TAKING ACTION 2017

Imperial County Community Health Assessment and Community Health Improvement Plan 2017-2021

Taking Action 2017 is a condensed summary of the Imperial County CHA/CHIP 2017-2021 report.
*Full version of the report: **Imperial County CHA/CHIP 2017-2021***

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REVISED 05/02/2018

*We envision
a community that supports and empowers
all people to thrive and be healthy.*

Determinants of Health

- Social Support Networks
- Income & Social Status
- Education
- Culture
- Employment & Working Conditions
- Gender & Sexual Diversity
- Neighborhoods & Built Environment
- Social Environments
- Biology & Genetics
- Health Services & Social Services
- Healthy Child Development
- Personal Health Practices & Coping Skills

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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 wishing to become involved in or continue engaging in health and wellness improvement. This single CHA/CHIP 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 Taking Action 2017 version of the 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. However, the process also confirmed that there are many gaps in services and ways to build on and strengthen efforts. Insights from the CHA allowed for the identification of three priority areas in Imperial County along with three impact targets within each priority area:

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

Community Prevention Linked with High Quality Healthcare
- Asthma detection, management and education
- Prenatal Care – Early and Adequate
- Diabetes detection, management and education

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. Although this report provides 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, the 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 stakeholders around the work to be done.
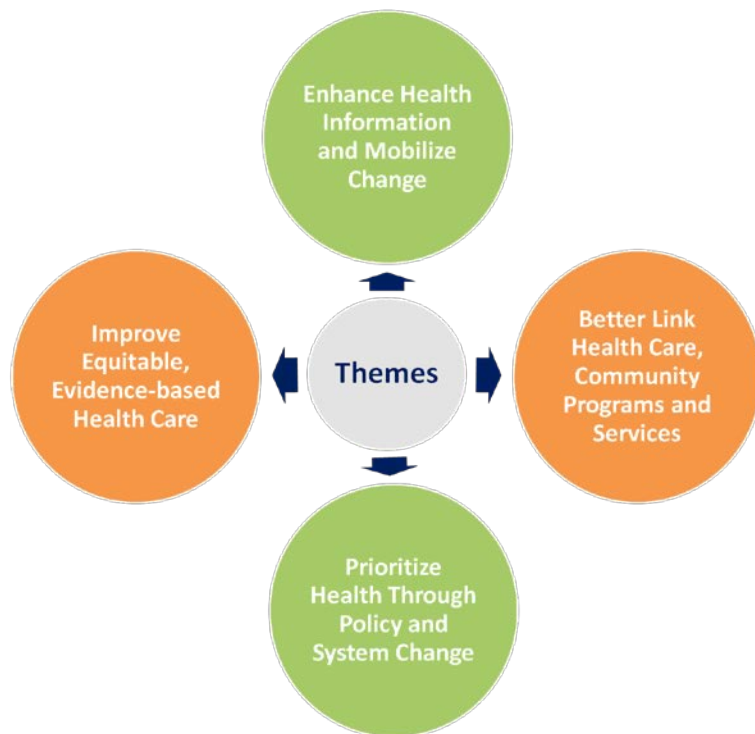

Figure 1: Themes

Our community has begun to align multiple infrastructures that will help collective impact to thrive. These infrastructures include: 1) a Community Partnership composed of the Community Health Improvement Partnership; 2) Leadership by Steering Committee; and 3) a Backbone Organization led by Public Health. 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 this 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
Imperial County Public Health Department
(442) 265-1479 | deniseandrade@co.imperial.ca.us

ACKNOWLEDGEMENTS

Thank you to those who…

Participated in the Stakeholder Process

2-1-1 Imperial
Alliance Healthcare Foundation
Calexico Neighborhood House
California Health & Wellness
Calipatria State Prison
Cancer Resource Center of the Desert
Centinela State Prison
City of Brawley
City of El Centro
Clinicas de Salud del Pueblo, Inc.
Comité Cívico del Valle, Inc.
El Centro Regional Medical Center
First 5 – Imperial
Gentiva Health Services
Heffernan Memorial Healthcare District
Imperial County Behavioral Health Services
Imperial County Department of Social Services
Imperial County Free Library

Imperial County Public Administrator / Area Agency on Aging
Imperial County Public Health Department
Imperial County Veteran's Service Office
Imperial Valley Child Asthma Program
Imperial Valley College
Imperial Valley Food Bank
Imperial Valley LGBT Resource Center
Imperial Valley Regional Occupational Program
Local Health Authority Commission
March of Dimes
Molina Healthcare
Pioneers Memorial Healthcare District
San Diego State University - Imperial Valley Campus
Sure Helpline Crisis Center
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

Imperial County Office of Education

Sodexo

First 5 - Imperial

Clinicas de Salud del Pueblo, Inc. – WIC Program

UC Cooperative Extension

Imperial Valley Food Bank

Imperial County Board of Supervisors Jack Terrazas

Priority Area: Community Prevention Linked with High Quality Healthcare

Clinicas de Salud del Pueblo, Inc.

El Centro Regional Medical Center

San Diego State University - Imperial
Valley Campus

American Diabetes Association

California Health & Wellness

Imperial Valley Child Asthma Program

UCSD Rady Children's Hospital

Comité Cívico del Valle, Inc.

Priority Area: Healthy and Safe Communities and Living Environments

Pioneers Memorial Healthcare District

Calipatria State Prison

El Centro Regional Medical Center

Imperial County Department of Social Services

Molina Healthcare

ORGANIZING FOR SUCCESS

Community Health Assessment (CHA)

A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal is to develop strategies to address the community's health needs and priority issues. Community engagement and collaborative participation are essential.
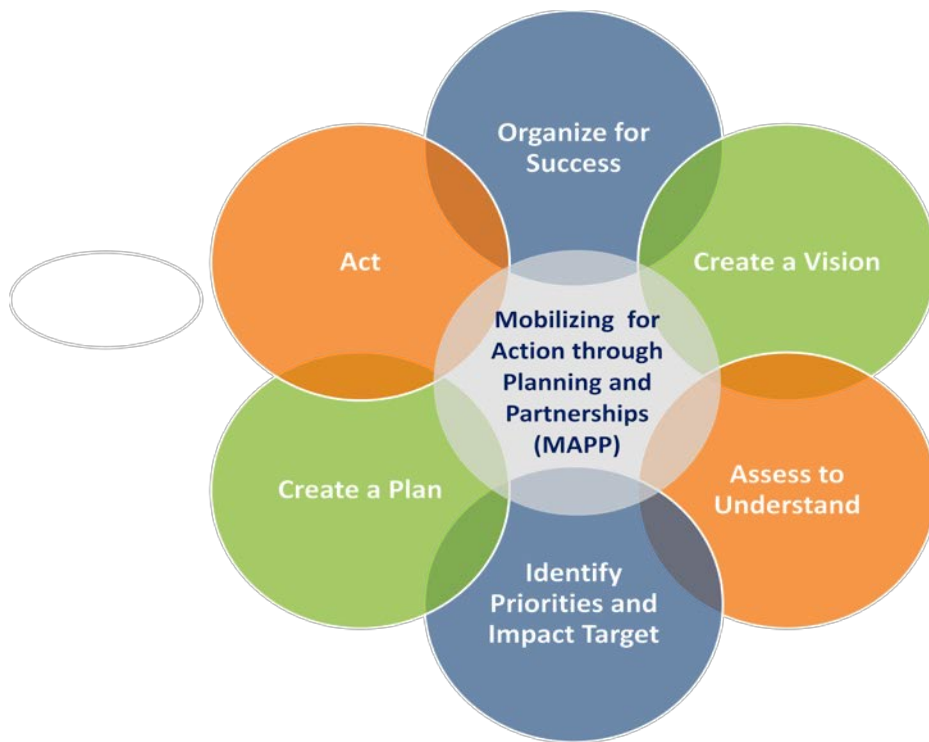
Overview

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

Figure 2: MAPP

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: assessing community themes and strengths, assessing the local public health system, assessing the community's health status, and assessing the forces of change. 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.

Steering Committee Members

- ❖ *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*

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 coalesced 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

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.

IDENTIFYING PRIORITIES AND IMPACT TARGETS

Data from the four assessments were used by the stakeholders to outline priority areas. Initially, stakeholders identified seven priority areas: obesity, air quality, mental health access, diabetes, poor nutrition, inactive lifestyle, and teen pregnancy. At subsequent meetings, stakeholders reviewed the seven priority areas along with a list of evidence-based interventions, the most important health risks identified from the community survey results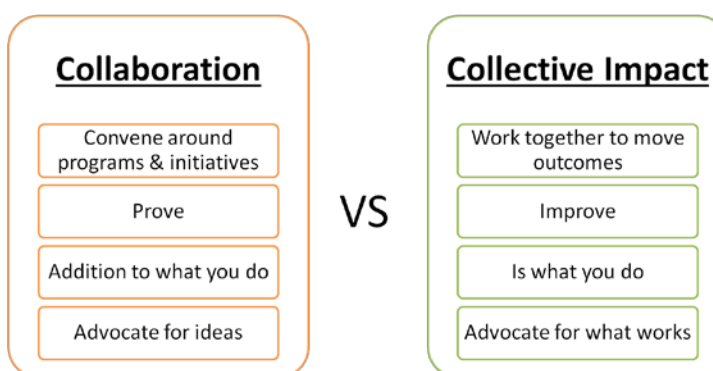, and feedback from the community forum. Stakeholders paid particular attention to whether the seven priorities they had identified matched priorities based on community feedback. By consensus, the stakeholders narrowed and refined the priorities to five items: obesity, food environment, asthma, inactive lifestyle, and drug use.

A final discussion about further refining priorities occurred. This discussion emphasized collaboration versus collective impact. Collaboration and collective impact are both terms that describe the convening of people and organizations to work together. Such convenings, however, vary in terms of their purpose, outcomes, and longevity. A 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.

Collaboration vs. Collective Impact

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.

Figure 3: Collaboration vs Collective Impact

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 manner to achieve impact on the common agenda. The comparison between collaboration vs collective Impact is shown in Figure 3.
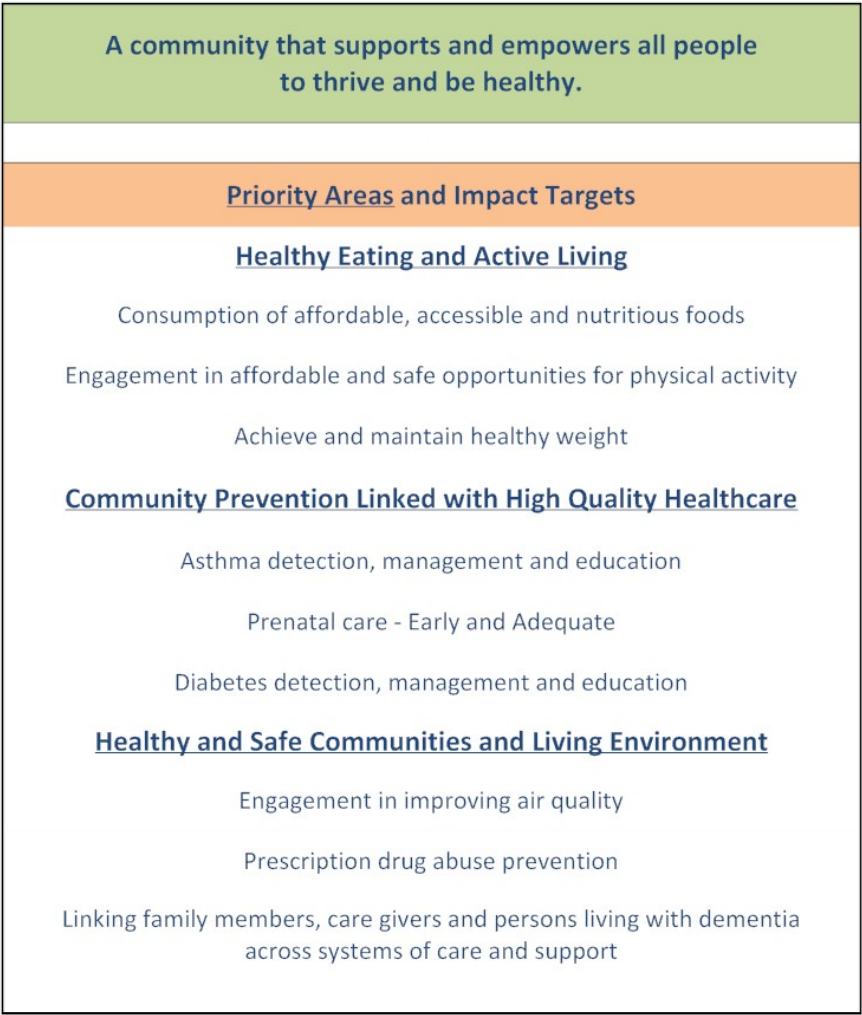
The collaboration versus collective impact discussion and restructuring of the final priority areas were critical steps in minimizing agency worry of being overburdened with additional workplans and activities, overlapping efforts and activities, and disjointed projects and efforts.

Selected Priorities and Impact Targets

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: a) Healthy Eating and Active Living; b) Community Prevention Linked with High Quality Healthcare; and c) Healthy and Safe Communities and Living Environments. 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

Healthy Eating and Active Living

Consumption of affordable, accessible and nutritious foods

Engagement in affordable and safe opportunities for physical activity

Achieve and maintain healthy weight

Community Prevention Linked with High Quality Healthcare

Asthma detection, management and education

Prenatal care - Early and Adequate

Diabetes detection, management and education

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

Figure 4: Priority Areas and Impact Targets

CREATING A PLAN

With priority areas and impact targets identified, the Community Partnership decided to create three focused workgroups—one for each of the priority areas. These workgroups invested a considerable amount of time and effort into conducting the in-depth work that served as the foundation for the following two sections: 1) *Taking Action: The Five-Year Community Health Improvement Plan (CHIP) 2017-2021* and 2) *Taking Action: The Year 1 Integrated Workplan - 2017*.

Workgroups were led by two chairpersons and were composed of interested community members and subject matter experts to allow for ample feedback related to each impact target. Workgroups conducted environmental scans to identify existing activities, programs, policies, and efforts in the community related to each of the three impact targets within their priority area. Workgroups also created cause and effect diagrams to discuss assets and gaps related to each impact target, and factors in our community that have led to the increased burden of each of the impact targets. Additionally, the workgroups reviewed relevant evidence-based and best practice strategies that are either in place or could be put in place to improve health outcomes.

Each workgroup, based on their evaluations, identified interventions, strategies, and related measures to include in the CHIP for their priority area. Recommendations were discussed and approved by consensus at meetings of the Community Partnership.

Taking Action: The Five-Year Community Health Improvement Plan (CHIP) 2017 -2021

A CHIP is defined as:

> *A long-term, systematic effort to address community health problems. A CHIP addresses the range of strengths, weaknesses, challenges and opportunities that exist in a community as identified through a collaborative CHA process. A CHIP is 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.*

Our community's CHIP is separated into three sections—one for each priority area. Each section follows a two-page scheme:

- First page – Identification of the priority area, data from the CHA that supports a need for intervention in the priority area, the three impact targets for the priority areas, and a list of strategies that are relevant to work in the priority area.

- Second page – A measurable, five-year workplan for the priority area. Each workplan includes a goal for each impact target, how the goal will be measured, the timeframe and indicators to measure progress, and the partners that will convene the collective efforts.

Taking Action: The Year 1 Integrated Workplan - 2017

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.

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.

Figure 1: Themes

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

MOVING FORWARD AND NEXT STEPS

Following the completion of the Community Health Improvement Plan, the Steering Committee in coordination with the Community Partnership decided that it was important to take the CHA/CHIP documents back to the community for input and feedback. This decision was grounded in the early work completed by the Community Partnership/Steering Committee, specifically around the Guiding Principles and Shared Values that were identified to help guide work and act as a framework for forward movement. To this end, three Community Forums were held (Brawley, El Centro and Imperial) in June of 2017. Community members provided comments and feedback on the document's layout, selected priority areas, and identified strategies.

A few other points of discussion during the community forums included: a) points of contact for individuals interested in participating in the CHIP and Integrated Workplan activities, b) strategies for involvement in the CHIP and Integrated Workplan activities, and c) the formation of current and future workgroups. Many community members have indicated interest in participating in the CHIP and Integrated Workplan activities, as well as getting involved in one of the three workgroups.

Moving forward, our community will continue to work to align infrastructures to maximize the collective impact approach (Figure 5). Specifically, a) **Community Partnership** input; b) **Leadership** by the Steering Committee; and c) a **Backbone Organization**—the Public Health Department—to support these efforts. As noted by the arrows connecting the groups in Figure 5, the goal is open and regular communication that will guide

Figure 5. Collective Infrastructure

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.

The Steering Committee, in coordination with the Community Partnership, will continue to serve as the engine for implementation of the integrated workplan, develop a system for aligning resources, and tracking, evaluating, and reporting of progress for each of the priority areas. Examples of next steps for the Steering Committee and Community Partnership may include:

- Reconvening the Community Partnership to provide updates and status on the CHIP and Integrated Workplan and best way to proceed with efforts and activities;
- Reestablishing Priority 1 (Healthy Eating, Active Living), Priority 2 (Community Prevention Linked with High Quality Healthcare), and Priority 3 (Healthy and Safe Communities and Living Environment) Workgroup members, meeting frequency and focus activities; and
- Revisiting the CHIP to augment workplan activities and workgroup efforts.

In looking forward, there is much to do. The Steering Committee and Community Partnership will work to engage community members who have shown interest in participating in CHIP efforts and reenergizing community members' interest in working collectively towards building a healthier community.

For more information and to learn how to get involved, contact:

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

Taking Action: The Five-Year Community Health Improvement Plan(CHIP) 2017-2021

Healthy Eating, Active Living

Community Prevention Linked With High Quality Healthcare

Healthy and Safe Communties and Living Environment

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)	➢ Wellness policies ➢ Health retail strategies ➢ Food recovery ➢ Creating & enhancement of physical activity opportunities ➢ Community education ➢ Resource coordination	% of children living in food secure households[1]	5% reduction[1] from baseline	December 2021	➢ Imperial Valley Food Bank ➢ Public Health ➢ Childhood Obesity Prevention Alliance (COPA)
Engagement in affordable and safe opportunities for physical activity (active living)		% of children meeting fitness standards[2]	10% increase[2] from baseline	December 2021	
Achieve and maintain healthy weight (healthy eating, active living)		Adults with BMI >30[3]	5% reductio0[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 5th graders, 23.6% of 7th graders and 30.3% of 9th 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

PRIORITY AREA: Community Prevention Linked with High Quality Healthcare

This priority area strengthens 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 though 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)	➢ 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)	➢ Resource coordination ➢ Community education	% of pregnant women who receive adequate prenatal care[5]	15% increase[5] from baseline	December 2019	➢ MCAH Board ➢ California Health & Wellness
Diabetes detection, management and education (diabetes)	➢ 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+

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)	➤ 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	December 2017	➤ LHA Commission
Prescription drug abuse prevention (prescription drug abuse)	➤ Community education ➤ Diversion programs ➤ Enhanced CURES 2.0 implementation	% of providers adopting 2016 CDC guidelines for prescribing opioids for chronic pain[8] & enhanced CURES 2.0 use[9]	25% increase from baseline	December 2021	➤ Prescription Drug Abuse Workgroup
Linking family, caregivers and persons living with dementia across systems of care and support (dementia)	➤ 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	December 2021	➤ Social Services ➤ Imperial County Public Health Department

Data Source for Health Improvement Plan Measures	Baseline for Goals
[7]*SIP – State Implementation Plan*	Number of providers engaged in the SIP process; Linking air quality data with health survey data
[8]*Center for Disease Control and Prevention (MMWR March 18, 2016)*	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] *CURES 2.0 (Controlled Substance Utilization Review and Evaluation System)*	Number of dispensers and prescribers consistently using CURES system (and features)
[10]*Office of Statewide Health Planning and Development, 2014*	Number of social admissions to the ED for persons with dementia

Data Source for Health Improvement Plan Measures

[1]**California 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.

[2]**Kidsdata.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).

[3]**California 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).

[4]**Office 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.

[5]**State 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.

[6]**Office 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.

[7]**SIP – 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.

[8]**Center 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.

[10]**Office 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.

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	➤ 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	❖ Branding strategy implemented for at least 1 Impact Target ❖ Website and selected social media presence launched ❖ Dissemination plan completed	❖ 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	➢ 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"	❖ 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	❖ Asthma: CACHI Asthma Workgroup ❖ Healthy Eating, Food Security & Active Living: COPA, SNAP-Ed Local Implementing Agencies, First 5 – Healthy Children, Healthy Lives ❖ Dementia: Dementia Linkages Workgroup
Link advocacy and community health education with social networking platforms and mobile health applications	➢ 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	❖ At least 1 draft social media plan developed ❖ At least 1 mobile health application piloted	❖ Prenatal Care: MCAH Advisory Board ❖ Diabetes: 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	➢ 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	❖ At least 1 wellness policy training delivered ❖ Wellness policy piloted in at least 1 school or child care center	❖ 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	➢ 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	❖ Healthy retail strategies piloted in at least 1 store in a priority neighborhood/community	❖ 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	➢ Research best practices ➢ Identify opportunities and challenges with current food drive initiatives	❖ A food drive tool kit developed for community partners interested in donating food	❖ Imperial Valley Food Bank ❖ Imperial County Public Health Department
Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity	➢ 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	❖ A new indoor or outdoor physical activity opportunity created for at least 1 site on the "To Do" list	❖ 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	➢ 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	❖ 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	❖ 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	➢ Identify and promote opportunities for participation ➢ Develop information sharing strategies	❖ Information sharing strategies implemented by the Local Health Authority (LHA) Commission	❖ 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	➢ 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	❖ Draft model released for input from healthcare facilities	❖ Prescription Drug Abuse Workgroup ❖ LHA Provider Committee
Increase and enhance use of CURES 2.0 system among prescribers and dispensers	➢ Assess compliance with CURES 2.0 implementation requirements ➢ Assist providers in meeting CURES 2.0 requirements ➢ Develop model CURES 2.0 enhanced utilization protocol	❖ Providers compliant with CURES 2.0 implementation requirements ❖ Model protocol piloted in at least 1 provider practice and 1 FQHC/RHC	❖ 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	➤ 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	❖ Opportunities for expanding-coordinating clinical rotation requirements identified ❖ Best practices for training program enhancement identified	❖ Dementia Linkages Workgroup
IMPACT TARGET: ASTHMA			
Adopt asthma standards across the clinical spectrum of care	➤ 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	❖ Training piloted in at least one FQHC/RHC clinic, one private pediatric practice, and one community health worker/promotora partner organization	❖ 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	➢ 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	❖ Assessment survey training curriculum developed and piloted in at least 1 home-based education - intervention program	❖ LHA Quality Improvement/ Utilization Management Committee
Increase coordination among local organizations, groups and agencies to enhance and maximize resources and services	➢ Inventory local resources and services targeting health goals ➢ Identify opportunities to coordinate resources and services to enhance services and programs for targeted health goals	❖ Opportunities to coordinate resources and services are identified ❖ Draft inventory document completed	❖ 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	➢ 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	❖ Continuity of healthcare system for child asthma established between hospital emergency departments and medical homes	❖ 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?
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.	**HEALTHY EATING - ACTIVE LIVING – DIABETES** *Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity*	Angela Ramirez angelaramirez@co.imperial.ca.us (442) 265-1367 www.icphd.org
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.	**ASTHMA** *Deliver community health education using value-based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications* *Adopt asthma standards across the clinical spectrum of care* *Improve continuity of healthcare between hospitals and medical homes with a priority target of emergency department linkage to primary care for child asthma*	Denise Andrade deniseandrade@co.imperial.ca.us (442) 265-1479 www.icphd.org

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

PARTNERS	IMPACT TARGETS AND STRATEGIES	HOW DO I JOIN?
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).	**HEALTHY EATING - ACTIVE LIVING** *Deliver community health education using value based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications* **HEALTHY EATING -FOOD SECURITY - ACTIVE LIVING – DIABETES** *Implement and support school and child care center wellness policies* *Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity*	Irene Garcia irenegarcia@co.imperial.ca.us www.iccopa.org (442) 265-1367
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.	**DEMENTIA** *Deliver community health education using value based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications* *Expand training for healthcare and social service providers to better support persons with dementia*	Dr. Amy Binggeli-Vallarta amybinggeli@co.imperial.ca.us (442) 265-1335

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

PARTNERS	IMPACT TARGETS AND STRATEGIES	HOW DO I JOIN?
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.	**HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING** *Deliver community health education using value based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications* **HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING - DIABETES** *Implement and support school and child care center wellness policies*	Irene Garcia irenegarcia@co.imperial.ca.us (442) 265-1367
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.	**HEALTHY EATING - FOOD SECURITY- ACTIVE LIVING – DIABETES** *Develop and implement system changes that promote and support food drives and donations* **HEALTHY EATING - FOOD SECURITY** *Recover edible, not saleable food for distribution*	For volunteer opportunities: (760) 370-0485 info@ivfoodbank.org www.ivfoodbank.org

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

PARTNERS	IMPACT TARGETS AND STRATEGIES	HOW DO I JOIN?
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.	**AIR QUALITY** *Increase community and healthcare provider participation in efforts to improve air quality in non-attainment areas of county* **PRESCRIPTION DRUG ABUSE** *Develop model healthcare facility-controlled substance Diversion Program* *Increase and enhance use of CURES 2.0 system among prescribers and dispensers* **ASTHMA** *Adopt asthma standards across the clinical spectrum of care*	Christina Olson christinaolson@co.imperial.ca.us (442) 265-1393 Meets the 3rd Monday of every month from 5:30 - 6:30 p.m. in Imperial County Behavioral Health Services Training Room
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.	**COLLECTIVE TARGETS** *Increase and enhance community engagement*	Christina Olson christinaolson@co.imperial.ca.us (442) 265-1393 Meets the 2nd Tuesday of every month from 4-5 p.m. in County Administration Bldg. Conference Room C&D

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

PARTNERS	IMPACT TARGETS AND STRATEGIES	HOW DO I JOIN?
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.	**COLLECTIVE TARGETS** *Integrate family-centered assessment and connection with social services and community resources and programs* *Increase coordination among local organizations, groups and agencies to enhance and maximize resources and services* **DIABETES** *Deliver community health education using value based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications*	Christina Olson christinaolson@co.imperial.ca.us (442) 265-1393 Meets the 4th Wednesday of every month from 4-5 p.m. in County Administration Bldg. Conference Room C&D
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.	**HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING – DIABETES** *Implement and support school and child care center wellness policies*	Adriana Ramirez adrianaramirez@co.imperial.ca.us (442) 265-1895

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

PARTNERS	IMPACT TARGETS AND STRATEGIES	HOW DO I JOIN?
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.	**PRENATAL CARE** *Deliver community health education using value based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications*	Adriana Ramirez adrianaramirez@co.imperial.ca.us (442) 265-1895
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.	**HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING – DIABETES** *Increase the number of stores that implement healthy food and beverage retail strategies*	**Imperial County Public Health Department:** Jorge Torres (442) 265-1377 jorgetorres@co.imperial.ca.us **Imperial Valley Food Bank:** Mireya Diaz (760) 970-4473 mireya@ivfoodbank.org

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

PARTNERS	IMPACT TARGETS AND STRATEGIES	HOW DO I JOIN?
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.	**PRESCRIPTION DRUG ABUSE** *Develop model healthcare facility-controlled substance Diversion Program* *Increase and enhance use of CURES 2.0 system among prescribers and dispensers*	Dr. Amy Binggeli-Vallarta amybinggeli@co.imperial.ca.us (442) 265-1335
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.	**HEALTHY EATING - ACTIVE LIVING** *Deliver community health education using value based and evidence- or practice-based curriculum* *Link advocacy and community health education with social networking platforms and mobile health applications* **HEALTHY EATING - FOOD SECURITY - ACTIVE LIVING - DIABETES** *Implement and support school and child care center wellness policies* *Identify community and neighborhood strategies to increase opportunities for safe and accessible physical activity*	**Catholic Charities of California local agency, Catholic Charities, Diocese of San Diego:** Joy Davis (619) 231-2828 Ext. 202 jdavis@ccdsd.org **Imperial County Public Health Department:** Jorge Torres (442) 265-1377 jorgetorres@co.imperial.ca.us **UC Cooperative Extension, Imperial County**: Mary Welch-Bezemek (760) 352-9474 mjwelchbezemek@ucanr.edu

Convening Organization