RIVERSIDE UNIVERSITY HEALTH SYSTEM

PUBLIC HEALTH STRATEGIC PLAN 2024-2028

Riverside University HEALTH SYSTEM
Public Health

March 2025

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Dear Community Members and Colleagues,

I am pleased to introduce Riverside County's ***Public Health Strategic Plan*****,** a key framework to guide our efforts in improving the health and wellbeing of all our residents. As the Public Health Director, it is my privilege to share with you the direction and priorities that will shape our public health landscape in the coming years.

The purpose of this strategic plan is to provide a clear and actionable roadmap that demonstrates the health department's priorities and direction for achieving our vision for Riverside County to become the healthiest county in the nation. Our goal is not only to improve health outcomes, but also to meaningfully enhance and extend life for everyone in Riverside County. This plan reflects our commitment to creating a healthier, more vibrant community where every individual has the opportunity to thrive.

Our journey began in 2022 with the development of our mission, vision, and guiding principles. We conducted a thorough landscape analysis, which included an assessment of Strengths, Weaknesses, Opportunities and Threats (SWOT), a review of our previous Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), and the identification of key organizational goals. This collaborative process enabled us to refine and prioritize our strategic initiatives, ensuring we are aligned with the needs and aspirations of our community.

Through strategy sessions with our program leaders, we further refined and developed specific key results for each strategic initiative. As a result, our plan is both comprehensive and adaptable, built on a foundation of collaboration and continuous improvement.

Our primary goals are:

- Improve Community Wellness Outcomes
- Expand and Integrate Services
- Build a Sustainable Workforce
- Build a Continuous Improvement Culture

To achieve these goals, we have identified seven strategic initiatives:

- Implement Blue Zones in four cities and one unincorporated community
- Strive for equity and justice in all that we do
- Roll out EPIC, an electronic health record, throughout the department
- Improve staff engagement, recruitment and retention
- Diversify Public Health funding streams
- Implement a system of managing for daily improvement and monitoring key performance indicators
- Hire, train and deploy Community Health Workers (CHWs) for community outreach and service navigation

Each of these initiatives is designed to address specific needs and challenges while fostering collaboration and innovation across the county. By focusing on these areas, we are confident that we will not only improve public health outcomes, but also build a more equitable, sustainable, and resilient public health system.

As we move forward, we will continue to monitor and evaluate our progress, adapting our approach as necessary to meet the evolving needs of our community. We are excited about the future of Riverside County, and we look forward to working alongside all of you–our remarkable staff, partners, and stakeholders to achieve these ambitious goals.

Thank you for your continued support and dedication to improving the health of Riverside County.

Sincerely,

Kim Saruwatari

Kim Saruwatari, Director

Riverside University Health System - Public Health

Kim Saruwatari

Public Health Director

Riverside University Health System - Public Health

Kim Saruwatari is the Director of Riverside University Health System – Public Health, Riverside County's public health department. She was appointed as the Public Health Director in 2017.

Kim began her career in public health over 25 years ago and has worked in Immunizations, HIV / AIDS, STD Control, Community Epidemiology and Outbreak Response, and Public Health Emergency Preparedness and Response. She led Public Health's response to the COVID-19 pandemic, including developing enhanced partnerships with community and faith-based organizations, schools, and businesses throughout the County.

In 2015, Kim briefly left RUHS – PH to become the first Director of Riverside County's Emergency Management Department (EMD), where she was an integral contributor to developing the new emergency management model in Riverside County.

She has a passion for social justice work, including working with communities to ensure equitable access to resources and services. Kim currently serves on the County Health Executives Association of California (CHEAC) Executive Committee and is a Co-Chair for the Public Health Alliance of Southern California.

Kim holds a B.A. in molecular and cell biology, and an M.P.H. in infectious diseases, from the University of California, Berkeley.

Dr. Jennifer Chevinsky

Public Health Officer

Riverside University Health System - Public Health

Dr. Jennifer Chevinsky is board certified in Preventive Medicine, Lifestyle Medicine, and Health Care Administration, Leadership and Management. Prior to her appointment as the County Public Health Officer, she served as the County's Deputy Public Health Officer and TB Controller since 2021.

Dr. Chevinsky earned her medical degree at the University of South Florida Morsani College of Medicine, completed her residency specialization and a master's degree in public health at Loma Linda University (LLU), and gained postdoctoral epidemiology training as an Epidemic Intelligence Service Officer for CDC within the National Center for Chronic Disease Prevention and Health Promotion.

Dr. Chevinsky serves on a number of local, state, and national public health committees. She has authored over 30 peer reviewed publications and has provided over 50 oral presentations which she has presented locally, nationally, and internationally. Dr. Chevinsky is passionate about working together with communities to promote health and wellness.


Public Health Officer
Executive Assistant
Director of Public Health
Executive Assistant
Office of the Director
Internal Audit & Compliance Program
Public Information Officer
Infectious Disease, Community Health Planning and Equity
Deputy Director
Deputy Public Health Officer
Maternal, Child, Adolescent and Family Health
Deputy Director
Deputy Public Health Officer
Administration
Deputy Director
Deputy Public Health Officer
• Blue Zones
• Lean
• Quality Improvement
Executive Assistant
Executive Assistant
Executive Assistant
Public Health Laboratory
Children's Medical Services
• California Children's Services
• Medical Therapy Program
• Childhood Lead Poisoning
Fiscal
• Medical Marijuana ID Cards
Disease Control
• Communicable Diseases
• Tuberculosis Control
Public Health Nursing / Maternal, Child, & Adolescent Health (MCAH)
• Adolescent Family Life
• Black Infant Health, PEI
• CalLearn
• Comprehensive Perinatal Services, SIDS
• Field Nursing Services, EMS, HCPCFC, Wraparound
• Healthy Families of America
• Nurse-Family Partnership
Information Technology
• Applications
• Project Management
• Data Integration and Informatics
HIV / STD
• Acquired Immunodeficiency Syndrome (AIDS)
• Human Immunodeficiency Virus (HIV)
• Sexually Transmitted Diseases
Procurement and Logistics
• Budgets & Grants
• Communications
• Contracts
• Facilities
Epidemiology and Program Evaluation
• Accreditation
• Data Program
• Riverside Overdose Data to Action (RODA)
• Vital Records
• Health Equity
• Health Equity Outreach
• Climate Justice Program
Nutrition & Health Promotion
• Blue Zones
• CalFresh Healthy Living (NEOP)
• Cooperative Extension
• Food Systems
• Integrative Dietitians
• Nutrition & Health Promotion
• Tobacco Control Project
• Women, Infants & Children
Community Outreach
Staff Development
Injury Prevention Services
• Injury Prevention Services
• Oral Health Program
• Volunteer Services
Immunization
• Emergency Response
• Family Planning
• Immunizations

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Riverside University HEALTH SYSTEM

Public Health

Vision

To be the healthiest County in the Nation.

Mission

To meaningfully enhance and extend life for all in Riverside County.

Guiding Principles:

1. **Engagement & Partnership** – Collaborate with communities, organizations, and partners to co-develop solutions that address public health challenges and promote equity.
2. **Equity & Inclusion** – Prioritize fair access to resources and services, ensuring historically marginalized populations receive the support needed to achieve optimal health outcomes.
3. **Service & Experience** – Deliver high-quality, culturally responsive public health services that are accessible, respectful, and tailored to community needs.
4. **Sustainability & Stewardship** – Responsibly manage resources to maintain long-term public health initiatives that effectively address systemic inequities.
5. **Data & Outcomes** – Use data-driven decision-making to identify disparities, measure impact, and improve public health interventions for equitable outcomes.
6. **Innovation & Lean** – Continuously improve public health strategies by embracing new ideas, streamlining processes, and adapting to emerging community needs.

2024-2028 Strategic Goals:

Improve Community Wellness Outcomes

Measurably improve wellness one person, one family, one neighborhood, one community at a time.

Expand and Integrate Services

Integrate and grow services within Public Health, RUHS, the County and the broader community by creating connections and reducing barriers.

Build a Sustainable Workforce

To build and retain a representative workforce, inclusive of community partners, that is committed to equity.

Build a Continuous Improvement Culture

Establish a culture that promotes team engagement and empowerment, performance transparency, and a mindset of continuous improvement.

Service Values

STRENGTHS:

Public Health is strong - both as an organization and as individuals. We will continue to maximize individual strengths for the good of the organization.

EXCELLENCE:

We anticipate and value the needs of our communities. We practice resilience to changes and challenges. We keep our knowledge and skills up-to-date. We learn from our mistakes.

RESPECT:

We display dignity and fairness toward one another and our communities to foster an inclusive culture where all individuals feel valued & heard in relation to their rights, needs and differences.

VOICE:

We nurture an environment where everyone can feel secure speaking up about issues of physical, psychological and emotional safety.

INTEGRITY:

We are honest, fair, and transparent with our Public Health, RUHS, and County colleagues, our partners, our communities, and all who benefit from our work.

COLLABORATION:

We work internally as a Public Health and RUHS team, and with our partners, to seek new ways to amplify and enhance our collective services to our communities.

EFFICIENCY:

We maximize output through policy improvements and the implementation, and use of lean methods, strategies and processes.

Strategic Objectives

Goal:	Initiative:	Objective:
Improve Community Wellness Outcomes	**CHW Outreach and Navigation**	Engage and connect individuals to care to improve longevity and quality of life.
	Blue Zones Project	Create and empower communities to make the healthy choice, the easy choice.
	Equity and Justice Strategy	Advance health equity, promote social justice and eliminate health disparities.
Expand and Integrate Services	**Electronic Health Record**	Meet the needs of our community through Public Health services and integration.
Build a Sustainable Workforce	**Sustainable Funding**	Establish sustainable funding streams to create a strong workforce that allows Public Health to innovate and thrive.
	Workforce Recruitment and Retention	Recruit new and maintain current pool of talented staff.
Build a Continuous Improvement Culture	**Continuous Improvement**	Establish an environment where all Public Health team members are empowered and supported to make daily improvements.

Goals	Strategic Initiatives
Improve Community Wellness Outcomes	**CHW Outreach and Navigation** **Blue Zones** **Equity and Justice Strategy**
Expand and Integrate Services	**Electronic Health Record**
Build a Sustainable Workforce	**Sustainable Funding** **Workforce Recruitment and Retention**
Build a Continuous Improvement Culture	**Continuous Improvement**

Strategic Initiatives

Aligned to Community Health Improvement Plan (CHIP) Priority Areas

Priority Area 1: *Access to Equitable and Just Care*

CHW Outreach and Navigation

Community Health Workers engage individuals disconnected from traditional health services due to barriers such as transportation challenges or lack of awareness.

They assist with navigating healthcare and community resources, and overcoming logistical obstacles to care. Additionally, they address social determinants that contribute to housing instability, including access to food, clothing / shoes, and employment.

Beyond these services, they offer support for harm reduction, and foster meaningful relationships with participants by maintaining contact, tracking progress and ensuring consistent follow-ups.

Epic ROLL OUT

Electronic Health Record

Using a fully integrated EHR system, such as Epic, enables the collection, sharing and analysis of comprehensive health data across healthcare providers and public health programs, helping to identify care gaps, track client progress and ensure timely, appropriate healthcare and public health services.

Sustainable Funding

Consistent funding allows public health to be innovative and improve access to care while supporting telehealth initiatives, mobile clinics and community outreach programs for those facing barriers such as transportation, language or financial constraints.

By adapting care delivery models to meet the specific needs of the community, the public health system can ensure broader access to care and resources.

Equity and Justice Strategy

The equity and justice strategy aims to strengthen infrastructure, reduce disparities, promote policy action, and reform unjust public health policies to create a more inclusive and effective Community Health Improvement Plan.

Through its coalitions and taskforces, the strategy ensures the development of policies and actions for better healthcare access, focuses on underserved and marginalized communities, and addresses critical issues such as housing, substance use, and mental health.

Strategic Initiatives

Aligned to Community Health Improvement Plan (CHIP) Priority Areas

Priority Area 2: *Housing*

Epic ROLL OUT

Electronic Health Record

This strategy improves care coordination and directly links and refers clients and community members to housing and other community supports using a closed loop referral process.

Blue Zones Project

Equity and Justice

Support the development and sustainment of public and private partnerships between local governments and organizations to advocate for policies that promote housing stability, affordability, and safety—critical factors for mental and physical health—while ensuring these efforts prioritize equity and justice by addressing systemic barriers, protecting marginalized communities, and fostering inclusive decision-making.

CHW Outreach and Navigation

Community Health Workers help connect individuals to housing assistance programs, which includes support around emergency housing services, sober living, affordable housing (section 8) and shelters. These workers educate and guide individuals to navigate and break down barriers to needed services which include rental and utility assistance.

Priority Area 3: *Mental Health*

Blue Zones Project

Blue Zones work fosters social connectivity by helping residents identify their personal mission and purpose, find ways to share their talents, and form small interest groups. By strengthening these social ties, individuals are more likely to access mental health services through supportive networks that reduce stigma and encourage help-seeking behaviors.

CHW Outreach and Navigation

Community Health Workers support individuals in accessing mental and behavioral health services by addressing structural barriers such as transportation, cost and service availability. They facilitate referrals, connect individuals with professionals who provide referrals, and link them to essential resources. Through their efforts, Community Health Workers ensure that individuals receive the comprehensive mental health care they need.

Epic ROLL OUT

Electronic Health Record

This EHR expansion strategy improves care coordination, directly links and refers clients and community members to mental health services and other community supports using a closed loop referral process.

ACTIVITIES AND TIMELINE

	By 2023	By 2024	By 2025
CHW Outreach & Navigation	1. Developed a Community Health Worker (CHW) module within electronic health record (Epic) – April	2. Developed a CHW billing module within electronic health record (Epic) – May	3. Deploy a total of 20 CHWs across County of Riverside – July 4. Expand partnerships and contracts with Managed Care Plans (MCPs) to increase CHW reimbursement rate – December
Blue Zones Project	1. Sponsorships secured and contracts executed for all intervention communities	2. Established a secure foundation with well-being measurements, coalition building, and the development of an implementation plan	3. Begin implementation and transformation by engaging communities, implement the Blue Zones blueprint, establish and report out on key performance indicators
Equity & Justice Strategy	1. Reestablished the Health Equity and Justice committee - August 2. Approve an updated Equity in all Policies department policy - March	3. Draft an equitable communication guide outlining best practices - March	4. Revise training modules 2 and 3 of the Improving Health for All peer led health equity discussion series - August
Epic ROLL OUT Electronic Health Record	1. Expanded use of Epic electronic health record system to include scheduling and clinical documentation for the Maternal, Child, and Adolescent Health (MCAH) and California Children's Services (CCS) programs, while leveraging Epic's referral functionality to enhance care management effectiveness	2. Epic was further expanded to include Women, Infants, and Children (WIC) In / Outpatient services	3. Went live with Beaker, Epic's Lab module, for the Public Health Lab and expanded billing and claims capabilities for the Medical Therapy Unit (MTU)s
Sustainable Funding	1. Completed charter, established teams and defined areas of focus for the initiative - June 2. Held Visioning Workshops to brainstorm revenue opportunities and build project plans - August	3. Implement revenue capture mechanisms	4. Establish revenue monitoring system
Workforce Recruitment & Retention	1. Conducted Employee Engagement Survey to gauge employee morale & satisfaction – December 2. Restructured Public Health New Employee Orientation to Public Health New Employee Training to improve employee engagement – January	3. Establish a standardized onboarding process across the RUHS-PH branches – January	4. Deploy a tiered-survey for new employees to obtain feedback regarding training and engagement – December
Continuous Improvement	1. Established Governance and Managing for Daily Improvement (MDI) Teams – September	2. Developed Key Performance Indicator (KPI) / Managing for Daily Improvement (MDI) Visual Management – July	3. Developed tiered coaching structure – December

By 2026	By 2027	By December 31, 2028
5. Deploy additional 31 CHWs (total of 51 CHWs) across County of Riverside – December	6. Generate sufficient revenue from CHW billable encounters to transition CHWs from secured (grant) funding to self-support – November	RUHS-PH will increase engagement in public health and care services and connect residents and visitors to care to improve longevity and quality of life, as measured by specific health outcomes and metrics.
	4. Create and implement a sustainable blueprint and showcase outcomes using a community well-being index	RUHS-PH will create & empower communities to make healthy choices by increasing community engagement opportunities and access to healthy options.
5. Develop a data collection and analysis guide for the department - October	6. Update, launch, and provide trainings on all six (6) modules of the Improving Health for All discussion series to RUHS-PH	RUHS-PH will advance health equity, promote social justice, and work to eliminate health disparities, by improving access to care and the reduction of disparities in health indicators across diverse populations.
4. Engaged Ellit Group consultants to conduct a comprehensive Epic assessment for Public Health, which led to the creation of a detailed implementation roadmap and a governance structure designed to support decision-making throughout the implementation process	5. Public Health plans to roll out Epic's Electronic Health Record (EHR) system across all remaining programs, aiming to improve care coordination, referrals, billing and claims, registration and scheduling	6. Post-implementation Improvements (for details, see page 22) — RUHS-PH will meet the needs of community by expanding public health services and integration with other health and human service agencies to improved service delivery and access to care and programs.
	5.RUHS-PH will increase Public Health billable services as appropriate in relation to branch operating budgets. RUHS-PH will also host one community base fundraising event to supplement funding	RUHS-PH will establish sustainable funding streams to support department operations and enable public health to innovate and thrive.
5. RUHS-PH will design and execute comprehensive recruitment and retention strategies to attract and secure top talent for hard-to-fill positions, incorporating retention stipends as an incentive for long-term commitment		RUHS-PH will maintain a staff retention rate of 90% or higher for key and / or difficult to recruit positions.
4. Establish an MDI roll out plan and continue to refine KPIs – April	5. Complete MDI training and roll out across the department – December	RUHS-PH will ensure 100% of public health teams are empowered to make daily improvements by participating in at least one improvement initiative per quarter.

IMPROVE COMMUNITY WELLNESS OUTCOMES

CHW Outreach & Navigation

Aim

Empower Communities to Make Healthy Choices and Actions.

Community members with a demonstrated or assessed Social Determinants of Health (SDOH) need will receive timely health education, outreach and navigation by a Community Health Worker (CHW).

Target

Design a CHW Hub that provides an **organized structure** for CHW deployment across Riverside University Health System (RUHS) and other county departments to ensure that RUHS CHWs are **utilized effectively** across the system.

CHWs will provide resource navigation to community members to help build their capacity.

IMPROVE COMMUNITY WELLNESS OUTCOMES

Goal: Improve community well-being by integrating Community Health Workers (CHWs) within health, social services, and public safety departments to empower individuals with knowledge and resources needed to help build their capacity.

Objective: Design a CHW Hub that provides an organized structure for CHW deployment across Riverside University Health System (RUHS) and other County departments. The hub will standardize training, coordination, and resource navigation, ensuring CHWs effectively connect community members to essential services, address social determinants of health, and improve health outcomes.

Current Conditions

Various RUHS entities are implementing programs and deploying staff in similar capacities to CHWs, without a coordinated effort across RUHS and other county departments.

Improve Community Well-being

What's Happening

Public Health is building the infrastructure to include **operational flow, program evaluation, staffing activities and responsibilities, electronic health records system, and hiring / onboarding / deployment of CHWs.**

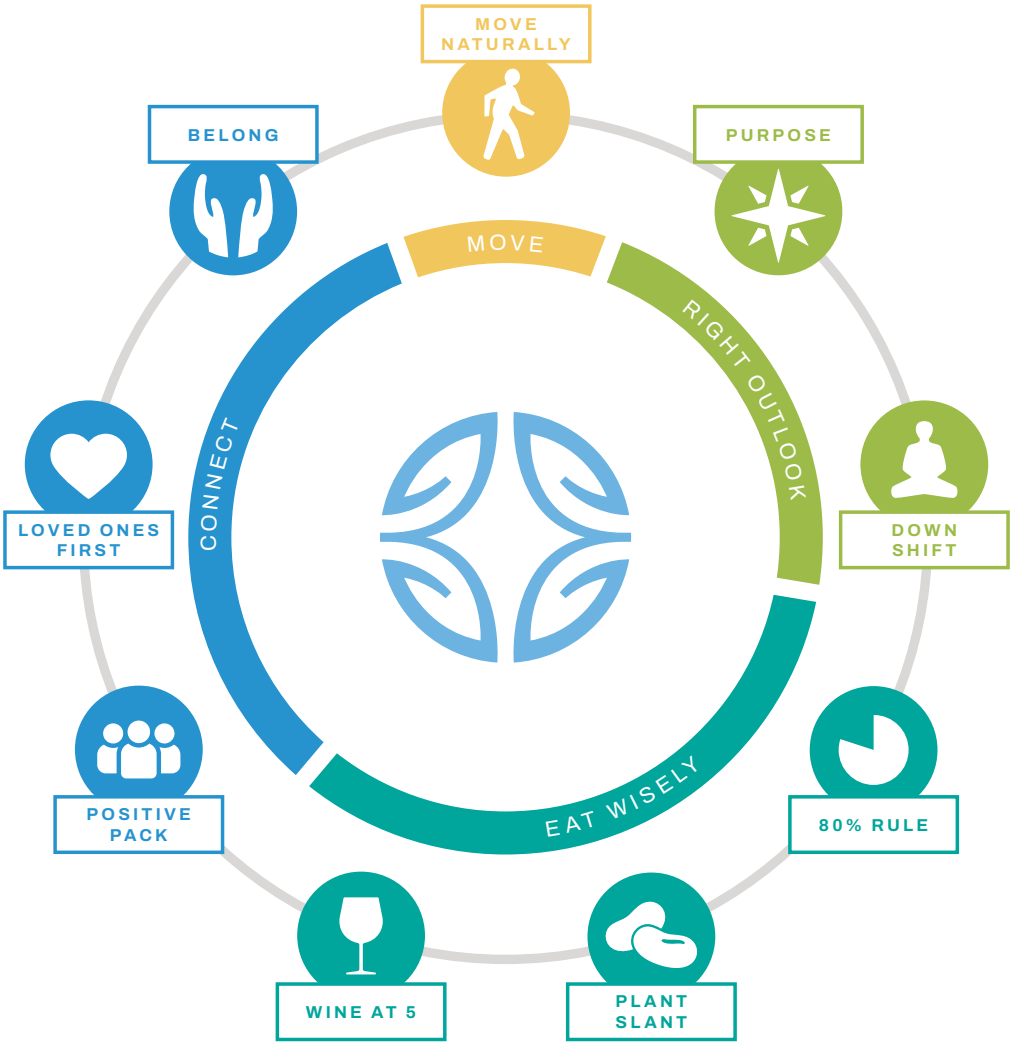
We are also collaborating with managed care plans to work towards improving health outcomes for Riverside County community members.

IMPROVE COMMUNITY WELLNESS OUTCOMES

BLUE ZONES PROJECT®

Riverside County Blue Zones Transformations

POWER 9 - Nine lifestyle habits of the world's healthiest, longest-lived people



IMPROVE COMMUNITY WELLNESS OUTCOMES

Goal: Improve Community Wellness outcomes by implementing Blue Zones projects in five communities in Riverside County.

Objective: Partner with Blue Zones Project to empower communities to make the healthy choice the easy choice by increasing community engagement opportunities and access to healthy options focusing on people, places and policies.

Current Conditions

Communities, where the people of Riverside County live, work, and play, do not provide equitable opportunities for healthful conditions – which contributes to health disparities. According to the 2023 County Health Ranking, the County is in **the lower middle range for health factors such as health behavior, clinical care, social and economic factors, and the built environment.**

Aim

By March 2030, the Riverside County Blue Zones Initiative aims to leverage Blue Zones methodologies in five Riverside County communities to **advance community-wide well-being** by collectively nudging people to move and connect more, eat wisely, and develop or enhance a positive outlook.

Target Metrics

The improvements in comparative community well-being ranking will be measured primarily via the **Gallup Wellbeing Index** – which measures five aspects of individuals' quality of life (i.e., purpose, social, financial, community, and physical well-being).

Additionally, RUHS-PH is using the **County Health Rankings; Whole Person Health Scores; the County's Healthy Places Index Score;** and the **Well-being Adjusted Life Years** to monitor the progress toward the RivCo Blue Zones Initiative aim. Community-selected metrics will be agreed upon once community-specific priorities are identified.

IMPROVE COMMUNITY WELLNESS OUTCOMES

Riverside County, CA

TRANSFORMATION SCOPES

Blue Zones Project
Palm Springs

(9 months + 3 years)
Population: 40,793

Blue Zones Project
Riverside

(9 months + 5 years)
Population: 247,079

Community Transformation Process

ASSESSMENT & DEVELOPMENT

- Preliminary community assessment (2-day visit)
- Focus groups, 1:1's
- Presentations
- Sponsor identification and return on investment (ROI) analysis
- Identify volunteers and talent to support project roles

FOUNDATION (9 Months)

- Community Input & Discovery
- Well-Being Measurement
- Coalition Building
- Training
- Blueprint Development
- Volunteer Mobilization

IMPROVE COMMUNITY WELLNESS OUTCOMES

Blue Zones Project
Activate Mead Valley

(3 years)
Population: 14,935

Blue Zones Project
Coachella

(9 months + 3 years)
Population: 43,590

Blue Zones Project
Banning

(9 months + 3 years)
Population: 23,456

TRANSFORMATION (2-4 Years)

- Implement Blueprint
- Engage people and places
- Impact policy to drive environmental change
- Key performance indicators (KPIs) reported on annual basis

CERTIFICATION + SUSTAINABILITY + EVOLUTION

- Celebrate!
- Create and implement sustainable blueprint
- Continue impacting well-being in the community
- Showcase outcomes using Community Well-Being Index

IMPROVE COMMUNITY WELLNESS OUTCOMES

Equity and Justice Strategy

Aim

To maintain a focused spotlight on equity and justice through improving department infrastructure and practices, improving linkage to services, identifying and reducing disparity gaps, improving Riverside County Healthy Places Index (HPI) score through addressing policy action areas, and reforming Public Health policies.

Target

1.) To enhance all programs and policies to effectively serve historically under-resourced and under-served groups county wide; **2.)** To increase the Riverside County HPI score by 15% ; and **3.)** To address all priority areas in the Health Equity Strategic Plan.

CALIFORNIA Healthy Places Index™ ↑15%

Current Conditions

In August 2020, the Riverside County Board of Supervisors unanimously adopted Resolution No. 2020-179 declaring racism and inequity as a public health crisis.

Through this resolution, RUHS-PH continues to be dedicated to **improving health conditions and reducing health disparities and inequities for all residents.**

Currently, Riverside County is healthier than 39.3% percent of other California counties according to the Healthy Places Index (HPI). In Riverside County, life expectancy has a value of 80 years (2018-2020), a decrease of 0.9 years from the prior years (2017-2019). The infant mortality rate is 4.4 per 1,000 live births (2019-2021) in comparison to California rate of 3.9 per 1,000 live births.

Health disparities and inequities continues to affect the health of residents in

IMPROVE COMMUNITY WELLNESS OUTCOMES

Goal: Ensure equitable practices in all programs and policies.

Objective: Implement and achieve the priority areas and objectives that are in the Health Equity Strategic Plan (2023-2028).

Riverside County and in order to equitably serve all residents, **equity must be at the forefront of RUHS-PH's structural, procedural, cultural, and organizational policies and practices.**

What's Happening

The reformation of the Health Equity and Justice Committee (HEJC) was launched in October 2023. The HEJC is made up of 50 plus members, two chairs, one vice chair, and two department executive sponsors.

The strategic plan is guided by five priority areas:

- Internal Capacity and Infrastructure
- Workforce and Culture
- Power-Sharing and Power-Building
- Equitable Data Practices
- Equity and Justice in all Policies

The **2023-2028 Health Equity Strategic Plan** serves as a road map to guide RUHS-PH in its efforts to embed equity work and address health inequities, disparities, and systemic racism.

The Health Equity Community Outreach Program aims to support underserved and at-risk communities by using community-driven outreach efforts to connect services and resources.

The outreach teams use the California Healthy Places Index (HPI) data tool to support targeted outreach efforts. Additionally, the Health Equity Community Outreach Program unites the outreach efforts of public health department programs with those of 17 other Riverside County departments, to address community needs and better serve diverse populations. This effort is focused on an integrated service delivery model to create a no-wrong-door environment for residents to access services and care with an aim to increase community engagement and improve public health resource distribution to ensure a strong, unified presence in the community.

EXPAND AND INTEGRATE SERVICES

Epic ROLL OUT

Goal Transition Public Health Programs to EPIC by 2026

Objective

To fully integrate Public Health programs into the EPIC system by 2026, establishing a comprehensive framework for an Electronic Health Record (EHR) that supports effective population health management and enhances overall care coordination within the health system and County of Riverside.

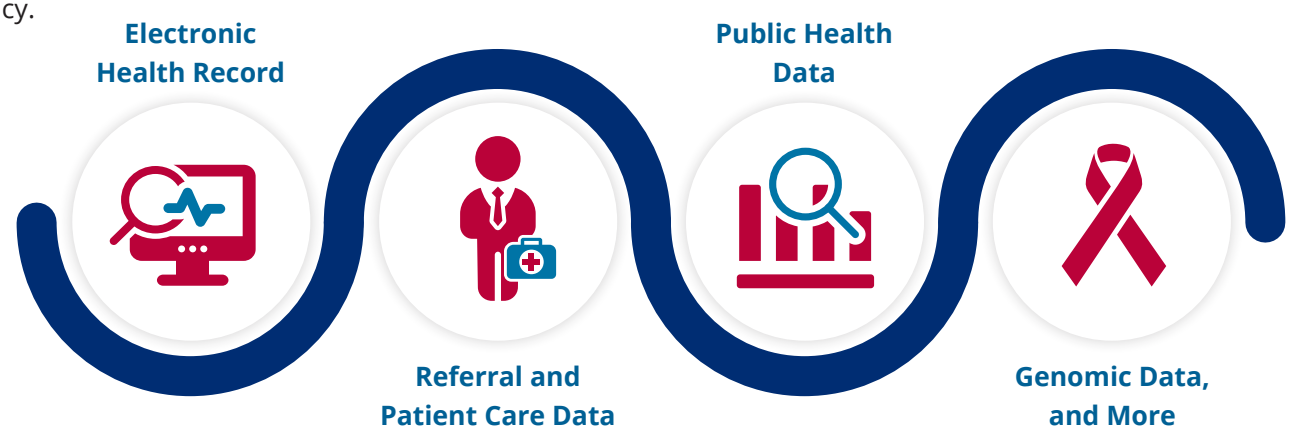
Core Foundations

1. Integrated Electronic Health Record (EHR) System

- **Integration Goals:** Implement EPIC's EHR system to unify patient data across Public Health programs and other programs within Riverside University Health System (RUHS), enabling seamless access and management of health information.
- **Data Standardization:** Ensure that health records are standardized within EPIC to facilitate accurate data entry, retrieval, and analysis across RUHS. This process will facilitate accurate and reliable data handling while ensuring compliance with mandatory regulatory requirements.
- **User Interface Customization:** Tailor the EPIC interface to meet the specific needs of Public Health professionals, enhancing usability and efficiency.

2. Coordinated Population Health Management

- **Population Health Tools:** Utilize EPIC's population health management tools to track and manage health outcomes across different communities and populations.
- **Analytics and Reporting:** Leverage EPIC's analytic capabilities to monitor health trends for decision - making, identify at-risk populations, and develop targeted interventions.
- **Preventive Care Integration:** Incorporate preventive care protocols into the EHR system to support proactive health management and early intervention strategies.



Key Initiatives

1. Internal Referrals to Programs

- **Referral Management:** Streamline the process for internal referrals within the health system, allowing healthcare providers to easily refer patients to appropriate Public Health programs.
- **Tracking and Follow-Up:** Implement tracking mechanisms to monitor the status of referrals and ensure timely follow-up and care continuity.

2. External Referrals for Services

- **External Coordination:** Develop mechanisms for efficiently managing external referrals to specialized services outside the health system.
- **Integration with External Systems:** Ensure EPIC to interface with external service providers for seamless referral information and update exchanges.

3. Expansion, Connection, and Coordination of Care

- **Care Coordination:** Enhance care coordination for patients shared between different departments and facilities within the health system, using EPIC's integrated care management features.
- **Communication Channels:** Foster better communication between healthcare providers to support coordinated care efforts and reduce duplication of services.
- **Patient Data Access:** Provide comprehensive access to patient data across various touchpoints in the health system to ensure continuity of care.

4. Health Plan Data Sharing - Health Surveillance

- **Data Exchange:** Facilitate secure data sharing with health plans and providers to improve care coordination, claims processing, and outcome measurement.
- **Interoperability:** Integrate EPIC smoothly with health plan systems and Health Information Exchanges (HIE) to efficiently exchange relevant patient and program data.

Post-Implementation Improvements (2027-2028)

1. Epic Enhancements

- **System Optimization:** Conduct a thorough review of the EPIC system's performance and identify areas for optimization, focusing on improving functionality and user experience.
- **Feature Updates:** Implement new features and updates based on user feedback and emerging needs to enhance system capabilities.

2. Ongoing Training and Support

- **Continuous Training:** Provide ongoing training for Public Health staff and other users to ensure they are up-to-date with the latest EPIC functionalities and best practices.
- **Support Mechanisms:** Develop robust support structures to address any issues or challenges that arise post-implementation.

3. Performance Evaluation

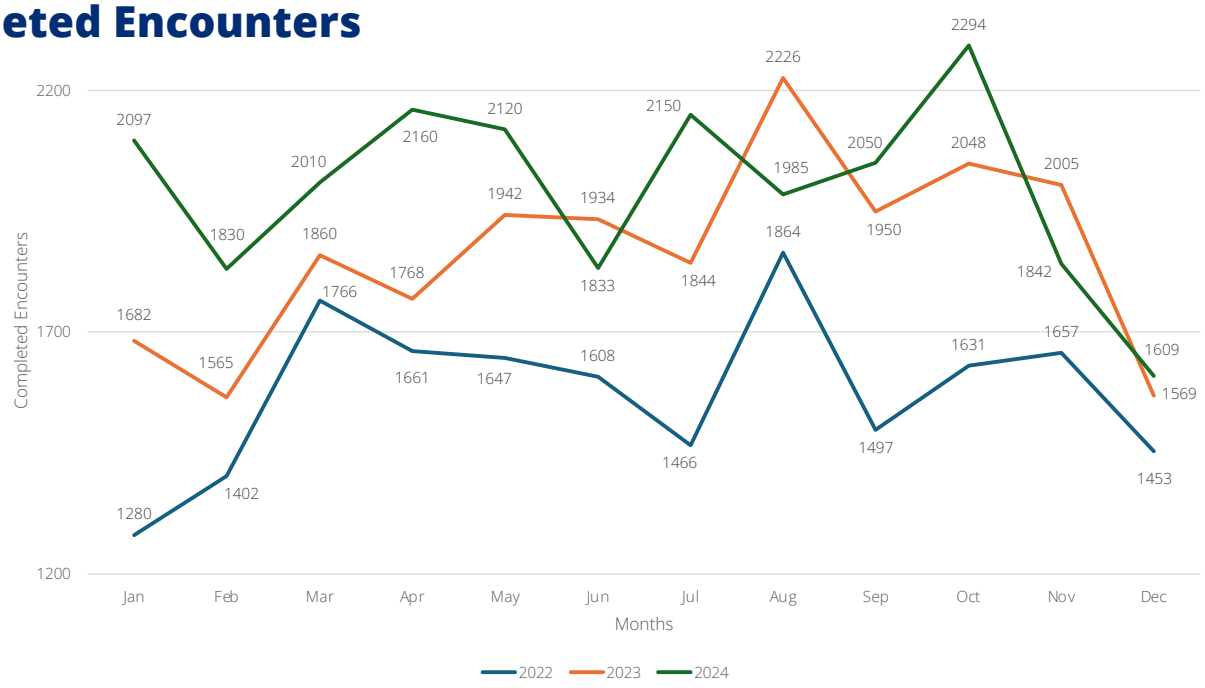
- **Regular Reviews:** Schedule regular performance evaluations to assess the impact of EPIC on Public Health programs and overall care coordination.
- **Feedback Loop:** Establish a feedback loop with users to continuously refine and improve the system based on real-world use and evolving requirements.
- **Interoperability:** Integrate EPIC smoothly with health plan systems and Health Information Exchanges (HIE) to efficiently exchange relevant patient and program data.

EXPAND AND INTEGRATE SERVICES

RUHS PH Epic Journey

RUHS Public Health, Early Intervention Program (EIP / HIV) and TB clinics began using EPIC in 2016, sharing the platform with Riverside University Health System's Medical Center and Community Health Centers. The use of EPIC expanded significantly during the COVID-19 pandemic, supporting various response efforts under the CARES Act. EPIC EHR included managing COVID testing, tracking, results, and contact tracing, as well as coordinating COVID vaccinations through mobile units and mass vaccination clinics. EPIC facilitated improved coordination of care across Public Health, the Medical Center, and associated clinics.

Completed Encounters



2024 Encounters and Patients in EPIC

Medical Therapy Units (MTU)

14.36K	1,564
Encounters	Patients

TB

233	124
Encounters	Patients

Field Nursing

584	212
Encounters	Patients

EIP

2,614	689
Encounters	Patients

Nurse Family Partnership

1,162	215
Encounters	Patients

Public Health Epic Implementation Journey - Improvements & Optimizations

BUILD A SUSTAINABLE WORKFORCE

SUSTAINABLE FUNDING

Aim

To diversify funding streams for Public Health to support innovative, groundbreaking work that allows us to address core program areas, social determinants of health, and the health of our communities more effectively.

Current Condition / Flow

- Public Health workforce has increased by 33% since June 2020 due to COVID-related grants.
- Funding for the increased workforce will not be sustainable in the near future as the COVID grants are nearing the end of their performance periods.
- Approximately 80% of Public Health's revenue comes from grants, which have specific objectives and limited performance periods.

Target Condition / Flow

- Increase Public Health billable services (where appropriate) to comprise 5% of Branch / Unit Operating Budget.
- Increase unrestricted Non-governmental Grants and Philanthropy.

Current Conditions

Public Health is funded largely by grants from government agencies (approximately 80%). While focused on developing specific public health program areas, these grants are very rigid in scope and have time-limited performance periods.

As a result, staff funded by these grants have no ability to address issues that arise outside of the grant objectives, and once the performance period ends,

Goal: Establish sustainable funding streams that enable Public Health to innovate and thrive.

Objective: Secure funding from new sources that are unrestricted or allow for greater flexibility to meet the needs of the community.

the staff must be transferred to another grant and project.

Very little of Public Health's funding is unrestricted. Unrestricted funding can be used to meet the current needs of the community to protect and improve health.

Additionally, Public Health received a considerable influx of funding during the COVID-19 pandemic that will terminate in 2026 and 2027. This funding was used to hire staff to enhance our capabilities for identifying and responding to infectious disease outbreaks.

The funding also supported laboratory infrastructure, technology infrastructure, data analytics capabilities and training for staff. Without the influx of new funding, many of these capabilities may be lost.

What's Happening

The teams are reviewing and updating the fee schedule. We are also engaging our current submitters and clients and looking for new ones too.

Our Public Health Lab recently became medicare certified as we prepare to becoming a provider to a managed care plan (MCP).

Lastly, the team is looking at using the EPIC electronic health record system to add new billable services in the department. This will allow us to collaborate with outside facilities. We've already experienced success with our Medical Therapy Unit and Community Health Worker billing.

BUILD A SUSTAINABLE WORKFORCE

Workforce Recruitment and Retention

Aim

The aim is to **create a stable, engaged, and motivated workforce** that is committed to the success of the department and our communities.

Target

By 2028, Public Health will **increase the retention rate to 90% or greater at 2 years** of employment by engaging staff during the New Employee Training, branch level on-boarding, and employee-specific follow up to obtain feedback.

This feedback will assist Public Health to make informed decisions and take appropriate actions to meet Public Health's objective of maintaining a sustainable workforce.

Current Conditions

The RUHS-PH staff turnover rate is adversely impacting the department's performance, productivity, and overall success.

Despite efforts to recruit and retain talented employees, we are facing significant challenges in hiring staff in hard to recruit positions. In some instances, retaining

Goal: Reduce staff turnover by implementing recruitment and retention strategies that foster employee satisfaction, development, and a long-term commitment to the department.

Objective: Decrease staff turnover rates, improve employee morale, and increase organizational stability.

experienced and skilled staff members is a challenge, which may result in increased costs, decreased morale, and reduced organizational stability.

Also, general recruitment has been more challenging since the pandemic because people saw the backlash experienced by Public Health employees across the country.

What's Happening

- New Employee Training launched January 2025
- Equitable Workforce Development Plan completed March 2025
- Department-wide standardized new employee onboarding under development

BUILD A CONTINUOUS IMPROVEMENT CULTURE

Continuous Improvement

Aim

For every Public Health branch, program and business unit to have well-defined, outcome-based Key Performance Indicators (KPI) by end of 2026. **KPIs will align with the Public Health initiatives and will facilitate:**

- Using data to make effective and informed decisions
- Identifying program challenges in a timely manner by tracking and monitoring the KPIs
- Visualizing KPIs in a centralized portal

By end of 2025, Public Health also aims to roll out Managing for Daily Improvement (MDI), a daily management system across all programs and business units that supports daily problem solving at the lowest possible level and continuous improvement.

Target

Public Health monitors the progression of these goals on a monthly basis by measuring:

- The number of branches and program units with defined, cascaded and managed KPIs
- The number of staff practicing daily readiness through daily huddles
- The number of implemented improvements across Public Health

BUILD A CONTINUOUS IMPROVEMENT CULTURE

Goal: Build a Continuous Improvement Culture.

Objective: Establish an environment where all public health team members are empowered and supported to make daily improvements.

Current Conditions

Collectively, Public Health monitors KPIs from all 12 branches and program units. **Leaders are able to:**

- Monitor and evaluate performance
- Visualize indicators of performance issues
- Identify gaps as opportunities for improvement

Currently, 432 employees (approximately 51%) are practicing MDI and advancing to various levels of problem solving and continuous improvement. MDI huddles are encouraging staff discussions, problem-solving amongst the team members, and resolution at the appropriate level. "A lot of small changes create big results through staff engagement."

What's Happening

Staff on the Performance Management / Continuous Improvement team are working with all Branches and programs to train staff on the Managing for Daily Improvement (MDI) process. This includes training on conducting effective huddles; escalating issues for resolution; maintaining "Huddle Boards" to visualize current processes and progress; and empowering staff to make improvements to workflows and other challenges.

Branches and programs are also developing and refining meaningful KPIs that allow for effective monitoring of progress and highlighting areas in need of improvement.

Tiered Huddles that extend up to the Executive Team have been successfully implementated.

Tracking Our Progress

Public Health has adopted a Lean Management System Framework to serve as the basis for the department's performance management efforts. Each strategic goal is directly linked to one or more strategic objectives with a corresponding strategic initiative. Each initiative is supported by a team, initiative owner, and an executive sponsor.

The department regularly reviews and tracks the progress on the strategic initiatives and objectives towards the achievement of department goals. Each strategic initiative is reviewed on a monthly basis by the department's executive team, with updates on key performance indicators shared by department initiative leads. These monthly meetings include reviewing progress on milestones and the escalation of any barriers that delay or impact critical activities. This is all done using the department's performance management system.

Public Health has developed a Quality Improvement and Performance Management Plan (QI / PM) that uses Objective and Key Results (OKR) methodology to define the work and results necessary to achieve the strategic goals and achieve success with the strategic initiatives. OKR is a goal-setting strategy that helps teams and organizations define and track measurable goals by connecting objectives to the key results required to achieve those objectives. Using this continuous improvement system and leveraging the lean approach, each strategic initiative used visioning and design workshops to develop detailed charters using A3 thinking, defined metrics, and key performance indicators. Cross functional teams were created within RUHS-PH to lead, develop, and evaluate the work of each strategic initiative.

What's Next for Public Health?

As we move forward, the strategies outlined in this plan provide a clear and actionable roadmap to improve the health and well-being of our community. By focusing on improving community wellness outcomes, expanding and integrating services, building a sustainable workforce, and building a continuous improvement culture, we aim to create an environment where every individual has the opportunity to experience a healthy and fulfilling life. By aligning our initiatives with the work of our community health improvement priority areas, we are laying the foundation for a stronger, more resilient public health system, with the ongoing support of community partners and key stakeholders.

Our commitment to innovation, equity, and accountability will guide our efforts as we implement these initiatives and priorities. The success of this plan relies on the collective dedication of individuals, organizations, and local leaders working together toward shared goals. While challenges remain, we are confident that with continued engagement and strategic action, we can make significant progress toward improving the health outcomes for all residents. The journey begins now, and we are excited to take these next steps alongside our community, knowing that together, Riverside County will become the healthiest county in the nation!

Riverside University HEALTH SYSTEM
Public Health

A3 – A logical, evidence-based approach that records all improvement or problem-solving activities with the objective being to deliver, sustain, and share best practices for the improvement.

Blue Zones – A comprehensive policy-based initiative that uses an evidence-based approach to make healthy choices easier in all the places people spend the most time.

CCS – California Children's Services. A statewide program that provides funding for the treatment of children with certain physical limitations and chronic health conditions or diseases. CCS also authorizes and pays for specific medical services and equipment provided by CCS-approved specialists.

CHA – Community Health Assessment. A state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection, and analysis.

CHIP – Community Health Improvement Plan. A plan that provides guidance to the health department, its partners, and stakeholders for improving the health of the population within the health department's jurisdiction.

CHIP Priority Area 1, Mental and Behavioral Health – The goal to improve the mental health landscape in our community through increased awareness, access, and integrated care solutions. Identify service gaps and advocate for evidence-based practices that support individuals facing mental health challenges.

CHIP Priority Area 2, Housing – The goal to increase the availability and accessibility of affordable, equitable, and climate-resilient housing, transitional housing units and shelter beds in Riverside County by prioritizing vulnerable populations and integrating housing with healthcare and support services for holistic community well-being.

CHIP Priority Area 3, Access to Equitable and Just Care and Resources – The goal to eliminate barriers to healthcare access and ensure that all community members can obtain necessary services and resources, including immunizations and vaccinations.

CHW – Community Health Worker. Preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being.

Cooperative Extension – A program that provides research-based solutions to agricultural and community issues in California.

EHR – Electronic Health Record. Digital versions of paper medical records used to guide the care health professionals give you. Like paper records, EHRs include important data such as your care plan, medical history, list of allergies and medications, test results and more.

EIP - Early Intervention Services Program. A program designed to alleviate the need for additional or extended mental health treatment by facilitating access to services and supports at the earliest signs of mental health struggles.

EPIC – Electronic framework that supports effective population health management and enhances overall care coordination within the health system.

Epidemiology – Study of the distribution and determinants of disease or disorders in groups of human populations.

Equity - Refers to the fair and just distribution of resources, opportunities, and support based on individual, and community needs to ensure everyone can achieve their fullest potential. Unlike equality, which provides the same resources to all, equity recognizes and addresses historical and systemic barriers that disproportionately affect marginalized groups.

Health Disparities - A difference in health outcomes closely linked to social, economic, or environmental disadvantages. These disparities often affect groups that have systematically experienced obstacles to health based on race, ethnicity, socioeconomic status, gender, or geographic location.

Health Equity – Efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

HEJC – Health Equity and Justice Committee. A committee within RUHS dedicated to promoting health equity and justice within the organization and the communities it serves. The committee's formation reflects a renewed commitment to addressing systemic health disparities and fostering an inclusive environment.

HPI – Healthy Places Index. A data and policy platform created to advance health equity through open and accessible data.

Inclusion – The act of creating environments where all individuals feel welcomed, respected, supported, and valued. An inclusive environment embraces differences and offers respect in the words, actions, and thoughts of all people.

KPI - Key Performance Indicators. A measurable value that demonstrates how effectively an individual, team, or organization is achieving a key business objective.

Lean Management System Framework – A management system approach focused on enhancing value and reducing waste.

MCP – Medical Care Plan. A structured approach to delivering healthcare services to individuals, ensuring that all necessary medical treatments and interventions are coordinated and effectively managed.

MCAH – Maternal Child & Adolescent Health. A program within RUHS dedicated to enhancing the health and well-being of women, infants, children, and adolescents. MCAH offers a range of programs and services aimed at promoting optimal health outcomes for these populations.

MDI – Managing for Daily Improvement. A management approach focused on continuous improvement within an organization, with an emphasis on small, incremental changes.

OKR - Objective and Key Results. A goal-setting strategy that helps teams and organizations define and track measurable goals by connecting objectives to the key results required to achieve those objectives.

PM – Performance Management. A systematic process of monitoring, evaluating, and improving performance.

Public Health - The science and art of preventing disease, prolonging life, and promoting health through organized community efforts. Public health focuses on population-level health interventions, including education, policymaking, and disease prevention.

QI – Quality Improvement. A systematic approach to improving processes and efficiency within an organization.

RODA – Riverside Overdose Data to Action. A program that was established to enhance surveillance of overdose morbidity and mortality in Riverside County.

ROI – Return on Investment. A financial metric used to evaluate the profitability of an investment relative to its cost.

RUHS PH – Riverside University Health System – Public Health. A division of the Riverside University Health System (RUHS) dedicated to promoting and protecting the health of Riverside County residents.

Social Justice – The pursuit of a fair and equitable society where all individuals and groups are valued and affirmed. This involves addressing systemic inequalities and ensuring equal rights, opportunities, and treatment for everyone, regardless of race, gender, sexual orientation, ability, or socioeconomic status.

Stewardship – The allocation and utilization of resources to ensure they are used effectively in healthcare services.

Sustainability – An approach to creating environments that support healthy living by integrating health considerations into the places where people reside.

SWOT - Strengths, Weaknesses, Opportunities and Threats. A way of considering all the good and bad features of a business situation or a company.

Unincorporated Community - A geographic area that lacks its own municipal government and is instead governed by the county or other higher levels of local or state government.

Riverside University HEALTH SYSTEM
Public Health

This Strategic Plan was created by:

Riverside University Health System - Public Health,
Riverside County's public health department.

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