2005 Project Update Grid

VCCC Committees are all collaborative efforts with multiple agencies involved.

PROJECT/COMMITTEE	OBJECTIVES	ACTIVITIES COMPLETE	WORK IN PROCESS
1. Health Insurance Exploring Options to Expand Access Committee Will look at opportunities for expanding access to health services in SPA 2 with a focus on the low income/ uninsured population by exploring innovative models and partnerships that could be implemented in SPA 2. Approximately 18.7% of adults in SPA 2 have no regular source of medical care. The West Valley Health District has the greatest number of adults with no regular source of medical care at 115,000 adults. The committee will also target the un and under insured adult and child population. The number of adults 18-64 who do not have health insurance in SPA-2 was estimated at 288,000 or 25% of the adult population. The number of children without health insurance is 44,000. Data shows that the majority of adults who are uninsured are employed. Affordable health insurance was a key need identified for adults and the	The committee will look at opportunities for increasing the number of persons covered by health insurance in SPA 2 by exploring options for affordable health insurance products available to businesses and individuals. Many programs serving the low-income population are capped and can't accept additional adult clients due to funding constraints. This sub-committee will conduct a survey of the capacity of all the public and private partners and make the information available to all the agencies. We will look for additional options to see if after hours care can be increased at any of the sites. Efforts to educate SPA-2 residents on available no cost and low cost plans will be a focus of the committee Improve access to care for the	Insurance plan data and collected and brochure has been drafted. Emergency Room and Urgent Care Center Brochures have been created and distributed at community health fairs, collaborative meetings and with agencies in SF Valley. Capacity survey conducted in early 2005 with a final report edited and placed on the VCCC web site in Jan. 2006. Funding was made available to breakdown the transportation barrier that was being faced by the frequent users of the ER at Olive View to support the Project Improving Access to Care that VCCC is a partner in.	Ongoing monthly meetings Co-sponsor health insurance conference for small business owners with Economic Alliance Continued support of Project Improving Access to Care Future projects we be determined by committee

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low-income populations based on interviews conducted with community stakeholders. The committee is addressing the need of adults, because there are already existing child programs out there that are working.	residents of SPA 2		
2. Chronic Disease Committee The number of children and adults with chronic disease continues to increase. Obesity is a driving factor in the onset and/or poor disease management of chronic disease such as diabetes and asthma. This committee will develop programs targeted at reducing obesity in the residents of the Pacoima area of SPA 2. Overweight adults make up 37% of the SPA 2 population and 15.9% of adults are considered obese. Approximately 41.8% of adults in SPA 2 are sedentary. An estimated 92,000 adults (18 and above) are diagnosed with diabetes.	To create an ongoing sustainable program to improve the health status of chronic disease patients in the Pacoima area Work with Pacoima Partners to bring in Farmers Market Create walking groups and support green/open space campaigns and projects Create permanent medical homes for chronic disease patients in FQHC's Secure public benefits for residents that qualify Develop, train and implement group model appoints at multiple sites Needs assessment with asset mapping	Community Health Forum "Salud Sin Gordura" Healthy Without Fat was held August 2005 Walkability Survey Conducted Proposal submitted to The California Endowment for funding Feasibility Study completed by Southland for Pacoima Partners Wrote and submitted a proposal to The California Endowment	Ongoing monthly meetings Waiting to hear back on funding request Plan and implement two community health forums Meet the timeline stated in the funding proposal if/when approved. This consist of training and starting up one group diabetes clinic, staffing the project, creating a walking group, work with Pacoima Partners to bring in a Farmers Market, and create a super collaborative and resource directory on the web for diabetes providers and patients.

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	Create super collaborative for diabetes that includes Project Alto and Access to Care Collaborative Provide ongoing nutritional and physical education through semi-annual health forums		
3. Mental Health Committee According to the Los Angeles County Department of Mental Health Planning and Program Support Bureau in SPA 2 there are 112,025 adults (18-54) with unmet mental health needs. The committee split into two groups to work on projects and seeking of funds for older adult mental health issues and for victims of sexual assault and their families	To provide education and information on the mental health issues surrounding older adults. A Senior Outreach Mental Health Project. This partnership would have been a collaborative project with TTC as the lead agency partnering with Sherman Oaks, SAGE department and Providence Health System. Collaborate to host a mental health knowledge conference on Promising Practices: Shaping the Future for Mental Health and Aging Collaborative creation of a project entitled Continuum of Care project for sexual assault survivors and their loved ones. The program will include a youth violence prevention component, mental health, physical health, economic, legal, academic, and other	Submitted grant proposal for a senior outreach program that was denied. The committee has discussed trying to submit the grant to other funders. TTC as lead in collaboration with VCCC, DMH, DHS, SFVMHC, and CSUN submitted a proposal to SAMHSA to fund the conference to take place Sept. 13th Letter of Intent has been drafted and is in final review with the hopes to submit by Feb. 28, 2006 Both committees were meeting bi-monthly to implement plans for events and fund seeking	Prior to a three month meeting break this Continuum of Care committee met every other week. Ongoing meeting schedule needs to be drafted. Will continue to submit projects that were created to additional funders for their consideration The Senior Mental Health committee will move to once monthly meetings until we hear back from SAMHSA on the funding. During which time we will all work on trying to secure sponsors and funds in the case that it is not funded by SAMHSA we will still be able to move forward with the event

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	essential needs of the target population. The project has four goals: 1 Increase early utilization of a broad scope of social services by reducing barriers to services and collaborating with community partners to ensure smooth transitioning between agencies 2 Mitigate psychosocial post-trauma symptoms secondary to disclosure of assault 3 Maximize the support of primary caregivers through skills training and prevention education 4 Empower survivors and caregivers to self-sufficiency by providing a central person overseeing all aspects of each case to ensure that attrition doesn't occur and services needed for self sufficiency are secured.		
Collaborative Projects			

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Oral Health Project **VCCC (lead agency) collaboration with Northeast Valley Health Corporation** This project came about as a result of the 2001 Community Needs assessment. A grant request was submitted to The California Wellness Foundation to fund a grant to improve access to dental services and to support the VCCC organizational infrastructure. This project has resulted in four agency recognitions: Certificate of Recognition form the California State Assembly, Certificate of Special Congressional Recognition, State of California Senate Certificate of Recognition, and a County of Los Angeles Commendation	This project consisted of four major components: To increase low-cost dental services in SPA 2 To provide professional oral health training for health and social service providers To work with NEVHC to begin a prenatal and early childhood oral health project: coordinating patient oral health education dental services and referrals and case management To improve and enhance the organizational infrastructure of VCCC Birth data was evaluated and it was noted that only one infant was small for gestational age and one was large. Other issues may also play a part in the positive birth weight outcomes in addition to better oral health services. Posttest scores show that the majority of those tested score 100% on the test. Very few score lower then 80%	Dental equipment was secured from LA DHS. NEVHC expanded their current dental clinic early 2005. Professional training session conducted in 2004. Ongoing project updates shared at VCCC large group and board of director meetings. Care was provided to 52 prenatal users and 170 pediatric users. CSUN intern was placed to work with NEVHC Consumer Relations Specialist to assist with the implementation of a program to encourage and start up an inter-office referral process to insure that prenatal patients were getting proper dental referrals. To solidify the infrastructure of VCCC the program manager attended additional education courses. Sessions included one-week training session at the Grantsmanship Training Center, participation in the 2005 class of Valley Leadership Institute, one	Project ended Dec. 31, 2005 Additional follow-up in six months with NEVHC will occur This target population has access to health benefits that will allow this program to be ongoing at NEVHC without further funding from VCCC. Receipt of health benefits for the population served will create a sustainable community oral health plan for prenatal and children 0-5.

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		day session at UCLA CHIS one day conference Staff to support the efforts of the 2005 Capacity Survey was completed. Helped to support staff for community health forum	
Lead Prevention Community Project in collaboration with Pacoima Beautiful (lead agency) The target area was identified as a hot zone for lead poisoning. This project was designed to increase the lead blood screening rates to determine the extent of lead poisoning in children living in Pacoima. In addition the project was designed to help 250 residents prevent lead poisoning through education and improvement in their living conditions and to examine code enforcement and housing policies Because of the success of this project new grant funds were secured to look at toxins in Pacoima and Sun Valley with the same partners that were at the table for this collaborative effort. Partners include NEVHC, LADHS, NLS, CSUN, and the	To increase the lead blood screening rates a housing survey was conducted. Questions were developed by PB, CSUN and other partners PB administered the survey at NEVHC along with CSUN students and then CSUN students along with Dr. Dagodag from the Department of Urban Studies Compile education materials Create and distribute provider survey Educate child care providers and school personnel on the need for lead testing Provide CEU's for school nurses and area physicians Identify lead home hazards in 250	Housing survey completed Education materials completed and distributed Physician survey currently being revised with fewer questions. Dr. Dean Baker, UC Irvine has been identified as the physician champion for the project and conducted a training session for family practice residence at Olive View UCLA Medical Center Debra Rosen, RN has conducted a nursing training session at Mid-Valley Comprehensive Health Center CME was conducted at NEVHC 225 Homes were identified and dust samplings were completed.	New survey will be completed and distributed to physicians with the County of Los Angeles Dr. Dean Baker will do additional lead presentations on Feb. 15th to the pediatricians and residents at Olive View UCLA Medical Center that will encompass other area pediatricians. On March 13 a presentation will occur at CHW Northridge Hospital for the family practice residents. On Feb. 14 Debra Rosen will do a lead education session for the LAUSD school nurses Continuing education by PB staff is provided to multiple child care provider locations Barriers to lead screening in children who are Medicaid eligible is an ongoing process

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Healthy Homes Collaborative	dwellings Control lead hazards in identified high-risk neighborhoods	A report on the findings is in process	Presentation to local policymakers and residents is planned for April 2006 NLS will assess gaps in existing CA, LA County and City housing code enforcement Stakeholder forum will occur in April 2006 A registry of lead free homes and apartments will be created
Community Action for a Renewed Environment (CARE) Project with Pacoima Beautiful (lead agency) Began 10/05 Items discussed are the items listed in PB's agreed upon task list The objective of this project is to keep together the same collaborative partners, LA County DHS Public Health SPA 2, NEVHC, NLS, CSUN Urban Studies and Planning Department, CSUN Department of Environmental & Occupational Health Department, and Healthy Homes collaborative to identify sources of toxins in the community	Identify and understand at least four sources of toxic risk in the Pacoima area Set priorities to reduce the toxic risk by establishing at least ten priorities to reduce toxic risk Develop an effective collaborative problem solving partnership to address the risk of at least seven stakeholder groups	Due to the early stages of this grant the items completed are limited An intern was on staff to create a report on possible toxic risk in Pacoima. The report was completed and list sources of risk, location, and stated reason why they are risk Evaluators have been secured to evaluate the project throughout the process	A community town hall meeting will be held Community risk assessment/toxic inventory report will be generated Mapping, analyses, and identification of health risk will occur Action plan to reduce area toxic risk will occur Additional collaborative partners will be added to sustain the problem solving activities in order to reduce the toxic risks in the community
Project Improving Access to Care (PIAC) a Frequent User Initiative	System level objectives	Staff has been hired	Secure additional partners because housing and mental health needs still

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grant with Tarzana Treatment Center (lead agency) Collaborative project This project is a collaborative project that includes multiple community partners. The steering committee consists of members from LA DHS, LA DMH, LA DPSS, LAFH, NLS, and NEVHC Homeless Health Project. The objective and primary goal of this project is to increase and improve the coordination of care for frequent users of the emergency room at Olive View UCLA Medical Center. The target population for this project consist of patients that have visited the ER 5 or more times in a 12 month period and meet one or more of the criteria established: homeless, substance abuse, mental health issues. The intensive case management model has seeks to create both system and client level improvements	Reduce barriers to services across systems Improve data sharing between agencies serving the target population Reduce overall cost Decrease the number of patients in the ER that leave without being seen Client level objectives Decrease number of ER visits per patient Secure third party health insurance for those with no coverage Provide housing to the homeless Increase access to vocational training Reduce incarceration of frequent users	Kaiser is interested in the model and has provided funding for an additional case manager they will be joining the steering committee to monitor the success and may possibly implement in the future Created and presented power point of program to additional community partners Added new partners Designed and refined evaluation, protocol, and implementation tools Ongoing outreach and enrollment of clients. Ending year one September 30, 2005 a total of 45 patients were enrolled. The goal of 70 to 75 was not met as a result of not hiring a full staff until Feb. 05 IRB was submitted and approved by DHS Transportation grant supports clients travel needs Creation of structured sub committees Implementation- Responsible for managing and reporting on the	prove to be a challenge Hire additional staff as funded by new Kaiser funds Continue to attend and identify technical assistance needs Continue to work on the Affinity electronic flag system to enhance the number of qualified alerts. Continued efforts by sub-committees Additional work needs to be done to solve the housing issues, which is still proving to be one of the largest challenges of the program.

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		overall implantation process of the project Evaluation – Responsible for all evaluation related activities and for reporting data to Lewin Group and maintaining internal project data Membership – Responsible for identifying new partners to increase the success of proper linkages to services Housing – Responsible to find housing sources for homeless clients served	
SAMHSA- Substance Abuse, HIV, and Hepatitis C Project with Tarzana Treatment Center (lead agency) Five year project The goal of this project is to reduce rates of substance abuse, HIV, and hepatitis C in LA County through coordinated prevention activities targeted to African American and Latino populations in SPA 2 inclusive of those recently released from prison or jail	TTC and VCCC will work together to build a collaborative that will work in partnership to plan, build capacity, service delivery and evaluation activities VCCC will conduct a community needs assessment TTC and all collaborative members will work jointly to promote capacity-building to strengthen programs and services among participating organizations and resource development to address problems	TTC has hired staff needed for the project inclusive of a Program Manager and Evaluator Three collaborative meetings have occurred with the first one occurring in Dec. 05 and the next two in 06. This project is new with little work being accomplished in 2005 Dr. Lawrence Chu and Dr. Roberta Madison were contacted to participate in the Epidemiological workgroup	Meet with CSUN students to conduct survey Complete final copy of survey questions Complete survey, compile data and present needs assessment report to TTC by April 30, 2006 Continue to work on needs assessment and collaborative building Put into place the SAMHSA five-step Strategic Prevention Framework

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	Create a strategic plan to formulate a local plan Implement a coordinated program services Monitor and evaluate coordinated services to continuously improve service delivery results		