Plumas County
Public Health Agency

GROWING HEALTHY COMMUNITIES

COMMUNITY HEALTH IMPROVEMENT PLAN

2023 - 2028

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EXECUTIVE SUMMARY

In the fall of 2022, the Plumas County Public Health Agency conducted a comprehensive evaluation of community health needs. This assessment involved analyzing quantitative data from 8 different data sources, reviewing mortality as well as morbidity to identify the top 10 community health issues affecting the county:

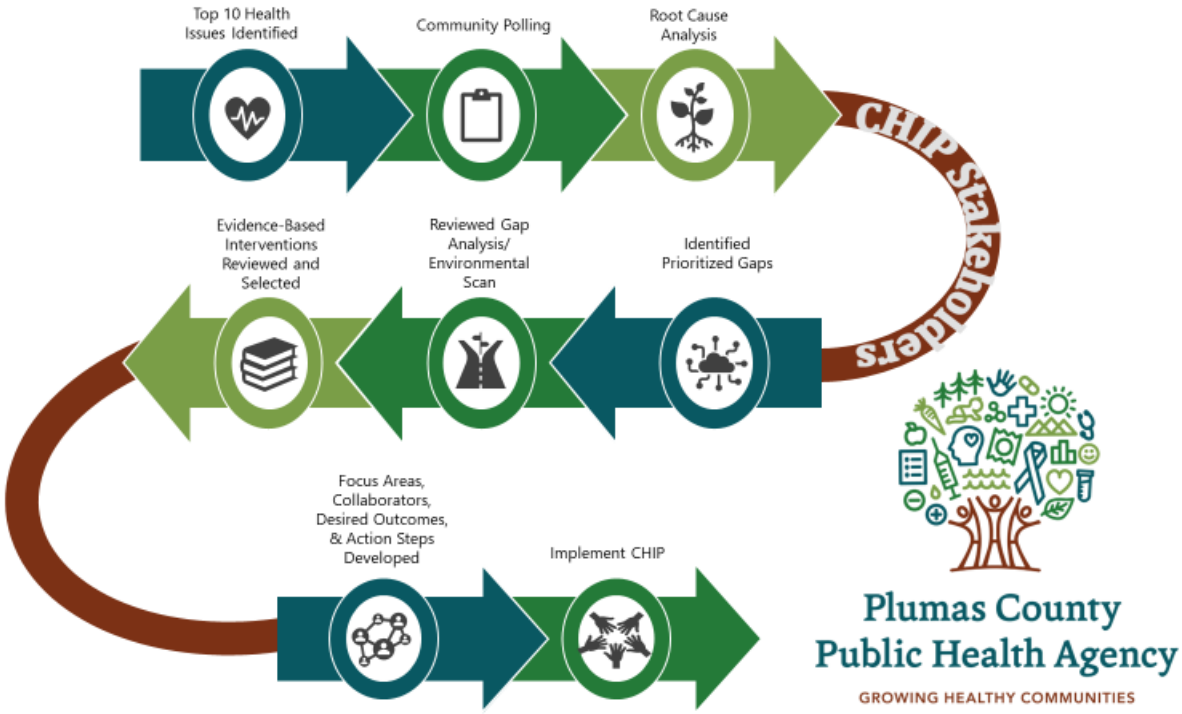
Figure 1: Top 10 Community Health Issues for Plumas County

The 10 health issues identified from the data-driven process were then taken to the community for their input into the top 3 priority health issues for Plumas County. To select the top 3 health priorities a mixed-methods community engagement process was undertaken resulting in 559 votes for the top 3 health priorities.

Figure 2: Community-Identified Top 3 Health Issues

A root cause analysis was completed resulting in identification of 11 overlapping root causes for the 3 community health priorities. Health Department Staff prioritized and selected three root causes to address in the CHIP. A Community Health Improvement Plan (CHIP) Stakeholder Taskforce was convened and met in June 2023 to conduct the community gaps analysis, prioritize the gaps to be addressed and select the categories of evidence-based interventions and focus areas as a framework for the 5-year CHIP.

Figure 3: 2023 Plumas County Health Improvement Plan Process



LETTER FROM THE DIRECTOR

PCPHA
PLUMAS COUNTY PUBLIC HEALTH AGENCY

Growing Healthy Communities

With this report, the Plumas County Public Health Agency is proud to present the 2023 Community Health Improvement Plan (CHIP). The CHIP is an action-oriented guide for improving population health and enhancing equity.

The 2023 CHIP is Plumas County's third, following previous plans released in 2012 and 2016. It builds on this Agency's 2020 Community Health Assessment and an addendum in 2022 to account for the effects of the COVID-19 pandemic and major wildfires in 2021 and 2022. The development of this report experienced delays due to the onset of the pandemic, but this unforeseen circumstance presented an opportunity to gather additional data and information concerning the trauma the county endured during the pandemic and wildfire events. As a result, the report now encompasses recommendations specifically designed to address and mitigate the trauma the community has experienced. In effect, the delay has allowed for a more comprehensive understanding of the situation, resulting in actionable guidance provided within these pages.

This document is the result of a broad-based, data-driven collaborative process involving input from citizens from across the county and from partner organizations representing healthcare, non-profit organizations, public schools and county government.

The resulting plan focuses on concrete actions to address the community's top health concerns by closing gaps in services through interventions delivered in the home, in the community, or in healthcare settings. The process identified several actions that will be led by the Public Health Agency and others that can be carried forward by partner organizations and the county's 20,000 Lives Coalition.

It's our hope that the entire community, acting together, will be able to use the 2023 CHIP to achieve the vision of making Plumas County home to the healthiest and happiest people in the nation.

Dana Loomis, MSPH, PhD
Director

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COMMUNITY STAKEHOLDERS

Community Health Improvement Plan -

Taskforce - As part of the Community Health Improvement Planning process, over a dozen community stakeholders were actively involved in the creation of the Community Health Improvement Plan.

Community Health Improvement Plan Stakeholders/Taskforce Participants

Organization	Representative
Eastern Pluas Health Care	Doug McCoy
First 5 Plumas	Pamela Becwar
Plumas District Hospital	Sierra Blanton
Plumas Crisis Intervention and Resource Center	Cathy Rahmeyer
Plumas County Behavioral Health	Jessica McGill
Plumas County Health Officer	Mark Satterfield
Plumas County Public Health Agency	Dana Krinsky
Plumas County Public Health Agency	Dana Loomis
Plumas County Public Health Agency	Nicole Reinert
Plumas County Public Health Agency	Tina Venable
Plumas Rural Services	Paula Johnston
Plumas Unified School District	April Gott

Public Health Agency Staff – The Community Health Improvement Planning process was led, supported and championed by numerous staff throughout the Public Health Agency. From serving on the CHIP Core Team to data analysis to ensuring healthy food options at the meetings, staff participated in all aspects of the process. The Health Department Staff listed below were members of the CHIP Core Team.

Plumas County Public Health Agency CHIP Core Team

Staff Member	Title
Bill Cook	Veteran Services Officer
Christopher Rouse Islas-Hernandez	Health Education Specialist
Dana Krinsky	Assistant Director
Dana Loomis	Director
Danielle Blust	Health Education Specialist
Jana McDowell	LVN II
Jessica Ahmadia	LVN II
John Rix	Director of Senior Services
Lori Beatley	Health Education Coordinator II
Nicole Reinert	Health Programs Division Chief
Ryan Hoben	Epidemiologist
Serena Troupe	Health Education Specialist
Terri Smith	PHN III
Tina Venable	Director of Nursing

This work would not have been possible without the involvement of the individuals listed above or without the input from the 559 community members who took their time to give input into the process. Thank you all.

METHODOLOGY

Data Sources:

A detailed data inquiry process was undertaken to arrive at a comprehensive list of data sources and major health issues affecting Plumas County. A host of federal, state, and local data sources, tools, and organizations were queried and researched, including:

- California Community Burden of Disease https://skylab.cdph.ca.gov/communityBurden/
- County Health Rankings https://www.countyhealthrankings.org/
- CDC Places https://www.cdc.gov/places/index.html
- Healthy People 2030 https://health.gov/healthypeople/objectives-and-data/leading-health-indicators
- US Census Bureau https://www.census.gov/quickfacts/fact/table/plumascountycalifornia/PST045221
- US EPA AirNow https://www.epa.gov/outdoor-air-quality-data/download-daily-data
- CDC National Syndromic Surveillance Program https://www.cdc.gov/nssp/index.html

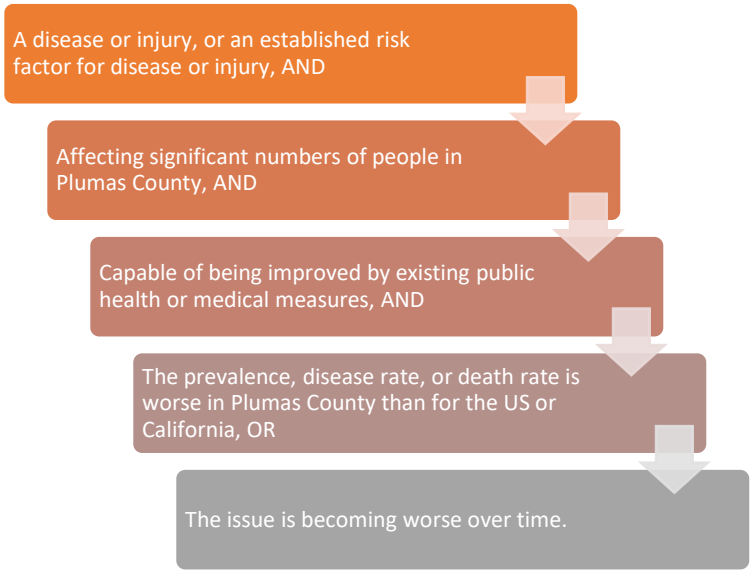
The 2020 Plumas County Community Health Assessment and the 2022 addendum on the effects of the COVID-19 pandemic and wildfires were also consulted for information.

Results:

Plumas County Top 10 Health Issues

The Plumas County Public Health Agency reviewed health data from government, academic and non-profit sources to identify 10 public health issues of high importance to Plumas County. The issues selected for further consideration met these criteria:

Figure 4: Health Issues Criteria



Top 10 Health Issues (note- for more detailed data on these issues, please see the Community Health Assessment: https://plumascounty.us/2074/CHA-CHIP---Health-Planning)

1. **Heart Disease**
   Diseases of the heart, mainly ischemic heart disease (heart attacks) are the leading cause of death and years of life lost in Plumas County. The death rate from heart disease is higher in Plumas County than for the state of California.

2. **Cancer**
   Cancer of all types is the second leading cause of death in Plumas County. Plumas County's death rate from cancer is higher than the rate for all of California.

3. **Unhealthy Air Quality**
   Plumas County's air quality has deteriorated because of wildfires. The average level of particulate air pollution over the last 3 years is higher than the EPA's health-based standard. On some days during fires, the air quality has been worse than in the world's most polluted cities. Exposure to particulate air pollution is a risk factor for cancer, lung disease, heart disease and death.

4. **Diabetes and Kidney Disease**
   About 1 in 8 Plumas County residents have been diagnosed with diabetes. Diabetes is one of the main causes of chronic kidney disease. Taken together, diabetes and kidney disease are among the leading causes of death in Plumas County. The county's death rate from diabetes is higher than average for California.

5. **Alcohol-Related Disease and Injury**
   Excessive alcohol drinking is a risk factor for injuries, cancer, heart disease and chronic liver disease (cirrhosis) and other diseases. Plumas County's rates of several alcohol-related conditions are higher than average for the state. Alcohol-related deaths tend to occur at relatively young ages, resulting in premature loss of productive life.

6. **Accidents and Injuries**
   All accidents are potentially preventable, yet Plumas County experiences higher than average rates of death from all forms of accidental injury, including road accidents. Injury deaths tend to occur at young ages; they are the leading cause of death for children and adolescents and lead to preventable losses of many years of life.

7. **Substance Abuse and Drug Overdose**
   Plumas County previously had the highest rate of drug-overdose deaths in California. The situation has improved significantly, thanks to public health and medical interventions. Nevertheless, drug overdoses remain one of the leading causes of death in Plumas County. Overdoses occur disproportionately among young people, so those deaths cause the loss of many years of life.

8. **Food Insecurity and Hunger**
   People in some parts of Plumas County do not have access to a grocery store within 1 to 10 miles. The share of county residents reporting that they sometimes do not have access to healthy food, or enough food for a healthy, active life, is higher than health targets set by the US Department of Health and Human Services.

9. **Limited Access to Preventive Health Services**
   Many serious diseases can be controlled or prevented by available measures. However, Plumas County residents may face difficulty accessing preventive health services. The percentage of county residents who are vaccinated against influenza is lower than average for California and the United States. The number of residents who regularly see a doctor for preventive care is also below the national average, as are the numbers who get screening for breast and colon cancer and the proportion with controlled hypertension.

10. **Suicide**
    The rate of death from suicide in Plumas County is higher than the state average. Abuse of drugs and alcohol and mental health conditions such as depression are risk factors for suicide. Victims of suicide are often middle-aged or younger, so suicide leads to the loss of many years of life.

Selecting the Top Three Priority Health Issues

As described above, *quantitative* data analysis methods were used to identify the top 10 health issues facing Plumas County. However, to select the top 3 Health Priorities a *qualitative*, mixed methods community engagement process was undertaken resulting in 559 people voting for their top 3 health priorities either through in-person, community "hot dots" polling or through an electronic survey.

Process:

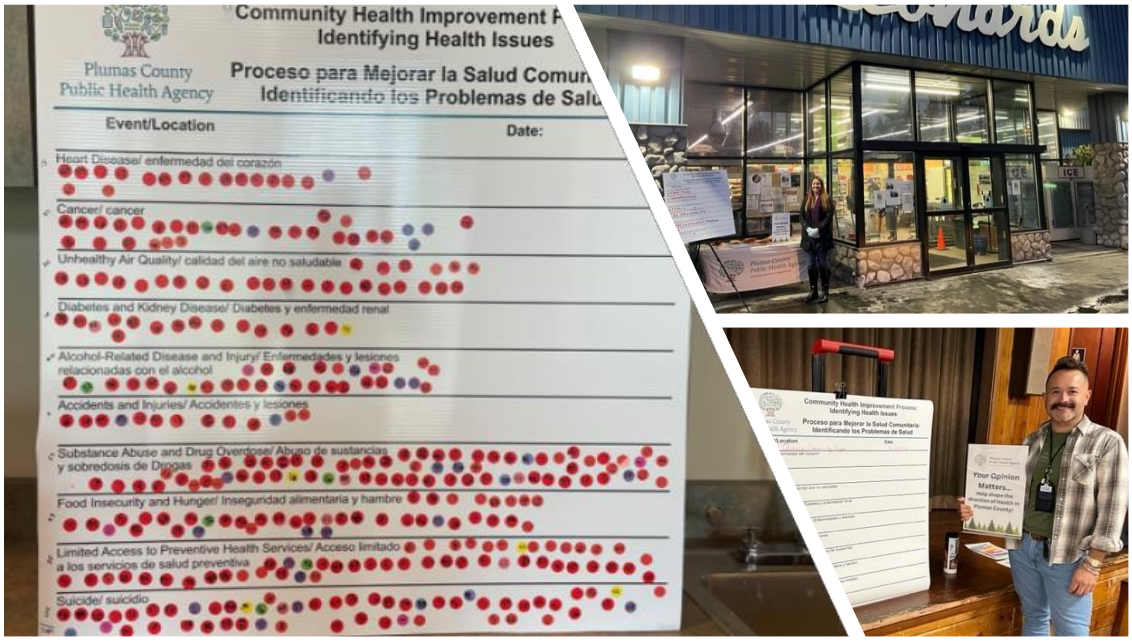
Method #1 - Community "Hot Dots" Polling:

From December 2022 – February 2023, eight Community Polling events were conducted throughout the county resulting in three hundred and thirty-seven (337) people voting for their top 3 health priorities. The venues were selected in consultation with community leaders and with explicit intent to 1) meet people where they were--especially populations least likely to participate in public health input sessions and 2) facilitate geographic representation. The locations varied from the Christmas tree lighting in Quincy to the grocery stores in Portola and Greenville. Public Health Staff attended each of these events supplied with a bi-lingual, pre-printed foam board with the Top 10 Health Issues (see Picture #1), a variety of colorful sticky dots, pens, and a table.

They engaged participants by asking them if they would be willing to give their input into the most important health issues in Plumas County. Participants were asked to voluntarily self-identify race/ethnicity and age and were given different colored dots based on the information provided. Participants then placed their three dots on their most important health issues.

Health Department staff identified this community engagement experience as a positive opportunity that allowed them to reconnect with the community they serve after the challenges of the pandemic.

Picture 1: Hot Dots Pictures



Method #2 - Community Survey

During this same timeframe, a bilingual English and Spanish), electronic survey posing the same questions was launched (see Appendix A for the survey). Survey respondents were asked to voluntarily provide their race/ethnicity and age. This survey was available on the PCPHA website and shared with dozens of public, private and nonprofit partners throughout the county, with a request to share with the populations they serve. Paper copies of the questionnaire were delivered by Plumas County Senior Services to ensure participation by older residents who often lack access to online resources. One hundred and eighty-eight (188) people finished the survey and voted for their top 3 health priorities.

Community Engagement Combined Results:

Overall, the race/ethnicity of respondents matched the County's overall demographic profile. The targeted, in-person community polling events oversampled minorities and younger people which helped to ensure their representation in the overall data (see Figure 5 and 6).

Figure 5: Race and Ethnicity Combined In-person and Survey Response

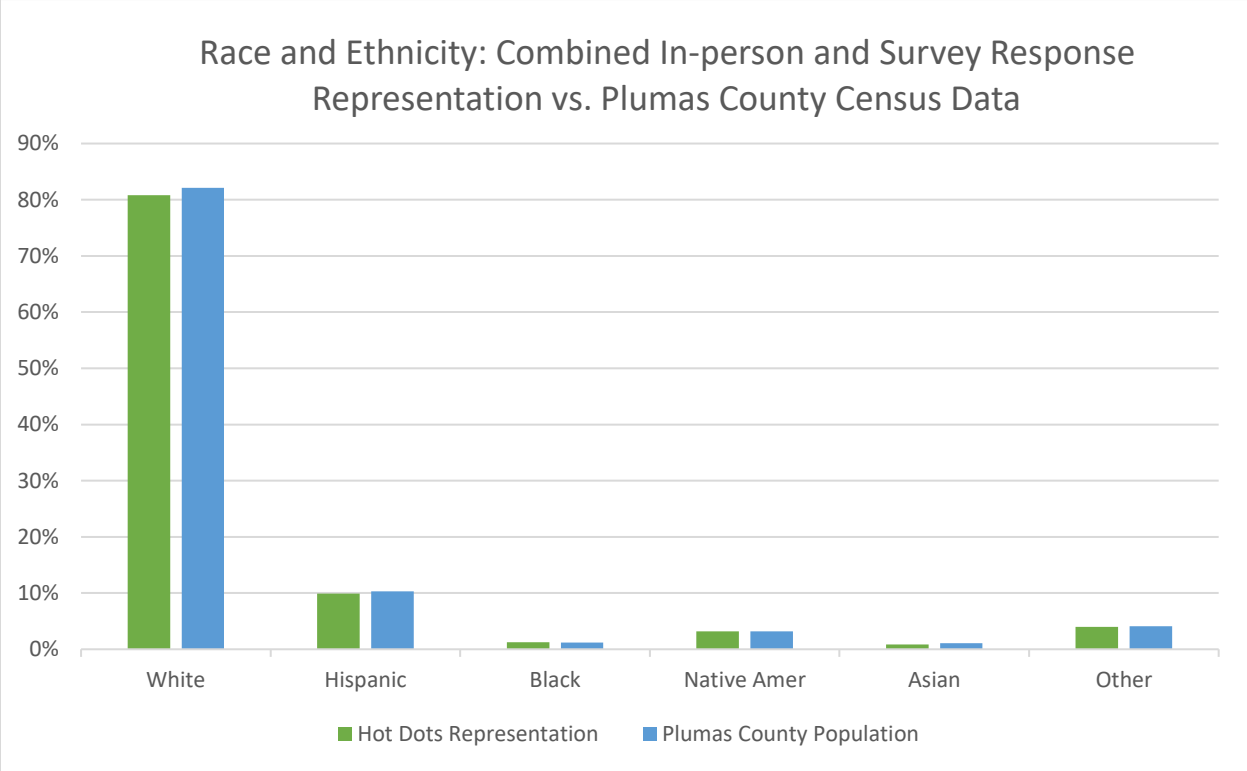
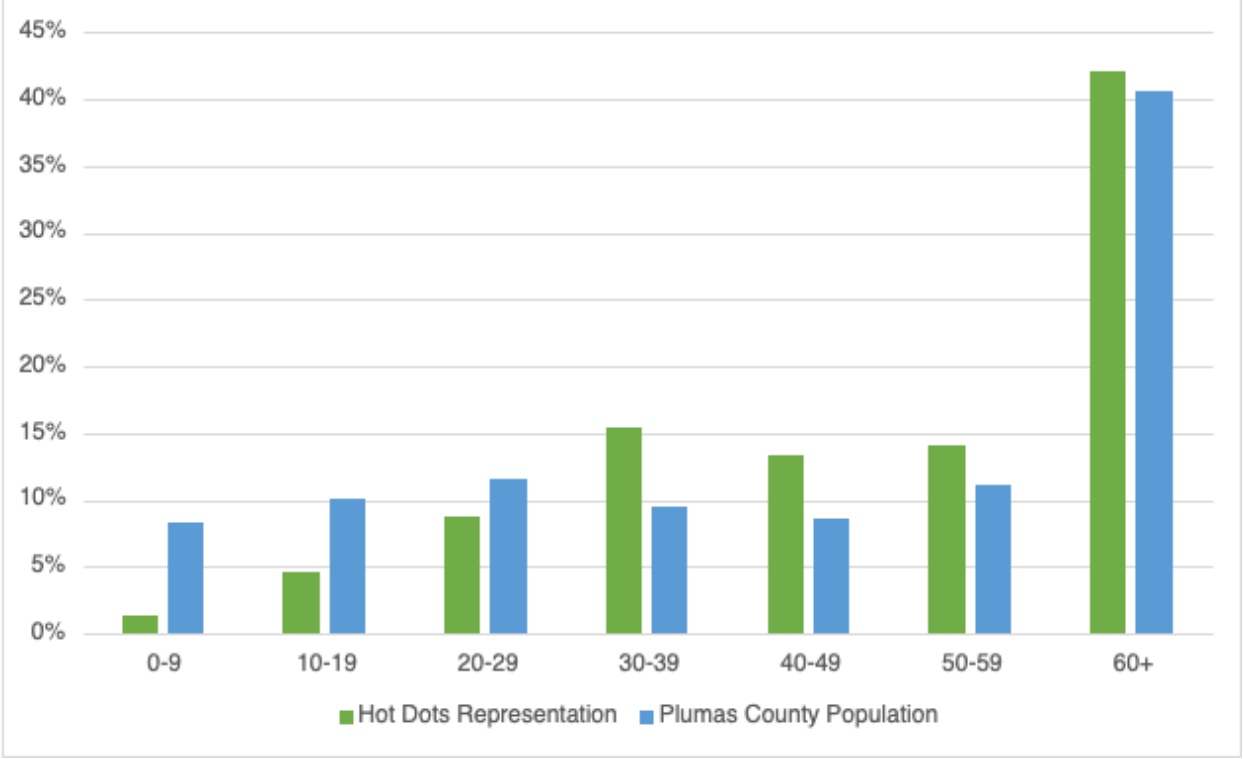


Figure 6: Ages: Combined In-person and Survey Response



When both data sets were combined, the health issues were ranked and the top 3 were selected as the focus for the root cause analysis (see Figure 7 for ranking results).

Figure 7: Final Rankings of Community Engagement/Voting Results

	Number	Percent
Substance Abuse and Drug Overdose	361	22
Limited Access to Preventative Health Services	249	15
Alcohol-Related Disease and Injury	198	12
Suicide	175	10
Cancer	174	10
Food Insecurity and Hunger	143	9
Heart Disease	141	8
Diabetes and Kidney Disease	106	6
Unhealthy Air Quality	74	4
Accidents and Injuries	56	3
Total Votes	1677	

The three priority health issues selected by the community were:

1. ***Drug & Alcohol Abuse and Overdose****
2. ***Limited Access to Preventive Services***
3. ***Suicide***

**Substance Abuse/Overdose and Alcohol-Related Disease and Injury were combined because of significant overlap in root causes*

ROOT CAUSE ANALYSIS

Once the top three community-identified health priorities of Drug & Alcohol Abuse and Overdose, Limited Access to Preventive Services and Suicide were selected, the root cause analysis (RCA) process began.

The first step for each matrix was a literature review via a keyword search on Pubmed, as well as an additional Google search. All relevant findings were compiled and compared, and those with strong evidence-based support were used to determine the main categories across which to classify the issues. These categories were continually refined throughout the process through additional research and discussion with subject matter experts. Upon completion of the

literature review and team discussion of findings, the matrix (see Figure 8 for the RCA matrix) was completed by adding supporting references (see Appendix B) for why a specific category was selected for each health issue, as well as specific examples, when needed, for clarity.

Figure 8: Plumas County Root Cause Analysis Matrix

	Adverse Childhood Experiences (ACEs)	**Adverse Community Events**	**Counselor/ Provider Burnout and Shortages**	**Stigma**	**Proximity to services**	**Failure to link people with services**	**Poverty**	**Lack of mental health services**	**High Access to Firearms**
Drug/Alcohol addiction/overdose	X [2]	X [2]	X [1]	X [1,13]	X [3]	X [3]	X [6]	X [40]	
Barriers to care			X [1,4,5]	X [3,4]	X [3,4]	X [3,4]	X [36]	X [40]	
Suicide	X [37]	X [37]	X [35,36]	X [35,36]	X [35]	X [38,39]	X [36]	X [36]	X [35,36]

Definitions:

- **Adverse Childhood Experiences (ACEs):** Events that occur in a person's life between the ages of 0-17 that are traumatic and/or lead to toxic stress. These include, but are not limited to, experiences such as abuse/neglect, close personal loss, unsafe/unstable living conditions, parental mental health issues, etc. These experiences can have life-long effects and be predictive of health, social, and behavioral problems in adulthood. ACEs are considered additive, thus, experiencing more ACEs increases one's risk of developing associated corollaries. [7]
- **Adverse Community Events:** ACEs and Adverse Community Events constitute the "Pair of ACEs". Like ACEs, Adverse Community Events lead to the development of toxic stress and have considerable implications for the long-term well-being of affected individuals. However, these events are on a community-level, rather than individual level, and include poverty, community violence, discrimination, etc. [8]
- **Counselor/Provider Burnout and Shortages:** Rural areas face high rates of provider shortages, which can stem from burnout, excessive turnover, and a lack of providers with sufficient experience, among other things.
- **Stigma:** Stigma is negative community sentiments and subsequent feelings of shame among affected individuals. In rural contexts, stigma is especially prevalent due to lack of anonymity in the community. [14]
- **Proximity to Services:** More services available within 100 miles of the community is associated with higher utilization of care. [3]
- **Failure to Link People with Services:** Lack of services offered in rural communities often leads to referrals outside of the community or a failure to follow-up with patients. Rural residents are also less likely to accept these referrals, leading to a lack of utilization of needed and/or available services. [X]
- **Poverty:** As a social determinant of health, poverty can lead to long-term toxic stress, physical illness, and lack of resources to meet one's basic needs. There are substantial disparities in poverty, with affected individuals facing higher rates of disabilities and mortality compared to those who do not experience poverty. [10]
- **Lack of Mental Health Services:** People who suffer from SUD often have co-occurring mental health conditions, which makes them difficult to treat [1]. Less mental health services are

available in rural areas and, among those that are available, providers often have less specialized training and there is less utilization of the services compared to urban areas. [18]

- **High Access to Fire Arms:** Gun ownership is considerably more common in rural settings than urban settings and the rate of suicide by firearms is also higher in rural areas than in urban areas. [36]

Prioritization of Root Causes

Health Department leaders reviewed the results of the root cause analysis for the priority health issues. Then, they reviewed and discussed the availability of root cause specific evidence-based interventions available for each prioritized health issue (see Figure 9 and Appendix B). Finally, they considered a root cause analysis prioritization index (see Figure 10) that factored in: 1) data availability; 2) number of evidence-based interventions and 3) cross-cutting impact across health issues for each root cause as one method to help participants select their priority root causes upon which the Community Health Improvement Plan will be built. Staff were encouraged to consider other, qualitative variables, including input from public health staff and their areas of expertise as they determined their top 3 root causes.

Figure 9: Root Causes for Priority Health Issues Interventions Matrix

	Pair of ACEs	Counselor/Provider Burnout and Shortages	Stigma	Proximity to services	Failure to link people with services	Poverty	Lack of mental health services	High access to firearms
Drug/Alcohol addiction /overdose								
Increase providers and community's knowledge on and awareness of SUD			X [14]					
Improve ability of providers and community to recognize SUD					X [15]			
Utilize community organizations (churches, employers, etc.) to create support network	X [15]			X [15]	X [15]	X [15]		
Supported employment services	X [20]		X [20]		X [21]	X [20,21]	X [20,21]	
Community outreach to combat stigma and social perceptions			X [13]		X [13]			

Treatment interventions	X [15]			X [15]	X [15]	X [15]	X [15]	
Community-based treatment options (with coordinated care)				X [15]	X [15]			
Ensuring access to basic needs (housing, food, mental health services) during SUD treatment	X [15]					X [15]	X [15]	
Youth substance use prevention								
Family- centered, school-based, and faith-based prevention programs	X [15]							
Barriers to care								
Improve access to and continuity of care	X [16]	X [17,19]	X [16]	X [15,17,19]	X [15,16,17,19]		X [15,17,19]	
Co-locate mental/behavioral health services with primary care				X [15]	X [15]		X [15]	
Transportation interventions								
Recruit providers and trainees from the community		X [17]						
Develop telemedicine and providers' comfortability with it		X [17,19]		X [17,19]	X [17,19]		X [17,19,40]	
Increase opportunities for students to train in rural health settings		X [17]						
Improve health literacy			X [41]		X [41]			
Strengthen community and family supports for patients	X [16]		X [16]		X [16]			
Suicide								
Improve access and delivery of suicide		X [38,39]	X [38]	X [39]			X [38]	

and mental health care								
Telehealth		X [38]	X [38]				X [38]	
Increase provider availability		X [39]		X [39]				
Improve household financial security	X [38]					X [38,39]		
Stabilize housing						X [39]		
Strengthen economic supports	X [38]					X [38,39]		
Create protective environments	X [39]							X [38,39]
Reduce access to firearms and other lethal means								X [38,39]
Reduce substance use in community	X [39]							X [39]
Identify and support people at risk					X [39]			
Train gatekeepers					X [39]			
Promote healthy connections	X [39]		X [39]					
Promote healthy peer norms	X [39]		X [39]					
Engage community members in shared activities	X [39]		X [39]					

Figure 10: Root Cause Analysis Prioritization Index

	Adverse Childhood Experiences (ACEs)	Adverse Community Events	Counselor/ Provider Burnout and Shortages	Stigma	Proximity to services	Failure to link people with services	Poverty	Lack of mental health services	High Access to Firearms
Drug/Alcohol addiction/overdose	X	X	X	X	X	X	X	X	
Barriers to care			X	X	X	X	X	X	
Suicide	X	X	X	X	X	X	X	X	X
Cross-cutting	2	2	3	3	3	3	3	3	1
EBI Strength	10	10	5	9	5	11	5	6	2
Data availability	2	2	2	1	1	1	2	2	1
Total Index Score	**14**	**14**	**10**	**13**	**9**	**15**	**10**	**11**	**4**

Green = *Highest likelihood of having available data, evidence-based interventions and cross-cutting impacts*

Yellow = *Moderate likelihood of having available data, evidence-based interventions and cross-cutting impacts*

Red = *Lowest likelihood of having available data, evidence-based interventions and cross-cutting impacts*

After much deliberation and discussion, the staff determined to prioritize the following root causes as the foundation for the CHIP:

1) Adverse Childhood Experiences
2) Adverse Community Events
3) Failure to Link People with Services

CHIP STAKEHOLDER ENGAGEMENT

Community Health Improvement Stakeholder Taskforce members met in June 2023. Through a facilitated, consensus-based process, their specific tasks were to: 1) review and prioritize evidence-based interventions to address the prioritized root causes; 2) conduct a rapid gaps analysis around prioritized interventions; 3) identify overlapping gaps and determine which would be addressed in the CHIP and 4) identify focus areas and desired outcomes for each intervention category. The results of these tasks are described below.

1) Review and Prioritize Evidence-Based Interventions

Stakeholders (see Page 5) met at the Plumas County Public Health Agency to review the evidence-based interventions (see Figure 11) associated with the three root causes selected by the agency staff.

Figure 11: Plumas County Interventions for Selected Root Causes Matrix

		Adverse Childhood Experiences	Adverse Community Events	Failure to Link People with Services
Healthcare-based Interventions				
Emergency department and primary care screenings for SUD			X [1]	X [1]
Provide toolkit for providers to increase comfort prescribing buprenorphine			X [58]	X [4,5,58]
Co-locate mental/behavioral health services with primary care				X [60,61]
Monitor and screen for ACEs				
	Screen health records	X [16]		X [16]
	Screen patients at pediatric/family medicine appointments	X [17,18]		X [17,18]
	Health/Mental Health Screening for Expectant Parents	X [51]		X [51]
Community-based Interventions				
Housing				
	Assertive Community Treatment		X [21,22,23]	X [21,22,23]
	Critical Time Intervention (CTI)		X [24,25]	X [24,25]
	Housing First*		X [26]	X [26]
	Permanent Supportive Housing		X [19,20]	X [7,9,10]
	Rapid re-housing		X [26]	X [26]
Financial Support				
	Supported employment*		X [13]	X [6]
	Strengthen Economic Supports for Families (Tax credits, childcare subsidies, paid maternity leave)*	X [27]	X [27]	
	Primary care-based resource connection		X [52,53]	X [52,53]
	Job training and support	X [54,55]	X [54,55]	X [54]
	FII UpTogether platform w/ financial support		X [56,57]	X [56]
Care Coordination Models				
	Continuing Care Model			X [11]
	Peer Specialist Programs			X [11]

	Clinical Case Management			X [11,59]
	Community Health Worker Care Coordinator/Manager Model			X [29]
	Individualized Management for Patient-Centered Targets (IMPaCT)			X [28]
	Medicaid payment for Community Health Worker services*			X [30]
Other				
Transportation assistance		X [31,32,33]	X [32]	X [11,12,32]
Community-led systems mapping		X [15]		
Community-wide education campaigns		X [34]	X [34]	X [34]
Safe Environment for Every Kid (SEEK) model		X [34,35]		X [34,35]
Positive Parenting Program (Triple-P)		X [36,76,77]		
Technology Interventions				
Project ECHO				X [2,3]
Standardize the use of and increase access to telehealth services				X [7,8]
Harm-reduction Interventions				
Group-based STI comprehensive risk reduction (CRR) interventions		X [63]		X [62,63]
Dual treatment programs for substance abuse and parenting skills		X [31,34]		X [31]
Trauma-informed Interventions			X [38.39]	
Mental Health First Aid		X [36,37]	X [36,37]	X [37]
Addiction and Trauma Recovery Integration Model (ATRIUM)		X [40]	X [40]	
Seeking Safety Model		X [36,41]	X [36,41]	X [41]
Sanctuary Model		X [42,43]	X [42,43]	
ACEs Aware Initiative		X [44,45]	X [44,45]	X [44,45]
Therapy Interventions				
CBT (individual, group, family, in-home, trauma-focused, school-based)		X [36,66,67,68]		X [66,68,69]
Interpersonal therapy		X [36,70,71,72]		X [70]
	Functional Family Therapy	X [70]		X [70]
	Preconception Counseling	X [72]		

	Parent-child Interaction Therapy	X [36,71]		
Multisystemic Therapy (MST)		X [68,73]	X [68,73]	
EMDR		X [74,75]		
School-based Interventions				
Healthy and Ready to Learn		X [47,48]	X [47,48]	X [47,48]
Anti-bullying interventions		X [49]	X [49]	
Vaccination programs				X [50]
Home-based Interventions				
Early Childhood Home-visitation Programs		X [34]		X [34]
	Nurse-Family Partnership	X [34,46]		X [34,46]
	Parents as Teachers	X [64]		X [65]

**Potential policy interventions.*

After reviewing and discussing the eight categories of interventions, participants used a modified Delphi technique to narrow the list down to three categories to focus on for the CHIP. They took into consideration interventions that:

- The community had the capacity to implement
- Had known or potential funding
- Addressed health issues/root causes from an upstream/ecological approach
- Were cross-cutting
- Could be implemented in a collaborative manner

The 3 categories selected were:

1) Community Based Interventions
2) Home Based Interventions and
3) Healthcare Based Interventions

2) Conduct Gaps Analysis

Stakeholders Discussed Gaps for each of the intervention categories and identified the following gaps (see Figure 12):

Figure 12: Gaps Identified

Community Based	Home Based	Healthcare Based
Detox and Rehab	Post-partum depression assessment and response	Specialist Care
Post high school career prep	Resources Knowledge and Coordination	OB Care/L&D
Transportation	Dementia Care	Resources Knowledge and Coordination
Foster Care Services	Family Support	Staff Shortages
Housing (transitional, affordable, post hospital discharge, post jail release, palliative/hospice care)	Poverty Mitigation	Access to mild to moderate therapy services for Medi-Cal recipients
Syringe Exchange/Harm Reduction	Staffing	Dementia Care
Veterans Services	Transportation	Family Support
Poverty Mitigation	Specialists Services	Poverty Mitigation
Resources Knowledge and Coordination	Harm Reduction	Transportation
Food Insecurity	Screening	Harm Reduction
Family Support	Sustainability	Screening
Childcare	Housing	Sustainability
Dementia Care		Housing
Specialist Services		
Screening		
Sustainability		

3) Identify Overlapping Gaps and determine which would be addressed in the CHIP

Overlapping Gaps:

- Resources Knowledge and Coordination
    - Community Health Worker Expansion
    - 211 Collaboration
- Dementia Care
- Family Support
    - Continuum of Support Services
- Staffing
- Housing
- Poverty Mitigation
- Transportation
    - Revive Social Service Transportation System
    - Role of Managed Care
- Specialist Services

    - Medical
    - Mental Health
- Harm Reduction
    - Syringe Exchange
    - Overdose Prevention
- Screening
    - Preventive
    - Resource Needs
- Sustainability
    - Advocacy and Coordination
    - Community Priorities and Gaps

4) Prioritize gaps and identify focus areas to be addressed in the CHIP

The CHIP Stakeholders identified priority gaps for the intervention categories selected. Gaps in four areas, as follows, were selected to addressed through interventions led by the Public Health Agency:

1) **Resources knowledge, coordination, and navigation**
2) **Family Support**
3) **Harm Reduction**
4) **Sustainability**

They then identified the following focus areas for each of the interventions/gaps:

1) **Resources knowledge, coordination, and navigation**

    Focus Areas:
    - Community Health Worker Expansion
    - Resource/211 Collaboration

2) **Family Support**

    Focus Areas:
    - Continuum of support services
    - Client access to services

3) **Harm Reduction**

    Focus Areas:
    - Syringe Exchange
    - Overdose prevention

4) **Sustainability**

Focus Areas:

- Advocacy and Coordination
- Public Health Agency priorities
- Workforce development and retention

The remaining overlapping gaps will be supported by the Public Health Agency when led by other community organizations/coalitions.

Staff took the information from the CHIP Stakeholders and developed the 5-year Community Health Improvement Plan action steps as documented in the CHIP Narrative and Timeline below.

COMMUNITY HEALTH IMPROVEMENT PLAN
July 1, 2023 – June 30, 2028

GAPS

1) **Resources knowledge, coordination, and navigation**
2) **Family Support**
3) **Harm Reduction**
4) **Sustainability**

Health Department Led Initiatives to Address Priority Gaps

1) **Resources knowledge, coordination, and navigation**

Focus Areas:
- CHW Expansion
- Resource/211 Collaboration

Action Steps:

1) By June 30, 2024, develop a plan to implement the Community Health Worker Benefit for Medi-Cal Managed Care.
2) By June 30, 2025, increase home visiting connection/referrals by 25% by working with partners (i.e., such as Social Services/CalWorks recipients) to develop a referral process.
3) By December 31, 2025, the Health Department and leaders of agencies developing a local 211 service will meet to review the resources PCPHA is able to provide as well as a list of resources PCPHA regularly utilizes.

2) **Family Support**

Focus Areas:
- Continuum of support services
- Client access to services

Action Steps:

1) By June 30, 2024, PCPHA will facilitate a collaborative gathering of parenting support service providers (e.g., Social Services, Behavioral Health, First 5 and Schools) to create a comprehensive service map and identify service gaps.
2) By June 30, 2024, PCPHA will convene a mental health provider group to create a plan to improve Postpartum Depression outcomes for home-visiting clients.
3) By December 31, 2023, the PCPHA transportation plan will be updated to include Medi-Cal Managed Care clients.

3) Harm Reduction

Focus Areas:

- Syringe Exchange
- Overdose prevention

Action Steps:

1) By June 30, 2023, PCPHA will have submitted a proposal to utilize Opioid Settlement Funds to community and home-based syringe exchange services.
2) By December 31, 2023, PCPHA will research and create a list of drug/rehab centers to include criteria, cost, and the referral process.

4) Sustainability

Focus Areas:

- Advocacy and Coordination
- Health Department priorities
- Workforce development and retention

Action Steps:

1) By December 31, 2024, PCPHA will have successfully billed for Medi-Cal Services (transportation, CHW, and/or ECM).
2) By December 30, 2023, PCPHA will develop and implement an employee wellness plan.
3) By December 30, 2023, CPPHA will develop and implement a career-enhancing educational opportunity system.
4) By June 30, 2023 and ongoing, PCPHA will have created a schedule of education and communication of services and supports to increase the Board of Supervisor's knowledge, awareness, and ability to positively influence factors that affect local health jurisdiction funding.

TIMELINE

2023 Plumas County Community Health Improvement Plan Timeline

Priority Gaps/Focus Areas	Action Steps	Responsible Team	Status/ Achievements	FY2024	FY2025	FY2026	FY2027	FY2028
Resources Knowledge, Coordination, and Navigation								
1. Community Health Worker Expansion and Resource/211 Collaboration								
	Develop a plan to implement the Community Health Worker Benefit for Medi-Cal Managed Care.	PCPHA		■	■			
	Increase home visiting connection/referrals by 25% by working with partners (i.e. such as Social Services/CalWorks recipients) to develop a referral process.	PCPHA		■	■	■		
	Health Department and 211 leadership will meet to review the resources PCPHA is able to provide as well as a list of resources PCPHA regularly utilizes.	PCPHA 211 Leadership			■	■		
Family Support								
2. Continuum of Support Services and Client Access to Services								
	Facilitate a collaborative gathering of parenting support service providers (e.g. Social Services, Mental Health, and Schools) to create a comprehensive service map and identify service gaps.	PCPHA		■	■			
	Convene a mental health provider group to create a plan to improve Postpartum Depression outcomes for home-visiting clients.	PCPHA		■	■			
	Update PCPHA transportation plan to include Medi-Cal Managed Care clients.	PCPHA		■				

2023 Plumas County Community Health Improvement Plan Timeline

Priority Gaps/Focus Areas	Action Steps	Responsible Team	Status/ Achievements	FY2024	FY2025	FY2026	FY2027	FY2028
Harm Reduction								
3. Syringe Exchange and Overdose Prevention								
	Submit a proposal to utilize Opioid Settlement Funds for community and home-based syringe exchange services.	PCPHA						
	Research and create a list of drug/rehab centers to include criteria, cost, and the referral process.	PCPHA						
Sustainability								
4. Advocacy and Coordination, Health Department Priorities, and Workforce Development and Retention								
	Successfully bill for Medi-Cal Services (transportation, CHW, and/or ECM).	PCPHA						
	Develop and implement an employee wellness plan.	PCPHA						
	Develop and implement a career-enhancing educational opportunity system.	PCPHA						
	Create a schedule of education and community of services and support to increase the Board of Supervisor's knowledge, awareness, and ability to positively influence factors that affect local health jurisdiction funding.	PCPHA						

APPENDICES

APPENDIX A – Electronic Surveys (English and Spanish)

PCPHA
PLUMAS COUNTY PUBLIC HEALTH AGENCY

Growing Healthy Communities

We want your input! Would you be willing to help influence what health issues the county focuses on over the next 3-5 years? This short survey would allow you to vote for what you think is most important in Plumas County.

*** 1. Please select the TOP THREE health issues that you think are impacting Plumas County the most.**

- ☐ Heart Disease
- ☐ Cancer
- ☐ Unhealthy Air Quality
- ☐ Diabetes and Kidney Disease
- ☐ Alcohol-Related Disease and Injury
- ☐ Accidents and Injuries
- ☐ Substance Abuse and Drug Overdose
- ☐ Food Insecurity and Hunger
- ☐ Low Utilization of Preventative Services
- ☐ Suicide

2. What is your race or ethnicity?

- ○ Asian
- ○ Black or African American
- ○ Hispanic or Latino
- ○ Native American
- ○ White
- ○ Other/ Do not want to say.

3. What is your age?

4. Are you a Plumas County Resident?

- ○ Yes
- ○ No

Please fill out and return to driver/ nutrition site. If have any questions call 530-283-6337

PCPHA
PLUMAS COUNTY PUBLIC HEALTH AGENCY

Growing Healthy Communities

¡Queremos tu opinión! ¿Estaría dispuesto a ayudar a influir en los problemas de salud en los que se enfoca el condado durante los próximos 3 a 5 años? Esta breve encuesta le permitiría votar por lo que cree que es más importante en el condado de Plumas.

*** 1. Seleccione los TRES problemas de salud PRINCIPALES que cree que están afectando más al condado de Plumas.**

- ☐ Enfermedad del corazón
- ☐ Cancer
- ☐ Calidad del aire no saludable
- ☐ Diabetes y enfermedad renal
- ☐ Enfermedades y lesiones relacionadas con el alcohol
- ☐ Accidentes y lesiones
- ☐ Abuso de sustancias y sobredosis de Drogas
- ☐ Inseguridad alimentaria y hambre
- ☐ Acceso limitado a los servicios de salud preventiva
- ☐ Suicidio

2. ¿Cuál es su raza o etnia?

- ○ Asiático
- ○ Negro o Afroámericáno
- ○ Hispáno o Látino
- ○ Nátivo Americáno
- ○ Blanco
- ○ Otro / No quiero decir.

3. ¿Cuál es tu edad?

4. ¿Es usted residente del condado de Plumas?

- ○ Sí
- ○ No

APPENDIX B—References for the Root Cause Analysis and Interventions (Figures 8 & 9)

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APPENDIX C—References for Interventions for Top 3 Root Causes (Figure 11)

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