COMMUNITY
HEALTH SYSTEM

2023-2025 IMPLEMENTATION **STRATEGY**

BASED ON THE 2022 COMMUNITY HEALTH NEEDS ASSESSEMENT

WHAT IS AN IMPLEMENTATION STRATEGY?

An implementation strategy is a framework used to guide community benefit activities - policy, advocacy and program-planning efforts. For hospitals and health systems, the implementation strategy describes their plan to respond to the needs identified through the previous Community Health Needs Assessment (CHNA) process. The implementation strategy also fulfills a requirement mandated by the IRS in Section 1.501(r)(3).

PREPARATION FOR THE 2023-2025 IMPLEMENTATION STRATEGY

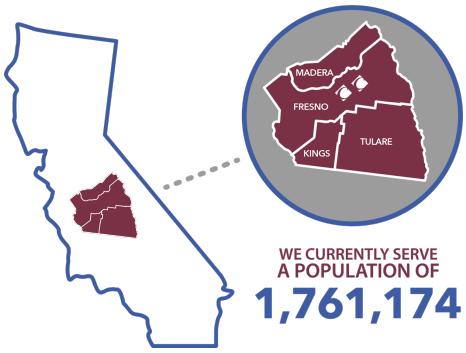
Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, healthcare access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use and misuse and preventative practices. Primary data were collected through key informant interviews with 50 experts from various organizations serving the Community Health System (CHS) service area, 59 focus groups (473 community members) and 4,856 resident responses to a community survey. The collection and analysis of the secondary and primary data resulted in the 2022 Community Health System CHNA. (Available at https://www.communitymedical.org/about-us/community-benefit)

The 2022 CHNA findings were used to select the priority health needs that will be addressed during the fiscal years 2023-2025. The data collected in the CHNA process were used to identify poor health outcomes, health disparities, health trends and community priorities. To be selected as a priority health need, the local data had to show a need when compared to state and national data, and the community had to rank the health need as a priority. The list of 2023-2025 priority health needs were finalized by reviewing the focus areas from the previous Implementation Strategy and CHS' capacity to address each health need.

DEFINING COMMUNITY HEALTH SYSTEM'S SERVICE AREA

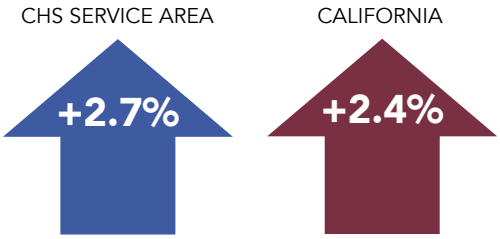
Community tracks zip codes of origin for all patient admissions, including all who received care without regard to insurance coverage or eligibility for financial assistance. **For the purposes of this report, CHS defines its primary service area as Fresno, Kings, Madera and Tulare Counties.**

CHS' SERVICE AREA
AT A GLANCE

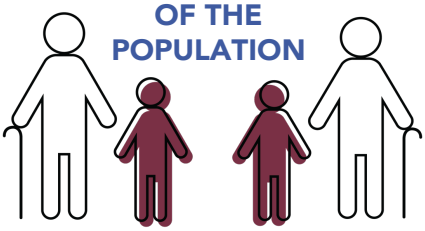


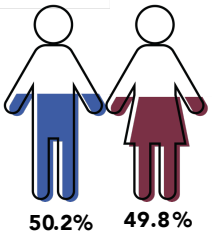
WE CURRENTLY SERVE A POPULATION OF
1,761,174

THE POPULATION OF EACH REGIONAL COUNTY IS INCREASING

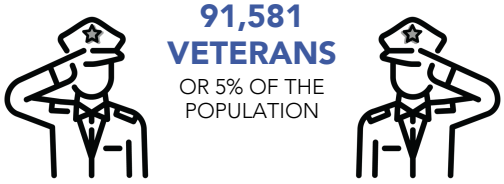


YOUTH (0-17) AND SENIORS 65+ MAKE UP
41%
OF THE POPULATION





THE % OF MALES AND FEMALES IS NEARLY EQUAL



91,581 VETERANS
OR 5% OF THE POPULATION

THE TOP CAUSES OF DEATH IN THE REGION ARE HEART DISEASE AND CANCER

OVER HALF OF THE REGION'S FOREIGN BORN RESIDENTS ARE NOT U.S. CITIZENS

A MAJORITY OF THE REGION'S RESIDENTS IDENTIFY AS HISPANIC OR LATINO

57.0%	29.1%	7.2%	3.6%	2.1%	0.6%	0.2%	0.1%
HISPANIC OR LATINO	WHITE	ASIAN	BLACK/ AFRICAN AMERICAN	MULTI-RACIAL	AMERICAN INDIAN/AK NATIVE	OTHER	NATIVE HI/PACIFIC ISLANDER

ALL COUNTIES RANK IN THE BOTTOM 20%
OF THE STATE'S 58 COUNTIES (1 BEING THE BEST) FOR SOCIAL AND ECONOMIC FACTORS

46%
OF RESIDENTS

SPEAK A NON-ENGLISH LANGUAGE AT HOME

MORE REGIONAL RESIDENTS DIE PRE-MATURELY (BEFORE AGE 75) COMPARED TO CALIFORNIA

ADDRESSING THE **HEALTH NEEDS**

The 2022 CHNA identified and ranked the following significant health needs from an extensive review of the primary and secondary data.

HEALTH NEEDS RANKED BY THE PUBLIC

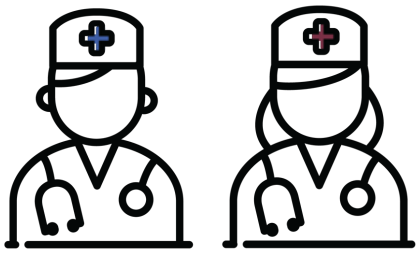
1. **Mental Health**
2. **Maternal and Child Health**
3. **Access to Care (includes dental and mental healthcare)**
4. **Chronic Diseases**
5. **Nutrition and Physical Health (overweight and obesity)**
6. **Access to Childcare**
7. **Preventive Care and Practices (screenings, immunizations/vaccines, etc.)**
8. **Substance Use (alcohol and drugs)**
9. **COVID-19**
10. **Adverse Childhood Experiences**
11. **Housing and Homelessness**
12. **Tobacco and Nicotine Use**
13. **Economic Stability**
14. **Education**
15. **Environmental Conditions (water and air)**
16. **Food Insecurity**
17. **Transportation**
18. **Internet Access**
19. **Crime and Violence**
20. **HIV/AIDS and STIs**

From the significant health needs identified and ranked by the CHNA, CHS chose health needs that considered the health system's capacity to address community needs, the strength of community partnerships and those needs that correspond with the health system's priorities. This Implementation Strategy explains how CHS plans to address the selected priority health needs identified by the CHNA.

THE FIVE PRIORITY HEALTH NEEDS THAT WILL BE ADDRESSED IN THE 2023-2025 IMPLEMENTATION STRATEGY ARE:

Priority Area 1: Access to Healthcare
Priority Area 2: Chronic Diseases
Priority Area 3: Economic Stability
Priority Area 4: Maternal and Child Health
Priority Area 5: Mental Health

#1 ACCESS TO **HEALTHCARE**



Goal: Increase access to healthcare services through primary care, preventative care and specialty care services, including HIV/AIDS/STIs, for medically underserved residents

STRATEGIES

- Provide health insurance enrollment assistance for persons who are uninsured or underinsured.
- Provide transportation support to increase access related to healthcare services.
- Partner with Family Health Care Network's Special Services Clinic to administer the federal Ryan White HIV/AIDS Program and provide healthcare and case management services for patients and their families.
- Provide in-hospital testing and examinations for those who have experienced sexual assault and rape through the Sexual Assault Forensic Examiners (SAFE) Program.
- Offer education and environmental modifications to reduce the incidence of injury, disability and death due to trauma through the Trauma Prevention Program.
- Work in collaboration with community agencies to increase access to healthcare services, including primary care, specialty care and mental health services.
- Provide cash and in-kind support to nonprofit community organizations that provide programs and services to expand healthcare access.

POPULATIONS

Strategies will positively impact all residents, but data shows these populations are most in need:

Insurance: American Indian and Alaskan Native (AIAN) residents, Hispanic residents, Native Hawaiian/Pacific Islander children, Kings County children and Tulare County adults

Primary care: Asian and multiracial residents, low-income and uninsured residents
Dental care: children and teens, low-income and uninsured residents
Mental healthcare: children and teens, AIAN and Asian residents, low-income and uninsured residents

Unmet need for mental healthcare: Madera County teens, Fresno, Kings and Tulare County adults, people with mental illness/mental health challenges, people with substance use disorders, those experiencing grief and loss, low-income and uninsured residents, LGBTQ+ residents, females and multiracial residents

The CHS service area has less access to all listed healthcare providers than California as a whole; ***access is particularly low in Madera, Kings and Tulare counties.***

DESIRED OUTCOMES

- Increase health insurance coverage for children and adults
- Increase youth & adult primary, dental and mental healthcare access
- Decrease untreated youth & adult mental health conditions

OVERALL IMPACT

- Increase access and quality of care
- Increase early chronic disease detection and management
- Increase equitable health outcomes
- Increase self-rated health

**Source: U.S. Census Bureau, 2016-2020 American Community Survey, DP03. http://data.census.gov/*
***Source: County Health Rankings, 2019 http://www.countyhealthrankings.org*
***Source: California Health Interview Survey, 2015-2019.*

#2 CHRONIC **DISEASES**

Goal: Reduce the impact of chronic diseases on health and increase the focus on chronic disease prevention and treatment, including through nutrition and physical health

STRATEGIES

- Provide diabetes self-management education through the Community Diabetes Education (CDE) program. Host the Sweet Success program, which supports women diagnosed with diabetes during pregnancy.
- Facilitate health education workshops and presentations on chronic disease prevention, treatment and management, including physical activity, exercise and nutrition.
- Participate in health and wellness fairs and offer preventive screenings.
- Provide public health education in the media and at community health awareness events to encourage healthy behaviors and prevent chronic diseases.
- Provide support groups to assist those with chronic diseases.
- Work in collaboration with community agencies to address the causes and management of chronic diseases.
- Provide cash and in-kind support to nonprofit community organizations that provide chronic disease-focused programs and services.

POPULATIONS

Strategies will positively impact all residents, but data shows these populations are most in need:

Asian, AIAN, Native Hawaiian/Pacific Islander and Black residents, non-binary individuals, men, teens and older adults

Madera County residents (heart disease and hypertension), Kings County residents (heart disease), Tulare County residents (hypertension and diabetes), Fresno County residents (hypertension), overweight and obese residents, sedentary residents and older adults

Risk factors include history, smoking/smoking exposure, unhealthy diet, sedentary behavior, overweight and obesity, unprotected sex, alcohol use, exposure to certain environmental factors, older age, lack of access to health care, low-income (mortality rates), White ethnicity (cancer diagnosis) and Black ethnicity (cancer mortality)

Risk factors include family history, smoking/smoking exposure, exposure to air pollution, overweight and obesity, other allergic conditions, Black and AIAN ethnicity and low-income

Overall, residents of the CHS service area have less access to exercise opportunities, heart disease, diabetes, cancer and asthma

DESIRED OUTCOMES

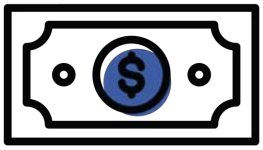
- Increase child and adult physical activity
- Increase healthy eating
- Increase access to Community Health Workers (CHW)

OVERALL IMPACT

- Decrease chronic disease (heart disease, diabetes, cancer, etc.)
- Increase early detection and management of these conditions
- Decrease mortality rates from these conditions
- Increase quality of life

**Source: County Health Rankings, 2021 ranking, utilizing 2010 and 2019 combined data. http://www.countyhealthrankings.org*
***Source: California Health Interview Survey, 2011-2018, **2011-2016, ***2013-2018, ****2013-2019. http://ask.chis.ucla.edu/*
****Source: U.S. Centers for Disease Control (CDC), Behavioral Risk Factor Surveillance System (BRFSS), PLACES Project 2021, 2019 data year. https://chronicdata.cdc.gov/500-Cities-Places/PLACES-Local-Data-for-Better-Health-County-Data-20/swc5-untb*
*****Source: California Health Interview Survey, 2015-2019 http://ask.chis.ucla.edu*

#3 ECONOMIC **STABILITY**



Goal: Increase access to resources to address homelessness, crime and violence, food insecurity and access to the internet

STRATEGIES

- Connect residents to linguistically and culturally appropriate services, including internet access resources, housing resources and food availability.
- Facilitate violence prevention and family stabilization initiatives.
- Work in collaboration with community organizations and agencies to address the impact that economic stability has on health and wellness.
- Provide cash and in-kind support to nonprofit community organizations that provide programs and services that address food insecurity, crime and violence, homelessness and internet access.

POPULATIONS

Strategies will positively impact all residents, but data shows these populations are most in need of support with homelessness, food insecurity and internet access:

Those with severe mental illness and/or chronic substance use disorder, those experiencing chronic homelessness, survivors of domestic violence, veterans, youth (ages 18-24), people living with HIV/AIDS, Black, Asian and AIAN residents

Black, Latino, Asian and AIAN residents, residents living in rural areas, Tulare County adults, Fresno County residents (children and availability of resources), Madera County residents (availability of resources), female head of household (HOH) with children under 18, children under 18, younger adults (18-39) and older adults (80+)

Black and Latino households, rural households, low-income households, less-educated households, older adults (65+) and residents of Kings, Madera and Tulare counties

DESIRED OUTCOMES

- Increase access to healthcare, social and housing supports for homeless population
- Increase availability and affordability of healthy foods neighborhoods
- Increase households with broadband internet access

OVERALL IMPACT

- Decrease homelessness (chronic and non-chronic)
- Decrease percentage of children and adults that are food insecure
- Increase educational and employment opportunities and outcomes
- Increase health outcomes

**Source: U.S. Department of Housing and Urban Development (HUD). 2018 & 2020 CoC reports. https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports..*
***Source: Feeding America, based on Current Population Survey data, 2019. https://feedingamericaaction.org/resources/state-by-state-resource-the-impact-of-coronavirus-on-food-insecurity/*
****Source: BroadbandNow. https://broadbandnow.com/California*

#4 MATERNAL AND **CHILD HEALTH**

Goal: Improve the health of new mothers, infants, adolescents and teens through preventive and postpartum practices

STRATEGIES

- Provide community health promotion and education programs targeting maternal, adolescent and teen health issues.
- Support breastfeeding initiatives.
- Facilitate increasing access to HPV vaccinations and HPV vaccination training.
- Encourage screenings for developmental milestones and for prenatal and postpartum depression.
- Offer education and support for parents through Community's Mother's Resource Center.
- Work in collaboration with community agencies and healthcare providers to increase access to prenatal care, safe birthing options and comprehensive child healthcare.
- Provide cash and in-kind support to nonprofit community organizations that provide programs and services to improve maternal and child health.

POPULATIONS

Strategies will positively impact all residents, but data shows these populations are most in need:

Preterm birth and infant mortality: Fresno, Kings and Tulare County residents, Black and AIAN residents, low-income residents, teen and older (40+) birthing persons

Maternal morbidity and mortality: Residents of all CHS service area counties (mortality rate for region is highest in California), pregnancies with comorbidities, older pregnant people (35+), those living with obesity, those who have public or no insurance, low-income residents, low education residents and Black residents

Breastfeeding: Asian, multiracial and Black parents, parents with barriers to breastfeeding (i.e., work schedule, mental and physical health challenges, lack of education)

Infant and child health: Various groups of infants, children and teens will benefit, including low-income and uninsured residents, and residents of Kings, Madera and Tulare counties in particular

DESIRED OUTCOMES

- Increase access to early and comprehensive prenatal care
- Increase access to innovative, culturally and linguistically appropriate birthing practices, breastfeeding and safe sleep education
- Increase healthy behaviors in children and youth
- Increase resources for mothers and parents

OVERALL IMPACT

- Increase infant and child health
- Decrease maternal morbidity and mortality
- Decrease preterm births
- Decrease infant mortality
- Decrease premature death and disability

**Source: Feeding America, based on Current Population Survey data, 2019. https://feedingamericaaction.org/resources/state-by-state-resource-the-impact-of-coronavirus-on-food-insecurity/*

***Source: California Health Interview Survey, Children 2015-2019 **2014 & 2017-2020 ***2018-2020. http://ask.chis.ucla.edu*

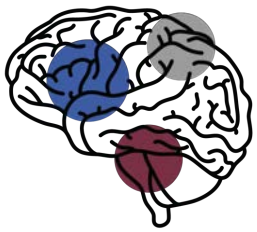
****Source: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2016-2020, on CDC WONDER. https://wonder.cdc.gov/natality-current.html*

*****Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016-2018. Tables 2 & 3.*

******Source: California Department of Public Health, Immunization Branch, 2019-2020. *For those schools where data were not suppressed due to privacy concerns https://data.chhs.ca.gov/dataset/school-immunizations-in-kindergarten-by-academic-year*

*******Source: California Health Interview Survey, 2015-2020 and **2011-2020. http://ask.chis.ucla.edu/*

#5 MENTAL HEALTH



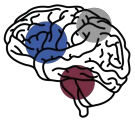
Goal: Increase access to mental health services, including Adverse Childhood Experiences (ACEs) and substance abuse, in the community

STRATEGIES

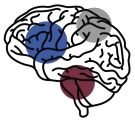
- Help individuals and families connect to needed resources (food, housing, navigating parenting, relationships, etc.) to reduce mental health crises.
- Provide appropriate medications in the emergency departments to support patients experiencing withdrawal symptoms from substance abuse through the Bridge Program.
- Offer community health education, lectures, presentations and workshops focused on mental health topics, including Adverse Childhood Experiences (ACEs), relational health and positive coping skills.
- Increase access to mental health screening, including ACEs screening and psychosocial distress screening.
- Work in collaboration with community agencies to increase access to mental healthcare services, address trauma and build resilience.
- Provide cash and in-kind support to nonprofit community organizations that provide mental health services, programs and resources.

POPULATIONS

Strategies will positively impact all residents, but data shows these populations are most in need:



Psychological distress and access to care: Madera County teens, Fresno, Kings, and Tulare County adults, people with mental illness/mental health challenges, people with substance use disorder, those experiencing grief and loss, low-income and uninsured residents, LGBTQ+ residents, females and multiracial residents



Suicide: Fresno, Kings, Madera and Tulare County youth and adults, men, non-Hispanic White residents, older adults (65+), residents with a history of psychological distress, suicidal ideation, self-inflicted injury and those experiencing grief and loss

ACEs: Low-income, food insecure and precariously housed residents, as well as those living with mental health and substance use challenges

DESIRED OUTCOMES

- Decrease psychological distress
- Decrease mental health hospitalizations
- Increase access to mental healthcare services
- Decrease ACEs

OVERALL IMPACT

- Increase youth & adult mental health
- Increase quality of life
- Decrease self harm
- Decrease suicide deaths

**Source: California Health Interview Survey, 2015-2019 & 2011-2019. http://ask.chis.ucla.edu/*
***Source: California Health Interview Survey, 2015-2019 & **2013-2019. http://ask.chis.ucla.edu*
****Source: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Mortality public-use data 2014-2019, on CDC WONDER. https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html*
*****Source: U.C. Berkeley Center for Social Services Research, California Child Welfare Indicators Project Reports, July 2019 to October 2021. Accessed from KidsData.org at http://kidsdata.org*

COLLABORATE WITH **THE COMMUNITY**

In Fall 2022, CHS and several community partners met to discuss and validate the priority health needs that the health system will focus on during the 2023-2025 cycle. Most importantly, CHS and our community partners selected strategies that will be used to address the priority health needs. The strategies on the previous pages were selected at that meeting and reflect the efforts by not only CHS but also the partnership of many organizations in the community. The meeting resulted in specific strategies that the partners will conduct to work together to address the priority health needs of the CHS service area.

POTENTIAL PARTNERS TO HELP ADDRESS EACH PRIORITY HEALTH NEED

ACCESS TO HEALTHCARE: County Departments of Public Health (Fresno, Kings, Madera, Tulare), Hospital Council of Northern and Central California, UCSF Fresno, CalViva Health, Camarena Health, Central Valley Health Network, Clinica Sierra Vista, United Health Centers, American Cancer Society, BLACK Wellness and Prosperity Center, California Health Collaborative, Centro La Familia, Cultiva La Salud, Exceptional Parents Unlimited, First 5 Fresno County, Fresno County Black Infant Health Program, Fresno County Health Improvement Partnership (FCHIP), Fresno HOPE Pathways Community Hub, Marjaree Mason Center, neighborhood resource centers

CHRONIC DISEASES: County Departments of Public Health (Fresno, Kings, Madera, Tulare), UCSF Fresno, American Cancer Society, American Heart Association, Central California Food Bank, Cultiva La Salud, Every Neighborhood Partnership, FCHIP, Fresno HOPE Pathways Community Hub, neighborhood resource centers

ECONOMIC STABILITY: Catholic Charities, Central California Food Bank, Central Unified School District, FCHIP, Fresno County Office of Education, Fresno HOPE Pathways Community Hub, Fresno Madera Continuum of Care (FMCoC) and partners, Fresno Metro Ministries, Fresno Mission, Fresno Unified School District, Every Neighborhood Partnership, Marjaree Mason Center, neighborhood resource centers, Poverello House, The Fresno Center, United Way of Fresno and Madera Counties

MATERNAL AND INFANT/CHILD HEALTH: County Departments of Public Health (Fresno, Kings, Madera, Tulare), UCSF Fresno, BLACK Wellness and Prosperity Center, CASA of Fresno and Madera Counties, Catholic Charities, California Health Collaborative, Central California Food Bank, Central Unified School District, Clovis Unified School District, Exceptional Parents Unlimited, FCHIP, First 5 Fresno County, First 5 Madera County, First 5 Kings County, Fresno County Black Infant Health Program, Fresno HOPE Pathways Community HUB, Fresno Unified School District, Marjaree Mason Center

MENTAL HEALTH: County Departments of Public Health (Fresno, Kings, Madera, Tulare), County Departments of Behavioral Health (Fresno, Kings, Madera, Tulare), California Health Collaborative, Central Unified School District, Clinical Pastoral Education of Central California, Clovis Unified School District, FCHIP, Fresno HOPE Pathways Community Hub, Fresno Unified School District, Every Neighborhood Partnership, Marjaree Mason Center, neighborhood resource centers, The Fresno Center, Valley Caregiver Resource Center

DEVELOP AND **ADOPT**

DEVELOP AND ADOPT

In compliance with the IRS regulations 501(r) for charitable hospitals, a hospital community health needs assessment (CHNA) and an implementation strategy (written plan) are to be made widely available to the public and public comment is to be solicited. These reports are posted on the CHS website: https://www.communitymedical.org/about-us/community-benefit

The 2023-2025 Implementation Strategy report was adopted by CHS leadership before January 15, 2023. Written comments on this report can be made by emailing CAivazian@communitymedical.org.

OTHER HEALTH NEEDS NOT PRIMARILY ADDRESSED

Community is dedicated to ensuring the region's identified health needs are addressed whenever possible. Taking into consideration our existing health system and community resources, CHS will primarily focus our resources on the five previously identified health needs and will not primarily address the other needs identified in the CHNA including child care, education, tobacco/nicotine and transportation. CHS does not intend to directly emphasize environmental conditions outside of the ongoing efforts to identify innovative ways to reduce and recycle clinical and nonclinical waste and utilize reclaimed water for landscaping irrigation. Additionally, CHS does not intend to specifically emphasize COVID-19 interventions but will continue to deliver acute medical care and be a community resource for COVID-19. CHS will strive to impact the other identified health needs as they fall within our areas of focus and expertise and as resources allow. We will continue to look for opportunities to partner with other organizations that are addressing these needs where we can make a meaningful contribution.

The Implementation Strategy will be sustained by the continuous collaboration between CHS and community partner relationships during the 2023-2025 cycle.

UPDATE, SUSTAIN, **AND EVALUATE**

UPDATE AND SUSTAIN

CHS conducts a community health needs assessment and implementation strategy process every three years. However, the implementation strategy may need to be updated based on changing community needs and priorities, changes in health system resources and evaluation results. The implementation strategy is not static and can change at any time within the cycle. Reviews and updates of the implementation strategy should be a part of the health system's overall planning. CHS will accomplish this by regularly communicating with community partners and revisiting the implementation strategy on a regular basis.

EVALUATION OF IMPACT

Community Health System will monitor and evaluate the programs and actions outlined above. The health system anticipates the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. The health system is committed to monitoring key indicators to assess impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. To demonstrate the CHS commitment to investing in the growing health needs of the region, a state-mandated Community Benefit report is submitted annually. Finally, a review of the impact of the health system's actions to address these priority health needs will be reported in the next scheduled CHNA.

IMPLEMENTATION STRATEGY FINAL NOTES

The 2023-2025 Implementation Strategy is not intended to be a comprehensive catalog of all the ways that the health needs of the community are addressed by the health system. Rather, it is a representation of specific strategies, actions and activities that CHS and its community partners commit to undertaking and monitoring as they relate to each identified priority health need.

The 2023-2025 Community Health System Implementation Strategy Report was prepared by Moxley Public Health, LLC, (www.moxleypublichealth.com) an independent consulting firm that works with hospitals and other community-based nonprofit organizations both domestically and internationally.

COMMUNITY
HEALTH SYSTEM

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