VENTURA COUNTY
COMMUNITY HEALTH
IMPROVEMENT COLLABORATIVE

VENTURA COUNTY
COMMUNITY HEALTH IMPLEMENTATION STRATEGY 2022

Adventist Health Simi Valley
Camarillo Health Care District
Clinicas del Camino Real, Incorporated
Community Memorial Health System
Dignity Health. St. John's Regional Medical Center | St. John's Hospital Camarillo
Gold Coast Health Plan A Public Entity
Ventura County Health Care Agency
Ventura County Public Health A Department of Ventura County Health Care Agency

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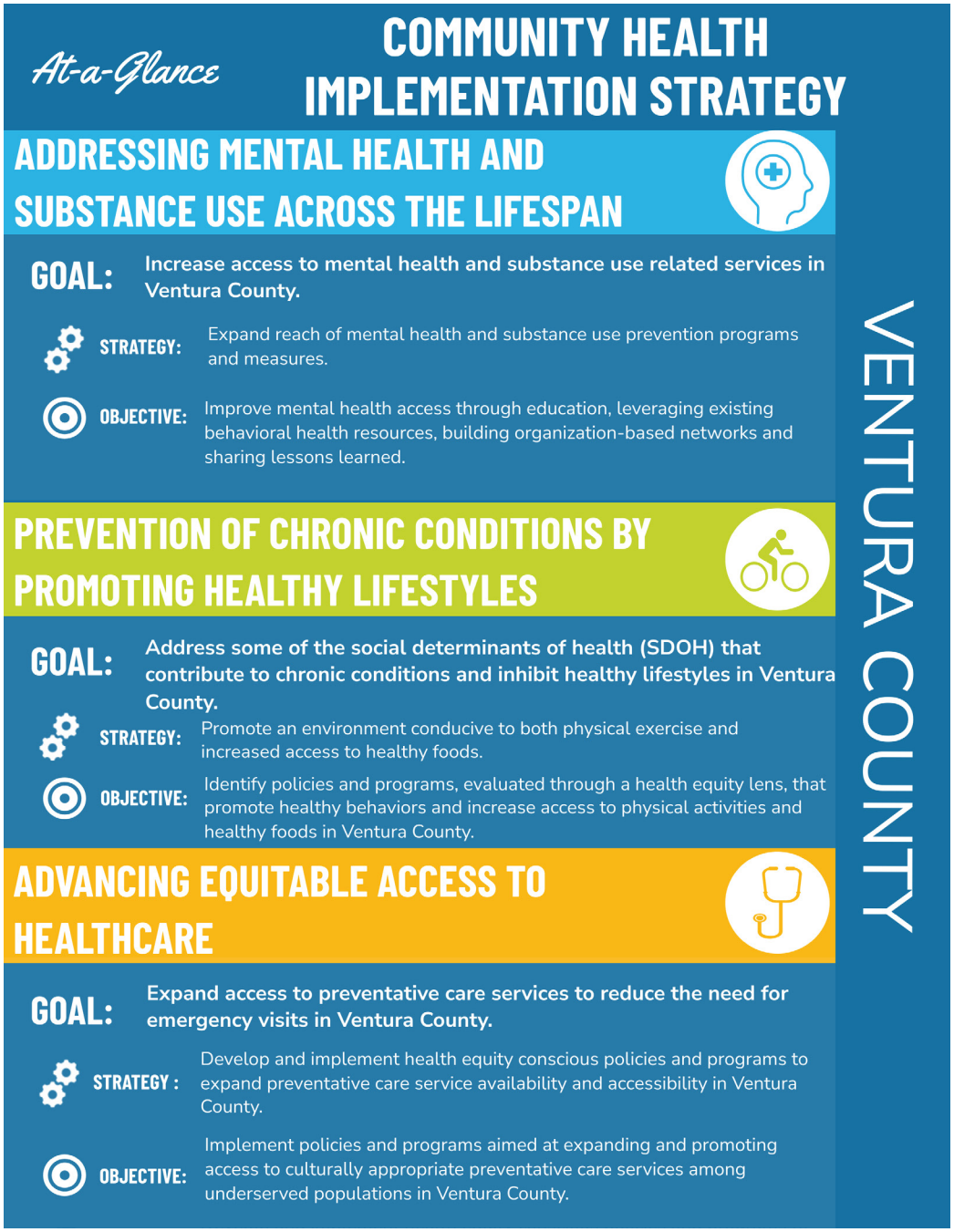
AT-A-GLANCE SUMMARY



INTRODUCTION

The Ventura County Community Health Improvement Collaborative (VCCHIC) is pleased to present its 2022 Community Health Implementation Strategy (CHIS). This plan follows the development of the VCCHIC 2022 Community Health Needs Assessment (CHNA). The CHNA report can be accessed on the Health Matters in Ventura County website at healthmattersinvc.org.

VCCHIC is a formal, charter-bound partnership of health agencies that came together in June 2018 to participate in the development of a joint CHNA exercise and report. VCCHIC continued to collaborate on the 2022 CHNA report. The agencies that constitute VCCHIC are:

- Adventist Health Simi Valley
- Camarillo Health Care District
- Clinicas Del Camino Real, Inc.
- Community Memorial Health System
- Gold Coast Health Plan
- St. John's Regional Medical Center, Dignity Health System
- Ventura County Health Care Agency Community Health Center
- Ventura County Public Health

The mission of VCCHIC is to build partnerships to improve population health outcomes in Ventura County. These partnerships are necessary to accomplish the shared vision of working collaboratively to develop strategies based upon the identified health priorities from the community health needs assessment. This will result in a collective approach to addressing population health and benefit the communities in which we serve.

THIS REPORT INCLUDES:

- An overview of the three health needs identified and prioritized in the most recent CHNA
- A description of the process and methods used to design the implementation plan
- Strategies designed to address each health need
- A framework describing key actions, responsible persons, process measures and anticipated outcomes for each strategy

Community Health Implementation Strategy (CHIS) Purpose

The purpose of this CHIS report is to identify the goals, objectives and strategies that VCCHIC will use to address the three health priorities identified in the most recent CHNA: (1) Addressing Mental Health and Substance Use Across the Lifespan; (2) Prevention of Chronic Conditions by Promoting Healthy Lifestyles; and (3) Advancing Equitable Access to Healthcare.

The VCCHIC CHIS has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r). It requires hospital facilities owned and operated by an organization, described in Code section 501(c)(3), to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. This report is intended to satisfy each of the applicable requirements set forth in final regulations released in December 2014 and also meet community health improvement plan requirements for Public Health Accreditation.

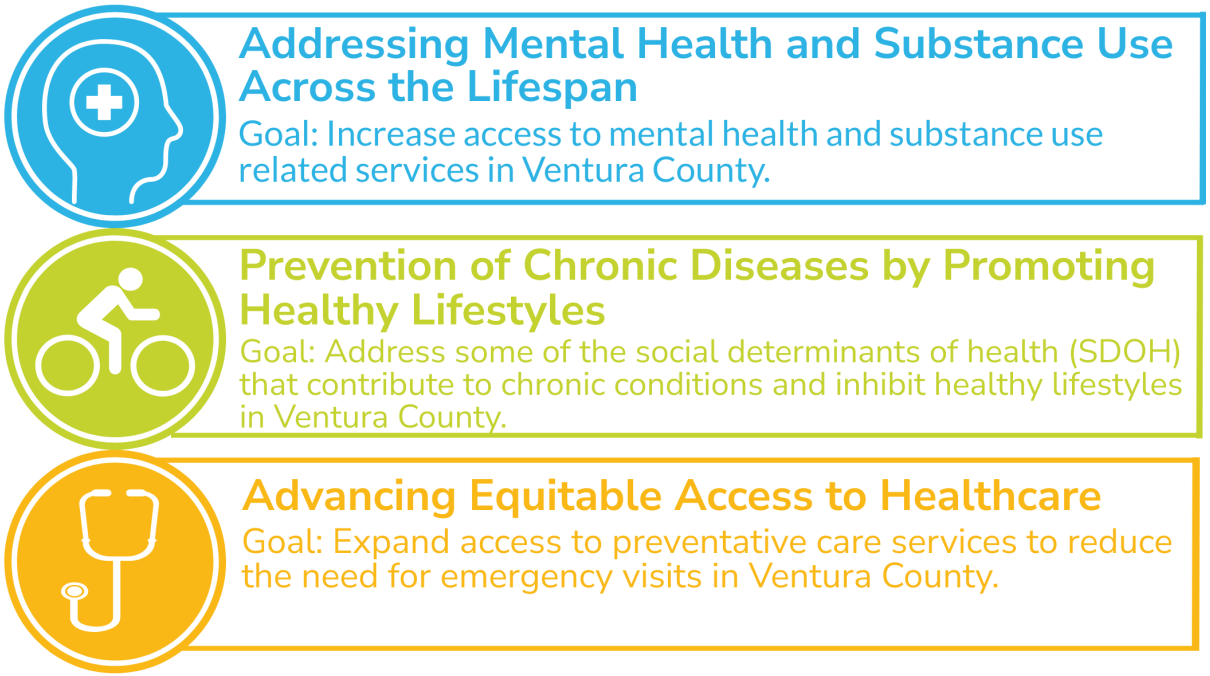
This CHIS describes the planned response by VCCHIC partner hospitals (listed above) to the needs identified in the 2022 joint CHNA. The CHIS was approved by each board of directors and applies to tax years December 2022 through December 2025.

Developing Strategic Implementation Plans

VCCHIC's action plans for 2022 include both policy and programmatic strategies that are designed to make a difference in the three priority areas. Recognizing that the social determinants of health (SDOH) have a major impact on people's health, wellbeing, and quality of life, the implementation plan includes actionable items that address social and economic factors such as access in low- income areas.

The 2022 implementation plans for VCCHIC were thoughtfully developed to leverage current community resources, while also working collaboratively across multiple sectors to engage new community partners. A series of virtual meetings and workshops were conducted to identify the goals, objectives and strategies documented in this plan. An overarching, goal was developed for each health need, ensuring alignment and consistency across collaborative partner organizations. These plans will guide VCCHIC and member organization health improvement efforts from 2023 to 2025.

Prioritized Significant Health Needs



Acknowledgments and Comments

VCCHIC commissioned Conduent Healthy Communities Institute (HCI) to support report development of the 2022 CHIS. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. This report was authored by Sharri Morley, MPH, Public Health Consultant at HCI. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/claims-and-administration/community-health-solutions/.

Written comments on this report can be submitted at www.healthmattersinvc.org.

DESCRIPTION OF THE COMMUNITY SERVED

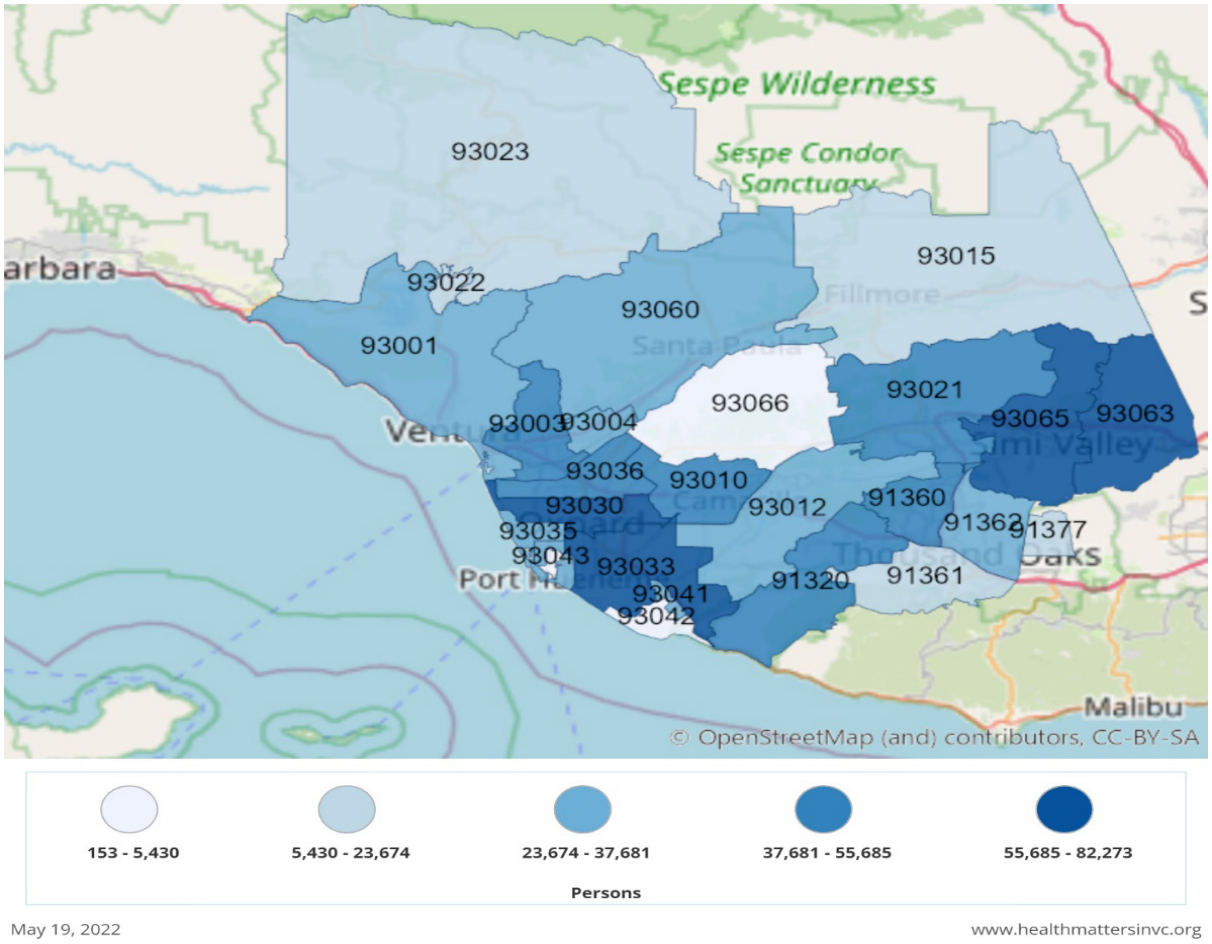
Community Definition and Description

In this document, community is defined as the resident population within the hospital's service area. Committed to addressing health disparities and serving communities with impactful solutions that leverage shared resources and coordinate care, the health agencies that make up the VCCHIC have come together in defining their service area as the County of Ventura.

Located in Southern California, Ventura County has a land area of 1,843.1 square miles which encompasses 10 cities, 23 census-designated places, and 15 other unincorporated communities. According to 2022 Claritas Pop-Facts, Ventura County has a population of 842,465 and is the 13th largest county in terms of population. Figure 1 illustrates the population size in Ventura County by zip code. The most populated zip codes are 93033 (Oxnard), 93065 (Simi Valley), 93030 (Oxnard), and 93063 (Simi Valley) with population totals of 82,273; 74,289; 60,815; and 55,685 respectively. Additional details describing the community in Ventura County, including demographics and social and economic determinants of health, can be found in the CHNA report on the Health Matters in Ventura County website at https://www.healthmattersinvc.org/.

FIGURE 1. POPULATION OF VENTURA COUNTY BY ZIP CODE

Data Source: Claritas



FINDINGS FROM THE 2022 CHNA

VCCHIC conducted its 2022 Community Health Needs Assessment (CHNA) between January and June 2022. The purpose of the CHNA was to identify and prioritize the significant health needs of the community.

Methods for Identifying Community Needs

Secondary data used in the assessment consisted of community health indicators, while primary data consisted of focus group discussions and an online community survey. Findings from all these data sources were analyzed to identify the significant health needs for Ventura County.

Summary of Findings

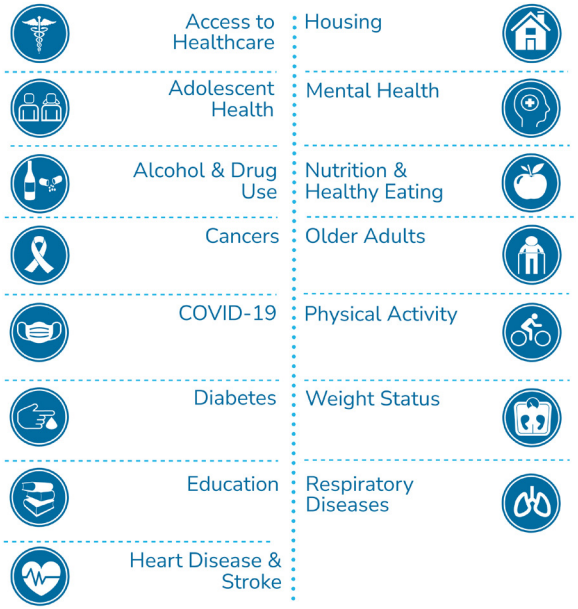
Health needs were determined to be significant if they met the following criteria:

- Secondary data analysis: top 10 health needs as ranked by HCI's Data Scoring Tool
- Survey analysis: identified by 25% or more of respondents as a priority issue
- Qualitative analysis: frequency topic was discussed within/across focus groups
- Life expectancy data: analysis of leading causes of death, leading causes of premature death and all-cause mortality

Through this criteria, fifteen needs emerged as significant. Figure 2 illustrates the final 15 significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all forms of data collected for the VCCHIC 2022 CHNA.

VCCHIC convened a group of community leaders to participate in a presentation of data on the 15 significant health needs. Following the presentation, participants engaged in a discussion and were asked to complete an online prioritization activity.

FIGURE 2. SIGNIFICANT HEALTH NEEDS



Process and Criteria

The online prioritization activity included two criteria for prioritization:

- Magnitude of the Issue
- Ability to Impact

Participants assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. Numerical scores for the two criteria were then combined and averaged to produce an aggregate score and ranking for each health topic.

Prioritization Results

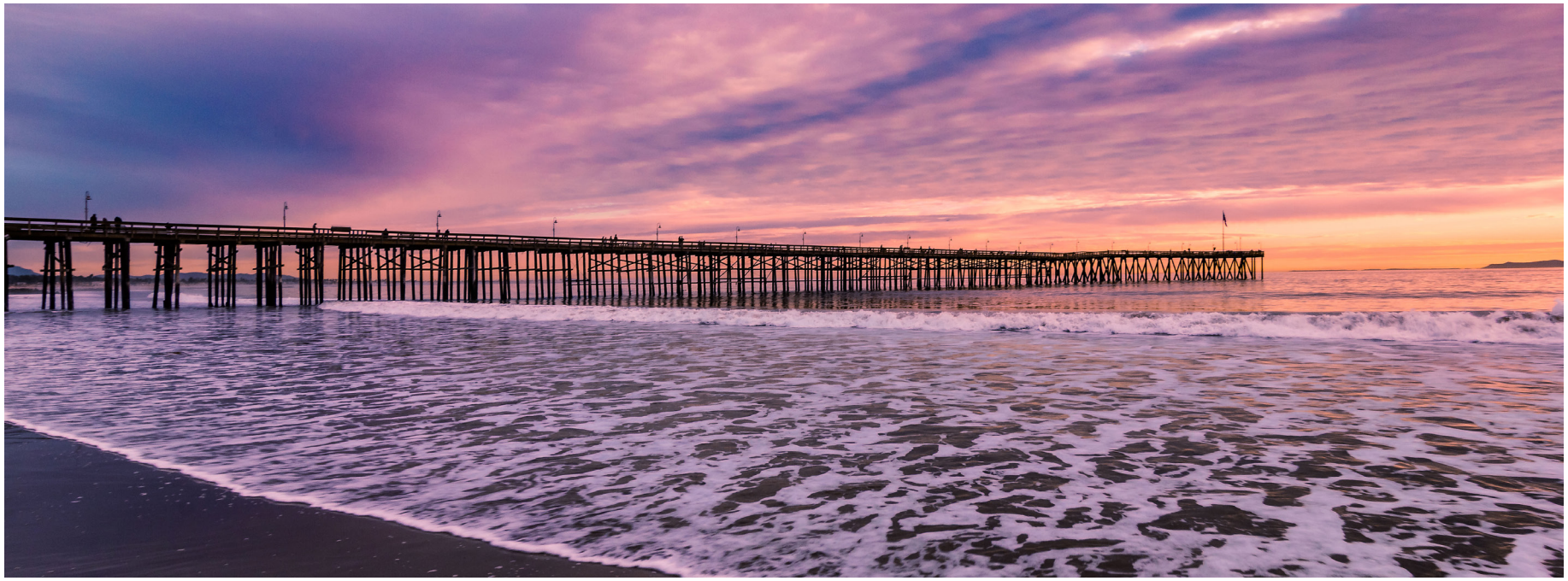
After discussing the results of the prioritization process, the VCCHIC founding members agreed to include each of the 15 significant health needs as subtopics to three prioritized significant health needs. The three priority health needs are shown in Table 1.

Prioritized Significant Health Needs

The first prioritized significant health need, Addressing Mental Health and Substance Use Across the Lifespan included Adverse Childhood Experiences (encompassing Adolescent Health, Substance Use, Housing Overcrowding and Education) and Health and Wellness for Older Adults. The second prioritized significant health need, Prevention of Chronic Conditions by Promoting Healthy Lifestyles, includes chronic disease related sub-topics like Diabetes, Cancer, Weight Status, Physical Activity, Heart Disease and Stroke and Nutrition and Healthy Eating. The third and final prioritized significant health need is Advancing Equitable Access to Healthcare.

TABLE 1. PRIORITIZED SIGNIFICANT HEALTH NEEDS

Addressing Mental Health and Substance Use Across the Lifespan
Prevention of Chronic Conditions by Promoting Healthy Lifestyles
Advancing Equitable Access to Healthcare



2022 CHIS

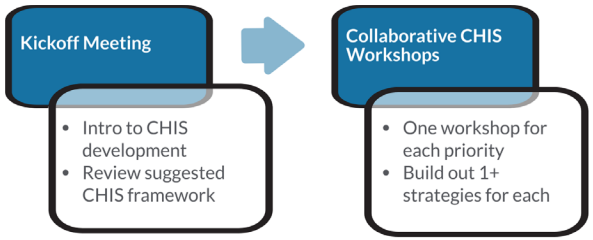
This section presents strategies and program activities that VCCHIC intends to deliver, support, and/or collaborate on to address significant prioritized community health needs over the next three years, including resources for and anticipated impacts of these activities. Planned activities are consistent with current needs and VCCHIC mission and capabilities. VCCHIC may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Following the identification of the three priority health needs, VCCHIC founding members began subsequent work on implementation planning with the following goals:

Overview

Following these initial planning meetings, Conduent HCI hosted a series of virtual meetings and workshops as shown in Figure 3.

FIGURE 3. CHIS WORKSHOP SERIES

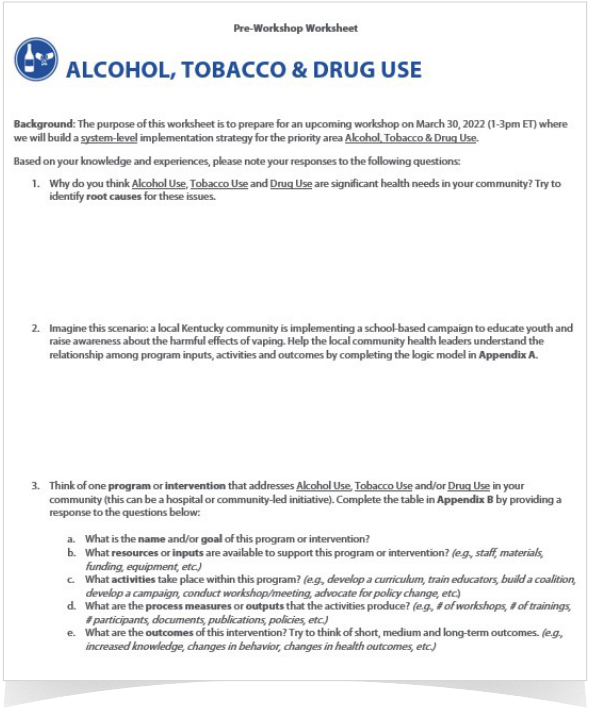


Kickoff Meeting

VCCHIC founding members were invited to participate in a CHIS kickoff meeting on July 5, 2022. A separate kick-off meeting was held on July 15 for all collaborative members. During each virtual meeting, participants reviewed the three health needs that emerged from the most recent CHNA and were introduced to the CHIS planning process (including logic models, process measures and outcome measures). During the founding members' meeting, participants were also asked to provide feedback on a draft framework that was proposed for developing the new implementation plan and were informed about worksheets that they would be asked to complete prior to attending the upcoming workshop series.

Pre-Workshop Worksheets

Conduent HCI developed three *Pre-Workshop Worksheets* (one per health need) to prepare participants for group discussion in the upcoming workshops. Participants were asked to consider root causes for each of the priority health issues, complete a sample logic model, and identify existing programs or interventions that address the relevant priority health need. Each worksheet also included an appendix of resources, with links to national, state, and local goals and objectives, a list of evidence-based resources, and relevant indicators from the secondary data analysis. Each worksheet was emailed to participants several days prior to the respective workshop.



Pre-Workshop Worksheet

ALCOHOL, TOBACCO & DRUG USE

Background: The purpose of this worksheet is to prepare for an upcoming workshop on March 30, 2022 (1-3pm ET) where we will build a system-level implementation strategy for the priority area Alcohol, Tobacco & Drug Use.

Based on your knowledge and experiences, please note your responses to the following questions:

1. Why do you think Alcohol Use, Tobacco Use and Drug Use are significant health needs in your community? Try to identify **root causes** for these issues.

2. Imagine this scenario: a local Kentucky community is implementing a school-based campaign to educate youth and raise awareness about the harmful effects of vaping. Help the local community health leaders understand the relationship among program inputs, activities and outcomes by completing the logic model in **Appendix A.**

3. Think of one **program** or **intervention** that addresses Alcohol Use, Tobacco Use and/or Drug Use in your community (this can be a hospital or community-led initiative). Complete the table in **Appendix B** by providing a response to the questions below:

   a. What is the **name** and/or **goal** of this program or intervention?
   b. What **resources** or **inputs** are available to support this program or intervention? *(e.g., staff, materials, funding, equipment, etc.)*
   c. What **activities** take place within this program? *(e.g., develop a curriculum, train educators, build a coalition, develop a campaign, conduct workshop/meeting, advocate for policy change, etc.)*
   d. What are the **process measures** or **outputs** that the activities produce? *(e.g., # of workshops, # of trainings, # participants, documents, publications, policies, etc.)*
   e. What are the **outcomes** of this intervention? Try to think of short, medium and long-term outcomes. *(e.g., increased knowledge, changes in behavior, changes in health outcomes, etc.)*

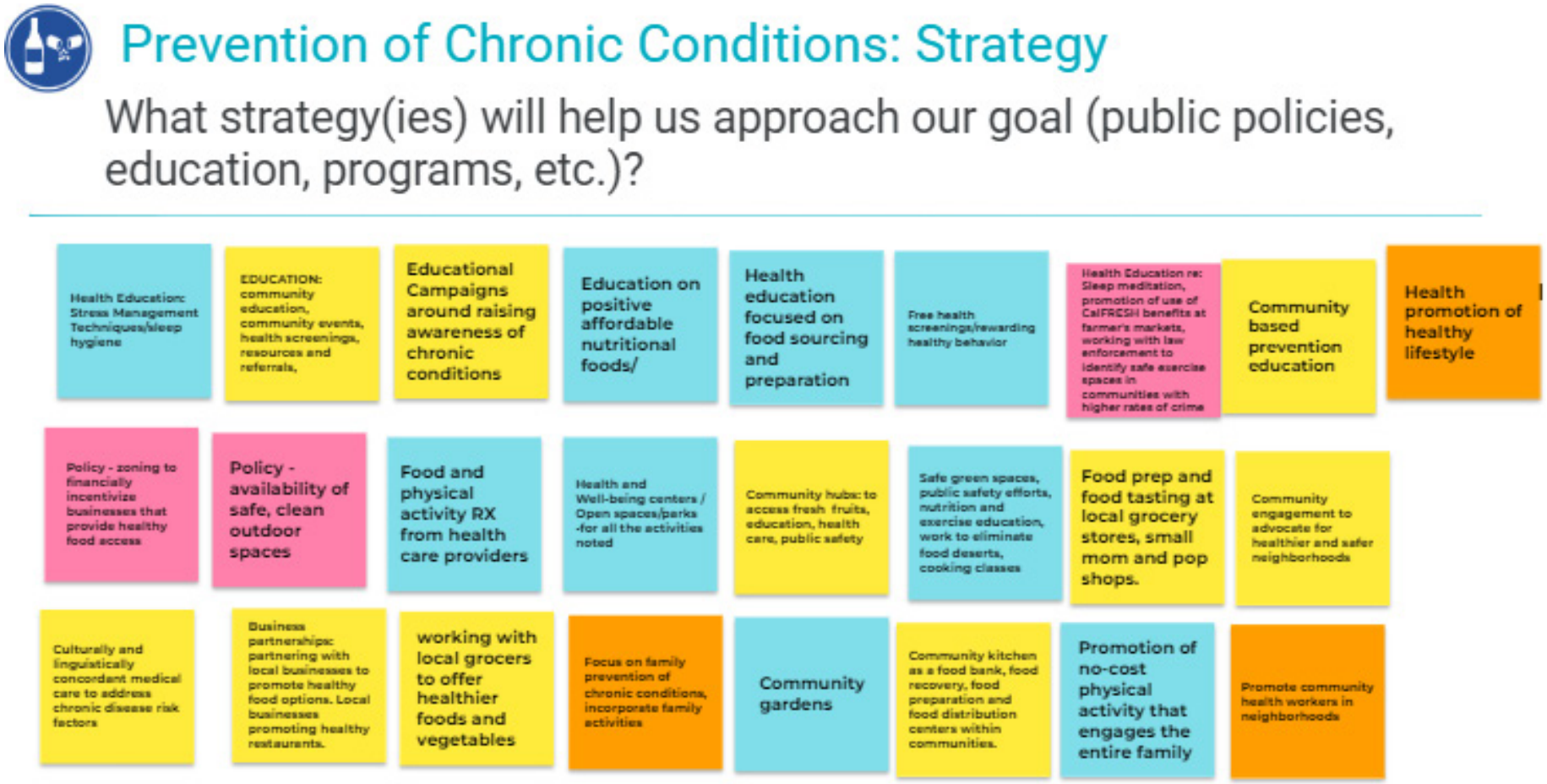
CHIS Workshops

Following the kickoff meeting, VCCHIC founding members were invited to two workshops on each significant prioritized health need. The first workshop was designed to discuss and define goals, strategies, objectives and associated activities to support the CHIS framework for the health topic. During the second workshop, participants refined activities and process measures within the context of the CHIS framework while identifying resources to lead the initiative and baseline measures for monitoring and evaluating activity progress over the next three years. Table 2 shows the timeline for each of the workshops.

TABLE 2. VCCHIC FOUNDING MEMBERS WORKSHOPS

Significant Prioritized Health Need	***Session 1: Brainstorm and Discussion***	***Session 2: Refine and Finalize the Framework***
Addressing Mental Health and Substance Use Across the Lifespan	July 16, 2022	August 2, 2022
Prevention of Chronic Conditions by Promoting Healthy Lifestyles	August 23, 2022	August 30, 2022
Advancing Equitable Access to Healthcare	September 6, 2022	September 13, 2022

FIGURE 4. EXAMPLE JAMBOARD FROM THE COLLABORATIVE BRAINSTORMING PROCESS



Prior to the first workshop for each health topic, participants were encouraged to review relevant initiatives within their organizations as well as best practices outlined in the pre-workshop worksheet. Then, HCI facilitated a group brainstorming session using Jamboard, a collaborative digital whiteboard, to begin building various elements of a logic model to support a strategic framework for the health need. Results of the session are shown in Figure 4. The group discussion initially focused on root causes of the prioritized significant health need as a means of identifying framework goals. Once identified, participants moved to discuss the strategic approach VCCHIC might take to reaching the identified goal. Strategies were categorized as policy, programmatic or educational approaches to increase general knowledge or change attitudes and practices. The group also identified the population they intended to impact most. Finally, specific activities were outlined to facilitate the selected strategy.

After conducting the workshop, HCI utilized the information gathered during the group brainstorming activity to create an implementation framework that was shared with VCCHIC founding members for review and approval. The group developed a separate framework for each strategy.

Action Plans

The action plans presented on the following pages outline the individual strategies and activities VCCHIC will implement to address the three prioritized health needs. The following components are outlined in detail in the frameworks that follow: (1) actions VCCHIC intends to take to address the health needs identified in the CHNA, (2) the anticipated impact of these actions as reflected in the process and outcome measures, (3) the resources VCCHIC plans to commit to each strategy, and (4) any planned collaboration to support the work outlined.

Contributors to Framework Development

VCCHIC is the decision-making entity for the 2022 Community Health Needs Assessment and is chaired by the Epidemiologist at Ventura County Public Health. Primary representatives for the founding members of the collaborative include:

- Mohnisha Jit, MPH, Ventura County Public Health — *Epidemiologist*, Maternal, Child, and Adolescent Health Programs
- Aruni Ganewatte, MS, Ventura County Public Health — *Community Service Coordinator*
- George West, JD, St. John's Regional Medical Center and St. John's Pleasant Valley Hospital, Dignity Health System — *Service Area Vice President, Mission Integration*
- Kathryn Stiles, Adventist Health Simi Valley — *Director of Community Integration*
- Lizeth Barretto, Ventura County Health Care Agency Community Health Center — *Ambulatory Care Administrator*
- Lynette Harvey, Camarillo Health Care District — *Clinical Services Director*
- Erin Slack, MPH, Gold Coast Health Plan — *Senior Manager of Population Health*
- Rachel Cox, MPH, Clinicas Del Camino Real, Inc. — *Operations Manager*
- Will Garand, Community Memorial Health System — *Vice President, Planning & Managed Care*

Addressing Mental Health and Substance Use Across the Lifespan

Goal: Increase access to mental health and substance use related services in Ventura County

Strategy 1: Expand reach of mental health and substance use prevention programs and measures

Objective: Improve mental health access through education, leveraging existing behavioral health resources, building organization-based networks and sharing lessons learned.

Intended Population: Children and Older Adults (0-75) in Ventura County

Resources: Ventura County Community Health Improvement Collaborative (VCCHIC) founding member organizations

Collaboration Partners: Ventura County Behavioral Health

Programs/Activities	Lead Person / Organization	Process Measure Y1	Process Measure Y2	Process Measure Y3	Data Source	Baseline
Activity 1: Expanding Substance Use Navigators (SUN) to all hospitals within Ventura County	VCCHIC Founding Members, Community Memorial Health System, Ventura County Public Health with the Ventura Department of Education as partner	• Leverage Continuing Medical Education (CME) program for providers to introduce substance use navigators and address stigma • Utilize and expand existing frameworks to address stigma via school-based and community programs • Schedule quarterly meetings of the SUNs to identify and maximize best practices	Identify opportunities to leverage diversion from the emergency department to the sobering center or other substance use treatment centers within the county	Engage the Ventura County Sheriff's Office and other associated organizations for jail diversion through sobering centers	California (CA) Bridge	Number of medical assisted therapy orders written in the emergency room prior to discharge
Activity 2: Leveraging lessons learned from Medi-Cal integrated behavioral health programs to expand access to behavioral health services	VCCHIC Founding Members, Gold Coast Health Plan	• Establish relationship and communication with commercial plans (via California Hospital Association, Hospital Association of Southern California, Veterans Affairs, etc.) • Schedule biannual meetings to support collaborative learning between BHIIP partners	Leverage Medi-Cal Behavioral Health Integration and Student Behavioral Health Integration Program pilots as a starting point for expanding integrated programs to more Medi-Cal providers and in working with commercial plans to expand Behavioral Health and Substance Use resources in Ventura County through the school-linked Behavioral Health statewide fee schedule and provider network mandates	Identify funding opportunities via existing programs to maximize county resources	Gold Coast Health Plan	Data from BHIIP partners
Activity 3: Leverage the Community Information Exchange (CIE) as a resource for providers connecting patients in the primary care setting with existing and future community behavioral health support programs and services	VCCHIC CIE Governance Board Member Organizations	Assess and categorize available community resources	Collaborate with providers and community-based organizations to develop a common referral approach/mechanism and determine how best to communicate results and troubleshoot challenges regularly	Coordinate with providers and community-based organizations to develop and distribute materials to communicate and strengthen the connection between primary care providers and community-based behavioral health support programs including school-based programs	CIE	Collect at CIE launch

Anticipated Outcomes	Data Source	Baseline
Short-Term: Number of providers and community members educated to address mental health related stigma	VCCHIC	Collect at program implementation
Medium-Term: Percentage of patients identified receiving mental health care through hospital or community-based services for depression, anxiety, suicide or substance use	Hospital records, CIE	Collect at program implementation
Long-Term: Reduced ER visits due to mental illness and/or substance use, by diverting those with mental health/substance use needs to mental health/substance use care specific centers	Department of Health Care Access and Information (HCAI)	Hospitalization Data (2021)

Preventing Chronic Conditions by Promoting Healthy Lifestyles

Goal: Address some of the social determinants of health (SDOH) that contribute to chronic conditions and inhibit healthy lifestyles in Ventura County

Strategy: Promote an environment conducive to both physical exercise and increased access to healthy foods

Objective: Identify policies and programs, evaluated through a health equity lens, that promote healthy behaviors and increase access to physical activities and healthy foods in Ventura County.

Intended Population: All age, race and ethnic groups in Ventura County

Resources: Ventura County Community Health Improvement Collaborative (VCCHIC) partner organizations, state and county health departments, local businesses and non-profit organizations

Collaboration Partners: VCCHIC partner organizations

Programs/Activities	Lead Person / Organization	Process Measure Y1	Process Measure Y2	Process Measure Y3	Data Source	Baseline
Activity 1: Increase access to healthy foods by connecting community members to available resources	VCCHIC Founding Members with Ventura County Public Health and Gold Coast Health Plan as lead organizations	• Leverage existing data to identify produce providers and philanthropy partners in and around communities at highest risk for food insecurity • Locate a Farmer's Market with free produce in the neighborhood	Provide on-site CalFRESH enrollment and healthy food education into the Farmer's Market location	Leverage existing programs to increase produce consumption in the homeless population and older adults	Ventura County Public Health and Gold Coast Health Plan	Collect at activity implementation
Activity 2: Promote physical activity as a key component of a healthy lifestyle	VCCHIC Founding Members with Camarillo Health Care District, Community Memorial Health System, Gold Coast Health Plan as lead organizations	Identify community-based programs and resources including green spaces, community centers and recreational clubs (walking, biking, running, sport, etc.) providing access to physical activities at low or no cost.	Identify and engage providers and other community partners to promote physical activity through physical activity prescriptions, family wellness workshops, recreational clubs and other community-based programs previously identified in Y1	Seek grant funding to improve access to recreational opportunities in areas with less access to open space including expanding walking paths, sports and club programs to include more age categories, etc.	VCCHIC Founding Member organizations	Collect at activity implementation
Activity 3: Facilitate coordination of hospital and health system cancer prevention programs	VCCHIC Founding Members hospital cancer coordinators with Cancer Support Community with Dignity Health as lead organization	Brand VCCHIC health education materials for partner and community-based organizations to support cancer prevention activities	Expand screening and prevention initiatives by leveraging partner resources and VCCHIC education materials developed in Y1	Develop a strategic plan for all cancer programs in Ventura County	Dignity Health	Collect at activity implementation
Activity 4: Coordinate referrals for strategic programs and promote events via the Community Information Exchange (CIE)	VCCHIC Founding Members with CIE Governance Board as lead organization	Assess and categorize available community resources	Onboard community resources identified in Y1 to the CIE	Utilize the referral data from the CIE to evaluate the needs and determine which programs VCCHIC wants to invest to increase availability of resources	CIE Governance Board	Collect at activity implementation

Anticipated Outcomes	Data Source	Baseline
Short-Term: • Number of community-based programs (CalFRESH, recreational clubs and screening events) that invest in a community activity to promote physical activity, healthy eating and/or cancer screening	CIE, community partners	Collect at program implementation
Medium-Term: • Number of community members utilizing CalFRESH benefits at Farmer's Markets. • Number of community members enrolled in physical activity programs • Planned cancer prevention coordination activities	Human Services Agency	Collect at program implementation
Long-Term: • Reduction in emergency room and hospital utilization from uncontrolled diabetes • Reduction in morbidity from all cancers • Reduction in mortality from all cancers	Department of Health Care Access and Information (HCAI)	Hospitalization Data (2021)

Advancing Equitable Access to Healthcare

Goal: Expand access to preventative care services to reduce the need for emergency visits in Ventura County

Strategy: Develop and implement health equity conscious policies and programs to expand preventative care service availability and accessibility in Ventura County

Objective: Implement policies and programs aimed at expanding and promoting access to culturally appropriate preventative care services among underserved populations in Ventura County

Intended Population: Underserved populations including low-income, immigrant, migrant, refugee, LGBTQIA+, Latinx and Black/African American

Resources: Ventura County Community Health Improvement Collaborative (VCCHIC) partner organizations, American Hospital Association Institute for Diversity and Health Equity (AHA IFDHE)

Collaboration Partners: VCCHIC partner organizations

Programs/Activities	Lead Person / Organization	Process Measure Y1	Process Measure Y2	Process Measure Y3	Data Source	Baseline
Activity 1: Develop a collaborative Population Health Management (PHM) strategy as the framework for CalAIM implementation (high-level, data-driven, risk-stratified strategy for intended populations across the collaborative)	VCCHIC Founding Members with Gold Coast Health Plan as lead organization and First5 Ventura County and Westminster Clinic as partner organization	Develop a PHM strategy aimed at enhancing access to primary care and prenatal/postnatal care services	Restructure health plan financial model(s) and/or programs to incentivize both patients and providers toward expanded opportunities to access primary care and prenatal/postnatal visits and preventative screenings	Develop collaborative community wellness and prevention programs to address the needs of highest risk community members	Gold Coast Health Plan	Collect at program start
Activity 2: Expand Sexual Orientation and Gender Identity (SOGI) knowledge and awareness in the community	VCCHIC Founding Members with Dignity Health as lead organization and Ventura County Diversity Equity and Inclusion (DEI) program as partner	Lead organization (Dignity Health) to facilitate Healthcare Equality Index (HEI) certification for other collaborative health systems	Support expansion of residency programs to include SOGI training	Elevate public awareness of SOGI concerns as well as classes and education available to increase knowledge	VCCHIC Founding Member organizations	Collect at program start
Activity 3: Assess the Diversity & Inclusion in Leadership and Governance state of VCCHIC founding member organizations and action plan based on those findings	VCCHIC Founding Members with Communities Lifting Communities as partner	Select assessment tool and Conduct Assessments	Develop and implement individual organization action plans and VCCHIC action plan based on assessment findings	Summit of DEI leadership from VCCHIC founding member organizations to include their respective Board representatives	AHA IFDHE	Collect at program start
Activity 4: Ensure Community Information Exchange (CIE) is integrated with Ventura County Health System electronic health records (EHR)	VCCHIC Founding Members with the CIE Governance Board as lead organization	Evaluate potential technology vendors for capability to connect with health systems' EHR	Ensure ability of health systems to make social needs referrals to the CIE and close the loop from their EHR	Evaluate type of referrals coming from the health care system and optimize community partnerships to address social needs	CIE	Collect at baseline

Anticipated Outcomes	Data Source	Baseline
Short-Term: • Number of organizations that participate in SOGI and/or DEI assessments • Number of organizations participating in the PHM strategy	American Hospital Association, Dignity Health, Gold Coast Health Plans and any state-level accreditation organization	Collect at program implementation
Medium-Term: • Number of collaborative wellness and prevention programs that were developed because of the PHM strategy	VCCHIC Founders	Collect at program implementation
Long-Term: • Increase primary care visits including screenings • Increase in infant, child, and adolescent well-child visits • Increase in childhood and adolescent vaccinations • Reduce emergency room visits	Gold Coast Health Plan, VCCHIC health care partners, Department of Health Care Access and Information (HCAI)	Collect at program implementation

CONCLUSION

This Community Health Implementation Strategy (CHIS) for Ventura County Community Health Improvement Collaborative (VCCHIC) meets the federal requirement for charitable hospital organizations to develop a three-year written plan describing how the hospital facility plans to address the significant health needs identified in the most recent Community Health Needs Assessment (CHNA) [IRS Section 501(r) (3)]. This CHIS also meets community health improvement plan requirements for Public Health Accreditation. VCCHIC partnered with Conduent Healthy Communities Institute to develop this 2022 CHIS.

A series of virtual meetings and workshops were conducted to identify the goals, objectives and strategies documented in this plan. The goals, objectives and strategies outlined in this report will guide VCCHIC in their collaborative efforts to address each of the three prioritized health needs. Periodic evaluation of process measures and outcome measures will be conducted to ensure that strategies are on track to be completed as described.

Please use this online form to send any comments or feedback about this report: Ventura County Public Health :: Contact Us (healthmattersinvc.org). Feedback received will be incorporated into the next assessment and CHIS development process.