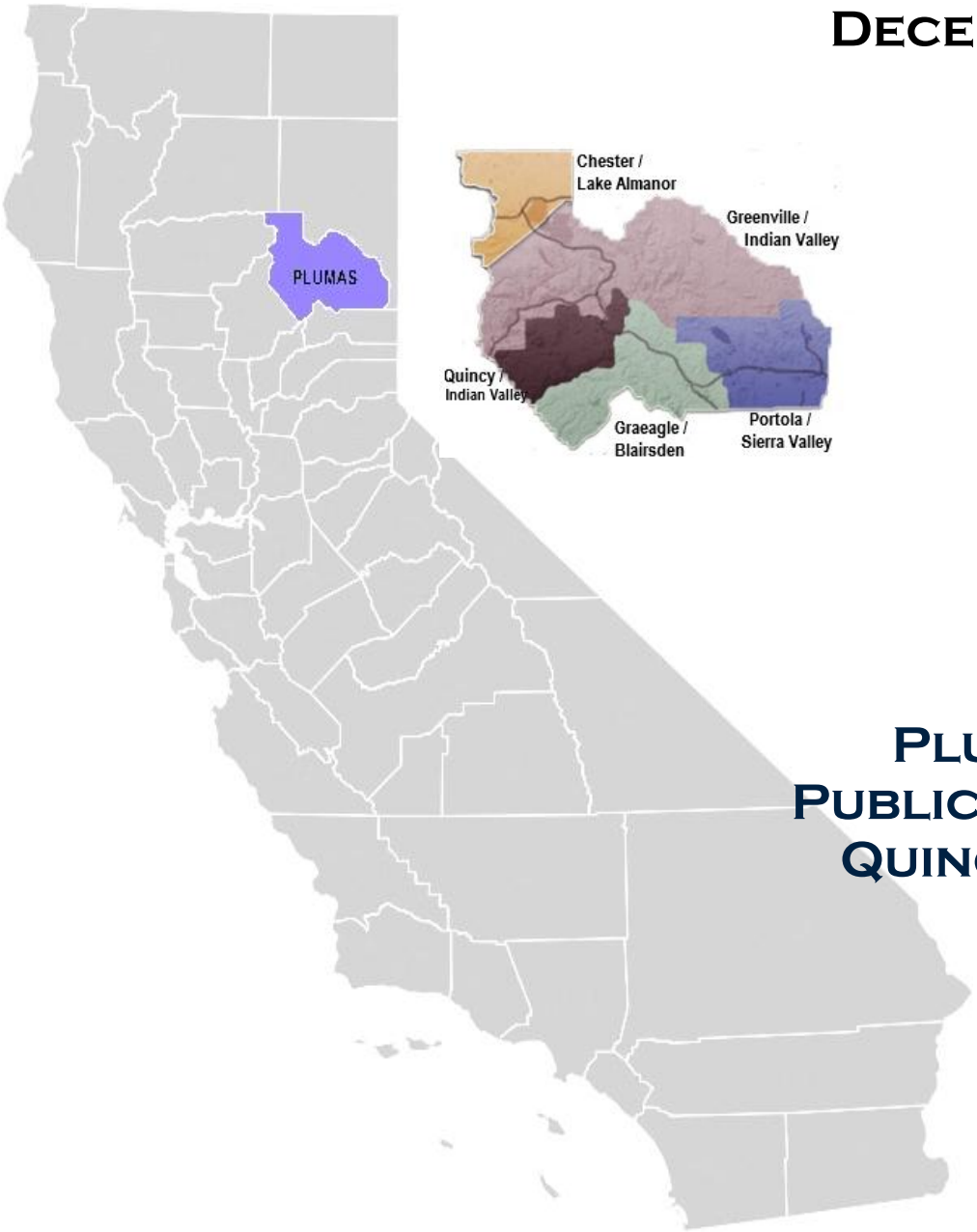
Plumas County

Community Health Improvement Plan (CHIP)



December 2012

Prepared by

Plumas County Public Health Agency

Quincy, California

The Plumas County Community Health Improvement Plan
Is posted online at www.countyofplumas.com

The Plumas County Community Health Improvement Plan, December 2012, is the culmination of an 18-month process led by the Plumas County Public Health Agency, the Local Health Department (LHD) located in the county seat of Quincy, California, with jurisdiction countywide. With suppport and funding from the National Association of County and City Health Officials (NACCHO) and the Robert Wood Johnson Foundation (RWJ), Plumas County Public Health Agency and its partners - Plumas District Hospital based in Quincy, the Greenville Rancheria Tribal Clinic based in Greenville, Eastern Plumas Health Care based in Portola, Seneca Healthcare District based in Chester, and the Sierra Institute for Community and Environment based in Taylorsville – completed a collaborative, countywide Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Both documents are accessible to agencies, organizations, and the general public on the county website at www.countyofplumas.com.

Completion of the CHIP marks the beginning of the Action or Implementation Phase of the community health improvement process starting in January 2013. All health delivery partners made commitments in writing to the ongoing collaborative partnership and to accountability for the CHIP Action Plan.

Acknowledgements

Plumas County Residents

More than 400 residents participated in project activities including

Town Hall Meetings in Fall 2011 and 2012

Eastern Plumas Heath Care

Tom Hayes, CEO; Mark Schweyer, Director of Clinical Operations and Telemedicine

Greenville Rancheria

Margaret Alspaugh, MD, Executive Director; Lee Brooks, FNP

Plumas County Mental Health

Michael Gunter, MFT

Plumas County Public Health

Karla Burnworth, Health Education Chief; Dana Cash, Health Education Specialist;
Mimi Hall, MPH, Director; Louise Steenkamp, MBA, Assistant Director;
Tina Venable, RN, PHN, Director of Nursing

Plumas Crisis Intervention and Resource Center

Dennis Thibeault, Executive Director

Plumas District Hospital

Dan Brandes, MPH, Facilities Director; Douglas Lafferty, CEO

Denise Lauffer, RN

Seneca Healthcare District

Linda Wagner, RN, CEO

Plumas County Social Services

Elliott Smart, Director

The Sierra Institute for Community and Environment

Jonathan Kusel, PhD, Executive Director; Rachel McDowell, Health Intern

Zach Revene, Health Associate

And Special Thanks to the Supporting Work of:

Plumas Alcohol Tobacco and Other Drug Coalition

Plumas County Community Corrections Partnership

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Letter to the Community

Dear Plumas County Residents,

The 2012 Plumas County Community Health Improvement Plan (CHIP) is the result of a robust Community Health Assessment process in which data was collected regarding the community health issues that are most important to Plumas County residents.

The CHIP is an action-oriented, living document to mobilize the community in areas where we can be most impactful on improving the health of all Plumas County residents, particularly those most vulnerable. It serves as a comprehensive set of policy and program recommendations for our community based on the most current information we have regarding the health status of our communities.

Clearly, health is influenced by things such as individual behaviors, age, genetics, and medical care. However, social and economic factors such as education, health insurance, employment and income, and living and working conditions all shape the overall health and vitality of our communities.

Our goal is to make Plumas County a healthier community. We envision a place where everyone has access to health care and preventative services, where we're celebrated for embracing healthy lifestyles and where our communities and neighborhoods are string and vibrant. As partners in the local health system, we recognize we can only achieve this goal through partnerships and positive changes at the individual, school, workplace, and community level.

This plan not only informs the community about the health status of county residents, it also serves as a living document that guides the health department, hospitals and clinics and our community partners, in aligning our program development, activities, and resources to collectively improve community health status over the next three years and beyond.

The Plumas County Community Health Improvement Plan provides a common vision and shared approach for local partners to carry out our work. More importantly, it is a foundation to stimulate strategic new partnerships towards a broad agenda to collectively influence a healthier Plumas County.

Implementation of the Community Health Improvement Plan strategies and activities will commence beginning in the spring of 2013. We invite you to visit the county public health department website at www.countyofplumas.com to view information about the Community Health Improvement Process. After May 1, 2013, you may also visit **www.healthyplumas.org** where we will post regular updates and annual reports.

Sincerely,

Dr. Margaret Alspaugh, Executive Director
Greenville Rancheria

Mimi Hall, Public Health Director,
Plumas County

Tom Hayes, CEO, Eastern Plumas Health Care

Doug Lafferty, CEO, Plumas District Hospital

Jonathan Kusel, Executive Director, Sierra Institute District

Linda Wagner, CEO, Seneca Healthcare

Executive Summary

The Plumas County Community Health Improvement Plan (CHIP) is a living document that will be updated regularly as new information, resources, and emergent issues are identified. The CHIP is a component of Mobilizing for Action Through Planning and Partnership (MAPP), a countywide community health assessment and improvement process led by the Public Health Agency in partnership with the county's three hospital districts - Plumas District Hospital, Eastern Plumas Health Care, and Seneca Healthcare District - and the Greenville Rancheria Tribal Clinic and the Sierra Institute for Community and Environment.

More than 400 Plumas residents participated in MAPP assessment and improvement activities as listed below:

- 9 Town Hall meetings
- 10 focus groups
- 15 key informant interviews
- a Strategic Visioning process
- an Issues Prioritization training
- 9 in-person health care partnership meetings
- 4 Data Indicator Group (DIG) meetings
- 4 Improvement-Measures-Planning-Accountability-Team (IMPACT) meetings
- 2 Strategic Planning Kick-Offs
- 2 selected public viewings of *Unnatural Causes*, the award winning documentary, and
- one countywide, two-day Public Health Summit on the Power of Prevention

Community-Driven Priorities

One hundred and thirty-two Plumas residents participated in the Issues Prioritization component of the process and rated Access to Health Care as the top priority. Effective Quality Care and Addressing Alcohol and Drug were the 2nd and 3rd priorities identified by residents (Appendix 1). Project partners synthesized the community-ranked priorities with assessment findings and, using a Multi-voting quantitative process, arrived at three overarching health priorities. The result is a 3-year, action-oriented Health Priorities Plan on the following pages that lays out goals and objectives, strategies, lead roles and outcome measures for the following three health priorities:

1. Increase access to health care
2. Improve health behaviors, and
3. Optimize existing resources.

Public health, and hospital and clinic partners are accountable for the implementation of the CHIP and have lead roles in improvement activities. Their commitment to improving health outcomes and leadership in the county's health care delivery system are evidenced in letters of support provided at the end of this report (Appendix 5).


Greenville Rancheria
Tribal Health Program

Vision

Healthy Plumas County has a sustainable and equitable continuum of care, vibrant residents, and communities that are connected through collaborations and partnerships.

CHIP Action Plan 2013-2015

Health Priority #1: Increase Access to Health Care

Timeframe: Years 1,2 and 3 - January 2013 through December 2015

Goals	***Objectives***	***Strategies***	***Lead Role and Community Partners***	***Health Status Outcomes and Indicators***
Goal 1 Insurance	**Objective 1.1** Increase percent covered by Medi-Cal, CMSP/LIHP ⇧	Provide assistance in enrollment and eligibility	Public Health, Social Services, PCIRC Application Assisters, WIC	-Enrollment data -Assister trainings -School EE -pursue Blue Shield Fund
	Objective 1.2 Enroll eligible applicants for Health Benefits Exchange (138% to 400% FPL) ⇧	Educate community and business organizations about available opportunities to expand coverage (SHOP and Covered California)	Public Health, School District, PCIRC, Hospitals and Clinics, Greenville Rancheria, County Board of Supervisors, Chambers of Commerce, Hospital Boards	-Information materials distributed and posted on websites -Town Hall meetings -Hospital Board mtgs -School In-service presentations -Covered California Grant
Goal 2 Clinical Services	**Objective 2.1** Establish medical and dental home ⇧	Work with hospitals and Social Services to identify target/at- risk populations	Hospitals and Clinics, Social Services, Public Health Clinic and home visitation program, dental providers	-Hospital patient discharge information/ flyer -Medical and dental provider brochure
	Objective 2.2 Continuity of Care ⇧	Provide coordination and case management follow through	Hospitals, clinics, primary care providers, In-Home Support Services, Home Health, SNFs	-MOU with medical and support service partners -Referral Flow Chart and information
	Objective 2.3 Timely preventive care ⇧	Coordinate with hospitals and community-based partners for outreach and education	Hospitals, clinics, Career and Business, Forest Service, major employers, Public Health, Social Services	-Health Summit during National Public Health Month -Hospital Prevention Screenings in Spring and Fall
Goal 3 Social and economic barriers	**Objective 3.1** Culture and language ⇧	Implement Culturally and Linguistically Appropriate (CLAS) training and CLAS activities	County Literacy program, Public Health bilingual/interpreter services, hospitals, clinics, CBOs,	-Policy -Conduct trainings -Spanish translator assistance -Language phone line
	Objective 3.2 Income ⇧		Career/Business, Social Services, PCIRC, Public Health, major employers	-Job training summits -Literacy program
	Objective 3.3 Social support network ⇧	Increase coordination and referral to community organizations and support	Food bank, career and business network, transportation assistance, community development	-Food Vouchers -Transportation Vouchers -Job training
	Objective 3.4 Cycle of poverty ⇩	Increase advocacy and coordination of support services including dental care, job training, housing	Housing, Social Services, PCIRC, Hospitals, Clinics, Public Health	-Public viewing events (*Un-natural Causes, Poor Kid/PBS,* etc) -social determinants education at Health Summit

Health Priority #2: Improve Health Behaviors

Timeframe: Years 1,2 and 3 - January 2013 through December 2015

Goals	***Objectives***	***Strategies***	***Lead Role and Community Partners***	***Health Status Outcomes and Indicators***
Goal 1 Sexual and reproductive health	**Objective 1.1** Address teen pregnancy ⇩	Engage young girls in leadership and goal-oriented activities including education	Hospitals, clinics, Public Health, schools, Round House Council and other community organizations	-Health education brochures -Health education curriculum in schools -County data
	Objective 1.2 Address single motherhood ⇩	Coordinate a campaign to raise awareness of challenges of single parenting	Hospitals, clinics, Public Health, schools, CBOs, Greenville Rancheria, youth groups, housing, social services, FRC	-Speakers bureau on positive parenting, socio-economic factors in raising families -Press release -Brochures
Goal 2 Address alcohol, tobacco and other drug (ATOD) use	**Objective 2.1** Reduce adolescent use of tobacco and chew ⇩	Coordinate youth activities/ATOD prevention activities across the county	Schools, Plumas County Tobacco and ATOD Prevention Coalition, County Tobacco Use Reduction Program, Feather River College	-California Healthy Kids Data -County Tobacco Reduction Program Data -Youth Prevention Summit
	Objective 2.2 Focus on use in sports and high school activities ⇩	Work with school district in high school sports and other youth programs/activities	PUSD, Indian Valley Recreation District, community youth programs, Fair Ground/rodeos, FRC	-California Healthy Kids Data -Survey among Rodeo youth
	Objective 2.3 Use of ATOD and related chronic disease ⇩	Develop standard policy statements, information, and change social norms/acceptance	ATOD Coalition, FRC, Hospitals, Clinics, Dental Providers, Primary Care Providers, Public Health, Public Housing	-Cessation Programs -Internet/Cell phone coaching -Provider Patient Questions -Discharge Follow-up
Goal 3 Address mental health issues	**Objective 3.1** Focus on adolescents early identification ⇧	Work with schools, parents and providers to engage youth, support activities and leadership	School Nurses/ Teachers, Public Health, Hospitals, Clinics, PCPs, Youth Programs/Activities, Parent Engagement	-School In-service Training on Early ID -Provider Workshop; UCSF/other Expertise -County Health Summit -Youth leadership activities
	Objective 3.2 Address specific issues including suicide, depression, feelings of hopelessness among high school students ⇩	Raise awareness about mental well-being, reduce stigma of mental disorders, and offer coping techniques	Indian Valley Summit Coalition, Roundhouse Council, Greenville Rancheria, Hospitals, Clinics, Schools, ATOD Coalition, Public Health	-California Healthy Kids Survey -Coping techniques workshop for children and parents -Mental health education in schools

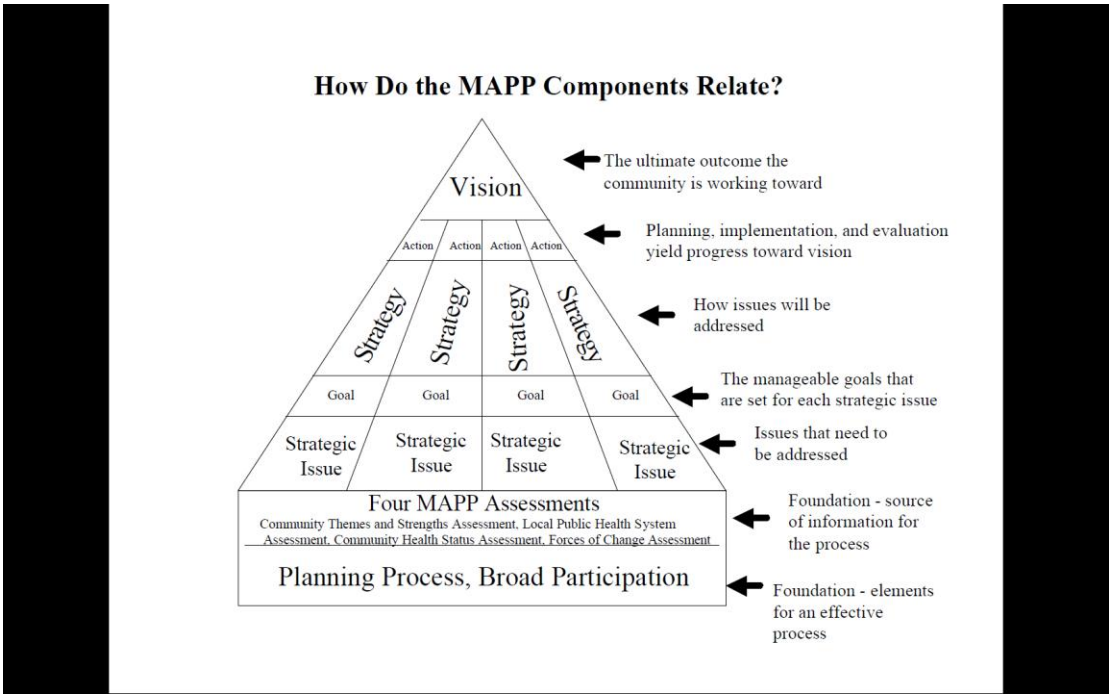
Health Priority #3: Optimize Current Resources

Timeframe: Project Year 2 and 3 – January 2014 through December 2015

Goals	*Objectives*	*Strategies*	*Lead Role and Community Partners*	*Health Status Outcomes and Indicators*
Goal 1 Achieve systems improvement to broaden and deepen the involvement of multiple stakeholders on planning, policy, service and coordination issues across local health system partners	**Objective 1.1** Efficiently and effectively leverage multiple resources across the system of services and partners so that there is broad and collective actions towards priorities and goals ⇧	Increase the number of agencies and organizations that are formal partners in the ongoing Community Health Improvement process	Local Health Connection Partners, Community Corrections Partnership, Oral Health Coalition, community organizations and business stakeholders, hospitals, clinics, tribal clinic, hospital board members, criminal justice system, district attorney's office, sheriff's office	-Memorandum of Understanding for institutional sustainability -Additional resources funding from grant applications
	Objective 1.2 Establish standards and practices for quality improvement across all partners and stakeholders (health care, law enforcement, mental health providers, business community) ⇧	Regularly train a diverse workforce across system partners on Plan Do Study Act and other QI tools and establish quality standards to provide quality, client and community centered services Implement effective, evidence based best practices across the continuum of services which includes multiple sector public and private partners	Public Health, Local Health Connection Partners, social services, mental health, probation, district attorney's office, Plumas Crisis Intervention and Resource Centers, hospitals, clinics, tribal clinic	-Policy and Common Framework for Quality Improvement - Standard Measures and agreed upon common set of tools, data gathering, results -Dissemination of reports and results on partner and county websites
	Objective 1.3 Move beyond a historic reliance on formal health system resources for health improvement efforts towards a model of multiple public and private community resources ⇧	Negotiate agreements with key implementation partners that clearly outline financing arrangement, roles and responsibilities and shared accountability, blending funds to work towards system outcomes	Local Health Connection Partners, Community Corrections Partnership, Oral Health Coalition, community organizations and business stakeholders, hospitals, clinics, tribal clinic, hospital board members, school district, community, law enforcement, Veteran's Services, Roundhouse Council, Greenville Rancheria	-MOU that articulates commitment of staff, resources, activities of the organization -Presentations to Boards of hospitals and organizations -Participation in Health Summit via informational display -Town Hall meetings
	Objective 1.4 Align outreach and communication efforts ⇧	Collectively plan education and marketing efforts from an "issue" perspective, rather than organizational or program specific approach	Local Health Connection Partners, Community Corrections Partnership, Oral Health Coalition, CBOs, businesses, hospitals, clinics, tribal clinic, hospital board members, school district, community	--MOU -Written Policy, Procedures and Standards - Countywide Health Summit

Methodology

The Plumas County Public Health Agency and partners used components of Mobilizing for Action through Planning and Partnerships (MAPP), a strategic approach to community health improvement. The tool helps communities improve health and quality of life through community-wide and community-driven strategic planning. Through MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs and forming effective partnerships for strategic action. The MAPP approach brings four assessments together to gather information and to drive the identification of strategic issues.



The Community Themes and Strengths Assessment provides an understanding of the issues that residents feel are important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?"

The Local Public Health System Assessment focuses on all of the organizations and entities that contribute to the public's health and answers the questions: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

The Community Health Status Assessment identifies priority community health and quality of life issues. Questions answered include: "How healthy are our residents?" and "What does the health status of our community look like?"

The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This answers the questions: "What is occurring or might occur

that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?"

The 10 Essential Public Health Services are:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Issue Prioritization and Strategy Development

Project partners formed a data sub-committee called the Data Indicators Group (DIG) that met 6 times in January-February 2012. The role of the DIG was to review county data and community feedback, analyze available data and sources for identifying health inequities, and compare local data with state and national indicators and sources (see sources in Appendix 2).
A key goal was to examine and identify racial/ethnic disparities given the growing Latino population in the community of Portola, and particular health issues for Native American/Maidu families in Greenville. Through focus groups and interviews, health issues of diabetes, obesity and depression/suicide have been identified; however, there is no local data or research to date that quantifies these disparities. Health disparities tied to cross-generational ties to poverty and ties to poorer health are evidenced through key informant interviews with safety-net and housing agencies. A cross-generational culture of poverty exists in Plumas County. Particularly alarming is the high rate of children living in poverty (24%) and the number of single, female-headed households with children under 18 comprise almost 36% of the county's households. The team anticipates collecting new data and developing indicators to measure outcomes. Key findings are summarized below:

1. Socio-economic factors

- Plumas County has double the proportion of seniors as compared to the rest of California, the majority lives on social security
- Single female-headed households with children under 18 comprise almost 36% of the county's households
- Plumas County has a smaller proportion of children compared to the rest of California but the percentage of children living in poverty (24%) has steadily increased and exceeds the state rate
- Employment in Plumas County is timber-based and seasonal in nature. As a result, the unemployment ranges from about 11% to double that rate during winter months. This has a major impact on the social and economic landscape
- 43% of housing units in Plumas County are vacant, compared to 8% in California and 12.8% in the United States

2. Health Behaviors and Mental Well-Being

- Alcohol, tobacco and substance use rates are alarming in the County as evidenced in ATOD Needs Assessment conducted by Plumas County in November 2011 and the California Healthy Kids Survey among high school students
- Self-inflicted intentional injuries and the suicide rate among Native Americans exceed state rates
- Diabetes and obesity are also concerns but local data are not currently available (anecdotal information from focus groups with Native American/Maidu families and the Greenville Rancheria Tribal Clinic)

3. Local Public Health System Infrastructure

- With less funding, county health and human services departments are operating in silos
- The county's three critical access hospitals are fiscally vulnerable and challenged to meet the requirements for electronic medical records, system and technological improvements, and leadership and management
- Health reform will require system improvements to broaden and deepen the involvement of multiple stakeholders on policy, service and assessment issues

Action Plan Leverages Assets and Resources

As part of the Community Health Assessment and Improvement process, partners recognized that existing resources within the county could be maintained, leveraged and enhanced to better impact positive health outcomes for the Plumas County population. Local Public Health System partners also acknowledge that building a partnership of key private and public community partners is a vital step in successfully addressing barriers to community wide health and wellness. Formal collaborations designed to address the specific issues of prevention, wellness, and access to health care would enable sustainable system wide changes across major community institutions.

In June of 2010, Plumas County Public Health Agency, Plumas County Department of Social Services and Plumas Unified School district signed a Memorandum of Understanding (MOU) to launch the Express Enrollment project. Express Enrollment (EE) expedites Medi-Cal and Healthy Families enrollment for uninsured children who receive free school meals, using the school lunch application to also serve as an Express Enrollment for Medi-Cal and Healthy Families, since the income eligibility guidelines for free and reduced school lunch are the same as those for Medi-Cal and Healthy Families, respectively.

These efforts were expanded when ten key stakeholders, including county health and human service agencies, law enforcement, local hospitals and clinics and local non-profits, signed the Local Health Connections MOU in February 2011. This was a natural expansion of the Express Enrollment effort and driven by the group's common vision to improve health outcomes for individuals with complex medical and/or social support issues.

In September 2011, the Plumas County Community Corrections Partnership (CCP) first convened. Members of the Executive Committee include the Superior Court Judges, District Attorney, Public Health Director, Probation Chief, Public Defender, and Sheriff. This group worked with county health and human service agencies, housing and community development, non-governmental organizations and the Career and Business Network (formerly Alliance for Work Force Development) to plan and implement activities targeting individuals in the criminal justice system with an overall goal of rehabilitation and reducing recidivism. These partners have leveraged funds from a variety of sources to provide health care, mental health and substance use disorder treatment services to inmates and individuals on post release community supervision. In addition, organizations work together to provide education, job training, Medi-Cal and County Medical Services Program enrollment assistance, and other ancillary services. The group developed the Plumas County Community Corrections Plan in January 2012, which marked the first major planning and implementation project to span across the criminal justice system, courts, health and human services, community organizations and the community at large.

In the fall of 2010, Plumas County's three district hospitals joined Plumas County Public Health Agency and the Sierra Institute for Community and Environment to form the Northern Sierra Collaborative Health Network. In the spring of 2011, the Greenville Rancheria joined the group. This partnership serves as a foundation for new and deeper partnerships to address health care delivery, access to and coordination of care, and quality of care while working towards a more integrated model of health care service delivery. Two major goals of the Collaborative are to improve community health outcomes and to increase the effectiveness of the local health care system though strengthened financial stability of our hospitals and clinics.

For the past 7 years, the Oral Health Coalition has worked with a broad group of partners to collaboratively reduce childhood tooth decay rates in all Plumas County communities. The Coalition members are partnering to implement county wide outreach, education and referral activities, Medi-Cal eligibility and enrollment assistance, school based screenings and preventative treatments, pro-bono and sliding fee dentistry, and case manage children with urgent or severe decay or in need of hospitalized dentistry.

Community and Partners Prioritize Key Issues

In fall 2012, community residents participated in five Town Hall meetings as part of the CHIP prioritization process to rate aspects of a healthy service delivery system. The 127 participating residents were asked to respond to questions based on dimensions in The Commonwealth Fund's National Scorecard on U.S. Health System Performance 2011. The priorities below are in rank order of the highest percentage of rating a particular dimension as "very important."

Community Issue Prioritization

1. Access – 90%
2. Effective Quality Care – 88%
3. Addressing AOD and Mental Well-Being – 87%
4. Quality of Care – 83%
5. Healthy Lives – 77%
6. Tobacco Use and Related Disease – 75%
7. Poverty and Households – 73%
8. Equity – 72%

Project partners formed the Improvement, Measures, Planning and Action Team (IMPACT). IMPACT members met over four planning sessions to prioritize issues by reviewing county health data, findings from the assessments, and other primary data from Town Hall Listening Sessions and Key Informant Interviews. The IMPACT team used a Multi-Voting Technique to narrow down the list of health issues and included the factors that affect health, the social determinants of health, and other considerations unique to Plumas County.

The goal of the first planning session was to establish priorities for actionable areas of improvement and propose specific strategies to that would result in meaningful improvement in priority areas. The IMPACT group noted that the community expressed ongoing interest in all nine Town Hall meetings; county prevention activities are essential as indicated in public health priorities as well as state and national guidelines for improving health outcomes; and health care providers are instrumental as indicated by facility priorities, capabilities and resources. Subsequent sessions were focused on finalizing strategies and outlining specific activities and deliverables to support each area of improvement.

Evidence-based Practices Drive Health Action Plan

The IMPACT team identified and used the best available evidence for making informed public health practice decisions in the CHIP Action Plan. Public health evidence-based practice requires health departments to use the best available evidence in making decisions and in

ensuring the effectiveness of processes, programs, and interventions. The IMPACT team began using The Guide to Community Preventive Services to help identify evidence-based and promising practices for developing strategies in the CHIP Action Plan. The Guide provides a host of interventions for tobacco, physical activity, chronic diseases and social environment, to name a few. As appropriate, practices will be incorporated into the design of new or revised processes, programs, and interventions. For interventions that involve Native American/Maidu families, evidence-based or promising practices will be adapted to integrate cultural values and beliefs.

The use of research results, evaluations, and evidence-based practices were used to develop data indicators and outcomes and the IMPACT team was mindful of aligning community priorities with the Healthy People 2020 Indicators, National Prevention Strategy Indicators and the California Department of Health Services Strategic Plan and Indicators. In addition, IMPACT members reviewed the 2009 Greenville Rancheria's Needs Assessment and worked with Dr. Alspaugh, Executive Director of the tribal clinic, to ensure that Indian health priorities and local Maidu family needs were included. The three action areas or Health Priorities are to improve access to health care, improve health behaviors, and to optimize current resources

CHIP Action Phase

The Community Health Improvement process is an ongoing effort to be revisited every three years based on changing needs and health status of the community, progress made towards existing priority areas changes in assets and resources. Public health and health care partners are scheduled to meet in January 2013 to review and refine the strategies in the CHIP Action Plan and develop a more detailed plan for developing standard data collection tools, monitoring and ongoing evaluation efforts. Project partners plan on addressing each of the three priority health issues more in depth with each of their organizations, partners and respective communities through the spring of 2013. As part of National Public Health Week, partners will work with community and business members to convene a Plumas County Health Improvement Summit. Each of the four major Plumas County communities and their respective hospital districts expressed the importance of engaging both community members and nontraditional partners specific to each community to more fully develop community specific measurable objectives and strategies to reach them.

As the CHIP project partners move into the Action Phase we will focus our efforts on each of the three priority issues. The Plumas County Health Assessment will be updated annually and will form the basis by which improvement may be measured in the priority areas.

CHIP project partners will work to implement and evaluate each Priority Area and related Objectives for success and impact. Implementation of the action plans will ultimately strengthen the public health infrastructure, enhance the planning and development of community health partnerships, and promote and support the health, well-being, and quality of life of Plumas County residents. CHIP partners have agreed to review the implementation on an annual basis to update the information and to continually, and collaboratively, improve the health of Plumas County.

In completing this phase of the Community Health Improvement Plan, project partners gained a great deal of insight directly from the communities we serve. Community members and new partners demonstrated a great deal of enthusiasm for engaging with their local health system. This certainly provided great motivation to move the process forward and remains a constant reminder of the commitment across multiple sectors of the community to improve the health and well-being of Plumas County residents through collaboration with others.

Appendix 1: Results from Community Issue Prioritization

	DIMENSION OF A HEALTH SYSTEM:									
	Equity	Greenville		Chester		Quincy		Portola A		Portola B	
1%	Not important at all	3%	1	0%	0	0%	0	0%	0	0%	0
0%	Not important	0%	0	0%	0	0%	0	0%	0	0%	0
2%	Neither important or Unimportant	0%	0	0%	0	2%	1	0%	0	3%	1
26%	Somewhat important	25%	8	17%	2	27%	12	30%	3	28%	8
72%	Very important	72%	23	83%	10	70%	31	70%	7	69%	20
127			32		12		44		10		29
	Access										
1%	Not important at all	0%	0	0%	0	2%	1	0%	0	0%	0
0%	Not important	0%	0	0%	0	0%	0	0%	0	0%	0
2%	Neither important or Unimportant	0%	0	0%	0	2%	1	0%	0	3%	1
8%	Somewhat important	3%	1	0%	0	11%	5	10%	1	10%	3
90%	Very important	97%	29	100%	10	85%	40	90%	9	87%	26
127			30		10		47		10		30
	Effective, Quality Care										
2%	Not important at all	0%	0	0%	0	4%	2	0%	0	3%	1
0%	Not important	0%	0	0%	0	0%	0	0%	0	0%	0
0%	Neither important or Unimportant	0%	0	0%	0	0%	0	0%	0	0%	0
10%	Somewhat important	17%	5	9%	1	2%	1	10%	1	14%	4
88%	Very important	83%	25	91%	10	93%	42	90%	9	83%	24
125			30		11		45		10		29
	AOD & Mental Health										
1%	Not important at all	0%	0	0%	0	0%	0	0%	0	3%	1
0%	Not important	0%	0	0%	0	0%	0	0%	0	0%	0
1%	Neither important or Unimportant	0%	0	0%	0	0%	0	0%	0	3%	1
12%	Somewhat important	7%	2	0%	0	13%	6	10%	1	20%	6
87%	Very important	93%	28	100%	10	87%	41	90%	9	73%	22
127			30		10		47		10		30
	Tobacco use and related disease										
1%	Not important at all	0%	0	0%	0	2%	1	0%	0	0%	0
2%	Not important	0%	0	0%	0	2%	1	0%	0	3%	1
4%	Neither important or Unimportant	13%	4	0%	0	0%	0	0%	0	3%	1
19%	Somewhat important	31%	10	0%	0	14%	6	10%	1	20%	6
75%	Very important	56%	18	100%	9	81%	35	90%	9	73%	22
124			32		9		43		10		30

	Poverty & Households										
1%	Not important at all	0%	0	0%	0	2%	1	0%	0	0%	0
2%	Not important	0%	0	0%	0	4%	2	10%	1	0%	0
5%	Neither important or Unimportant	0%	0	0%	0	2%	1	0%	0	16%	5
20%	Somewhat important	24%	8	0%	0	11%	5	50%	5	26%	8
73%	Very important	76%	26	100%	9	81%	38	40%	4	58%	18
131			34		9		47		10		31
	Quality of Care										
0%	Not important at all	0%	0	0%	0	0%	0	0%	0	0%	0
1%	Not important	3%	1	0%	0	0%	0	0%	0	0%	0
3%	Neither important or Unimportant	3%	1	0%	0	2%	1	0%	0	6%	2
13%	Somewhat important	18%	6	0%	0	2%	1	30%	3	23%	7
83%	Very important	76%	26	100%	12	96%	43	70%	7	71%	22
132			34		12		45		10		31
	Healthy Lives										
1%	Not important at all	3%	1	0%	0	0%	0	0%	0	0%	0
0%	Not important	0%	0	0%	0	0%	0	0%	0	0%	0
4%	Neither important or Unimportant	6%	2	0%	0	2%	1	0%	0	6%	2
18%	Somewhat important	18%	6	0%	0	16%	7	20%	2	26%	8
77%	Very important	73%	24	100%	10	82%	36	80%	8	68%	21
128			33		10		44		10		31

Appendix 2: Health Indicators

INDICATORS			MEASURES	DATA	SOURCE
Behaviors and Physical and Mental Condition	Health Behaviors	Alcohol Use	1. The percentage of adolescents who report ever using alcohol	***Plumas:*** ***7th Grade:*** 32% ***9th Grade:*** 65% **11th Grade:** 77%	California Healthy Kids Survey, California Department of Education, 2008
				California: ***7th Grade:*** 24% ***9th Grade:*** 47% ***11th Grade:*** 66%	
			2. The percentage of adolescents who report drinking alcohol in the past 30 days	***Plumas:*** ***7th Grade:*** 19% ***9th Grade:*** 37% ***11th Grade:*** 52%	
				California: ***7th Grade:*** 15% ***9th Grade:*** 24% ***11th Grade:*** 42%	
			3. The percentage of adolescents who report ever being sick or "drunk" from drinking	***Plumas:*** ***7th Grade:*** 11% ***9th Grade:*** 45% ***11th Grade:*** 60%	
			4. Number of driving under the influence (DUI) arrests	***Plumas:*** 243 DUIs for drugs or alcohol	Plumas County Sheriff's Department, 2010
		Oral Health	1. The proportion of young children aged 3-5 with untreated dental decay in primary and permanent teeth	***Plumas:*** 27% of preschoolers	Plumas County Public Health Oral Health Sceenings
				USA: 23.8% of children ages 3-5	National Health and Nutrition Exam. Survey (NHANES), CDC, NCHS, 1999-2004
		Fitness	1. The percentage of students who were in the "Healthy Fitness Zone" for body composition during physical fitness testing	***Plumas:*** ***5th Grade:*** 64.8% ***7th Grade:*** 62.3% ***9th Grade:*** 58.0%	California Department of Education
				California: ***5th Grade:*** 52.1% ***7th Grade:*** 55.5% ***9th Grade:*** 59.4%	

INDICATORS			MEASURES	DATA	SOURCE
Behaviors and Physical and Mental Condition	Health Behaviors	Tobacco Use	1. The percentage of adults who are current smokers	***Plumas:*** 18.7% ***California:*** 13.2%	The California County and statewide archive of tobacco statistics, The California Tobacco Survey, 2008
			2. The percentage of adults who are daily smokers	***Plumas:*** 14.1% ***California:*** 9.2%	
			3. The percentage of adults who use smokeless tobacco	***Plumas:*** 3.2% ***California:*** 1.7%	
			4. The percentage of adolescents who report ever smoking a cigarette in their lifetime	***Plumas:*** ***7th Grade:*** 10% ***9th Grade:*** 31% ***11th Grade:*** 44%	California Healthy Kids Survey, the California Department of Education, 2008
				California: ***7th Grade:*** 7% ***9the Grade:*** 20% ***11th Grade:*** 34%	
			5. The percentage of adolescents who report smoking a cigarette in the past 30 days	***Plumas:*** ***7th Grade:*** 5% ***9th Grade:*** 15% ***11th Grade:*** 21%	
				California: ***7th Grade:*** 6% ***9th Grade:*** 11% ***11th Grade:*** 17%	
			6. The percentage of adolescents who report ever using chew or snuff	***Plumas:*** ***7th Grade:*** 7% ***9th Grade:*** 22% ***11th Grade:*** 41%	
			7. The percentage of adolescents who report using chew or snuff in the past 30 days	***Plumas:*** ***7th Grade:*** 4% ***9th Grade:*** 12% ***11th Grade:*** 16%	

INDICATORS			MEASURES	DATA	SOURCE
Behaviors and Physical and Mental Condition	Clinical Care	Access to Care	1. The proportion of the population with health insurance	***Plumas:*** 80.9% of people 18 years and older have health insurance	American Community Survey, US Census Bureau, 2008-2010 estimates
				California: 85.5% of Californians 18-65 have health insurance	California Health Information Survey, UCLA, 2009
				USA: 83.2% of people under 65 years old have health Insurance	National Health Information Survey, CDC, 2008
			2.The proportion of children under 19 years old who have no health insurance	***Plumas:*** 9.7%	Small Area Health Insurance Estimates, US Census Bureau, 2009
				California: 10%	
				USA: 9.7% of people under *18 years old* have no health insurance	US Census Bureau, 2009
			3. The proportion of Emergency Room visits which are self-pay	***Plumas:*** 7.9% paid out-of-pocket in 2010	OSHPD 2010
			4. Number of Primary Care Providers per 100,000 population	***Plumas:*** 84 (approx. 37 total PCPs)	HRSA Area resource file, 2008
				California: 116	HRSA Area resource file, 2009
			5. The *rate* of Emergency Room visits due to non-fatal, unintentional injuries per 100,000 population	***Plumas:*** 10,481 (2,279 total incidents)	The California Department of Public Health, California Injury Data Online, 2009
				California: 5,143	
				USA: 9,219.3 in 2008 (age adjusted to the year 2000 standard population)	

INDICATORS			MEASURES	DATA	SOURCE
Behaviors and Physical and Mental Condition	Mental Condition	Mental Health	1. *Rate* of suicides per 100,000 population	***Plumas:*** 18.4 between 2005-2007	National Vital Statistics System (NVSS), CDC, NCHS, 2007, The California Department of Public Health, 2007-2009
				California: 9.4 in 2007	
				USA: 11.3 in 2007	
			2. The percentage of adolescents who *in the past 12 months* felt so sad or hopeless every day for two weeks or more that they stopped doing some usual activities	***Plumas:*** ***7th Grade:*** 32% ***9th Grade:*** 30% ***11th Grade:*** 26%	California Healthy Kids Survey, the California Department of Education, 2008
				California: ***7th Grade:*** 29% ***9th Grade:*** 32% ***11th Grade:*** 33%	
			3. The *rate* of non-fatal Emergency Room visits due to self-inflicted injury per 100,000 population	***Plumas:*** 128.8 for non-fatal intentional self-harm	The California Department of Public Health, 2009
				California: 72.0 for non-fatal intentional self harm	
				USA: 125.3 for nonfatal intentional self-harm injuries per 100,000 in 2008 in the US (age adjusted to the year 2000 standard population)	National Electronic Injury Surveillance System—All Injury Program (NEISS-AIP), CDC, NCIPC, US Consumer Product Safety Commission (CPSC)
		Substance Abuse	1. The *rate* of non-fatal Emergency Room visits due to alcohol or other drugs per 100,000 population	***Plumas:*** 620.9 ER visits per 100,000 (135 total events)	California Department of Public Health, Safe and Active Communities Branch with assistance from California Department of Alcohol and Drug Programs, Office of Applied Research and Analysis, 2009 and 2010
				California: 335.9 ER visits per 100,000	
			2. The *rate* of non-fatal hospitalizations due to alcohol or other drugs per 100,000 population	***Plumas:*** 193.2 hospitalizations per 100,000 (42 total events)	
				California: 145.8 hospitalizations per 100,000	

INDICATORS			MEASURES	DATA	SOURCE
Social, Economic, and Environmental Factors	Social and Economic Factors	Education	1. Educational attainment of persons 25 years and older	***Plumas:*** 90.7% have at least a high school diploma, and 20.5% have a bachelor's degree or higher	The California Department of Finance (Originally American Community Survey, US census bureau, estimates, 2008 - 2010)
				California: 80.6% have at least a high school diploma, and 30% have a bachelor's degree or higher	
				USA: 84.6% have at least a high school diploma and 27.9% have a bachelor's degree or higher	The US Census Bureau, 2012
		Employment	2. High school graduation rate (the percentage of ninth graders who graduate in four years)	***Plumas:*** 90.4%	The American Community Survey, 2009 and 2010
				California: 80.5%	
			1. Unemployment rate	***Plumas:*** 16.4%	The State of California Employment Development Department, EDD, 2010
				California: 12%	
				USA: 9.6%	U.S. Bureau of Labor and Statistics BLS, 2012
		Poverty	1. The percentage of all people living below the federal poverty level	***Plumas:*** 13.9%	The California Department of Finance (Originally American Community Survey, US Census Bureau, estimates, 2008 -2010)
				California: 14.5%	
				USA: 15.1%	The US Census Bureau, 2010
			2. The percentage of families living below the federal poverty level	***Plumas:*** 9.4%	The California Department of Fiance (Originally American Community Survey, US census bureau, estimates, 2008- 2010)
				State: 10.8%	
				USA: 13.2%	The US Census Bureau, 2010
			3. The percentage of Individuals 18 years of age or younger living below the federal poverty level	***Plumas:*** 24.3%	The California Department of Fiance (Originally American Community Survey, US census bureau, estimates, 2008- 2010)
				California: 20.3%	
				USA: 22%	The US Census Bureau, 2012
		Income	1. The annual median household income	***Plumas:*** $41,520	The California Department of Finance, 2010
				California: $54,459	
				USA: $49,445	The US Census Bureau 2010
			2. The annual median family income	***Plumas:*** $47,019	The California Department of Finance, 2010
				California: $67,874	The US Census Bureau 2010
				USA: $60,395	The US Census Bureau 2010
		1 Parent Households	1. The percentage of single parent households with children under 18 years old	***Plumas:*** 35.7%	The California Department of Finance (Originally from the American Community Survey 3 year estimates 2008-2010)
				California: 29.1%	

INDICATORS			MEASURES	DATA	SOURCE
Social, Economic, and Environmental Factors	Environmental Factors	Air Quality	1. The number of days during the year which the air quality was unhealthy for sensitive groups, generally unhealthy or very unhealhty (Air Quality Index or AQI >100)	***Plumas:*** 9 days exceeded the AQI of 100 in in 2008 (4 days unhealthy for sensitive groups and 5 days unhealthy for the general public) ***USA:*** 11 days in 2008	Air Quality System (formerly the Aerometric Information Retrieval System), EPA, 2008 http://www.epa.gov/airdata/
			2. Air pollution particulate matter days	***Plumas:*** 2 unhealthy air quality days due to particulate matter annually ***California:*** 16 unhealthy air quality days due to particulate matter annually	County Health Rankings (originally the US EPA)
			3. Air pollution ozone days	***Plumas:*** 0 unhealthy air quality days due to ozone annually ***California:*** 51 unhealthy air quality days due to ozone annually	County Health Rankings (originally the US EPA)
		Built Environment	1. The percentage of housing units which are vacant	***Plumas:*** 43% ***California:*** 8% ***USA:*** 12.8%	The California Department of Fiance (Originally American Community Survey, US census bureau, estimates, 2008 - 2010) US Census Bureau, 2012
			2. Housing ownership rate of occupied housing units	***Plumas:*** 65.6% ***California:*** 57.4% ***USA:*** 66.6%	US Census Bureau 2006 - 2011

INDICATORS			MEASURES	DATA	SOURCE
Health Outcomes	Morbidity	Cancer	1. Age adjusted *rate* of all cancers per 100,000 population	***Plumas:*** 428.8 persons per 100,000	California Health Collaborative 2005-2009
				California: 474.7 persons per 100,000	
			2. Age adjusted *rate* of lung cancer per 100,000 population	***Plumas:*** 62.9 persons per 100,000	
				California: 52.5 persons per 100,000	
			3. Age adjusted *rate* of other respiratory cancers per 100,000 population	***Plumas:*** 66 persons per 100,000	
				California: 56.2 persons per 100,000	
		Asthma	1. The age adjusted *rate* per 100,000 population of hospitalizations due to asthma	***Plumas:*** 6.94 hospitalizations per 100,000 in 2009 (17 total events)	The California Department of Public Health Environmental Health Tracking Program, 2009 and 2010
				California: 9.42 hospitalizations per 100,000 in 2009	
				USA: 11.1 hospitalizations of persons 5-64 years old per 100,000 in 2007	The National Hospital Ambulatory Medical Care Survey, NHAMCS, CDC, NCHS
			2. The age adjusted *rate* per 100,000 population of Emergency Room visits due to asthma	***Plumas:*** 56.61 ER visits per 100,000 in 2009 (110 total events)	The California Department of Public Health Environmental Health Tracking Program, 2010
				California: 47.99 ER visits per 100,000 in 2009	
				USA: 57 ER visits of persons 5-64 years old per 100,000 population in 2007	The National Hospital Ambulatory Medical Care Survey, NHAMCS, CDC, NCHS

INDICATORS			MEASURES	DATA	SOURCE
Health Outcomes	Morbidity	Teenage Mothers	i. The *rate* of births to females 15-19 years old per 1,000 teens	***Plumas:*** 22.7 births per 1,000 (confidence Interval: 18.5-26.8)	Bridged-Race Population Estimates for Census 2000 (CDC, Census) NVSS-N (CDC, NCHS), 2001-2009
				California: 38.8 births per 1,000 in 2005	
				USA: 40.5 per 1,000 in 2005	
			2. The percentage of all live births to teenage mothers 15-19 years old	***Plumas:*** 11%	The California Department of Public Health, 2009-2010
				California: 9.1%	
		Maternal and Child Health	1. The percentage of babies weighing less than 2500 grams (5lbs 8 oz) at birth	***Plumas:*** 4.5%	
				California: 6.8%	
				USA: 8.2%	National Vital Statistics System (NVSS), CDC, NCHS
			2. The percentage of mothers who received care in 3rd trimester or no prenatal care at all	***Plumas:*** 4.8%	The California Department of Public Health, 2009
				California: 3.2%	
			3. The percentage of babies born before 37 weeks gestation (pre-term)	***Plumas:*** 4.3%	The National Vital Statistics System (NVSS), CDC, 2007, The California Department of Public Health, 2009-2010
				California: 10.4%	
				USAl: 12.7%	
			4. The percentage of new mothers exclusively breast feeding at the time of hospital discharge	***Plumas:*** 80.1% in 2005-2007 (approximately 45-50 breast feeding mothers monthly)	PCPHA MCAH report 2005-2007, Local WIC office
				California: 42.6% in 2005-2007	
				USA: 33.6% for a three-month period after hospital discharge in 2006	The National Immunization Survey http://www.healthindicators.gov/Resources/DataSources/NIS_96/Profile

INDICATORS			MEASURES	DATA	SOURCE
Health Outcomes	Mortality	Causes of Death	1. The *rate* of deaths due to cancer per 100,000 population (age - adjusted rate)	***Plumas:*** 131.14 per 100,000 in Plumas, Lassen and Modoc counties in 2007 (48 total deaths due to cancer in 2009; deaths due to cancer were the number one cause of death in 2009)	The California Cancer Registry, 2007
				California: 164 per 100,000 in 2007	National Vital Statistics System (NVSS), CDC, NCHS
				USA: 178.4 per 100,000 in 2007	
			2. The *rate* of deaths due to digestive system cancers per 100,000 population (age-adjusted rate)	***Plumas:*** 43.69 in 2009 (39.67 for the period 2005-2009)	The California Cancer Registry 2009, 2005-2010
				California: 42.02 in 2009 (42.66 for the period 2005-2009)	
			3. The *rate* of deaths due to respiratory cancers per 100,000 population	***Plumas:*** 30.94, in 2009 (42.69 for the period 2005-2009)	
				California: 38.98 in 2009 (40.95 for the period 2005-2009)	
			4. The *rate* of deaths due to lung cancers per 100,000 population	***Plumas:***30.94 in 2009 (42.25 for the period 2005-2009; 53.9 in 2007)	
				California: 37.81 in 2009 (39.76 for the period 2005-2009; 39.4 in 2007)	
				USA: 50.6 in 2007 (age-adjusted to the 2000 population)	National Vital Statistics System (NVSS), CDC, NCHS
			5. *Rate* of deaths due to coronary heart disease per 100,000 population	***Plumas:*** 73.6	National Vital Statistics Surveillance - Mortality NVSS-M (CDC, NCHS), 2007-2009
				California: 136.2	
				USA: 135.5	

			6. The *rate* of deaths due to motor vehichle crashes per 100,000 population	***Plumas:*** 19.9 (12.6 - 27.1 Confidence Interval)	Bridged-Race Population Estimates for Census 2000 (CDC, Census) , NVSS-M (CDC, NCHS) 2001-2009
				California: 12.2 (12-12.3 Confidence Interval)	
				USA: 15.3 (15.2-15.3 Confidence Interval)	
			7. The *rate* of deaths due to unintentional injury per 100,000 population	***Plumas:*** 41.1 in 2009 (9 total events)	The California Department of Public Health, California Injury Data Online, 2009-2010
				California: 26.8 in 2009	
				USA: 40.0 in 2007 (age-adjusted to the year 2000 population)	National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS

Appendix 3: Community Health Partnership Description

July 2009 Project Outline

Closing the Gap: Building a Multi-sector Community Partnership to Improve Health Outcomes

Building a partnership of key private and public community partners is a vital step in successfully addressing barriers to community wide health and wellness. A formal collaboration designed to address the specific issue of prevention, wellness, access to health care would enable sustainable system wide changes across major community institutions. These changes would improve access to preventive and primary health services by 1) increasing enrollment, utilization and retention in public health insurance programs (Coverage Initiative), 2) provide diverse community momentum and resources to obtain affordable private health insurance for the uninsured, and 3) build capacity to sustain community wide prevention efforts, the Coverage Initiative, and increased timely utilization of health care services.

Issue:

Rural areas experience unique set of challenges in eliminating health disparities, with one of the key barriers being access to health care coverage. Poor health outcomes are directly related to numbers of uninsured, underinsured and those disenrolled in eligible programs as well as significant impacts to health care providers in uncompensated care, bad debt and charity care. A successful response to these challenges requires a collaborative approach that engages multiple sectors of the community that, collectively, have the power to affect change across the spectrum of the local health care system. Local planning for increasing access to preventive and primary health care must be brought into sync across the organizations that impact the local health care system so that the solutions for implementation will be supported, institutionalized and sustained by all partners.

Assessment Findings:

The Sierra Institute for Community and Environment partnered with the Plumas County Public Health Agency to conduct an assessment of the Plumas healthcare system and how it manages the needs of the uninsured and underserved. Key findings from this assessment that will be addressed by this project are:

1. A significant percentage of patients are underinsured or uninsured.
2. There are multiple and complex reasons why people eligible for Medi-Cal, Healthy Families, and CMSP are not enrolled.
3. Under-enrollment and underutilization of patients eligible for state and county health care coverage can be a major factor in district solvency and financial stability.
4. Enrolling more people and keeping them enrolled in public programs will reduce bad debt by shifting payment responsibility from individuals and providers to state and federal agencies.
5. The uninsured face a different set of medical options - typically receive inadequate preventative care; they lack a medical home

Building Community Partnerships:
A collaborative effort engaging key partners across community sectors (health and human service agencies, non-profits, schools, health care providers and practitioners, large employers, small businesses, community members) will produce partnerships that reflect the needs and available resources of the health care system as well as the values, concerns and interests of the community. Both are essential for an effective response to access to health care.

Strategies should focus on three key issues:

1. Engage and convene partners to identify the factors that drive their decisions in policy and protocol within their own "system" that affect access to preventative care and a medical home.
2. Provide diverse community momentum and resources to obtain health care coverage
3. Build community wide organizational capacity to sustain high levels of access to timely and local health care services.

The process:
To be successful, partnerships must lead to visible action by those in a position to make critical decisions. The following steps constitute the main components of the process from inception to action:

1. Establish formal collaborations with organizations that have the capacity to affect the community's health and wellness. Convene an ongoing conversation among citizens, hospitals, practitioners, and other community institutions about the nature of the community's response to the issue of access to health and come to specific recommendations for actions that will be effective and the partners will embrace.
2. Increase the knowledge, expertise and capability of the collaborative through training, network building and education geared towards availability of health care coverage for diverse populations and needs and enrollment, utilization and retention.
3. Project staff and coalition partners should identify a core team with representation from each sector, to arrive at a set of strategies to increase health care coverage availability, enrollment, utilization and retention that will effectively meet the needs of the community members.
4. Pilot, Assess, Implement, Evaluate

Resources in Place:

- **MAA Program partners – PUSD, PCIRC, PRS, Round House Council.** These organizations can coordinate Outreach Enrollment Retention and Utilization in health programs as MAA reimbursable activities
- **Family Resource Center County Funding –** County General Fund dollars have been granted again to family resource centers to support health and wellbeing. This originated as the PCN project and supported Community Health Outreach Workers.
- **Public Health Agency –** has resources in terms of staff, training, and technical assistance
- **Sierra Institute –** has resources of staff, training, TA.

Appendix 4: Definitions and Terminology

Federal and state requirements

Federal law and laws in many states require tax-exempt hospitals to conduct periodic community health needs assessments and adopt plans to meet assessed needs. In order to comply with federal tax-exemption requirements in the Affordable Care Act, a tax-exempt hospital facility must:

- conduct a community health needs assessment every three years. The assessment must
    - take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
    - be made widely available to the public.
- adopt an implementation strategy to meet the community health needs identified through the assessment.
- report how it is addressing the needs identified in the community health needs assessment and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

In addition to these new federal requirements, many states require tax-exempt hospitals to conduct community needs assessments and develop community benefit plans, in varying degrees of specifications.

Check the Advocacy and Public Policy section of CHA 's community benefit website (www.chausa.org/communitybenefit) for the status of federal regulations and instructions and a description of state requirements.

What is a Community Health Needs Assessment and an Implementation Strategy?

A community health needs assessment is a systematic process involving the community, to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs. An implementation strategy is the hospital's plan for addressing community health needs, including health needs identified in the community health needs assessment. The implementation strategy is also known as the hospital's overall community benefit plan.

Mobilizing for Action through Planning & Partnership (MAPP)

MAPP is a community-wide strategic planning process for improving community health and strengthening the local public health system. By engaging in MAPP, hospitals build new partnerships and benefit from the community's strengthened public health infrastructure and improved ability to anticipate and manage change. United with a common framework and shared values, non profit hospitals, local health departments, and local public health system partners can collectively move communities closer to the ultimate goal of improving the public's health (wwww.naccho.org/topics/infrastructure/mapp/index.cfm).

Source: National Association of County and City Health Officials FACT SHEET

Evidence-based Program

An evidence-based program has been:

- Implemented within a specific population.
- Critically appraised for its validity and relevance.
- Found to be effective.

Zul Surani, USC Norris Comprehensive Cancer Center
From: http://healthequity.ucla.edu/docs/identifying_accessing_data_sources.pdf
The Guide to Community Preventive Services

Objectives

According to the Centers for Disease Control and Prevention, objectives should be SMART:

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**ime specific

Social Determinants of Health

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.
World Health Organization

Appendix 5: Letters of Support (partial list)

Greenville Rancheria
Tribal Health Program
"A Community Clinic"

Red Bluff Clinic: 1425 Montgomery Road • Red Bluff, Ca 96080 • 530.528.8600 • Fax 530.528.8612
Greenville Clinic: PO Box 279 / 410 Main Street • Greenville, Ca 95947 • 530.284.6135 • Fax 530.284.7594

Mimi Hall, Director
Plumas County Public Health Agency
270 County Hospital Road
Quincy, CA 95971

Dear Mimi,

We are providing this letter of support to implement the Plumas County Community Health Improvement Plan, December 2012. As discussed throughout the community health assessment and improvement process, we are committed to improving the health of Plumas County residents and will implement the activities we have developed together. We are committed to keeping our community informed of our plan through public meetings such as the Town Hall meetings we recently completed. We are committed to taking on lead and/or support roles as identified in the plan and will provide data and ongoing monitoring for reporting purposes as needed.

We look forward to achieving improved health outcomes together and to continue collaboration with our health partners, community and business stakeholders.

Sincerely,

Margaret Alspaugh, M.D., Ph.D.
Executive Director Greenville Rancheria

Plumas
DISTRICT HOSPITAL

December 13, 2012

Mimi Hall, Director
Plumas County Public Health Agency
270 County Hospital Road
Quincy, CA 95971

Dear Mimi,

We are providing this letter of support to implement the Plumas County Community Health Improvement Plan, December 2012. As discussed throughout the community health assessment and improvement process, we are committed to improving the health of Plumas County residents and will implement the activities we developed together. We are committed to keeping our community informed of our plan through public meetings such as the Town Halls we recently completed. We are committed to taking on lead and/or support roles as identified in the plan and will provide data and ongoing monitoring for reporting purposes as needed.

We look forward to achieving improved health outcomes together and to continue collaboration with our health partners, community and business stakeholders.

Sincerely,

Douglas L. Lafferty
C.E.O.

Eastern Plumas Health Care
"People Helping People."

Eastern Plumas Hospital

Portola Campus
500 First Avenue
Portola, CA 96122
Tel: 530.832.6500
Toll Free: 800.571.3742
Fax: 530.832.4494

Loyalton Campus
700 Third Street
Loyalton, CA 96118
Tel: 530.993.1225
Fax: 530.993.4878

Eastern Plumas Clinics & Services

Portola Medical & Dental Clinic
480 First Avenue
Portola, CA 96122
Tel: 530.832.6600
Fax: 530.832.5968

Graeagle Medical Clinic
7597 Hwy. 89
Graeagle, CA 96103
Tel: 530.836.1122
Fax: 530.836.1642

Loyalton Medical Clinic
725 Third Street
Loyalton, CA 96118
Tel: 530.993.1231
Fax: 530.993.4857

Indian Valley Medical Clinic
176 Hot Springs Road
Greenville, CA 95947

Mimi Hall, Director
Plumas County Public Health Agency
270 County Hospital Road
Quincy, CA 95971

December 12, 2012

Dear Mimi,

I am pleased to provide this letter of support to implement the Plumas County Community Health Improvement Plan, December 2012. As we have discussed throughout the community health assessment and improvement process, we are committed to improving the health of Plumas County residents and will implement the activities we developed together. We are committed to the ongoing collaboration and to keeping our community informed of our plan through public meetings such as the Town Halls we recently completed. We are committed to taking on lead and/or support roles as identified in the plan and will provide data and ongoing monitoring for reporting purposes as needed.

We look forward to achieving improved health outcomes together and to continued collaboration with our health partners, community and business stakeholders.

Sincerely,

Thomas P. Hayes

Thomas P. Hayes, CEO
Eastern Plumas Health Care