CAMARILLO HEALTH CARE DISTRICT

Strategic Plan 2017-2020

Redesigning systems and expectations.
Transforming access and delivery.
Restructuring role and relevance.
Changing lives and communities.

April 25, 2017

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Executive Summary

Strategic planning is an organizational management activity used to describe direction, focus energy and resources, strengthen operations, provide for a success or progress measurement tool, and assess and adjust the organization's direction in response to a changing environment. It is a process that produces decisions and actions that shape and guide what an organization is, who it serves, what it does, and why it does it, with a steadfast focus on the future. This draft outlines a preliminary approach to fundamental initiatives as recommended by staff, and as it pertains to the three-year period of 2017-2020.

Organization Background

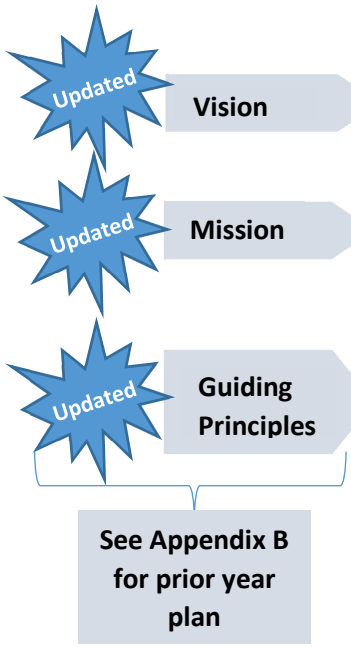
The Camarillo Health Care District (District) is a local public agency established in 1969, and defined within the California Health and Safety Code. In addition to the service area defined by the Local Agency Formation Commission boundaries of generally the Greater Camarillo area, Somis, and parts of the Las Posas and Santa Rosa Valleys, District services are also available throughout Ventura County as defined in the California Health and Safety Code 32121(j). The District is governed by a five-member elected Board of Directors, and further guided by organizational Bylaws which establish operational parameters.

Today, the District is recognized as an award-winning special district and community-based organization (CBO) specializing in a wide range of high-quality, direct client services and supportive programs serving the continuum of health care, including transitional care services, case management, chronic disease management, caregiver education and training, health promotion and disease prevention, health counseling and advocacy, nutrition and exercise, fall prevention and safety, health screenings and support programs, and transportation services.

The District joins the new health care environment in recognizing that the home setting is a critical component in addressing the challenges of adopting healthier lifestyles to slow disease progression and delay functional decline. Issues such as family meal expectations, availability of caregivers, environmental safety issues and barriers, neighborhood conditions, and economic security, all known as "*social determinants of health*", are usually hidden from most medical providers due to a lack of access to the home environment. To that end, the District continues to advocate that community-based care become globally recognized as an essential component of an individual's health care plan.

Guided by our commitment to the Vision, Mission and Guiding Principles, the District is a uniquely-positioned partner, with recognized expertise in improving access and coordination of specialized community-based services among physically or socially complex patients. The District's proven delivery method for integrated home-based and long-term supportive services provides essential and strategic resources for the health care sector. Experienced and professional, the District is considered the trusted source for meeting the health and community needs of varied and complex patients, and for achieving the federal "Triple Aim" goal of "*improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care*".

Proposed Update: Mission, Vision & Guiding Principles



Ventura County is a model healthy community with seamless access to high quality health and community-based services that optimize well-being, empower healthy lifestyles, and build strong communities.

The mission of the Camarillo Health Care District is to be a highly respected, preferred partner in Ventura County's continuum of health care by providing valuable, effective, measurable and integrated community-based health services that optimize health and wellness.

- Valuing public trust through transparency and integrity in governance
- Acknowledging the value of resources through accountable stewardship and visionary development of funding opportunities
- Engaging in Patient-Centered Care to tailor client services base on individual goals, preferences and values
- Improving patient outcomes, reducing costs, and improving quality of care across a continuum of providers
- Building core competencies and a knowledge base of emerging research, programs, technologies, policies and initiatives that improve health outcomes in the community, by recruiting, training and retaining a professional workforce
- Recognizing and honoring the significant contribution and sacrifice of family caregivers by providing excellence in education, training and support

Environmental Landscape

Health care reform, and specifically the Affordable Care Act, has set into motion a changing health care environment with significant implications for emerging partnerships and opportunities for community-based care organizations (CBOs). Organizations that can align their core competencies, develop others as needed, and who are willing to modify their strategies accordingly, can thrive in the midst of these historic shifts in the ***need for, access to, delivery of, and improved outcomes*** of health care services.

The transformation of health care service, in general, continues to be significantly driven by historic shifts in ***need, access, delivery and outcome***. The implementation of the Affordable Care Act demanded dramatic shifts in how service was accessed and delivered. Additionally, the Centers for Medicare and Medicaid Services' (CMS) Demonstration Project on the management of chronic disease and avoidable readmissions, demanded shifts, not only in access and delivery, but also in how service was measured.

Today, there continues to be an unprecedented number of people turning 65, people who are living longer and sicker, people with multiple chronic health conditions who need long-term support at home, and a significant segment of the population who are family caregivers. This wave is taxing the capacity of health services, community resources, and available medical professionals of nearly all specialties and levels.

Although the District serves citizens of all ages, it is an undeniable statistic that the majority of services are utilized by people age 60 and older; ***24% of Camarillo's population is aged 60+; compared to Ventura County total of 10.4%***[1]. In the most recent strategic plan developed by the Ventura County Area Agency on Aging, whose mandate is to serve people age 60+, the top five needs identified in Ventura County are ***transportation, access to food, health and fall prevention, and family caregiver services***[2]. Further, in a report conducted by The SCAN Foundation, ***over 20% of people age 65+ are living with 5 or more chronic conditions, of which 26% also live with substantial functional limitations***[3].

As a key participant in the only CMS Demonstration Project in Ventura County, and due to early positioning and investment in evidence-based prevention interventions and other care transitions interventions, the District is uniquely positioned to continue in leadership roles in integrating community and home-based health services. As a preferred partner with hospitals, health plans and medical provider groups, the District has shifted its core competencies by developing innovative, cost-effective service delivery modules that increase access to care, transform how that care is delivered, and that have an ultimate goal of improving the overall health of the community.

Community and home-based settings for health care are not necessarily new ideas. In much earlier times, territories and regions had a few doctors, or didn't! Communities usually had someone in their midst who served as an identified healer. Babies were born and the elderly died, both usually in the home setting. What *has* become relatively "new" is a verification, through measured outcome, that the best "health" most often happens at home. Home is where people want to be, can't wait to return to, and where they would prefer to heal, or die. A seldom-discussed truth in health care remains, that although there has been, and continues to be, heavy investment in medical facilities, latest technology services, and multiple care access points, in reality, health happens best at home.

Planning Process

The initiatives proposed here were developed and informed by a variety of local, state and national perspectives, and reports and trends that can have effect on the District's capacity and role in the health care continuum. Sources that support, confirm or drove the development of these initiatives are referenced in **Appendix A.**

Although this draft proposes a three-year outline, these plans will be reviewed each year with adjustments made to reflect emerging forces of change, new information and a changing policy environment. Through research, ongoing monitoring of issues, a presence in appropriate and important forums, and participation in collaborative activities, the District stays continuously informed on current issues, community needs and changing concerns.

[1] *Ventura County Area Agency on Aging Summary of Strategic Plan 2016-2017, pg 7*
[2] *Ventura County Area Agency on Aging Summary of Strategic Plan 2016-2017, pg 3*
[3] *The SCAN Foundation Data Brief; Seniors with Chronic Conditions and Functional Impairment 2011*

Strategic Plan Overview

Understanding these local needs and realities, combined with state and national perspectives such as increasing population health needs, emerging trends, and the evolving redesign of the health care and policy environment, the proposed initiatives continue to reflect the District's need for responsiveness, innovation, and visionary management of resources.

Priority initiatives and District direction are set through the strategic planning process, keeping in mind the mission, as well as available resources, and any limitation on how those resources may be expended; for example, some contracts and grants are obligated or otherwise constrained. In the enthusiasm of envisioning excellence and ongoing improvement, the Board of Directors and staff recognize that this strategic plan, in any form, will not address every unmet community need.

The proposed initiatives reflect the core competencies of the District, and represent a priority focus that staff supports as the opportunity to best position the District for success in service, resource and funding development. Even so, the District values the multiple collateral needs that each community has, and will continue to partner and collaborate appropriately, while maintaining sharp focus on the priority initiatives.

With proven expertise, trained staff and an unrelenting drive toward excellence, the following initiatives represent an important and required shift from simply providing services, to actually transforming and extending access and delivery, while meeting needs and measuring the outcomes. The initiatives include:

1) **Transform care delivery** systems to integrate community, home-based and transitional care for improved outcomes.
2) Continuous improvement in **quality health outcomes**, at home and in the community.
3) **Increase patient access** to evidence-based health promotion and disease prevention services.
4) Support **health system transformation** through infrastructure and technological upgrades.
5) **Value the public trust** through transparency, integrity in governance and excellence in stewardship of resources.

Measurement & Limitations

The measurement of some of the pioneering and transformative activities outlined in this plan are dependent upon research, installation and implementation. Upon Board approval of the initiatives, specific measures will be selected and documented for each of the objectives to ensure that implementation of the plan and associated outcomes are measured in the most feasibly robust manner possible, and reported on a regular basis. Measurement timelines will be refined and reported annually.

STRATEGIC INITIATIVES

Initiative 1

Transform care delivery systems to integrate community, home-based and transitional care, for improved outcomes

Goal: Deliver integrated community programs and services that protect and support patients with complex health and social service needs, including frail elders, people with disabilities, caregivers, and families. Community and home-based health and social services will be included, through health practice integration, as strategic and sustainable resources in population health services.

Objective 1.1

Participate in a leadership role in the SCAN Foundation's *Community of Constituents Initiative,* to advocate for the integration of community-based health and social services into the reimbursable health care continuum.

Objective 1.2

Pioneer, partner, innovate and test traditional and alternative payment models, through participation in the *Ventura County Bundled Payment Coalition* (which includes hospitals, physician networks, health plans, community-based organizations, federal and state agencies), and other similar efforts, to incentivize value-based health care.

Objective 1.3

Target community-based care delivery to high-risk/high-cost consumers, in order to reduce costs and improve health outcomes. These services include transitional care services, case management, medication management, evidence-based health promotion and disease prevention services, and other supportive services.

Objective 1.4

Participate in a leadership role in the *Ventura County Hospital to Home Alliance's* mission to increase quality of care, improve health outcomes, enhance patient experience, lower costs, and support patient independence and dignity, creating optimum care.

Objective 1.5

Partner with the Hospital Association of Southern California's three-year initiative *Person-Centered Care Project*, to assist provider communities (hospitals and their primary care, post-acute and community-based organization partners) in delivering person-centered care throughout the care continuum (health systems improvement, population medicine and population health), and developing a business case for program sustainability.

Objective 1.6

Research *Community-Based Adult Day Support (CBAS)* certification to mitigate the costs of institutional care, maintain adults with complex health needs in maximally independent and dignified settings, and increase choice to remain in the community to the greatest extent possible.

Objective 1.7
Invest in innovative and evidence-based interventions in support of family caregivers, and advocate for formal recognition of the key role that family caregivers play in the health care continuum.

Objective 1.8
Support the implementation of *Ventura County's Aging and Disability Resource Center* by becoming an extended partner and providing critical support for people with functional limitations, in order to reduce high-cost, avoidable utilization of health care services.

Objective 1.9
Serve on the *Dementia Friendly Implementation Committee* toward creating a *Dementia Friendly Ventura County* by delivering evidence-based interventions such as REACH (*Resource and Education for Alzheimer's Caregiver Health*), Memory Screening, Alzheimer's education, Memory Café's, and caregiver support.

Initiative 2

Develop continuous measurement metrics that serve to improve health care delivery, at home and community.

Goal: Transform delivery models and philosophies of community and home-based health care, to create high quality, cost-effective, integrated, person-centered outcomes for vulnerable people with complex health needs.

Objective 2.1
In efforts to expand the District's ability to address social determinants of health through a clinical lens and improve integration of service across the care continuum, the District will engage clinical oversite to bridge the medical and social models of care for greater understanding of key quality indicators.

Objective 2.2
To assure improved service coordination, program effectiveness and outcomes, and evidence of professional standards and quality care, the District will be an early adopter of the new *National Community for Quality Assurance* (NCQA) certification to provide Long-Term Services and Supports (LTSS) case management.

Objective 2.3
In efforts to achieve health system efficiency, improvement in quality, and reduced health care expenditures, the District will partner with the *Hospital to Home Alliance of Ventura County* in conducting root cause analysis of poor acute care transfers to identify opportunities for improvement and conduct tests of change.

Objective 2.4
In efforts to provide improved quality care and cost savings, the District will implement "person-centered care" across all programs and services, thereby improving the care process (*the way care is organized*) and the human interactions (*how staff interact with patients and families*).

Initiative 3

Increase patient access to evidence-based health promotion and disease prevention services.

Goal: Support the improved health of individuals and the community through the increased access to a full range of evidence-based preventative services that empower individuals to manage their health conditions and support their clinical care plan.

Objective 3.1

To optimize ED and physician visits, reduce the costs associated with avoidable readmissions, and improve health outcomes, the District will utilize HomeMeds, an evidence-based intervention that facilitates medication reconciliation that supports patient self-care and self-management, identifies adherence problems, and contributes to the reduction of falls and confusion.

Objective 3.2

To improve population health and self-management skills, the District will provide Stanford University School of Medicine's evidence-based health promotion/disease prevention programs, including Chronic Disease Self-Management, Diabetes Self-Management, and Pain Self-Management programs, and will seek additional contracting opportunities.

Objective 3.3

In efforts to reduce the incidence of diabetes in Ventura County, empower individuals to manage their diabetes, and decrease health care utilization, the District will provide Stanford University School of Medicine's Diabetes Self-Management Program and Diabetes Empowerment Education Program (DEEP) (DEEP/Stanford), and will seek additional contracting opportunities.

Objective 3.4

To improve community health, prevent personal injury and avoidable service utilization, the District will be a leader in providing evidence-based fall prevention programs such as Walk with Ease, Matter of Balance, HomeMeds, and TUG Tests (timed up and go) and others similar programs.

Objective 3.5

In efforts to reduce preventable readmissions, the District will provide Care Transitions Interventions, in which hospital patients at risk of readmission are followed by a transitions specialists who, through skill transferring techniques, empowers the patient in managing their conditions at home.

Objective 3.6

To support caregiver health and the long term care system, the District will provide such evidence-based programs through its Wellness and Caregiver Center, as REACH (*Resources and Education for Alzheimer's Caregiver Health*), Powerful Tools for Caregivers, and respite services.

Objective 3.7

In an effort to improve coordination, collaboration, and create seamless access to evidence-based programs, the District will lead the Ventura County Evidence-based Health Promotion Coalition and identify resources and partnerships for program

sustainability and decrease duplication of effort, Ventura County Evidence-based Health Promotion Coalition support

Initiative 4

Support health system transformation through infrastructure and technological upgrades

Goal: Plan for and implement a technology philosophy to include an enterprise-wide health information technology system, database management, electronic registration and enrollment management, and a broader overall technological presence at the District, that can support care coordination across the service continuum, provide outcome measurement and evaluation for the transformation of health care, offer greater efficiency to client data management, and offer a more technologically accessible facility overall.

Objective 4.1

To maintain the District's status as a trusted business partner, support the development of business lines of service, explore additional forms of reimbursement such as Medicare and Medi-Cal, and to achieve overall greater efficiency and accessibility, the District will secure an IT platform of sufficient scope and scalability to address:

- data collection and analysis
- quality improvement and risk stratification
- guided interventions with documented health outcomes
- control cost of care and identify return on investment
- provide improved operational efficiency
- improve technological access to services

Initiative 5

Value the public trust through transparency and integrity in governance, and excellence in stewardship of resources

Goal: Continually develop, implement, monitor and update, governing policies and procedures in alignment with best practices, state mandates and governing codes.

Objective 5.1

To maintain strong governing principles, the District will participate in state-wide transparency efforts, such as those offered by California Special Districts Association, and the Association of California Healthcare Districts.

Objective 5.2

To maintain a compliant operating platform, the District will continually review and amend governing policies, seeking appropriate independent review as needed.

APPENDIX A

LOCAL

- VCAAA Summary of Strategic Plan FY 2016/2017; *Comparison of Needs Expressed by Consumers versus Professionals*; page 3
- Ventura County Public Health's *City Specific Adult Health Indicators for the 10 Ventura County Cities*; page 1; Camarillo ranks 1st in cause of death by heart disease, strokes, chronic lung disease, diabetes, Alzheimer's disease and hyptertension

STATE

- Senate Select Committee on Aging and Long Term Care; Senator Carol Liu; *A Shattered System: Reforming Long-Term Care in California*
- CA Legislative Analyst Office; January 2015; *The Universal Assessment Tool: Improving Care for Recipients of Home- and Community-Based Services*
- The SCAN Foundation Policy Brief on California's implementation of key models from the *Patient Protection and Affordable Care Act* (July 2015)
- AARP/SCAN/The Commonwealth Fund's *Raising Expectations: A* ***State*** *Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*
- The SCAN Foundation Policy Brief; *System Transformation in California: Coordinating Health Care and Long-Term Services and Supports* (July 2015)

NATIONAL

- Administration on Aging's (now Administration for Community Living) Affordable Care *Act Opportunities for the Aging Network, 2011*
- AARP/SCAN/The Commonwealth Fund's *Raising Expectations: A* State *Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (nationwide comparison of state ratings)
- National Committee for Quality Assurance (NCQA)'s press release "*NCQA's New Accreditation and Distinction Programs Improve Quality of Long-Term Services and Supports*"
- Justiceinaging.org's *Health Homes Program: The Basics*; (fighting senior poverty through law)
- AARP Public Policy Institute's *Family Caregivers and Managed Long-Term Services and Supports*
- Administration for Community Living's (ACL) (formerly Administration on Aging) *Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living Quality*
- Alzheimer's Association's 2016 Alzheimer's Disease Facts and Figures; Alzheimer's & Dementia 2016, *Caregiving*

APPENDIX B

Strategic Plan 2011-2016
VISION
The Camarillo Health Care District will be the leading organization in understanding and serving our community's health and wellness needs by:

- Developing programs and services to mirror the ongoing and thorough assessment of community needs
- Developing and enhancing services through communication, cooperation and collaboration with our partners
- Utilizing tools and resources that facilitate best practice and prudent investments in our programs and services
- Recruiting and retaining an ethical, motivated, creative, compassionate and qualified workforce
- Being recognized as the community's resource and referral agency of choice
- Exceeding the community's service expectations

Strategic Plan 2011-2016
MISSION
The Camarillo Health Care District ensures that quality health and wellness services are available to all District residents.

Strategic Plan 2011-2016
CORE VALUES (*proposed reference as "Guiding Principles")*

- **Community Health and Wellness:** District programs and services will reflect the community's health and wellness needs.
- **Employees and Volunteers:** We acknowledge and respect our employees and volunteers as critical assets of the District.
- **Fiscal Responsibility:** The District makes responsible use of our public's funds and avoids program duplication.
- **High Quality Programs:** We provide progressive leadership, innovation, best practices, and creativity in our programs and services.
- **Collaboration**: Our programs and services build on and leverage our broad support network.
- **Integrity in Governance**: Our Board of Directors governs with honesty, advocacy, and continual improvement.

APPENDIX C