local community programs and their partners have been working closely with agencies serving preschool-aged children to change or enhance the local environment to create opportunities for physical activity through the implementation of the Painting Preschool Playgrounds for Movement. Through this Movement, sites are encouraged to enhance their playgrounds with stencil designs to help increase active play among children. Not only do children become more physically active by making the designs available, it is a mechanism for them to gain motor skills while complementing learning in the social-emotional development, language and literacy, English-language development, mathematics and nutrition areas.

Earlier in 2016, Sacred Heart Preschool, Imperial County Office of Education's Calexico Early Head Start, and Wellness 4Kids, a wellness initiative funded by the Heffernan Memorial Healthcare District and ran by Studio Fit, were the first to implement the Painting Preschool Playgrounds for Movement in Imperial County. All, with support from partners and volunteers, re-designed their play areas with the intent of creating additional opportunities for movement. Recently, the City of El Centro expressed interest in further promoting health and wellbeing by increasing outdoor physical activity opportunities for children at two of their sites. Before the end of fall 2016, the City of El Centro will be integrating the Painting Preschool for Playgrounds for Movement stencil kit components throughout several areas of their community center to encourage maximal opportunities for physical activity.

If interested in learning more about the Painting Preschool Playgrounds for Movement or converting your play area into a more interactive learning zone, contact the Imperial County Public Health Department at (442) 265-1390.

The Components

The Painting Preschool Playgrounds for Movement makes available an array of stencils to help design a play area.

Components that can be integrated to encourage movement include tracks, group activity space, pathways, shapes, letter, numbers, colors, bull's-eye for tossing, throwing and kicking, and hopscotch among others.



Community Prevention Linked with High Quality Health Care



PRIORITY AREA: COMMUNITY PREVENTION LINKED WITH HIGH QUALITY HEALTHCARE

This priority area strengthening the broad mix of programs and services that help to keep us healthy. It improves the physical and social environments in which we live, work, and play. Linking healthier community environments with high quality healthcare increases our ability to be healthy and to prevent and manage chronic health issues. While we strive for high quality healthcare across the board, the health issues identified through the community health assessment process reflect significant disparities in our community and will be the focus of our health improvement plan.

Supporting Assessment Data

- Significant shortage of primary-care and specialty-care providers (*Community Health Status Assessment*)
- High rates of hospitalizations for asthma and diabetes (*Community Health Status Assessment*)
- Air quality and diabetes identified as most important health risks (*Community Themes and Strengths Assessment*)
- Low percentage of women who receive adequate prenatal care (*Community Health Status Assessment*)
- Creation of Local Health Authority to focus on community health issues of concern (*Forces of Change Assessment*)
- Good communication and collaboration across agencies (*Local Public Health System Assessment*)
- Lack of awareness of free on-line resources (*Cause and Effect Diagrams*)
- Few preventive care educators (*Cause and Effect Diagrams*)
- Lack of knowledge of asthma national guidelines (*Cause and Effect Diagrams*)
- Good job of establishing local partnerships and alliances (*Local Public Health System Assessment*)

Impact Targets

- ❖ Asthma detection, management and education (asthma)
- ❖ Prenatal Care – Early and Adequate (prenatal care)
- ❖ Diabetes: Detection, management and education (diabetes)

Strategies

Increase community resource coordination and capacity

- Impact Targets: asthma, prenatal care, diabetes

Adopt quality standards and enhance training in the healthcare system

- Impact Targets: asthma, prenatal care, diabetes

Integrate care across the healthcare system

- Impact Targets: asthma, prenatal care, diabetes

Increase availability of healthier, affordable food and beverage choices

- Impact Target: diabetes

Increase opportunities for indoor and outdoor physical activity for all ages

- Impact Target: diabetes

Enhance health information and mobilize change

- Impact Targets: asthma, prenatal care, diabetes

Community Prevention Linked with High Quality Healthcare Workplan 2017-2021

| Impact Targets | Indicators | Measures | Goals | Timeframe | Responsible Partners |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------|
| Asthma detection, management and education (asthma) | <ul style="list-style-type: none"> ➤ Linkages with community-based programs and across the continuum of care ➤ School and home asthma management ➤ Asthma standards adoption | Rates of ED visits due to asthma ⁴ | 20% reduction ⁴ from baseline | December 2020 | ➤ CACHI Asthma Workgroup |
| Prenatal Care – Early and Adequate (prenatal care) | <ul style="list-style-type: none"> ➤ Resource coordination ➤ Community education | % of pregnant women who receive adequate prenatal care ⁵ | 15% increase ⁵ from baseline | December 2019 | <ul style="list-style-type: none"> ➤ MCAH Board ➤ California Health & Wellness |
| Diabetes detection, management and education (diabetes) | <ul style="list-style-type: none"> ➤ Resource coordination ➤ Community education | Rate of preventable hospitalizations due to short-term complications of diabetes ⁶ | 10% reduction ⁶ from baseline | December 2020 | ➤ LHA Quality Improvement/Utilization Management Committee |

| Data Source for Health Improvement Plan Measures | Baseline for Goals |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ⁴ Office of Statewide Health Planning and Development, 2014 | Rate of Imperial County children aged 0-17 seeking emergency department (ED) services: 149.6 per 10,000; Rate of Imperial County adults (18 and older) seeking emergency department (ED) services: 55.8 per 10,000 |
| ⁵ State of California, Department of Public Health: 2012-2014 Birth Records | 50.3% of pregnant women receive adequate or adequate plus prenatal care |
| ⁶ Office of Statewide Health Planning and Development, 2012-2013 | Rate of preventable hospitalizations due to short-term complications of diabetes: 39.7 discharges per 100,000 population age 18+ |

Data Source for Health Improvement Plan Measures

⁴Office of Statewide Health Planning and Development, 2014 (OSHPD) - collects data and distributes information on healthcare quality, outcomes, and utilization in California. Data are available on hospital utilization (hospitalizations, emergency department visits) for certain conditions and diseases, including asthma and diabetes. Release of data can lag 2 or more years.

⁵State of California, Department of Public Health: 2012-2014 Birth Records – The County Health Status Profiles report contains selected health status indicators recommended by the U.S. Department of Health and Human Services for monitoring state and local progress toward achieving the goals set forth in Healthy People 2020. Profiles 2016 contains data from 2008-2014. Profiles are updated each year.

⁶Office of Statewide Health Planning and Development, 2012-2013(OSHPD) collects data and distributes information on healthcare quality, outcomes, and utilization in California. Data are available on hospital utilization (hospitalizations, emergency department visits) for certain conditions and diseases, including asthma and diabetes. Release of data can lag 2 or more years.

Community Spotlight

Healthy Breathing

The Imperial Valley Child Asthma Program (IVCAP) has been providing no-cost, community-based support to asthmatic children and their families for the last fifteen years. IVCAP is a grant-funded program administered by El Centro Regional Medical Center (ECRMC) in partnership with Pioneers Memorial Healthcare District (PMHD). The program focuses on reducing hospitalizations of children from the ages of 0-18 by building children's and parents' asthma management skills, alleviating in-home environmental asthma-triggers, and educating the community and local providers about asthma and standards of care.

IVCAP partners with a variety of providers, including the pediatric departments at ECRMC and PMHD to receive referrals for patients with asthma. Once a patient is contacted and enrolled in IVCAP, the program provides the patient with at least two home visits by a registered nurse or a community health worker. The in-home visits allow IVCAP staff to work closely with children that suffer from asthma and their family members, and provide tailored interventions to meet each family's needs.

IVCAP is a persistent advocate for improving the quality of life for children with asthma, and has extended program efforts to work with schools, landlords, and the community at large to support environments that help children with asthma to live happy and healthy lives.

If you would like to learn more about IVCAP, how to enroll your child, or how to get involved in the program's asthma efforts, visit www.ivcap.org or call the Child Asthma Program Director at (760) 482-0978.

Fun Ways to Keep Kids Physically Fit

Physical activity has an abundance of physical, health, and emotional benefits. In Imperial County, local community programs and their partners have been working closely with agencies serving preschool-aged children to create opportunities for physical activity through the implementation of the Painting Preschool Playgrounds for Movement.

IVCAP Quick Facts



IVCAP has provided asthma case management services to the families of more than 8,000 children.

In May of each year, IVCAP partners with schools and other agencies to host various events in observance of Asthma Awareness Month and World Asthma Day.

IVCAP's annual Stop and Listen Asthma Forum brings together students, researchers, and community leaders to discuss asthma and promote cross-sector community action to help people breathe healthy.

Through this project, sites are encouraged to enhance their playgrounds with stencil designs to help increase active play among children. Not only do the designs help children become more physically active, but they also help them gain motor skills while

In 2016, Sacred Heart Preschool, Imperial County Office of Education's Calexico Early Head Start, and Wellness 4 Kids, a wellness initiative funded by the Heffernan Memorial Healthcare District and run by Studio Fit, were the first to implement the Painting Preschool Playgrounds for Movement in Imperial County. All, with support from partners and volunteers, re-designed their play areas with the intent of creating additional opportunities for movement. Recently, the City of El Centro expressed interest in further promoting health and wellbeing in their children by increasing outdoor physical activity opportunities at two of their sites. Before the end of 2016, the City of El Centro plans to integrate the Painting Preschool for Playgrounds for Movement stencils around the block of its community center and at Bucklin Park to encourage maximal opportunities for physical activity.



If you're interested in learning more about the Painting Preschool Playgrounds for Movement or converting your play area into a more interactive learning zone, contact the Public Health Department at (442) 265-1390.

Support for Diabetes Wellness

Local hospitals are addressing the need for more education to help individuals better manage their diabetes.

The Diabetes Wellness Program at Pioneers Memorial Hospital (PMH) offers the latest health information for persons with diabetes and their caregivers. Increased knowledge and understanding of diabetes is key to maintaining a healthy lifestyle and reducing the risk of medical complications.

The Pioneers Diabetes Wellness Program follows the National Standard for Diabetes Education and the Life with Diabetes Curriculum. The program is recommended for individuals who meet one or more of the following: newly diagnosed with diabetes, new health complications due to diabetes, change of therapy program, uncontrolled diabetes as evidenced by elevated A1C, or no prior education.

El Centro Regional Medical Center (ECRMC), in partnership with Calexico Heffernan Memorial Healthcare District, offers a variety of classes led by a certified diabetes educator. Classes are available in Spanish or English at either the Calexico Outpatient Center or ECRMC. Topics include diabetes

overview; medication & physical activity; acute and chronic complications; lifestyle changes; and goal setting and psychological adjustment.

There is no charge to participate in the diabetes education classes or support group meetings.

For more information or to reserve a space, contact the PMH community educator at (760) 351-4495 or the ECRMC educator at (760) 482-5000.

Healthy and Safe Communities and Living Environments



PRIORITY AREA: HEALTHY AND SAFE COMMUNITIES AND LIVING ENVIRONMENT

This priority area supports our vision by linking and increasing coordination among local organizations and groups around dementia, improving air quality, and accountability and appropriate use of prescription medications. Increasing coordination to meet the needs of families with dementia supports a living environment that is healthy, safe, and offers families the option to keep loved ones at home longer. Efforts to monitor prescription medication are in place, but more is needed to support safe communities and living environments. Air quality, although improvements have taken place, continues to impact the health of our community. The target areas identified—dementia, air quality, and prescription drug abuse, were identified through the community health assessment (CHA) process and will be the focus of our health improvement plan

Supporting Assessment Data

- Lack of local respite care programs, caregiver support programs, and volunteers for family members, caregivers and persons living with dementia (*Cause and Effect Diagrams*)
- Prescription Drug Abuse identified as one of the health risks (*Community Themes and Strengths Assessment*)
- Air quality identified as one of the most important health risk (*Community Themes and Strengths Assessment*)
- Dissatisfaction with Adult Caregiver Support (*Community Themes and Strengths Assessment*)
- Few prescribers and dispensers are using the CURES system (*Cause and Effect Diagrams*)
- No local prescription drug abuse prevention taskforce (*Cause and Effect Diagrams*)
- Inadequate training for caregivers and family members of persons living with dementia (*Cause and Effect Diagrams*)
- Insufficient coverage of In-Home Support Services for persons living with dementia (*Cause and Effect Diagrams*)

Impact Targets

- ❖ Engagement in improving air quality (air quality)
- ❖ Prescription drug abuse prevention (prescription drug abuse)
- ❖ Linking family members, caregivers and persons living with dementia across systems of care and support (dementia)

Strategies

Develop model diversion program

- Impact Target: prescription drug abuse

Expand training for healthcare and social service providers

- Impact Target: dementia

Enhance education and information for family members and caregivers

- Impact Target: dementia

Increase and enhance use of CURES 2.0

- Impact Target: prescription drug abuse

Increase coordination among local organizations, groups and agencies

- Impact Target: dementia

Enhance health information and mobilize change

- Impact Target: dementia

Increase engagement in improving air quality

- Impact Target: air quality

Healthy and Safe Communities and Living Environment - Workplan 2017-2021

| Impact Targets | Indicators | Measures | Goals | Timeframe | Responsible Partners |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------|
| Engagement in improving air quality (air quality) | <ul style="list-style-type: none"> ➤ Community education ➤ Integration of health and air quality metrics ➤ Information sharing strategies | Engagement in SIP, and integration of health and air quality metrics ⁷ | 25% increase from baseline ⁷ | December 2017 | <ul style="list-style-type: none"> ➤ LHA Commission |
| Prescription drug abuse prevention (prescription drug abuse) | <ul style="list-style-type: none"> ➤ Community education ➤ Diversion programs ➤ Enhanced CURES 2.0 implementation ➤ Community education | % of providers adopting 2016 CDC guidelines for prescribing opioids for chronic pain ⁸ & enhanced CURES 2.0 use ⁹ | 25% increase from baseline ⁸⁹ | December 2021 | <ul style="list-style-type: none"> ➤ Prescription Drug Abuse Workgroup |
| Linking family, caregivers and persons living with dementia across systems of care and support (dementia) | <ul style="list-style-type: none"> ➤ Number of providers trained in dementia assessment and care guidelines ➤ Resource coordination ➤ Community education | Number of social admissions to ED for persons with dementia ¹⁰ | 10% reduction from baseline ¹⁰ | December 2021 | <ul style="list-style-type: none"> ➤ Social Services ➤ Imperial County Public Health Department |

| Data Source for Health Improvement Plan Measures | Baseline for Goals |
|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ⁷ <i>SIP – State Implementation Plan</i> | Number of providers engaged in the SIP process; Linking air quality data with health survey data |
| ⁸ <i>Center for Disease Control and Prevention (MMWR March 18, 2016)</i> | Number of patients who OD on Rx narcotics; Number of accidental Rx overdoses; Number of providers who are following the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain |
| ⁹ <i>CURES 2.0 (Controlled Substance Utilization Review and Evaluation System)</i> | Number of dispensers and prescribers consistently using CURES system (and features) |
| ¹⁰ <i>Office of Statewide Health Planning and Development, 2014</i> | Number of social admissions to the ED for persons with dementia |

Data Source for Health Improvement Plan Measures

⁷SIP – State Implementation Plan - The State Implementation Plan (SIP) is the federally-enforceable plan for each State which identifies how that State will attain and/or maintain the primary and secondary National Ambient Air Quality Standards (NAAQS). A SIP contains the control measures and strategies developed through a public process to attain and maintain the national ambient air quality standards.

⁸Center for Disease Control and Prevention (MMWR March 18, 2016) -The Centers for Disease Control and Prevention (CDC) is a federal agency that conducts and supports health promotion, prevention and preparedness activities in the United States with the goal of improving overall public health. It is a federal agency under the Department of Health and Human Services. Guidelines are developed and/or updated as appropriate.

⁹ CURES 2.0 (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

¹⁰Office of Statewide Health Planning and Development, 2014 (OSHPD) collects data and distributes information on healthcare quality, outcomes, and utilization in California. Data are available on hospital utilization (hospitalizations, emergency department visits) for certain conditions and diseases, including asthma and diabetes. Release of data can lag 2 or more years.

Community Spotlight

Respite Program

Imperial County Area Agency on Aging offers Respite Care as In-Home Support to families and other paid caregivers in order to offer support and relief to those that are committed to tending to the needs of family members who are being managed at home. Respite hours serve to empower the individual caring for the family member by allowing for restorative time off and rejuvenating themselves in order to regain or protect physical and inner strength.

The local AlzCare, Inc in coordination with the local Area Agency on Aging Program offers services community education and caregiver support meetings. The local Alzheimer's Respite Care Program approach is twofold, focusing both on the elderly and disabled adults and caregivers. Services available for the elderly and disabled adults include assisting adults in their home by providing care, supervision, companionship, and activities while their caregiver gets a break. The goal is to prevent or delay institutionalization of either the person being cared for or the caregiver themselves. The Caregiver Respite Services offers an opportunity for caregivers to have a much needed break. Services for caregivers include helping caregivers take care of the frail elderly or disabled adult in their home. This allows for the caregivers to have some free time, take care of other responsibilities, and obtain (often much-needed) mental breaks.

If interested in learning more about the local Respite Care Program and how you can become involved, contact AlzCare at (442) 265-7000.

National Drug Take-Back Day

National Take Back Day: The National Prescription Drug Take-Back Day aims to provide a safe, convenient, and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications.

The National Prescription Drug Take-Back Day addresses vital public safety and health issues. Many Americans are not aware that the medicines in home cabinets are highly susceptible to diversion, misuse, and abuse. Rates of prescription drug abuse in the U.S. are alarmingly high, as are the number of accidental poisonings and overdoses due to these drugs. Studies show that many abused prescription drugs are obtained from family and friends, including from the home medicine cabinet. In addition, many Americans do not know how to properly dispose of their unused medications, often flushing them down the toilet or throwing them away – posing safety and environmental hazards.



Local Drug Take-Back Day events occur twice a year. These efforts are spearheaded through the local Drug Enforcement Agency, local law enforcement and community partners. For each event, local DEA agents set up and man a “Take-Back” booth where the public can drop off expired, unused, and unwanted prescription drugs. A total of three Imperial County locations are available for community members to drop off prescription drugs. This gives community members an opportunity to prevent pill abuse and theft by ridding their homes of potentially dangerous drugs. The service is free and anonymous, no questions asked.

Community members who are interested in disposing of their expired, unused, and unwanted prescription drugs or want more information about local Drug Take-Back Day events can (760)337-4400

Advocating for Healthy Environments

For nearly thirty years, Comité Cívico del Valle, Inc. (CCV) has worked to improve the health of Imperial County residents by advocating for environmental health and justice. CCV aims to educate residents, build capacity, and mobilize community engagement in health and equity efforts. CCV works with a variety of partners including community members, schools, researchers, grassroots organizations, and state and local government agencies to achieve its mission.

CCV’s current efforts emphasize air quality and asthma. To improve community awareness about air pollution levels, the organization implemented the School Flag Alert Program (SFAP). This program was adopted by 10 local schools and helps inform the community, especially school children, about the air quality through the display of different brightly colored flag – each color indicating a different level of air pollution. In addition to the SFAP, CCV operates the largest community-based air monitoring network in the country with over 40 monitors located throughout Imperial County, Mexicali, and the Salton Sea region; 13 of the monitors are located in schools. CCV has also partnered with Clinicas de Salud del Pueblo and San Diego State University’s Institute for Behavioral and Community Health to provide in-home asthma education to children with asthma and their families. With over 580 home visits in the past 12 months, Comité Cívico has helped to increase asthma self-management by educating families about how to track asthma symptoms, use medications and a peak flow meter properly, and understand and follow an Asthma Action Plan. During home visits, families are also shown how to identify and reduce in-home asthma triggers and monitor air quality and adjust activities accordingly.

CCV also empowers the community to take charge of environmental problems through their online tool called IVAN, which stands for Identifying Violations Affecting Neighborhoods. The tool allows residents to report concerns which are then investigated and resolved by government agencies in a timely manner. If you are interested in reporting a concern, please visit: <http://ivan-imperial.org/>.

If you would like more information about how to get involved with CCV's efforts, including their Youth Environmental Health Leadership Training Institute or their annual Environmental Health Leadership Summit, please visit <http://ccvhealth.org/> or call (760) 351-8761.

Integrated Workplan



INTEGRATED WORKPLAN

After development of the CHIP, an integrated workplan was created to emphasize how collective impact will help to move efforts forward. As a reminder, collective impact is the concept of convening organizations around a common agenda, acknowledging that successful work requires active engagement from a variety of sectors instead of work in silos. Collective impact recognizes that activities in one sector can be mutually reinforced by- and connected to activities in another sector.

To create this integrated workplan, first, strategies from all the priority areas were assessed for overlapping themes. Four themes emerged (Figure 1) that allow for alignment of strategies to leverage resources, reinforce efforts, and reduce duplication in work across the priority areas. These four themes include: 1) Enhance health information and mobilize change; 2) Prioritize health through policy and system change; 3) Improve equitable evidence-based healthcare; and 4) Better link healthcare, community programs and services.

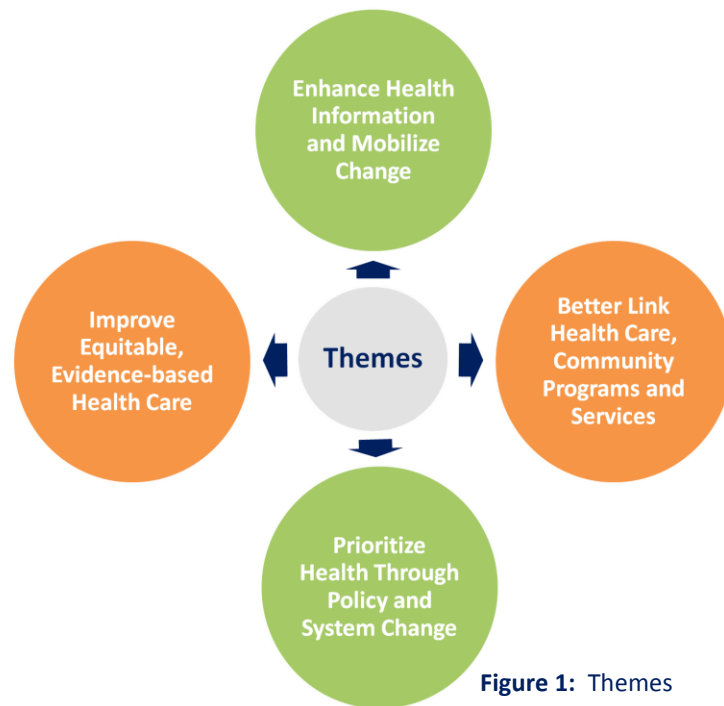


Figure 1: Themes

Under each theme, the integrated workplan aligned milestones that would minimize agency worry of being overburdened with additional activities. Organizations listed in the integrated workplan were working in silos towards selected impact targets. The organizations produced the integrated work plan to identify overlapping and disjointed projects in order to effectively build on each other's projects and efforts. The first year's milestones have as a focus the convening of diverse organizations, sharing of information, and strengthening of relationships; encouraging organizations to work outside silos.

The integrated workplan outlines how various strategies fall under each of these four themes. Three strategies discussed during the CHA encompass all priority areas and health issues and are part of the integrated workplan. These strategies are titled "Collective Targets" and will help to create a more informed, connected, and engaged community of residents and stakeholders. The Collective Targets in the integrated workplan are:

- Increase and support community engagement

- Integrate family-centered assessment and connection with social services and community resources and programs within healthcare
- Increase coordination among local organizations, groups and agencies to enhance and maximize resources and services.

As with the CHIP, this integrated workplan document identifies the lead organization or group that will convene stakeholders around the common agenda.

Our community has begun to align multiple infrastructures that will help collective impact to thrive (Figure 4). These infrastructures include: 1) **Governance** by the Local Health Authority Commission; 2) **Leadership** by the Steering Committee; 3) **Community Partnership** input from the Community Health Improvement Partnership; and 4) a **Backbone Organization**—the Public Health Department—to support these efforts. As noted by the arrows connecting the groups in Figure 5, the goal of this collective infrastructure is to have open and regular communication that will guide health efforts in the community. More details about these organizations and groups and how to become involved in their work are found in the *Taking Action to Mobilize Change – How to Join* section of this report.

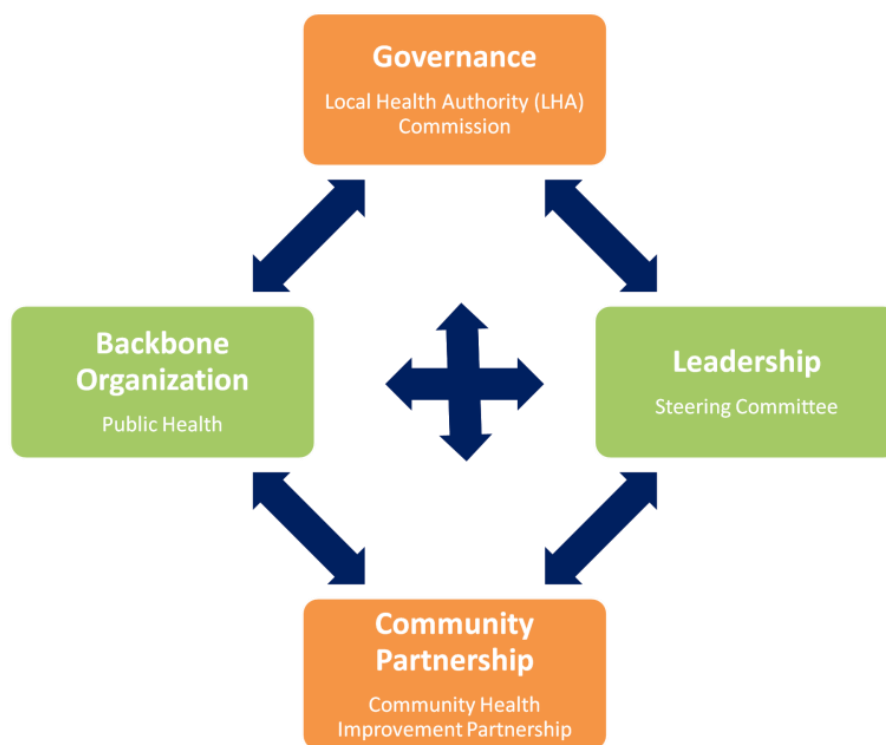


Figure 4

As we work toward building a healthier community, there is much to do. Don't hesitate to ask how you can be part of this exciting work. Inquiries regarding this plan may be directed to:

Collective Impact Initiative Manager: Imperial County Public Health Department at (442) 265-1479 | deniseandrade@co.imperial.ca.us

Taking Action: The Year 1 Integrated Workplan - 2017

TAKING ACTION: THE YEAR 1 INTEGRATED WORKPLAN - 2017

Acronyms

| | |
|-----------------|----------------------------------------------------------|
| CACHI | California Accountable Communities for Health Initiative |
| COPA | Imperial County Childhood Obesity Prevention Alliance |
| FQHC/RHC | Federally Qualified Health Center / Rural Health Clinic |
| LHA | Local Health Authority |
| MCAH | Maternal, Child, and Adolescent Health |
| NEOPP | Nutrition Education and Obesity Prevention Program |
| SNAP-Ed | Supplemental Nutrition Assistance Program Education |

Taking Action to Enhance Health Information and Mobilize Change – Year 1

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| COLLECTIVE TARGET | | | |
| Increase and enhance community engagement | <ul style="list-style-type: none"> ➤ Identify branding strategy and develop implementation plan ➤ Develop LHA Commission website ➤ Develop LHA Commission social media capacity and implementation policies ➤ Develop workplan result tracking, reporting and dissemination plan | <ul style="list-style-type: none"> ❖ Branding strategy implemented for at least 1 Impact Target ❖ Website and selected social media presence launched ❖ Dissemination plan completed | <ul style="list-style-type: none"> ❖ LHA Public Policy/Community Advisory Committee |

Taking Action to Enhance Health Information and Mobilize Change – Year 1 (Cont.)

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IMPACT TARGETS: HEALTHY EATING – FOOD SECURITY – ACTIVE LIVING – ASTHMA – DIABETES – PRENATAL CARE – DEMENTIA | | | |
| Deliver community health education using value- based and evidence- or practice-based curriculum | <ul style="list-style-type: none"> ➤ Develop catalog of evidence- and practice-based resources ➤ Develop community and stakeholder organization input process ➤ Develop guidelines and standards for community education programs ➤ Identify opportunities to blend messages and leverage community education opportunities to reduce duplication and community “message fatigue” | <ul style="list-style-type: none"> ❖ Guidelines and standards adapted or developed and piloted in at least 2 stakeholder organizations ❖ Strategies for blending messages and leveraging opportunities identified and piloted in at least 1 community setting | <ul style="list-style-type: none"> ❖ <u>Asthma</u>: CACHI Asthma Workgroup ❖ <u>Healthy Eating, Food Security & Active Living</u>: COPA, SNAP-Ed Local Implementing Agencies, First 5 – Healthy Children, Healthy Lives ❖ <u>Dementia</u>: Dementia Linkages Workgroup |
| Link advocacy and community health education with social networking platforms and mobile health applications | <ul style="list-style-type: none"> ➤ Develop social media plans ➤ Identify potential mobile health application resources ➤ Establish a workgroup including social media and health subject matter experts ➤ Identify specific mobile health application resources for targeted health goals | <ul style="list-style-type: none"> ❖ At least 1 draft social media plan developed ❖ At least 1 mobile health application piloted | <ul style="list-style-type: none"> ❖ <u>Prenatal Care</u>: MCAH Advisory Board ❖ <u>Diabetes</u>: LHA Quality Improvement/Utilization Management Committee |

Taking Action to Prioritize Health through Policy and System Change – Year 1

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| IMPACT TARGETS: HEALTHY EATING – FOOD SECURITY– ACTIVE LIVING – DIABETES | | | |
| Implement and support school and child care center wellness policies | <ul style="list-style-type: none"> ➤ Convene through existing local coalitions, alliances, school and child care councils and other groups ➤ Train youth, adults, and key stakeholders on wellness policies ➤ Identify opportunities to adopt, implement, or enhance school or child care wellness policies | <ul style="list-style-type: none"> ❖ At least 1 wellness policy training delivered ❖ Wellness policy piloted in at least 1 school or child care center | <ul style="list-style-type: none"> ❖ COPA, SNAP-Ed Local Implementing Agencies; First 5 – Healthy Children, Healthy Lives; MCAH Program |
| Increase the number of stores that implement healthy food and beverage retail strategies | <ul style="list-style-type: none"> ➤ Assess store marketing and promotion practices ➤ Identify opportunities and barriers for implementing healthy retail strategies ➤ Map stores in priority neighborhoods/communities for implementation of healthy retail strategies | <ul style="list-style-type: none"> ❖ Healthy retail strategies piloted in at least 1 store in a priority neighborhood/community | <ul style="list-style-type: none"> ❖ NEOPP |

Taking Action to Prioritize Health through Policy and System Change – Year 1 (Cont.)

| STRATE3GIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| IMPACT TARGETS: HEALTHY EATING – FOOD SECURITY– ACTIVE LIVING – DIABETES | | | |
| Develop and implement system changes that promote and support food drives and donations | <ul style="list-style-type: none"> ➤ Research best practices ➤ Identify opportunities and challenges with current food drive initiatives | <ul style="list-style-type: none"> ❖ A food drive tool kit developed for community partners interested in donating food | <ul style="list-style-type: none"> ❖ Imperial Valley Food Bank ❖ Imperial County Public Health Department |
| Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity | <ul style="list-style-type: none"> ➤ Identify opportunities and barriers to increasing indoor and outdoor physical activity ➤ Map community and neighborhood current and potential opportunities for physical activity ➤ Create “To Do” list of physical activity projects ➤ Identify partners and stakeholders needed for implementation | <ul style="list-style-type: none"> ❖ A new indoor or outdoor physical activity opportunity created for at least 1 site on the “To Do” list | <ul style="list-style-type: none"> ❖ COPA, SNAP-Ed Local Implementing Agencies, Active Transportation Program |

Taking Action to Prioritize Health through Policy and System Change – Year 1 (Cont.)

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| IMPACT TARGETS: HEALTHY EATING – FOOD SECURITY | | | |
| Recover edible, not saleable food for distribution | <ul style="list-style-type: none"> ➤ Research existing policies governing the transportation of opened food ➤ Identify target schools ➤ Provide training to partnering schools ➤ Increase collaboration between Environmental Health Division, Imperial Valley Food Bank, and others to identify means to save edible food from becoming waste | <ul style="list-style-type: none"> ❖ A school pantry established and/or school backpack program expanded to distribute more food in school community ❖ Imperial Valley Food Bank supported to seek funding to establish new food rescue programs | <ul style="list-style-type: none"> ❖ Imperial Valley Food Bank ❖ Imperial County Public Health Department |
| IMPACT TARGET: AIR QUALITY | | | |
| Increase community and healthcare provider participation in efforts to improve air quality in non-attainment areas of county | <ul style="list-style-type: none"> ➤ Identify and promote opportunities for participation ➤ Develop information sharing strategies | <ul style="list-style-type: none"> ❖ Information sharing strategies implemented by the Local Health Authority (LHA) Commission | <ul style="list-style-type: none"> ❖ LHA Provider Committee |

Taking Action to Improve Equitable, Evidence-Based Healthcare – Year 1

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| IMPACT TARGET: PRESCRIPTION DRUG ABUSE | | | |
| Develop model healthcare facility controlled substance Diversion Program | <ul style="list-style-type: none"> ➤ Select Diversion Program model for local modification and alignment ➤ Develop guidelines surrounding prevention efforts, detection and response activities, policies and procedures, and educational programs ➤ Track and analyze data trends surrounding diversion | <ul style="list-style-type: none"> ❖ Draft model released for input from healthcare facilities | <ul style="list-style-type: none"> ❖ Prescription Drug Abuse Workgroup ❖ LHA Provider Committee |
| Increase and enhance use of CURES 2.0 system among prescribers and dispensers | <ul style="list-style-type: none"> ➤ Assess compliance with CURES 2.0 implementation requirements ➤ Assist providers in meeting CURES 2.0 requirements ➤ Develop model CURES 2.0 enhanced utilization protocol | <ul style="list-style-type: none"> ❖ Providers compliant with CURES 2.0 implementation requirements ❖ Model protocol piloted in at least 1 provider practice and 1 FQHC/RHC | <ul style="list-style-type: none"> ❖ Prescription Drug Abuse Workgroup ❖ LHA Provider Committee |

Taking Action to Improve Equitable, Evidence-Based Healthcare – Year 1 (Cont.)

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| IMPACT TARGET: DEMENTIA | | | |
| Expand training for healthcare and social service providers to better support persons with dementia | <ul style="list-style-type: none"> ➤ Research best practices for training healthcare and social service providers ➤ Identify current training programs available for local providers and expansion opportunities ➤ Identify current clinical rotation requirements | <ul style="list-style-type: none"> ❖ Opportunities for expanding-coordinating clinical rotation requirements identified ❖ Best practices for training program enhancement identified | <ul style="list-style-type: none"> ❖ Dementia Linkages Workgroup |
| IMPACT TARGET: ASTHMA | | | |
| Adopt asthma standards across the clinical spectrum of care | <ul style="list-style-type: none"> ➤ Align community health worker/promotora training curriculums with state draft standards and develop training methodology ➤ Develop a methodology for provider training meeting national standards for the diagnosis and management of asthma | <ul style="list-style-type: none"> ❖ Training piloted in at least one FQHC/RHC clinic, one private pediatric practice, and one community health worker/promotora partner organization | <ul style="list-style-type: none"> ❖ CACHI Asthma Workgroup ❖ LHA Provider Committee |

Taking Action to Better Link Healthcare, Community Programs and Services – Year 1

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| COLLECTIVE TARGETS | | | |
| Integrate family-centered assessment and connection with social services and community resources and programs | <ul style="list-style-type: none"> ➤ Identify family-centered assessment survey tools ➤ Identify opportunities to integrate family-centered assessments with a priority target of families residing in asthma disparity communities ➤ Develop training program for selected assessment | <ul style="list-style-type: none"> ❖ Assessment survey training curriculum developed and piloted in at least 1 home-based education - intervention program | <ul style="list-style-type: none"> ❖ LHA Quality Improvement/ Utilization Management Committee |
| Increase coordination among local organizations, groups and agencies to enhance and maximize resources and services | <ul style="list-style-type: none"> ➤ Inventory local resources and services targeting health goals ➤ Identify opportunities to coordinate resources and services to enhance services and programs for targeted health goals | <ul style="list-style-type: none"> ❖ Opportunities to coordinate resources and services are identified ❖ Draft inventory document completed | <ul style="list-style-type: none"> ❖ LHA Quality Improvement/Utilization Management Committee |

Taking Action to Better Link Healthcare, Community Programs and Services – Year 1

| STRATEGIES | ACTION STEPS | YEAR 1 MILESTONES | WHO'S WORKING ON THIS |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| IMPACT TARGET: ASTHMA | | | |
| Improve continuity of healthcare between hospitals and medical homes with a priority target of emergency department linkage to primary care for child asthma | <ul style="list-style-type: none"> ➤ Establish workgroup to identify means and methods to link child asthma patients to timely primary care after receiving emergency department services ➤ Identify model process to link child asthma patients to medical homes ➤ Pilot model process in both hospital emergency departments, and revise and refine as needed | <ul style="list-style-type: none"> ❖ Continuity of healthcare system for child asthma established between hospital emergency departments and medical homes | <ul style="list-style-type: none"> ❖ CACHI Asthma Workgroup |

Taking Action to Mobilize Change – How to Join

TAKING ACTION TO MOBILIZE CHANGE – HOW TO JOIN

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <p>Active Transportation Program: The program is funded to establish Safe Routes Programs in twelve El Centro schools and at a park. Interventions will provide education opportunities that support pedestrian and bike safety, as well as healthy eating and active living in community and school settings.</p> | <p>HEALTHY EATING - ACTIVE LIVING – DIABETES</p> <p><i>Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity</i></p> | <p>Angela Ramirez angelaramirez@co.imperial.ca.us (442) 265-1367 www.icphd.org</p> |
| <p>CACHI Asthma Workgroup: The goal of the California Accountable Communities for Health Initiative (CACHI) Asthma Workgroup is to improve health outcomes for residents with asthma using evidence-based system, policy and/or environmental strategies that align with national Healthy People 2020 asthma objectives.</p> | <p>ASTHMA</p> <p><i>Deliver community health education using value-based and evidence- or practice-based curriculum</i></p> <p><i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> <p><i>Adopt asthma standards across the clinical spectrum of care</i></p> <p><i>Improve continuity of healthcare between hospitals and medical homes with a priority target of emergency department linkage to primary care for child asthma</i></p> | <p>Denise Andrade deniseandrade@co.imperial.ca.us (442) 265-1479 www.icphd.org</p> |

Taking Action to Mobilize Change – How to Join (Cont.)

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
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| <p>COPA: The Childhood Obesity Prevention Alliance (COPA) brings together key traditional and non-traditional partners to work on local obesity prevention efforts. Current membership consists of over 64 individuals representing more than 31 agencies. COPA works to improve and maintain the health of children and their families through the prevention of obesity and related complications, and strives to encourage an environment that promotes and supports a healthy lifestyle for children and families in Imperial County. Active COPA workgroups include: COPA Leadership, Early Care and Education and School Wellness, ReThink Your Drink, Safe Routes to School, and County Nutrition Action Plan (CNAP).</p> | <p>HEALTHY EATING - ACTIVE LIVING</p> <p><i>Deliver community health education using value based and evidence- or practice-based curriculum</i></p> <p><i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> | <p>Irene Garcia irenegarcia@co.imperial.ca.us www.iccopa.org (442) 265-1367</p> |
| | <p>HEALTHY EATING -FOOD SECURITY - ACTIVE LIVING – DIABETES</p> <p><i>Implement and support school and child care center wellness policies</i></p> <p><i>Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity</i></p> | |
| <p>Dementia Linkages Workgroup: The Dementia Linkages Workgroup was formed during the CHA/CHIP process. This workgroup will focus on improving the linkages of family members, care givers and persons living with dementia in Imperial County across system of care and support.</p> | <p>DEMENTIA</p> <p><i>Deliver community health education using value based and evidence- or practice-based curriculum</i></p> <p><i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> <p><i>Expand training for healthcare and social service providers to better support persons with dementia</i></p> | <p>Dr. Amy Binggeli-Vallarta amybinggeli@co.imperial.ca.us (442) 265-1335</p> |

Taking Action to Mobilize Change – How to Join (Cont.)

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
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| <p>First 5 - Healthy Children, Healthy Lives Project: The objective of the First Five- Healthy Children, Healthy Lives Project is to help reduce the prevalence of overweight and obesity in preschool aged children and their families in Imperial County.</p> | <p>HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING <i>Deliver community health education using value based and evidence- or practice-based curriculum</i> <i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> | <p>Irene Garcia irenegarcia@co.imperial.ca.us (442) 265-1367</p> |
| | <p>HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING - DIABETES <i>Implement and support school and child care center wellness policies</i></p> | |
| <p>Imperial Valley Food Bank (IVFB): The IVFB is a non-profit organization with the primary function to resource, allocate and distribute nutritious food through non-profit agencies in the county who distribute food directly to their local communities. By working with existing agencies, IVFB is able to provide emergency food assistance to all of Imperial County.</p> | <p>HEALTHY EATING - FOOD SECURITY- ACTIVE LIVING – DIABETES <i>Develop and implement system changes that promote and support food drives and donations</i></p> <p>HEALTHY EATING - FOOD SECURITY <i>Recover edible, not saleable food for distribution</i></p> | <p>For volunteer opportunities: (760) 370-0485 info@ivfoodbank.org www.ivfoodbank.org</p> |

Taking Action to Mobilize Change – How to Join (Cont.)

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
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| <p>LHA Provider Committee: The Local Health Authority (LHA) Provider Committee serves as an advisor to the LHA Commission on healthcare issues, peer review, and credentialing/ recredentialing decisions. This committee also oversees medication prescribing practices by contracting providers, assesses usage patterns by members, and assists with study design and clinical guideline development. The Provider Committee consists of a variety of practitioners to represent the appropriate level of knowledge to assess and adopt healthcare standards.</p> | <p>AIR QUALITY <i>Increase community and healthcare provider participation in efforts to improve air quality in non-attainment areas of county</i></p> | <p>Christina Olson christinaolson@co.imperial.ca.us (442) 265-1393</p> <p>Meets the 3rd Monday of every month from 5:30 - 6:30 p.m. in Imperial County Behavioral Health Services Training Room</p> |
| | <p>PRESCRIPTION DRUG ABUSE <i>Develop model healthcare facility controlled substance Diversion Program</i> <i>Increase and enhance use of CURES 2.0 system among prescribers and dispensers</i></p> | |
| | <p>ASTHMA <i>Adopt asthma standards across the clinical spectrum of care</i></p> | |
| <p>LHA Public Policy/Community Advisory Committee: The Public Policy/Community Advisory Committee provides a mechanism for structured input from the Medi-Cal beneficiaries regarding how the managed care plans' operations impact the delivery of their care. This Committee has the role to implement and maintain community linkages.</p> | <p>COLLECTIVE TARGETS <i>Increase and enhance community engagement</i></p> | <p>Christina Olson christinaolson@co.imperial.ca.us (442) 265-1393</p> <p>Meets the 2nd Tuesday of every month from 4-5 p.m. in County Administration Bldg. Conference Room C&D</p> |

Taking Action to Mobilize Change – How to Join (Cont.)

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
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| <p>LHA Quality Improvement/Utilization Management (QI/UM) Committee: The QI/UM Committee is dedicated to improving the health status of members, while maintaining the medically appropriate and efficient use of available resources. The Committee oversees all covered healthcare services delivered to members by systemic methods that develop, implement, assess, and improve the integrated health delivery systems of the Local Initiative Health Plan.</p> | <p>COLLECTIVE TARGETS</p> <p><i>Integrate family-centered assessment and connection with social services and community resources and programs</i></p> <p><i>Increase coordination among local organizations, groups and agencies to enhance and maximize resources and services</i></p> | <p>Christina Olson christinaolson@co.imperial.ca.us (442) 265-1393</p> <p>Meets the 4th Wednesday of every month from 4-5 p.m. in County Administration Bldg. Conference Room C&D</p> |
| | <p>DIABETES</p> <p><i>Deliver community health education using value based and evidence- or practice-based curriculum</i></p> <p><i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> | |
| <p>MCAH: The Maternal, Child, and Adolescent Health (MCAH) Program of Imperial County works to promote, coordinate, and assess the capacity of healthcare and human services for all children and families regardless of disparities. Children and families are provided with opportunities to develop healthy lifestyles in a safe and nurturing environment through equal access to and appropriate utilization of culturally sensitive healthcare and human services.</p> | <p>HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING – DIABETES</p> <p><i>Implement and support school and child care center wellness policies</i></p> | <p>Adriana Ramirez adrianaramirez@co.imperial.ca.us (442) 265-1895</p> |

Taking Action to Mobilize Change – How to Join (Cont.)

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
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| <p>MCAH Advisory Board: The Maternal, Child, and Adolescent Health Advisory Board of Imperial County works to promote, coordinate, and assess the capacity of healthcare and services for children and families regardless of disparities. The Board meets to mobilize community partnerships between policymakers, healthcare providers, families, the general public and others, to identify and solve problems within the maternal, child, adolescent health populations.</p> | <p>PRENATAL CARE</p> <p><i>Deliver community health education using value based and evidence- or practice-based curriculum</i></p> <p><i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> | <p>Adriana Ramirez adrianaramirez@co.imperial.ca.us (442) 265-1895</p> |
| <p>NEOPP: The Nutrition Education and Obesity Prevention Program (NEOPP) is a comprehensive and integrated nutrition program in Imperial County that strives to create innovative partnerships that empower low-income individuals to increase their fruit and vegetable consumption, physical activity, and food security with the overall goal of preventing obesity and the onset of related chronic diseases.</p> | <p>HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING – DIABETES</p> <p><i>Increase the number of stores that implement healthy food and beverage retail strategies</i></p> | <p>Imperial County Public Health Department: Jorge Torres (442) 265-1377 jorgetorres@co.imperial.ca.us</p> <p>Imperial Valley Food Bank: Mireya Diaz (760) 970-4473 mireya@ivfoodbank.org</p> |

Taking Action to Mobilize Change – How to Join (Cont.)

| PARTNERS | IMPACT TARGETS AND STRATEGIES | HOW DO I JOIN? |
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| <p>Prescription Drug Abuse Workgroup: The Prescription Drug Abuse Workgroup was formed during the CHA/CHIP process. This workgroup will focus on preventative measures for prescription drug abuse within Imperial County.</p> | <p>PRESCRIPTION DRUG ABUSE</p> <p><i>Develop model healthcare facility controlled substance Diversion Program</i></p> <p><i>Increase and enhance use of CURES 2.0 system among prescribers and dispensers</i></p> | <p>Dr. Amy Binggeli-Vallarta amybinggeli@co.imperial.ca.us (442) 265-1335</p> |
| <p>SNAP-Ed Local Implementing Agencies: SNAP is the Supplemental Nutrition Assistance Program (formerly known as Food Stamps). The Supplemental Nutrition Assistance Program Education (SNAP-Ed) is the nutrition promotion and obesity-prevention component of SNAP. States provide nutrition education and obesity prevention interventions for low-income people who are eligible for SNAP or other means-tested Federal assistance programs.</p> | <p>HEALTHY EATING - ACTIVE LIVING</p> <p><i>Deliver community health education using value based and evidence- or practice-based curriculum</i></p> <p><i>Link advocacy and community health education with social networking platforms and mobile health applications</i></p> | <p>Catholic Charities of California local agency, Catholic Charities, Diocese of San Diego: Joy Davis(619) 231-2828 Ext. 202 jdavis@ccdsd.org</p> <p>Imperial County Public Health Department: Jorge Torres (442) 265-1377 jorgetorres@co.imperial.ca.us</p> <p>UC Cooperative Extension, Imperial County: Mary Welch-Bezemek (760) 352-9474 mjwelchbezemek@ucanr.edu</p> |
| | <p>HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING - DIABETES</p> <p><i>Implement and support school and child care center wellness policies</i></p> <p><i>Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity</i></p> | |



Convening Organization

