PLUMAS COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN 2016

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Introduction

The 2016 Plumas County Community Health Improvement Plan (CHIP) is the result of a participatory, community-driven planning process led by the Plumas County Public Health Agency, in formal partnership with Plumas District Hospital, the Greenville Rancheria Tribal Clinic, Eastern Plumas Health Care, and Seneca Healthcare District.

Together, these health system partners engaged the community in a robust assessment and planning process in which organizations and residents participated in reviewing and prioritizing our most important community health issues. This effort, which is a continuation of the 2012 Community Health Assessment (CHA) and CHIP process, is known locally as the 20,000 Lives initiative, named for the number of residents in Plumas County. The ongoing work of the CHA and CHIP is a long range, systemic effort to address the health of all 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, where they live, learn, work and play, 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, access to healthy foods, and living and working conditions all shape the overall health and vitality of Plumas County.

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 strong, connected 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, community partners and residents in aligning our program development, activities, and resources to collectively improve community health status over the next five years and beyond.

The Plumas County CHIP provides a common vision and shared approach for local communities 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.

Completion of the 2016 CHIP not only marks the continuation of the 2012 CHA and CHIP, it is the beginning a new Implementation Phase of the CHIP, that builds on the actions and progress on the prior Plan.

Based on analysis of data, a collaborative review of assets and systems capacity, and a clear process for prioritization, the 2016 CHIP identifies key areas where we can focus our shared resources to have the largest impact on improving the quality of life for all Plumas County residents – particularly the most vulnerable residents of our community. All health delivery partners made commitments in writing to the ongoing collaborative partnership and to accountability for the CHIP Implementation.

The plan is intended to be used by the entire community - health, government, education, community, social service, faith-based organizations and residents across the county. Individuals and agencies are encouraged to identify the areas they are best positioned to support and use the recommended strategies to help make their community healthier. Working together we can reach our vision of Plumas County being home to the healthiest and happiest people in the nation.

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 was developed using a strategic planning process called Mobilizing for Action through Planning and Partnership (MAPP), a countywide community health assessment and improvement process. This was a cooperative effort of the Plumas County Health Collaborative, led by the Public Health Agency with support and contribution from county's three hospital districts - Plumas District Hospital, Eastern Plumas Health Care, and Seneca Healthcare District - and the Greenville Rancheria Tribal Clinic.

More than 100 Plumas residents participated in MAPP process activities as listed below:

- 5 community forums
- 6 focus groups
- 11 key informant interviews
- a Visioning process
- a Prioritization process
- 8 Advisory Committee, Steering Committee and Action Committee meetings to collect and review data, and identify priorities, goals, objectives and strategies.

Health Priorities

The 2016 CHIP is a 5-year, action-oriented plan, resulting from a 12-month community-driven, countywide, collaborative process. The CHIP Implementation Plan (page 12) lays out goals and objectives, strategies, lead roles and outcome measures for the following four overarching Priorities:

PRIORITY 1: Increase access to services across the spectrum of prevention and treatment

PRIORITY 2: Improve behaviors that promote health, prevent disease, and reduce harm

PRIORITY 3: Strengthen cross-sector infrastructure to optimize resources by formal partnerships engaged in collaborative planning, well-leveraged resources, and shared implementation of strategies

PRIORITY 4: Promote healthy social, physical, economic and educational environments

The Health Collaborative partners of public health, hospital and clinic partners are formally 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 1).

The CHIP will continue to be implemented through the 20,000 Lives initiative, a collective impact model that engages local residents and community partners in addressing the health of Plumas County. The collaborative effort to improve the health of Plumas County, first started with the 2012 CHA and CHIP, serves as a foundation for ongoing cooperation of multiple sectors of the community to meet our most significant health needs. The identified Priorities in the CHIP will provide direction to Plumas County in determining the allocation of public health resources and will serve to inform and stimulate greater collaboration across multiple systems and stakeholders.

Vision (to be revisited 1/18)

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

About Plumas County

The Plumas County Community Health Improvement Plan pertains to Plumas County as an official Local Health Jurisdiction in California. The County spans 2,613 square miles and is located in an isolated, sparsely populated area in the northern Sierra Nevada Mountains. It is ranked as the eighth smallest population of 58 California counties and 22nd largest by area. According to 2015 U.S. Census Bureau data, there are 18,409 residents in Plumas County, or approximately 7 people per square mile.

As a frontier county, distances between the four key population centers of Portola, Quincy, Greenville, and Chester are great and transportation is challenging, especially during heavy snow and ice in winter months. Isolated, rural counties such as Plumas are challenged to maintain a focus on community priorities while navigating major changes to the local health care system such as implementation of the Affordable Care Act and California's transition of Medicaid to managed care organizations. Clearly, there is significant diversity among California counties in funding and service levels, programs, needs of residents and capacity of local health jurisdiction partners, presenting a formidable challenge to local health system partners.

The county population is 90% Caucasian, 7% Hispanic/Latino, 3% American Indian and nearly 4% % identified as being two or more races. Although the county is ethnically much less diverse than the state as a whole, the Latino population is growing and nearly doubled over the past 20 years.

The economic downturn of the last decade continues to affect Plumas County residents in many ways that ultimately impact the health of our communities, which is a county's greatest resource. One of the most striking and consistent patterns in the distribution of poor health and disease in the United States is its relationship to poverty.

Due to high rates of seasonal employment of residents, unemployment rates are often double, and sometimes triple that of the state's during winter months. Economic conditions may still not be ideal for those who are employed. Although the 2014 median household income of $48,032 increased over 32% since 2000, it still remains nearly 30% below the median household income for California.

Plumas County has an increasingly aging population. Since 2010, the proportion of individuals 60 years of age is over 30% of the county population, almost double that of California. With this trend also comes a larger portion of the population, as compared with the state, living on fixed retirement incomes.

A full description of Plumas County demographics and health indicator data is available in the Plumas County Community Health Assessment.[1]

Collaborative Community Health Improvement Process

Description of the Plumas County Health Collaborative

In the fall of 2010, Plumas County's three district hospitals and tribal clinic joined the local health department in a collaborative effort to improve the health of Plumas County. At the same time the health care system faced a wave of change with implementation of the Affordable Care Act (ACA), communities across the nation were impacted by the effects of a deep economic recession. The group sought to align and leverage local capacity, infrastructure and resources of health care system partners in Plumas County to achieve the triple aim of the ACA in Plumas County – a healthier community, better health care, and more affordable health care services.

In 2011, Plumas County Public Health Agency, with support from the Sierra Institute for Community and Environment, served as the strategist and convener for a core group of health system partners – Eastern Plumas Health Care, Greenville Rancheria Tribal Health Clinic, Plumas District Hospital, and Seneca Healthcare District. Together, these Plumas County Health Collaborative partners agreed to work on Plumas County's first collective Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), which was completed in 2012.

Formalized through a Memorandum of Understanding first initiated in 2012, and renewed in 2016, the governing boards of each of the five core Health Collaborative partners committed resources, staff and leadership from each of their organizations to actively participate in the CHA and CHIP planning as well as play key roles in ongoing CHIP implementation.

This Health Collaborative was structured to insure that each organization contributed to the planning and implantation of the health improvement process. Each core partner committed its top administrator as a member of the Steering Committee.

Steering Committee members were responsible for assuring recommendations reflect connections between the elements MAPP findings and providing input and strategic direction. It was also responsible for analyzing and finalizing recommendations from two additional groups - Advisory and Action Committees

The Advisory Committee consisted of Steering Committee members from the Health Collaborative, joined by key county decision makers, health and human service directors, and leaders of community institutions and organizations. Together,

[1] Download a copy at http://www.countyofplumas.com/index.aspx?NID=2491

committee members would lend their knowledge, experience and subject matter expertise to the health improvement process.

The Action Committee was comprised of key management, clinical and program staff from each organization in the Health Collaborative. This committee served as the working group to review and analyze system capacity and indicator data, develop preliminary recommendations on key areas of need, formulate recommendations for the Advisory Committee on priorities, review and assist in finalizing the Community Health Improvement Plan.

The Community Health Assessment and Community Improvement Plan Process

The Plumas County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are a result of using a modified version of the Mobilizing for Action through Planning and Partnership (MAPP), a community-driven strategic planning process for improving community health. The MAPP framework was developed by the National Association of City and County Health Officials (NACCHO) and the US Centers for Disease Control (CDC) for communities to conduct in-depth community health assessments, identify and prioritize public health issues, and develop goals and strategies to address them. The MAPP model has six phases:

1. Organizing
2. Visioning
3. Conducting Assessments
4. Identifying Strategic Issues
5. Formulating Goals and Strategies
6. Executing the Action Cycle

The planning process was led by the Public Health Agency with a significant commitment of time and resources from the Health Collaborative partners - Plumas District Hospital, Eastern Plumas Health Care, Seneca Healthcare District and the Greenville Rancheria Tribal Clinic. This framework allowed the partners to apply strategic thinking to prioritize public health issues and identify resources to address them. The process was highly interactive and was chosen for its proven ability to improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

Key community leaders, community organizations and residents participated in the three of four assessment phases of the MAPP process described below to obtain a complete snapshot of Plumas County's health status.

1. The **Community Themes and Strengths Assessment** gathers people's feedback to better understanding the health issues that matter most to Plumas County residents

2. The **Local Public Health System Assessment** evaluates the performance of all of the organizations and entities that contribute to the public's health

3. The **Community Health Status Assessment** collects reviews and synthesizes quantitative and qualitative data on health, quality of life and risk factors to provide a broad overview of the health status of the community.

A fourth element of MAPP, The **Forces of Change Assessment** identifies forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. While the Plumas CHA process did not complete this assessment with broad engagement of community members, forces of change elements that could influence the work of the broader health system were carefully considered in the Steering Committee's Prioritization session.

Prioritization

The 2016 CHA consisted of data organized in nine health indicator categories used in the 2012 Community Health Assessment. The Action Committee carefully reviewed and updated 2012 indicator data and selected additional health indicators within each group to be added for 2016.

Health Indicator Categories

1. Access to Care
2. Chronic Diseases
3. Clinical Care
4. Environment
5. Health Behaviors
6. Health Outcomes
7. Maternal and Infant Health
8. Mental Health and Substance Abuse
9. Social Determinants of Health

The Action Committee met over a series of five planning sessions to assist in identifying health issues by collecting and reviewing county health data across each of the nine health indicator categories. Broad based community feedback on county health issues was gathered from community forums, focus groups which included vulnerable populations, and key informant interviews.

In the fall of 2016, the fifteen-member Steering Committee convened for a prioritization session. The process was facilitated by a strategic planning consultant and the two objectives for the day were to increase stakeholder understanding of the health status of Plumas County residents and identify health priorities for the 2016 Community Health Improvement Plan. The major findings and common themes that emerged from the community engagement and assessment process were summarized in twenty health indicators, which were organized using Fact Sheets that summarized quantitative data, community feedback, and the relevance of each health indicator to community health.

Led by the facilitator, the Steering Committee examined the comprehensive findings of the CHA, reviewed the 2012 CHIP Implementation Plan, and participated in a multi-step individual and group prioritization process. Data in each of the twenty health indicators against four factors: need, feasibility, impact, and the potential to collaborate.

Using electronic voting system software, each Steering Committee member organization participated in a quantitative multi-voting technique to arrive at top issues to address to improve the health of Plumas County:

1. Recruitment and Retention
2. Alcohol, Tobacco and other Drugs
3. Mental Health
4. Chronic Disease
5. Senior Care
6. Transportation
7. Employment & Economy
8. Children's Oral Health
9. Youth
10. Multi-sector Collaboration

Once the Steering Committee identified priority issues, it was necessary to review progress on the prior 2012 CHIP, existing assets, and current capacity. Public Health staff then synthesized recurring themes and major findings from the assessment process, priority session, and progress made on the 2012 CHIP Implementation Plan. Plumas County fully embraced the philosophy that health "happens" at the local level. In order to be a part of the healthiest state, in the healthiest nation in the world, each local health jurisdiction must align its local health improvement efforts with statewide and national goals and objectives for improving the health of all Americans.

Towards this end, development of the CHIP priority areas included evaluating assessments and prioritization findings against the CDC's National Prevention Strategy, the Office of Disease Prevention and Health Promotion's Healthy People 2020, and California's State Health Improvement Plan, Let's Get Healthy California.

Recognizing that health is dependent on a number of factors where people live, learn, work and play, the CHIP planning process resulted in four overarching Priorities for improving the health of Plumas County. The Priorities are listed below, with an overview would include strategies aimed at individual behavior, organizational practices, and the environments that influence health.

PRIORITY 1: Increase access to services across the spectrum of prevention and treatment

PRIORITY 2: Improve behaviors that promote health, prevent disease, and reduce harm

PRIORITY 3: Strengthen cross-sector infrastructure to optimize resources

PRIORITY 4: Promote healthy social, physical, economic and educational environments

CHIP Implementation Plan 2016-2021 - Health Priority #1

Increase access to quality, whole person health services across the spectrum of prevention and treatment

Goals	Objectives	Strategies
Increase the number of residents with health care coverage and other benefits *(Measureable outcome:* *By 2021, increase percentage of covered residents to a minimum of 95%)*	Develop outreach, enrollment, and retention activities	Establish systems wide OER best practices
		All community institutions and partners serving eligible populations will employ OER best practices
Timely access to direct services *(Measureable outcomes:* *By 2021, document at least three shared agreements that increase timely access to health services.* *By 2021, provide at least one training in Harm Reduction, SBIRT, and CLAS to community partners.)*	Strengthen partnership with EMS providers	Utilize EMS to meet community gaps in services.
	Define and identify care coordination systems	Increase access to supportive services
		Establish shared agreements across criminal justice, HHS, school, faith and other partners that define commitments to increase timely access to services.
		Prioritize place-based services
	Educate partners about Harm Reduction strategies and best practices	Provide community wide data, information, and education about evidenced based harm reduction practices to reduce morbidity and mortality
	Incorporate prevention and early intervention into program planning	Provide training opportunities of Screening, Brief Intervention, and Referral to Treatment (SBIRT)
		Provide health and wellness education aimed at reducing stigma and promoting timely access to care

	Increase efficiency in patient experience of health services	Increase access to coordinated transportation
		Streamline appointment making systems
		Establish formal partnerships with specialists for professional consultation
Strengthen and support health care workforce *(Measureable outcome:* *By 2021, document at least one formalized Employee Wellness Policy.* *By 2021, increase the number of county employers with competency-based job descriptions.)*	Increase capacity through training	Establish competency-based professional development goals
	Implement Employee Wellness Policies / Programs	Create culture of healthy, safe, and balanced work environments
	Ensure consistent, competent staffing	Provide incentives to employees /recruits
		Promote creativity in recruitment / retention practices
Improve care coordination across multi-sector partners. *(Measureable outcome:* *By 2021, establish one set of policies or protocols for multi-disciplinary teams with shared clients.)*	Prioritize place-based services	Partnership between agencies with shared clients
	Systems Coordination	Partnership between agencies with shared clients

CHIP Implementation Plan 2016-2021 - Health Priority #2

Improve behaviors that promote health, prevent disease, and reduce harm

Goals	Objectives	Strategies
Create opportunities for healthy, safe active communities *(Measureable outcome:* *By 2021, conduct at least one activity from the Pedestrian and Bicycle Master Plan.)*	Ensure opportunities for safe, active living	Promote knowledge and behaviors that prevent accidental injuries
		Increase community wide recreation opportunities
		Increase opportunities for safe walking and biking
	Promote healthy eating	Access to healthy food on a limited budget
		School & Community Gardens promotion and education
	Incorporate "aging well" strategies into program planning	Increase access to senior resources
Comprehensive behavioral health prevention & early intervention services *(Measureable outcome:* *By 2021, document reduction of accidental drug overdose deaths.)*	Align multiple funding sources for ATOD services	Actively engage youth in efforts to reduce underage drinking and youth prescription drug misuse
		Expand tobacco use reduction activities
		Provide education about opiate use and overdose
		Increase referrals for alcohol use reduction in adults
	Reduce stigma through education	Emphasize the social determinants of health in all education and outreach
	Promote early intervention and	Life skills training in school

	supportive services	settings
		Increased access to community wide supportive services
Improved community sexual & reproductive health *(Measureable outcome:* *By 2021, document an downward trend of teen pregnancy rates compared to historical averages from 2012-2016.)*	Support comprehensive education	Increase access to sexual and reproductive health education for children and youth
	Increase knowledge about available prevention services	Expand opportunities for testing and treatment throughout county
		Expand opportunities for family planning throughout county
Comprehensive and meaningful youth engagement *(Measureable outcome:* *By 2021, document increased participation in youth leadership activities.)*	Provide opportunities for youth leadership and development	Increase frequency of organized activities for youth and young adults
		Actively engage underserved youth participation
	Connect children and families to appropriate services	Increase community engagement with schools

CHIP Implementation Plan 2016-2021 - Health Priority #3

Strengthen cross-sector infrastructure to optimize resources through formal partnerships

Goals	Objectives	Strategies
Ensure healthy physical spaces *(Measureable outcome:* *By 2021, establish at least one health promotion policy.)*	Improve ability to make healthy choices	Establish policies that promote healthy retail, school, and work environments
	Improve infrastructure	Ensure school sites have outdoor education that includes gardens, clean water access
		Modernize and beautify shared spaces
Ensure full and equal access	Promote safety in school and community	Increase inclusion and reduce stigma
	Equal opportunity to participate in healthy activities	Remove barriers to participation
Improve housing options and economic opportunities *(Measureable outcome:* *By 2021, finalize comprehensive community housing among multiple partners.)*	Match resources to individual needs to increase economic stability	Provide expanded adult/continuing education
		Direct clients to job training, life skills, family support services
	Increase number of people with stable housing	Develop a comprehensive community housing plan
Promote safe routes, active transportation, and mobility	Increase walkability and active transport	Partner with planning, public works, SSTAC, CHP, schools, SNAP-Ed to do a comprehensive walkability and active transport countywide assessment
	Address travel barriers	Assess in-county travel barriers
		Assess out-of-county travel barriers

CHIP Implementation Plan 2016-2021 - Health Priority #4

Promote healthy social, physical, economic, and educational environments

Goals	Objectives	Strategies
Countywide workforce development *(Measureable outcome:* *By 2021, document at least one organizational partnership for increasing training opportunities.)*	Increase local professional capacity	Share organizational resources for training current workforce
		Increase collaborative efforts to develop tomorrow's workforce
	Increase referrals to workforce development partners	Match countywide workforce needs with job seekers
Integrated planning, funding, and data sharing *(Measureable outcome:* *By 2021, develop at least one new local data set for use in the 2021 CHA [e.g. unduplicated patient numbers for individual hospitals and/or clinics; implementation of community survey].)*	Increase program integration across organizations	Identify 1-3 countywide issues (i.e. physical activity and nutrition, safe and walkable communities, transportation, etc.) to develop a county-wide, integrated work plan and budget with share responsibility for funding, deliverables and outcomes
	Accept feedback about funding allocations	Insure community and stakeholder input is meaningfully incorporated into allocations of public funds
	Ensure use of multi-sector data sets	Seek and share relevant data to assess local health issues in order to define, assess, and track outcomes

Resource guide *Measureable outcome:* *By 2021, develop and distribute a comprehensive community resource guide.)*	Develop a comprehensive Resource Guide	Consolidate countywide resource guides into well distributed and recognized access points
Multi-use facilities *(Measureable outcome:* *By 2021, establish at least one joint-use / multi-use agreement between at least two partners.)*	Increase community access to resources	Alternative outreach sites Alternative space for services

Sustainability: 20,000 Lives CHIP Implementation for a Healthier Plumas

Collective Impact Model

Ongoing implementation of the Plumas County CHIP is carried out through an initiative using the collective impact initiative called 20,000 Lives. Recognizing a new era in which Public Health and local government, alone, do not have the ability to solve our communities' towering issues, Plumas County Public Health Agency assumed a central role in facilitating and sustaining 20,000 Lives initiative. Utilizing the CHIP Implementation Plan as a road map, 20,000 Lives brings people and organizations together for powerful, lasting change, mobilizing the entire community, from public institutions to individual residents, to share the responsibility for the county's overall quality of life.

20,000 Lives was launched on the heels of a nationwide recession and the Affordable Care Act, both the county and traditional health system partners lacked the funding, infrastructure and capacity to successfully tackle our most pressing health and community problems. In the past, the local health department and partners would have looked for outside funding, such as grants, to finance solutions to address health priorities. However, community stakeholders were discouraged when programs were not sustainable after grant funding ended. Additionally, such funding was often not flexible, came with burdensome administrative requirements, and did not always address issues unique to our small communities.

As we mapped the numerous assets across every layer of the community, the community health improvement collaborative believed that it would not be new or outside funding that would help achieve our priorities, but the garnering of existing community resources, strategically aligned towards mutual goals, that would be the key

to sustaining lasting community change. The feedback from the community led to one of three overarching health priorities in the Community Health Improvement Plan - Optimizing Current Resources.

Organizational Structure

Plumas County Public Health Agency's role in 20,000 Lives is to serve as the backbone organization, acting as a catalyst for achieving community-level progress. The framework of the last decade, in which the public health department assumed the primary responsibility for population health, with reliance on health system partners to address individual health service was no longer working optimally to serve Plumas County residents.

Under the 20,000 Lives initiative, Public Health lends its centralized infrastructure, dedicated staff, and structured processes, to facilitate, link and leverage resources to improve population health. The agency invests time, expertise and energy in partners, recognizing that partnership is essential given the current financial landscape. More than twenty community institutions and organizations and nearly 200 community members, through their participation, also do their part. These partners help to focus the entire community in making progress on shared goals, align multiple efforts and existing resources to increase effectiveness and impact, contributing to large scale, lasting change on all three Priority Areas, as a result of from cross sector coordination.

The Public Health Agency and several community partners committed to align relevant existing grants, projects, and staff to make measurable contributions and progress towards the 20,000 Lives Implementation Plan goals. Additionally, the County General Fund Maintenance of Effort match for Public Health Realignment was redirected to fund Targeted Grants of $20,000 and numerous $500 mini-grants, for projects addressing one of the three priority areas of the Community Health Improvement Plan. The support provided to the community was multiplied many times with personal and organizational investments of staff time and other resources.

Community Partners

In its third year of implementation, the 20,000 Lives initiative, through the re-design of the existing county public health system, has achieved a new level of effectiveness and performance across the county. Individuals and small grass roots organizations are now able to join larger partners and contribute towards strategic actions in accomplishing shared community goals. Institutions such as hospitals, higher education, schools, and county departments benefit from on-the-ground knowledge, expertise and experiences of partners outside of government.

The Path Ahead

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. 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 four 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.