Tulare County
Community Health Improvement Plan
2023–2028

HHSA
Public Health

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

Accredited 2020

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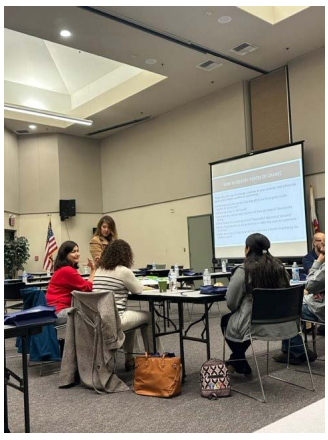
Community Health Improvement Partners

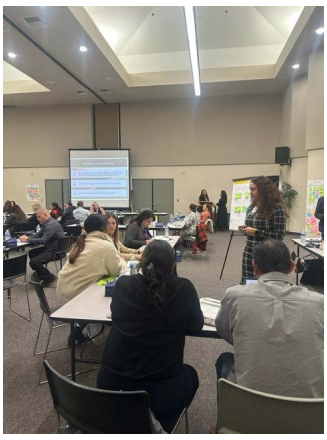
PARTNERS | Access to Care

Altura Centers for Health
Anthem Blue Cross
California Farmworkers Foundation
Central Valley Regional Center
Central Valley Empowerment Alliance
California Rural Indian Health Board (CRIHB)
Community Services Employment Training (CSET
Family HealthCare Network
Health Force
HealthNet
Kaweah Health
Proteus Inc.
Pro-Youth Heart
Red Cross
Sierra View Medical Center
The Source LGBT+ Center
Tulare County Association of Governments (TCAG)
Tulare County Office of Education (TCOE)
Tulare County Behavioral Health
Tulare County Public Health
Tule River
United Way
Valley Children's Hospital
Visalia Medical Clinic

PARTNERS | TAME Diabetes

Altura Centers for Health
Anthem Blue Cross
Aria Health
Community Medical
California Rural Indian Health Board (CRIHB)
Davita Dialysis
Family HealthCare Network
First 5
FoodLink
HealthNet
Kaweah Health
Lindsay Unified
Pro-Youth Heart
Self-Help
Sierra View Medical Center
Tulare County Public Health
Valley Children's Hospital





FROM THE TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY

Greetings:

The Tulare County Health & Human Services Agency is pleased to introduce the 2023–2028 Community Health Assessment. We partnered with nearly 70 representatives from an array of public agencies, nonprofit organizations, businesses, and numerous residents to gain insight on issues impacting county residents' health and well-being. This report provides an in-depth, comprehensive look at the state of health in Tulare County.

The framework implemented was the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 process that was released in Spring 2023. The Public Health Branch gathered partners and stakeholders to review health data, assess the strengths and areas for improvement of the community and its local public health system, and identify outside factors that may impact our overall county health. Additionally, the Public Health Branch coordinated ten focus groups with community members. With the support of partners, we were able to accomplish two data collection phases. The first phase took place in October 2021 through December 2021 in collaboration with the hospital council and three neighboring counties (Kings, Madera, and Fresno). There were 10 focus groups conducted and 10 key informant interviews, and we disseminated more than 300 countywide surveys. The second phase of data collection was facilitated in the month of October 2022 by Garrow Consulting, Inc. Four focus groups captured conversations that included residents' experiences that impacted their health as well as the communities' strengths and resources. Lastly, the collection and analysis of secondary data was led by the Tulare County Public Health Epidemiology Team.

The Public Health Branch continued collaborating with our community partners to focus on the identified priority areas that were formed into subcommittees: Access to Care and Tulare County Alliance for Management and Education of Diabetes (TAME). We revised and implemented the second version of the Community Health Improvement Plan (CHIP) that serves as a roadmap for the Public Health Branch and community to begin addressing some of the health issues described in this report. The Public Health Branch is also updating the 2023–2028 Strategic Plan to advance health equity while delivering public health programs and services.

There will be challenges ahead, but the opportunities to improve our community are great. We look forward to starting this journey with you.

Sincerely,

The Tulare County Health & Human Services Agency

Introduction

This second iteration of the Tulare County Community Health Improvement Plan (CHIP) is a continuation of the partnership between the Tulare County Health & Human Services Agency (HHSA), Public Health Branch, and its community partners, which represents a broad spectrum of community sectors. Maintaining the vision *Healthy Lives through Vibrant and Supportive Communities* as their guide, the partnership analyzed data from the Tulare County Community Health Assessment (CHA) 2022–2027. The partnership agreed to stay the course in addressing *Access to Care and Diabetes*.

The planning process was a modified version of Mobilizing for Action through Planning and Partnerships (MAPP). Each group underwent the assessment process and revisited the goals and objectives set forth in the first version of the CHIP. Given that this planning process occurred at the tail end of the Covid-19 pandemic, the teams leveraged many lessons learned from that response to reshape their strategies in addressing access to health care and diabetes.

The CHIP provides a framework for the two collaborative teams. The detailed work plan for each of the goals will be maintained in a separate document where the groups will track and monitor progress toward their goals.

Executive Summary

Tulare County organized and coordinated the planning meetings of the Access to Care group and the TAME Diabetes group. Each group met separately to update their goals and objectives as well as to identify the strategies that will achieve them. The Tulare County Community Health Improvement Plan (CHIP) is the result of this process that started in December 2022.

Access to Care

The Covid-19 pandemic response, along with the Community Health Assessment data, highlighted the need to continue to address access issues to health care. The move toward virtual care during the initial Covid-19 response shutdown aided in getting care to the many remote communities located within this geographically large county. However, these communities still lack access to broadband service that is necessary for quality connectivity in virtual care. Some types of health care must be provided in person, rendering virtual care insufficient to meet those needs. That means that there continue to be transportation barriers, given the distance between these remote communities and the location of clinics.

There continues to be a shortage of health care providers in the county. The number of primary and specialty care providers continues to be insufficient, especially since the population continues to grow quickly. More clinics have opened in the area, and some partners have expanded their mobile care services, but there is still an unmet demand for care and services, especially in specialty care. Many specialists are only available outside of the county area, which means that residents need reliable transportation to get that specialty care.

Cultural competence, language communication, and patient care experience continues to be a concern among the residents. The Access to Care team will be revamping their strategies in this area under this second version of the CHIP.

Diabetes

Diabetes continues to be the top health issue of concern. Data presented during the Community Health Assessment indicate that compared to the state of California, Tulare County has higher rates of diagnosed diabetes, diabetes-related hospitalizations, and diabetes-related mortality. Health behaviors that are related to diabetes, such as healthy eating and physical activity levels, continue to be an opportunity area for improvement.

The TAME Diabetes group decided to continue to build on the work started with the inaugural CHIP, which addresses diabetes from prevention to treatment and disease management. There will be a focus on community education by leveraging community health workers to provide outreach, education, and referrals. They would like to expand diabetes screening and referrals for follow-up care. Additionally, they will continue to build a repository of community fitness opportunities that are low-cost or no-cost, while promoting their availability to the public. Lastly, they would like to build on expanding markets that sell fruits and vegetables in rural and remote areas.

Executive Summary

Objectives

The purpose of addressing access to care and diabetes is to improve the health and quality of life for Tulare County residents. Measurable objectives are used to determine the achievement of this purpose. The measurable objectives in the CHIP are:

1.1 Ensure 100% of participating facilities implement a cultural humility training plan by 2024

2.1 Reduce the use of emergency room (ER) visits in local hospitals for non-emergency care to no more than 75% of ER visits by 2028

3.1 Increase the number of community-based organizations providing population-based primary prevention services

4.1 Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations

5.1 Ensure prediabetics and diabetics are appropriately managing their condition by screening 100 people annually by 2028

5.2 Increase the number of individuals who manage their diabetes or prediabetes to reduce diabetes-related hospitalization in Tulare County by 10% by December 2028

6.1 Increase annual participation of 80–100 individuals in physical activity opportunities provided by diabetes coalition and partners through December 2028

7.1 Increase the number of sites annually by a margin of 1 location in Tulare County where healthier food and beverages are readily accessible through December 2028

Policy Needs

Strategies sometimes run into challenges where a policy would enable them to achieve their objectives without constraints. Some of the goals have highlighted policy work that needs to be done for the objective to be met as outlined. These are discussed within those areas of the plan.

Linkages with State and National Goals and Strategies

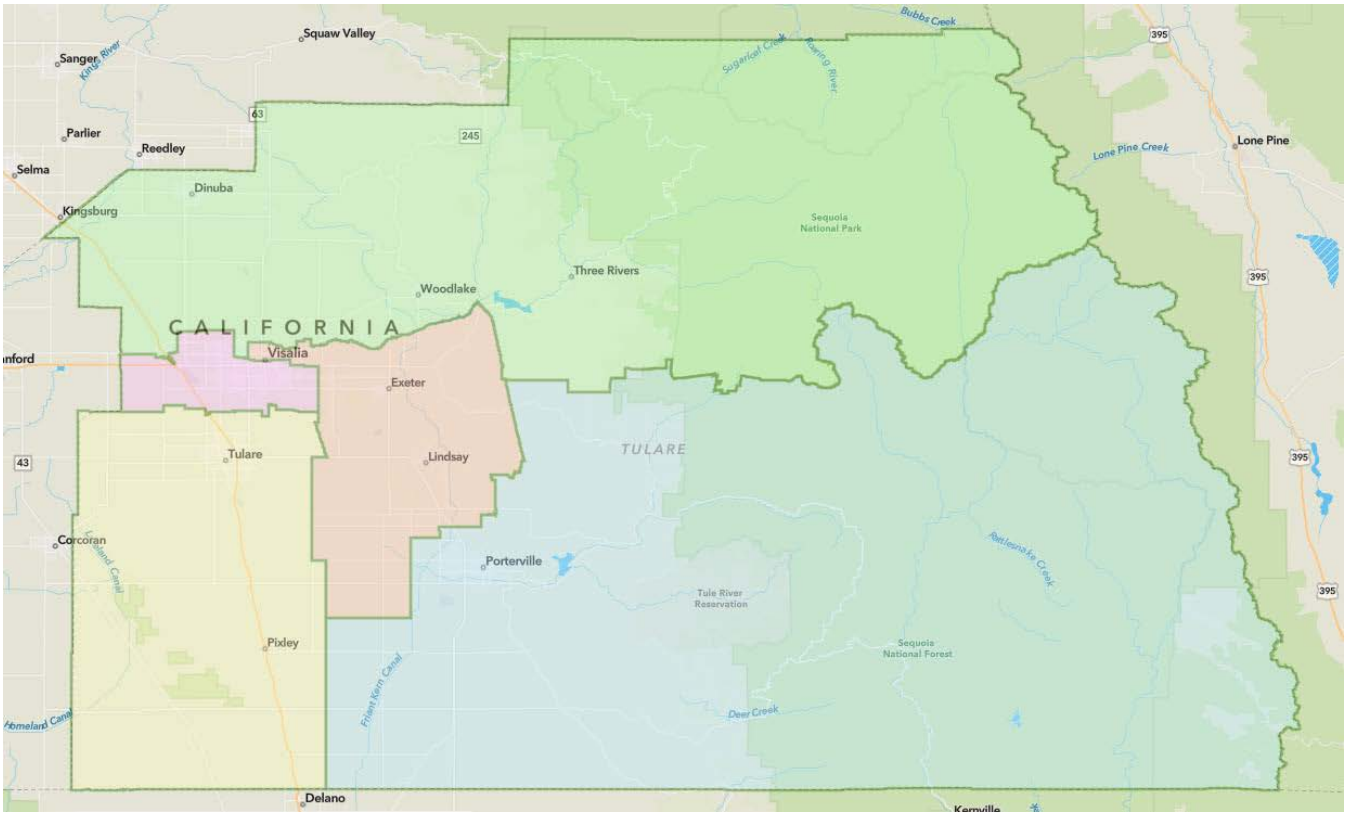
The CHIP activities continue to link with Let's Get Healthy California and the National Prevention Strategy. The CHIP Access to Care team is working on cultural and linguistic competency, which is also reflected in the state plan. The national plan calls for local governments to foster collaboration among community-based organizations.

About Tulare County

Tulare County is centrally located in the southern region of California's San Joaquin Valley, between Sacramento and Los Angeles. It is a 2.5-hour drive from California's central coast and a short distance from Sequoia and Kings Canyon National Parks, Sequoia National Monument and Forests, and Inyo National Forest. State Highways 99 and 198 provide convenient access to these destinations.

Tulare County is situated in a geographically diverse region, covering 4,824 square miles (about the area of Connecticut) of land area. Mountain peaks of the Sierra Nevada rise to more than 14,000 feet (about half the cruising altitude of a commercial jet) in its eastern half, composed primarily of public lands within the Sequoia National Park, Sequoia National Forest, and the Mineral King, Golden Trout, and Domelands Wilderness areas.

Meanwhile, the extensively cultivated and very fertile valley floor in the western half of the county has enabled the county to become 2015's leading producer of agricultural commodities in the United States. In addition to substantial packing/shipping operations, light and medium manufacturing plants are becoming a crucial factor in the county's total economic picture.



The Planning Process

The inaugural edition of the Tulare County CHIP used the Mobilizing for Action through Planning and Partnerships (MAPP) model, developed by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Since that time, NACCHO has updated the model to MAPP 2.0 to reflect the evolution of the field of public health and include emphasis on addressing community health inequities. This community-driven health improvement process consists of three phases:

Phase 1: Build Community Health Improvement Foundation
Phase 2: Tell the Community Story
Phase 3: Continuously Improve the Community

Organizing for success and partnership began in 2016, when the first planning process commenced. Since that time, Tulare County has maintained and grown its partnerships and continues to build upon its community health improvement foundational infrastructure.

The partnership agreed to maintain their vision of Healthy Lives through Vibrant and Supportive Communities. The assessments were conducted by external consultants, one in conjunction with the local Hospital Council. MAPP consists of a total of three assessments:

- Community Partners Assessment
- Community Status Assessment
- Community Context Assessment

For this round of planning, the group conducted fourteen community focus groups and ten key informant interviews, surveyed their community partners, and conducted a robust update to their community health indicators. Some of the questions asked were used to assess community health equity, and a statewide assessment of the local public health departments' ability to address health equity was also considered. A more detailed description of the assessment process can be found in the Tulare County Community Health Assessment 2023–2028 document.

Both the Access to Care and the TAME Diabetes groups reviewed the results of these assessments in a virtual workshop conducted on December 5, 2022. Data from these assessments provided the foundation for the community partnership discussion regarding community context. On December 7, 2022, two in-person facilitated sessions were held: one for the Access to Care group and the other for the TAME Diabetes Coalition. Each group discussed the focus of their work for the 2023–2028 CHIP based on the data that they reviewed from all assessments.

After confirming with both groups, the two areas of focus for the CHIP will continue to be access to care and diabetes. The remaining planning sessions all took place virtually. Each group met in January 2023 to update its goals and objectives. The goals and objectives were finalized in February 2023. In May 2023, the TAME Diabetes Coalition group finalized their strategies, while the Access to Care Team finalized their strategies in June 2023.

TIMELINE

October – November 2021

- Conducted 10 community focus groups
- Completed 10 key informant interviews in partnership with the Hospital Council

October 2022

- Conducted 4 additional focus groups with special populations
- Completed a survey of the Tulare County CHIP partners
- Began pulling quantitative data from a variety of sources

December 2022

- CHIP partners participated in a review of the quantitative and qualitative data
- CHIP partners completed a Forces of Change assessment
- CHIP partners began discussing updates to the CHIP

January 2023

- TAME group met to update the goals and objectives of their part of the CHIP
- Access to Care group met to update the goals and objectives of their part of the CHIP

February 2023

- TAME group met to finalize goals and objectives
- Access to Care group met to finalize goals and objectives
- Each group established a meeting schedule and selected chairs

May 2023

- TAME group met to finalize the strategies and select leads for the strategies to accomplish the goals and objectives

June 2023

- Access to Care group met to finalize the strategies and select leads for the strategies to accomplish the goals and objectives

Healthy Lives Through Vibrant and Supportive Communities

Access to Care Goals 1–4
TAME Diabetes Goals 5–7

Access to Care

The 2022 Community Health Assessment showed that many barriers to accessing health care still exist in the county. The team was able to identify more specific areas to target with the updated Community Health Improvement Plan (CHIP). The numerous communities in this geographically large county continue to experience limited access to primary and specialty medical care. Since the first edition of the CHIP, more providers utilized mobile clinics to provide services to these areas. The Covid-19 pandemic shutdowns provided the impetus to rapidly increase virtual access to care, which helped alleviate some access issues experienced in remote communities. However, broadband internet service is the necessary infrastructure for virtual video visits with providers, and not all these communities have access to broadband service.

Access to primary and specialty care services continues to be limited within the county. Residents still must travel outside the county to the Bay Area to receive some specialty care. This drive takes over three and a half hours without traffic. Primary care clinics have expanded in the area, but the population is rapidly growing, which means that the increase in clinics may not be keeping up with demand. In addition to transportation barriers and limited services, the level of cultural competence and humility continues to be an area of opportunity for improvement.

The goals and objectives for the Access to Care work over the next five years are as follows:

GOAL 1

Ensure all providers and staff receive cultural humility training in conjunction with diversity, equity, and inclusion practice

- **Objective 1.1:** Ensure that 100% of participating facilities implement a training plan by 2024

GOAL 2

Ensure the public knows how and when to access care

- **Objective 1.1:** Reduce the use of emergency room (ER) visits for non-emergency care to no more than 75% of ER visits by 2028

GOAL 3

Help people get recommended health care services, including prevention

- **Objective 3.1:** Increase the number of organizations providing population-based primary prevention services

GOAL 4

Provide care to people where they are at

- **Objective 4.1:** Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations

Strategies to reduce these barriers to improve access to care will include cultural humility training for providers and their staffs, educating the public about when to go to an emergency room and when to use urgent care, expanding hours of primary care and urgent care services, assessing where there are gaps in health care services, identifying strategies to fill those gaps, and promoting clinic health screenings as part of prevention and early detection.

Cultural Humility for Special Populations

To address the need to improve patient care experience, the partnership will agree to provide cultural humility training to all their staff. Cultural humility training will go beyond increasing provider awareness of special populations to include specifics in modes of care to address individual needs. Training should include the types of screening, treatment, and preventive care for reproductive health in special populations with an emphasis on functional reproductive care. For example, how to prescribe and oversee the care of someone on PrEP, how and when to prescribe PEP. Gay men should receive 3-site testing when they seek an STI test (not just a urine sample). Currently this is not a standard of care across the county. There is also a need for comprehensive health education materials and other preventive measures, such as the availability of prophylactic resources like condoms.

Health Care Navigation

The partnership started implementing a health care navigation pilot to have people call 211 for health care navigation and ER diversion when the Covid-19 pandemic was starting, causing this effort to come to a halt. The navigator will guide, connect, and transfer people to the right medical resources; however, the navigator cannot provide medical guidance or advice. The group will finish the flowchart that was started in 2019 with any relevant updates. 211 could ask these callers if they would like to receive a follow-up contact to ensure that they were able to obtain the proper health care services. Additionally, they would like to see outreach to community members who don't have Medi-Cal or other types of insurance coverage. This outreach would include enrolling them into a plan and connecting them to a primary care provider.

Appropriate Use of the Emergency Rooms

The group also will explore a variety of methods to educate the public on the appropriate use of the emergency room, including the community health workers, signage, and campaigns. This will include education on where to seek primary care and urgent care. They also will work with local clinics to expand hours to reduce the burden on the local hospital emergency rooms. Patients with non-emergency situations will also be informed about the potentially long wait and be referred to the nearest urgent care, where the wait may be much shorter. Outreach will have a focus on immigrants who may not be familiar with the local medical system and where to go for the appropriate level of care.

Diabetes continues to be a primary health burden in the county, and as such, it remains the health issue of greatest concern. Diabetes is significant because it can contribute to other chronic diseases and make infectious diseases more lethal to those with it. A recent study found that the global prevalence of diabetes is associated with the severity of COVID-19 disease. Diabetes contributed to 9.5% of severe COVID-19 cases and 16.8% of COVID-19–related deaths. (Li R, 2023 Apr)

Health behaviors related to healthy eating and active living continue to be a challenge for Tulare County residents.

GOAL 5

Improve Identification and management of prediabetes and diabetes

- **Objective 5.1:** Ensure prediabetics and diabetics are appropriately managing their condition by screening 100 individuals annually through 2028
- **Objective 5.2:** Increase the number of individuals who manage their diabetes or prediabetes to reduce diabetes-related hospitalization in Tulare County by 10% by December 2028

GOAL 6

Increase opportunities for physical activity

- **Objective 6.1:** Increase annual participation of 80–100 individuals in physical activity opportunities provided by diabetes coalition and partners through December 2028.

GOAL 7

Increase consumption of healthy food and beverages

- **Objective 7.1:** Increase the number of sites annually by a margin of 1 location in Tulare County where healthier food and beverages are readily accessible through December 2028

Diabetes Screening

Diabetes rates in the county are higher than those of the state. The partnership understands that there is a need to expand screening and detection so that those with prediabetes and diabetes are referred as soon as possible for education about lifestyle changes and medication that could help them successfully manage their condition and perhaps reverse it if caught early enough. Emphasis on ensuring that they are connected with a health care provider for regular ongoing care would be a part of the overall strategy.

Healthy Lifestyles

To make the healthy choice the easy choice, there are still many opportunities to address healthy eating and active living. Being located in California's Central Valley, air quality is of great concern. Wildfires have become frequent in California, and the resulting low-quality air poses a challenge to anyone who likes to go outdoors for physical activity. Atmospheric inversions can also make the quality of the air over the area reach unhealthy levels. Heat is another deterrent for those enjoying physical activity outside. During the summer months, temperatures frequently soar over 100 degrees. The partnership will continue to look for low-cost or no-cost options for indoor activities, such as Zumba classes, to promote.

Healthy Lifestyles

Healthy eating can be a challenge when living in a food desert. The county's Nutrition Education and Obesity Prevention (NEOP) program continues to work with local communities to add places where residents can purchase fresh food at reasonable prices. This will include expanding farmers markets and adding produce to corner stores. The health plans will implement programs that support healthy eating by "prescribing" and providing fresh produce to patients who may benefit from them.

Bibliography

Li R, et al. (2023 Apr). Gobal Diabetes Prevalence in COVID-19 Patients and Contribution to COVID-19-Related Severity and Mortality: A Systematic Reivew and Meta-Analysis. Diabetes Care, 1;46(4):890-897.

Community Assets

Community	Asset Category Alcohol/Drug Treatment and/or support services	Free Physical Activity Programs	Senior Centers	Family Resource Centers	Farmers Markets/ Produce Markets	Fitness Centers	Emergency Services & Assistance	Libraries	Memorial Hall or Community Center	Parks
Farmersville			Farmersville Senior Center				FoodLink; St. Vincent De Paul	Farmersville Library (T-W)	Farmersville Community Center & Boys & Girls Club;	**Veteran's** Memorial Park; Farmersville Sports Complex; Liberty Park; Roy's Park; Riverbank Park; Jennings Park; Armstrong Park
Goshen			Goshen Senior Center							
Ivanhoe								Ivanhoe Library (T, Th, F)	Ivanhoe Memorial Hall	
Kingsburg*			Kingsburg Senior Center			Valkommen Fitness, Workouts Unlimited				
Lemon Cove							First Presbyterian (FoodLink, 4th Wednesdays)		Lemon Cove Women's Club	
Lindsay			Lindsay Senior Center	Lindsay FRC		Lindsay Wellness Center; McDermott Field House;		Lindsay Library (T-F)	Lindsay-Strathmore Memorial	Lindsay City Park
London								London Library (W-F)	Hodges Community Center (Proteus)	
Pixley				Pixley FRC				Pixley Library (T-F)	Pixley Memorial Hall; Pixley Community Garden?	Pixley Park
Poplar							Poplar Church of God (FoodLink, 3rd Tuesdays)		Tule River Youth Center	
Porterville	PAAR Center		Porterville Senior Center	Porterville FRC; Parenting Network	Seasonal Thursdays 8-11:30 @ Sierra View Hospital	multiple available	St. Vincent De Paul; Salvation Army; St Anne's (FoodLink, Wed & Thurs); Porterville Rescue Mission		Porterville Veterans Memorial Building	
Richgrove									Richgrove Memorial Building	
Springville								Springville Library (Th-S)	Springville Veterans Memorial Building	
Strathmore								Strathmore Library (T-W)	Strathmore Veterans Memorial Building	

Community Assets

Community	Asset Category Alcohol/Drug Treatment and/or support services	Free Physical Activity Programs	Senior Centers	Family Resource Centers	Farmers Markets/ Produce Markets	Fitness Centers	Emergency Services & Assistance	Libraries	Memorial Hall or Community Center	Parks
Sultana										
Terra Bella								Terra Bella Library (Pop-up only)	Terra Bella Veterans Memorial Building	Setton Playground (Avenue 94 and Road 236)
Three Rivers						Three Rivers Yoga		Three Rivers Library (T-S)	Three Rivers Memorial Building	Our Place Playground
Tipton								Tipton Library (Th-F)	Tipton Veterans Memorial Building	
Traver										
Tulare	Kings View Substance Abuse Program		Tulare Senior Center	Tulare FRC		multiple available	Church of Nazarene (food/clothes); St. John's (neighborhood MKT); Temporary Homeless Encampment	Tulare Library (T-S)	Tulare Veterans Memorial Building, Tulare Community Center, City of Tulare Youth Center	Refer to City of Tulare Parks and Recreation
Visalia	Lifestyle Center; via voucher for health diagnosis referral		Visalia Senior Center; Visalia Gleaning Seniors	Parenting Network	Visalia Farmers Market Saturday 8-11:30; Akers & Tulare Ave. May–Aug Wed 8–11:30	multiple available	Bethlehem Center; Visalia Rescue Mission; Visalia First Church (Foodlink 1st & 2nd Tues); Neighborhood MKT:	Visalia Library (T-S)	Visalia Veterans Memorial Building, Whitendale Center, Manuel Hernandez Community Center	Refer to City of Tulare Parks and Recreation
							Nazarene Church, United Methodist Church, Seven Oaks Church.			
Woodlake			Woodlake Senior Center	Woodlake FRC		Iron Grip Gym		Woodlake Library (T-F)	Woodlake Veterans Memorial Building	Woodlake City Park; Woodlake Botanical Garden & Bravo Lake; Castle Rock Park; Valenica Heights Park; Willow Court Park;
Woodville										Woodville Park

Community Assets

Community	Asset Category Pharmacies	Places with Free Indoor walking/physical activity	Public Transportation Routes	Primary Care Clinics	Schools	Urgent Care/Walk-in Clinics	Diabetes Support Groups	Focus Group Community Resources	Pharmacies	Places with Free Indoor walking/physical activity
Allensworth	Express Pharmacy aden				Allensworth Elementary School				Allensworth Community Center	Colonel Allensworth State Park
Alpaugh					Alpaugh Unified Schools				Alpaugh Memorial Hall	Alpaugh Co Park
Cutler-Orosi	Wenbo Liu Pharmacy Cutler; Foothill Pharmacy Orosi				Cutler-Orosi Joint Unified School District				Orosi Memorial Hall	Ledbetter Park; School grounds & play structure at Ave 419 & Rd 128;
Dinuba	Dinuba Pharmacy; Walmart; Walgreens; Rite Aid		https://www.dinuba.org/public-transit		Dinuba Unified School District				Dinuba Memorial Building, Dinuba Parks & Rec Center	Refer to City of Dinuba Parks and Recreation
Ducor										
Earlimart					Earlimart Elementary, Alila School; Earlimart Middle School;				Earlimart Memorial Hall	Earlimart Neighborhood Park
Exeter	Rancho Pharmacy; Rite Aid				Exeter Unified School District				Exeter Veteran's Memorial Building	Unger Park; Schroth Park; Brick House Park
Farmersville	Sierra Vista Pharmacy; Rite Aid				Farmersville Unified School District				Farmersville Community Center & Boys & Girls Club;	Veterans Memorial Park; Farmersville Sports Complex; Liberty Park; Roy's Park;
										Riverbank Park; Jennings Park; Armstrong Park
Goshen										
Ivanhoe					Ivanhoe Elementary School				Ivanhoe Memorial Hall	
Kingsburg*										
Lemon Cove									Lemon Cove Women's Club	
Lindsay	Rite Aid				Lindsay Unified School District		Lindsay Family Resource Center/Kaweah Health	Lindsay Diabetes Project	Lindsay-Strathmore Memorial	Lindsay City Park
London									Hodges Community Center (Proteus)	
Pixley					Pixley Elementary/Middle /Adult Schools				Pixley Memorial Hall; Pixley Community Garden?	Pixley Park
Poplar									Tule River Youth Center	
Porterville	Express Pharmacy; John A Mikhael Pharmacy;				Porterville Unified School District;				Porterville Veterans Memorial Building	

Community Assets

Community	Asset Category Pharmacies	Places with Free Indoor walking/physical activity	Public Transportation Routes	Primary Care Clinics	Schools	Urgent Care/Walk-in Clinics	Diabetes Support Groups	Focus Group Community Resources	Pharmacies	Places with Free Indoor walking/physical activity
	Valley Pharmacy Careplus; Rite Aid; Walmart; CVS; Walgreens									
Richgrove									Richgrove Memorial Building	
Springville									Springville Veterans Memorial Building	
Strathmore									Strathmore Veterans Memorial Building	
Sultana					Monson-Sultana elementary school					
Terra Bella					Terra Bella Union Elementary School District	N=1 Sierra View			Terra Bella Veterans Memorial Building	Setton Playground (Avenue 94 and Road 236)
Three Rivers	Three Rivers Drug				Three Rivers Unified School District				Three Rivers Memorial Building	Our Place Playground
Tipton					Tipton Elementary School				Tipton Veterans Memorial Building	
Traver					Traver Joint Elementary School					
Tulare	Wenbo Liu Cherry St Pharmacy; Walgreens; CVS; Rite Aid		https://www.tulare.ca.gov/residents/transit		Tulare City School District; Tulare Joint Union High School District;	N=3			Tulare Veterans Memorial Building, Tulare Community Center, City of Tulare Youth Center	Refer to City of Tulare Parks and Recreation
Visalia	All chains; Visalia Pharmacy; Boyd's Pharmacy		https://www.visalia.city/depts/general_services/transit/default.asp		Visalia Unified School District	N=6	Kaweah Health Diabetes Support Group	The Source; Planned Parenthood; Visalia Wellness Center	Visalia Veterans Memorial Building, Whitendale Center, Manuel Hernandez Community Center	Refer to City of Tulare Parks and Recreation
Woodlake	Foothill Pharmacy Woodlake; Rite Aid				Woodlake Unified School District				Woodlake Veteran's Memorial Building	Woodlake City Park; Woodlake Botanical Garden & Bravo Lake; Castle Rock Park; Valenica Heights Park; Willow Court Park;
Woodville	Altura; can verify what are the pharmacies that serve this area									Woodville Park

Community Assets

Community	Asset Category Pharmacies	Places with Free Indoor walking/physical activity	Public Transportation Routes	Primary Care Clinics	Schools	Urgent Care/Walk-in Clinics	Diabetes Support Groups	Focus Group Community Resources	Pharmacies	Places with Free Indoor walking/physical activity
	16686 Rd. 168, Woodville, CA 93257									

Policies to Support the Work

When implementing strategies to achieve the goals and objectives in this plan, sometimes it becomes necessary to create or change policies. The Access to Care partners will be creating or adapting cultural humility training. They will agree to adapt this as a condition for employment and set an expectation for clinicians and their staff to treat all patients with respect and dignity.

California has recently changed regulations to allow nurse practitioners to provide care without physician oversight. This change helps to alleviate the shortage of primary care providers in the area. Although there has been an increase in primary care clinics and providers, the county's population has been growing quickly, so there still may be a shortage when trying to meet demand.

Other policy areas to explore would include leveraging California Advancing and Innovating Medi-Cal (CalAIM) to address the needs of those enrolled in Medi-Cal managed care health plans. Per 2022 the State Plan Amendment 22-0001 CHW services are preventive health services as defined in Title 42 Code of Federal Regulations (CFR) Section 440.130(c).1,2 CHW services may assist with a variety of concerns impacting MCP Members, including but not limited to the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services. Additionally, CHW services can help Members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence-prevention services. CHWs tend to be members of the community they are serving and a larger component to linking health and social services for members with an overall improvement in quality of services delivered. The CHIP partnership will leverage CHWs in the implementation of this plan.

The CHIP partnership will continue to work with local schools, cities, and community centers on joint use permits, in addition to working with local employers to expand fitness opportunities to workers. To encourage healthy eating, the partnership will work with local markets to increase the amount of fresh produce space, encourage community gardens, use "gleaner" programs that pick fruit from yards, with permission, to provide to low-income residents.

Aligning with *Let's Get Healthy California*

As with the inaugural Tulare County CHIP, this next iteration aligns with the California State's *Let's Get Healthy California* State Health Improvement Plan (SHIP). The table below shows where the Tulare County CHIP (blue) best aligns with California's goals (gold), including the indicators that the state is monitoring to track progress in each of these goal areas.

Table XX: Alignment Between *Let's Get Healthy California* and the Tulare County CHIP

Let's Get Healthy California	Tulare County CHIP
Healthy Beginnings: Laying the foundation for a healthy life. A healthy beginning sets the stage for health and well-being for a person's entire life. These indicators represent important dimensions of children's health and well-being from infancy through the teenage years. As a society, we can work together to ensure all our children have the opportunity to thrive and reach their full potential. Indicators: • Childhood Fitness • Adolescent Fruit and Vegetable Consumption • Adolescent Sugar-Sweetened Beverage Consumption • Childhood Obesity	**CHIP Goal 6** Increase opportunities for physical activity. **Objective 6.1** Increase annual participation of 80–100 individuals in physical activity opportunities provided by diabetes coalition and partners through December 2028. **CHIP Goal 7** Increase consumption of healthy food and beverages. **Objective 7.1** Increase the number of sites annually by a margin of 1 location in Tulare County where healthier food and beverages are readily accessible, through December 2028.
Living Well: Preventing and managing chronic disease. The goal of the Triple Aim is to help people achieve optimal health at all stages of life. This includes physical and mental health as well as social well-being. Preventing and managing chronic disease is a particular focus, given the rising prevalence of chronic diseases and the impact they have on the state's residents. Reducing obstacles that block access to care is an important way to help individuals prevent and/or manage chronic disease. Indicators: • Adult Obesity • Adult Physical Activity • Adult Sugary-Beverage Consumption • Adult Fruit and Vegetable Consumption • Overall Health Status	**CHIP Goal 5** Improve Identification and management of prediabetes and diabetes. **Objective 5.1** Ensure prediabetics and diabetics are appropriately managing their condition by screening 100 individuals annually through 2028. **Objective 5.2** Increase the number of individuals who manage their condition (diabetes or prediabetes) to reduce diabetes-related hospitalization in Tulare County by 10% by December 2028.

Let's Get Healthy California	Tulare County CHIP
Redesigning the Health System: Efficient, safe, patient-centered care. Being the healthiest state in the nation will require the health care system to be better aligned toward population health goals and outcomes. The system should be patient-centered and look beyond illness to health. To advance this goal, health care systems and plans across the state are already innovating ways to redesign the health delivery system. Indicators: • Access to Primary Care • Timely Care • Access to Culturally and Linguistically Appropriate Services • Coordinated Outpatient Care for Adults • Preventable Hospitalizations • Hospital Readmissions	**CHIP Goal 1** Ensure all providers and staff receive cultural humility training in conjunction with diversity, equity, and inclusion practice. **Objective 1.1** Ensure that 100% of participating facilities implement a training plan by 2024. **CHIP Goal 2** Ensure the public knows how and when to access care. **Objective 2.1** Reduce the use of emergency room (ER) visits for non-emergency care to no more than 75% of ER visits, by 2028. **CHIP Goal 3** Help people get recommended health care services, including prevention. **Objective 3.1** Increase the number of organizations providing population-based primary prevention services. **CHIP Goal 4** Provide care to people where they are at. **Objective 4.1** Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations.
Creating Healthy Communities: Enabling healthy living. Where we live plays a major role in our health. Community conditions can enhance or create barriers to health. Communities that are safe and provide opportunities for active living and healthy eating are needed to support people in developing and maintaining healthy lifestyles. Indicators: • Access to Fruits and Vegetables • Walk Trips	**CHIP Goal 6** Increase opportunities for physical activity. **Objective 6.1** Increase annual participation of 80–100 individuals in physical activity opportunities provided by diabetes coalition and partners, through December 2028. CHIP Goal Increase consumption of healthy food and beverages. **Objective 7.1** Increase the number of sites annually by a margin of 1 location in Tulare County where healthier food and beverages are readily accessible, through December 2028.

Aligning with the National Prevention Strategy

Released in June 2011, the National Prevention Strategy is a comprehensive plan that focuses on increasing the number of Americans who are healthy at every stage of life. It prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives. This strategy focuses on both increasing the length of people's lives and ensuring that people's lives are healthy and productive.

The Strategy consists of four strategic directions and seven priorities. The strategic directions that align with this CHIP are Clinical and Community Prevention Services, Empowered People, and Elimination of Health Disparities. The priorities that align with this plan are Healthy Eating, Active Living, and Reproductive and Sexual Health. Table XX summarizes this alignment.

Table XX: Alignment Between the National Prevention Strategy and the Tulare County CHIP

National Prevention Strategy	Tulare County CHIP
Clinical and Community Preventive Services Evidence-based preventive services are effective in reducing death and disability and are cost-effective or even cost-saving. Preventive services consist of screening tests, counseling, immunizations, or medications used to prevent disease, detect health problems early, or provide people with the information they need to make good decisions about their health. While preventive services are traditionally delivered in clinical settings, some can be delivered within communities, work sites, schools, residential treatment centers, or homes. Clinical preventive services can be supported and reinforced by community-based prevention, policies, and programs. Indicators: • Proportion of adults aged 18 years and older with hypertension whose blood pressure is under control. • Proportion of adults aged 20 years and older with high low-density lipoprotein (LDL) cholesterol whose LDL is at or below recommended levels	**CHIP Goal 3** Help people get recommended health care services, including prevention. **Objective 3.1** Increase the number of organizations providing population-based primary prevention services. **CHIP Goal 4** Provide care to people where they are at. **Objective 4.1** Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations.

Aligning with the National Prevention Strategy

National Prevention Strategy	Tulare County CHIP
Empowered People Although policies and programs can make healthy options available, people still have the responsibility to make healthy choices. People are empowered when they have the knowledge, ability, resources, and motivation to identify and make healthy choices. When people are empowered, they are able to take an active role in improving their health, support their families and friends in making healthy choices, and lead community change. Indicators: • Proportion of persons who report their health care providers always explained things so they could understand them	**CHIP Goal 1** Ensure all providers and staff receive cultural humility training in conjunction with diversity, equity, and inclusion practice. **Objective 1.1** Ensure that 100% of participating facilities implement a training plan by 2024.

Aligning with the National Prevention Strategy

National Prevention Strategy	Tulare County CHIP
Elimination of Health Disparities America benefits when everyone has the opportunity to live a long, healthy, and productive life, yet health disparities persist. A health disparity is a difference in health outcomes across subgroups of the population. Health disparities are often linked to social, economic, or environmental disadvantages (e.g., less access to good jobs, unsafe neighborhoods, lack of affordable transportation options). Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health on the basis of their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion. Many health concerns, such as heart disease, asthma, obesity, diabetes, HIV/ AIDS, viral hepatitis B and C, infant mortality, and violence, disproportionately affect certain populations. Reducing disparities in health will give everyone a chance to live a healthy life and improve the quality of life for all Americans. Indicators: • Proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines • Proportion of persons who report their health care provider always listens carefully	**CHIP Goal 1** Ensure all providers and staff receive cultural humility training in conjunction with diversity, equity, and inclusion practice. **Objective 1.1** Ensure that 100% of participating facilities implement a training plan by 2024. **CHIP Goal 4** Provide care to people where they are at. **Objective 4.1** Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations.

Aligning with the National Prevention Strategy

National Prevention Strategy	Tulare County CHIP
Healthy Eating Eating healthy can help reduce people's risk for heart disease, high blood pressure, diabetes, osteoporosis, and several types of cancer, as well as help them maintain a healthy body weight. As described in the Dietary Guidelines for Americans, eating healthy means consuming a variety of nutritious foods and beverages, especially vegetables, fruits, low-fat and fat-free dairy products, and whole grains; limiting intake of saturated fats, added sugars, and sodium; keeping trans-fat intake as low as possible; and balancing caloric intake with calories burned to manage body weight. Safe eating means ensuring that food is free from harmful contaminants, such as bacteria and viruses. Indicators: • Proportion of adults and children and adolescents who are obese • Average daily sodium consumption in the population	**CHIP Goal** Increase consumption of healthy food and beverages. **Objective 7.1** Increase the number of sites annually by a margin of 1 location in Tulare County where healthier food and beverages are readily accessible, through December 2028.

Aligning with the National Prevention Strategy

National Prevention Strategy	Tulare County CHIP
Active Living Engaging in regular physical activity is one of the most important things that people of all ages can do to improve their health. Physical activity strengthens bones and muscles, reduces stress and depression, and makes it easier to maintain a healthy body weight or to reduce weight if overweight or obese. Even people who do not lose weight get substantial benefits from regular physical activity, including lower rates of high blood pressure, diabetes, and cancer. Healthy physical activity includes aerobic activity, muscle strengthening activities, and activities to increase balance and flexibility. As described by the Physical Activity Guidelines for Americans, adults should engage in at least 150 minutes of moderate-intensity activity each week, and children and teenagers should engage in at least one hour of activity each day. Indicators: • Proportion of adults who meet physical activity guidelines for aerobic physical activity • Proportion of adolescents who meet physical activity guidelines for aerobic physical activity • Proportion of the nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours	**CHIP Goal 6** Increase opportunities for physical activity. **Objective 6.1** Increase annual participation of 80–100 individuals in physical activity opportunities provided by diabetes coalition and partners, through December 2028.

Aligning with the National Prevention Strategy

National Prevention Strategy	Tulare County CHIP
Reproductive and Sexual Health Healthy reproductive and sexual practices can play a critical role in enabling people to remain healthy and actively contribute to their community. Planning and having a healthy pregnancy is vital to the health of women, infants, and families and is especially important in preventing teen pregnancy and childbearing, which will help raise educational attainment, increase employment opportunities, and enhance financial stability. Access to quality health services and support for safe practices can improve physical and emotional well-being and reduce teen and unintended pregnancies, HIV/AIDS, viral hepatitis, and other sexually transmitted infections (STIs). Indicators: • Proportion of pregnant females who received early and adequate prenatal care • Proportion of sexually active persons aged 15 to 44 years who received reproductive health services • Proportion of people living with HIV who know their serostatus	**CHIP Goal 4** Provide care to people where they are at. **Objective 4.1** Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations.

Tracking and Monitor Progress

The Access to Care team and the Tame Diabetes team will meet bimonthly, when the community partners will provide progress updates on their work using a template provided by the County. Status updates will consist of a summary of actions taken between meetings and review of data against their targets. Gaps to target will be addressed through action items for update and review at the subsequent meetings. This template can be found in Appendix D.

The County will produce an annual report to summarize accomplishments, status, and actions to be taken to achieve goals set forth in this plan. This report shall be made available to the partnership and community at large.

Conclusion and Next Steps

It takes many groups and individuals coming together to improve the health of the county. There are many community groups represented in one or more of the Community Health Improvement Plan committees and coalitions. However, participation is not limited to only those that have been a part of developing this plan. **Anyone interested in participating in the ongoing activities of the Tulare County Community Health Improvement Plan is welcome to join the Access to Care Coalition and/or the TAME Diabetes Coalition by contacting Tulare County Public Health.**

The Tulare County CHIP partnership is looking to continue expanding efforts within the strategies of this Community Health Improvement Plan to ensure its success in achieving the goals. As part of the ongoing management of implementing this plan, each group will meet bimonthly, with working meetings as needed in between. Status updates will be provided along with consistent data review to ensure the group remains on course.

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Appendices A-D

Appendix A: Access to Care Implementation Plan

Appendix A: Access to Care Implementation Plan

Access to Care			
Goal 1: Ensure all providers and staff receive cultural humility training related to diversity, equity, and inclusion			
Objective 1.1 Ensure that 100% of participating facilities implement a training plan by 2024			
Policies, Systems, and Environmental Changes: Consider drafting agreements from partners to adapt this as a condition for employment and an expectation for clinicians and their staffs to treat all patients with respect and dignity.			
Strategy	Implementation Lead	Output/Process Measure(s)	Outcome Measure(s)
1.1.1 Create (if needed) and implement training plan sharing current plan, share best practices, for all other organization} i.e., share topics found in your training plan (**Per org.)	• VHCC: Jessica Vasquez • Ercilia Montemayor • Maria Arias • Denise Gonzalez • Altura: Graciela • Sonia- Kaweah Health • Trainer- Tino on diversity and inclusion	• Number of participating clinics, organizations, hospitals with training plans • Percent/number of clinic staff/providers completing the training (note that there will need to be agreement for partners to share their data, and data can be reported in aggregate) • Progress on training plan	• Patient satisfaction data • *AHRQ surveys households (Medical Expenditure Panel Survey – MEPS) to get this data to assess the proportion of people who report poor communication with providers – probably not available at the county level (yet)* • *If focus groups are done again, can ask for feedback on how county healthcare centers/clinics are doing in this area*
1.1.2 Explore implementing tools to aid in hiring staff	• The Source LGBT+ Center		
and providers that represent the population served.	• CFF - Jose/Nayeli • Erica Cubas, Community Development Director, Altura Centers for Health • Sonia Duran-Aguilar, Director of Population Health, Kaweah Health		

Appendix A: Access to Care Implementation Plan

Goal 2: Ensure the public knows how and when to access care			
Objective 2.1 Reduce the use of emergency rooms (ER) visits for non-emergency care to no more than 75% of ER visits, by 2028			
Policies, Systems, and Environmental Changes: *Think about systems changes that can help in reducing incorrect use of the ER (e.g., can an urgent care facility be collocated or located near a hospital ER so patients can be redirected based on a triage assessment) If expanding telehealth, include policy work to expand broadband to rural communities.*			
Strategy	Organization representative	Output/Process Measure(s)	Outcome Measure(s)
2.1.1 Conduct campaigns to educate the public on the appropriate use of the emergency room in partnership with health plans. Notes: Sonia/Shannon; Kaweah health; to capture uptake/usage	• VHCC -Ercilia Montemayor • Anthem: Lali • Martin: 211 (to utilize the prog. for diversion and also provide some data for pts calling in, and will need to further assess how to handle a call that may need medical attention, will need to work on a plan to determine the outcome of • Sonia: Kaweah Health	• Depending on the campaign: ○ Number of ads ○ Number of cars passing a billboard ○ Number of likes/comments on social media • If a phone number (e.g., 2-1-1) is part of the campaign, track number of callers requesting/receiving this type of information. • social media messaging	• Percent of ER patients receiving non-emergency care • Number or percentage of patients diverted from ER to urgent or primary care when appropriate. • Urgent care utilization
2.1.2 Provide classes to Medi-Cal recipients on how to use their insurance. 2.1.3 Develop workshops and deliver them to specific areas in the county. Notes: ***MEDICAID re-enrollment process knowledge on pre-authorization and benefits, telehealth, nurse line (after-hour use)	• Sonia Duran Aguilar Director of Population Health Kaweah Health • Health Plans* Health Net and Anthem (revise during Thursday planning meeting) • Shannon T. HHSA Integrated Services to collaborate with Sonia to ensure we capture all important pieces	• Number of classes being offered, locations, and languages. • Number of CHW or trusted messengers to disseminate the messaging/training	• Number of participants completing education classes

Appendix A: Access to Care Implementation Plan

Goal 2: Ensure the public knows how and when to access care			
Objective 2.1 Reduce the use of emergency rooms (ER) visits for non-emergency care to no more than 75% of ER visits, by 2028			
Policies, Systems, and Environmental Changes: *Think about systems changes that can help in reducing incorrect use of the ER (e.g., can an urgent care facility be collocated or located near a hospital ER so patients can be redirected based on a triage assessment) If expanding telehealth, include policy work to expand broadband to rural communities.*			
***partnering with school districts to be able to have the classes *** CHW as trusted messengers for the training	• CFF • The Source LGBT+ Center *Obtain agreement from insurance companies to provide data on quarterly basis.*		
2.1.3 Explore how to expand urgent care and primary care hours. **Notes:** Altura and VHCC after hours, no intent on making changes Kaweah Health will look into the hours of operation and bring it back to the committee. Anthem: purpose will be to compile and education and share this tool with the entities providing the resources **Notes:** we can first track the hours of operation and plan in the future if gaps identified potential next steps: work with clinics on operational best practices	• FHCN • 211 Martin; "flow chart" of all providers and what is being provide, hours, services etc.	• The number of urgent care and primary clinic hours expanded (evenings, weekends, holidays, etc.) • Compile a resource guide to share the resources and office hours to share with the clients/patients.	
2.1.4 Explore promoting telehealth and training community members on how to use technology		• Number of promotional	• Percent of population with access to broadband/telehealth visits to be captured
2.1.5 Finalize flowchart to guide with healthcare navigation assistance	• CFF - Jose/Nayeli		

Appendix A: Access to Care Implementation Plan

Goal 3: Help people get recommended health care services, including prevention			
Objective 3.1 Increase the number of organizations providing population-based primary prevention services			
Policies, Systems, and Environmental Changes: *How can you make the healthy choice the easy choice? Land use or zoning issues? Transportation infrastructure? Broadband accessibility?*			
Strategy	Organization representative	Output/Process Measure(s)	Outcome Measure(s)
3.1.1 Assess (all) gaps in primary prevention services provided across the county's many communities and develop a plan to close the gaps.	• VHCC -HEDIS /UDS measures; George Jagatic, Supervisor • Tulare County Health Care Centers • Kaweah: Sonia (invite other supporting staff)	• Gap analysis report	• Plan with strategies to address the gaps in provided primary prevention services
3.1.2 Promote various health behaviors/screenings based on what is learned in the gap analysis done 3.1.1.	• Tulare County Behavioral Health • Tucker-Program Manager, The Source LGBT+ Center • Sonia Duran-Aguilar, Director of Population Health, Kaweah Health, DM-TAME • CFF Jose/Nayeli	• Number of people calling to inquire about targeted health services depending on the program: ○ Number of people screened ○ Number of people educated ○ Number of likes/comments/ followers on social media	• Outcome measure will relate to the issues being promoted and screened.

Appendix A: Access to Care Implementation Plan

Goal 4: Provide care to people where they are at			
Objective 4.1 Increase the ability of primary care and behavioral health professionals to provide more high-quality care to vulnerable populations			
Policies, Systems, and Environmental Changes: Leverage CalAIM. Nurse practitioners are now able to practice on their own.			
Strategy	Organization representative	Output/Process Measure(s)	Outcome Measure(s)
4.1.1 Increase outreach (street) medicine to vulnerable and underserved communities (PRAPARE Screening Tool)	• Tulare County Behavioral Health • The Source Tulare County Health Care Centers	• Number of individuals receiving care each (week, month, etc.)	• Percent of ER patients receiving non-emergency car
4.1.2 Provide wraparound services for whole person care for underserved populations	• Sonia Duran-Aguilar Director of Population Health Kaweah Health	• Number of clients served	• Homeless census • HIV/AIDS surveillance report (data source)
	• WIC	• Homeless Information Management System (HIMS) • PRAPARE implementation toolkit	
4.1.3 Gain an understanding of transportation barriers to implement strategies to address them	• TCAG	• Analysis report to identify the barriers (coordinated transportation plan findings)	
4.1.4 Increase number of CBOs with Cal AIM contracts/certifications (placeholder for when state releases more guidance)			• Number of contracts with CBOs.

Appendix B: TAME Diabetes Implementation Plan

Appendix B: TAME Diabetes Implementation Plan

TAME Diabetes			
Goal 5: Improve Identification and management of prediabetes and diabetes			
Objective 5.1 Ensure prediabetics and diabetics are appropriately managing their condition by screening 100 individuals annually through 2028			
Policies, Systems, and Environmental Changes: *What changes can be made to make it easier to get more at-risk people screened? Leverage CalAIM?*			
Strategy	Implementation Lead	Output/Process Measure(s)	Outcome Measure(s)
5.1.1 Develop an education campaign for outreaching to high-risk populations to encourage screening, testing, referral, and prevention that will include: • Leveraging community health workers (CHWs) • Collaborating on educational materials and messaging • Conducting a social media/radio campaign	• Sandra Escudero: Lindsay Unified • Kaweah: Alma Torres • Altura: Erica Cuvas • CFF: Nayeli • FHCN: Veronica	• Number of people referred for screening • Number of people receiving educational information	• Number of people screened for prediabetes or diabetes • Percent of adults aged 18 years and over with diagnosed diabetes ever had received formal diabetes self-management education and support (BRFSS data) • Prediabetes and diabetes rates
5.1.2 Explore developing a website with resources and links to other sites with information about the importance of being screened and managing blood glucose levels (*maybe add to 211 website)*		• Implementation of a robust website with resources	
over the next five years		to organize this	events

Appendix B: TAME Diabetes Implementation Plan

Objective 5.2 Increase the number of individuals who manage their diabetes or prediabetes to reduce diabetes-related hospitalization in Tulare County by 10% by December 2028			
Policies, Systems, and Environmental Changes: *Leverage CalAIM? What are the barriers to their ability to manage their condition? Cost of medication? New reduction in monthly cost of insulin for Medicare patients (will this be promoted with that population?)*			
Strategy	Implementation Team	Output/Process Measure(s)	Outcome Measure(s)
• 5.2.1 Refer those screening positive for prediabetes or diabetes range for follow-up care and education.	• Devon: Sierra View • Alma Torres: Kaweah • Adventist Health • Kaiser	• Percent of those screening positive that scheduled a follow-up appointment for care and disease management education	• Diabetes hospitalizations • ED visit data could be tracked if hospitals provide it. (pull by DRG billed for that specific visit) • OSHPD data – maybe • Consider tracking both new diabetics and those non-compliant.
5.2.2 Expand capacity to provide formal diabetes education by: • Training CHWs/Promotoras on evidence based self-management techniques. • Providing them with stipends to deliver workshops in targeted communities (e.g., rural areas) • Creating and fostering more support groups	• Sandra Escudero: Lindsay Unified • Alma Torres: Kaweah • Nayeli: CFF		
5.2.3 Improve the capacity of the diabetes workforce to address factors related to SDOH that impact health outcomes for priority populations with and at risk for diabetes.		• # of workers trained in SDOH	
5.2.4 Build upon the blood pressure monitors and cuffs in the homes of hypertensive patients so they can monitor their blood pressure and message their providers if necessary (Tipton medical clinic)	• Living Water Clinic	• Percentage of patients with blood pressure monitors and cuffs (or glucose meters) in their homes • Number or percentage of patients alerting their care providers about elevated blood pressure levels	
5.2.5 Ensure patients monitor their blood glucose levels by securing funding for new glucose meters for home monitoring	• Each organization	• Percentage of patients with glucose meters in their homes • Number or percentage of patients alerting their care providers about elevated blood sugar levels	

Appendix B: TAME Diabetes Implementation Plan

Goal 6: Increase opportunities for physical activity			
Objective 6.1 Increase annual participation of 80-100 individuals in physical activity opportunities provided by diabetes coalition and partners through December 2028			
Policies, Systems, and Environmental Changes: Work with local schools, cities, and community centers on joint use permits, work with local employers to provide fitness opportunities to workers, etc.			
Strategy	Implementation Lead	Output/Process Measure(s)	Outcome Measure(s)
6.1.1 Develop a directory of organizations supporting this objective (consider mapping locations of what is available, open to the public) 6.1.2 Communicate/promote the availability to the public (211 page) 211tularecounty.com 6.1.3 Increase the number of venues with exercise equipment	Examples of fitness classes and events: Zumba classes, Bailoterapia, Tai Chi, monthly community walks, walkathons, Zumbathons, etc. • Altura and County NEOP • Aurora • Crystal • Consider adding a community partner	• # of promotions • # of free classes offered by type of class • # of locations where free activity classes • Consider using 211 metrics to track visits to their website for this information	• # of people participating in the opportunities/physical activity

Appendix B: TAME Diabetes Implementation Plan

Goal 7: Increase consumption of healthy food and beverages			
Objective 7.1 Increase the number of sites annually by a margin of 1 location in Tulare County where healthier foods and beverages are readily accessible through December 2028			
Policies, Systems, and Environmental Changes: Work with local markets to increase the amount of fresh produce space, encourage community gardens, use 'gleaner' programs that pick fruit from yards with permission to provide to low-income residents, etc.			
Strategy	Implementation Lead	Output/Process Measure(s)	Outcome Measure(s)
7.1.1 Work with rural markets to makes fruits/veggies accessible	• NEOP	• # markets that add fruits/vegetables to their product lines • # of retail stores willing to participate in	• Sugar-sweetened beverage consumption • Healthy stores, healthy community survey
7.1.2 Continue working with Dinuba Farmers Market	• Kaweah • Central Valley Network for Dance & Diversity • NEOP	the Shop Healthy Partner pledge initiative • # of referrals to the program • # of food distributions events each site did	
7.1.3 Pilot test veggie Rx program	• Kaweah	• # of people placed on a veggie Rx program	• *Monitor related health metric (e.g., HbA1C, blood lipids, etc.)*
7.1.4 Leverage Anthem, Healthnet, and Humana medically tailored meals program to provide healthy meals to patients who have recently discharged from the hospital to reduce 30-day hospital readmissions		• # of patients put on medically tailored meals post hospital discharge per month	• 30-Day hospital readmission rate (or observed/expected hospital readmissions)

Appendix C: Linkages Between Tulare County Public Health Strategic Plan and CHIP

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

The Public Health Branch is the convening organization to support the community health improvement partnership in addressing access to care and diabetes prevention and treatment. The department took a different approach in this version of its strategic plan. They wanted to focus more on infrastructural goals and objectives. Strengthening the Public Health Branch's infrastructure enables the organization to provide support and resources to its community partners to advance the goals found in the Tulare County Community Health Improvement Plan (CHIP). Alignment between these plans may not be as direct as the previous versions; however, the support alignment with the CHIP goals and objectives is illustrated in the table below.

Public Health Safety and Protection	
Public Health Strategic Plan	Tulare County CHIP
Goal 1: Ensure Public Health Safety and Protection. **Objective 1.5** Coordinate and collaborate with other Agency Branches to link the homeless to care and services.	**Goal 4:** Provide care to people where they are at. **Objective 4.1** Increase the ability of primary care and behavioral health professionals to proivde more high quality care to vulnerable population.
Description of Alignment	
By coordinating and collaborating within Agency branches to link the homeless to care and services, Public Health will be supporting the CHIP objective to linking the homeless, a vulnerable population to high quality care.	

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

Community Mobilization and Health Promotion

Public Health Strategic Plan	Tulare County CHIP
Goal 2: Enhance Community Engagement Across the Branch. **Objective 2.1:** Educate all programs (100%) about the Health Equity framework and ensure that 80% of programs establish partnerships with clear expectations of partnership engagement while advancing equity and inclusiveness by 2024. **Objective 2.2:** Collaborate with Behavioral Health to promote mental wellness to vulnerable populations such as aging or homeless. **Objective 2.3:** Ensure the community's representation is included in program development and implementation by: • Creating a community survey guidance document for including the community's voice in program development and implementation by 2024. • Training staff from all public health programs on how to ensure they are including the voice of the community in their program development and implementation by 2025. • Using community survey guidance to conduct community surveys for program development and implementation through 2028.	**Goal 3:** Help people get recommended health care services, including prevention. **Goal 4:** Provide care to people where they are at. **Objective 4.1:** Increase the ability of primary care and behavioral health professionals to provide more highquality care to vulnerable populations. **Goal 6:** Increase opportunities for physical activity. **Objective 6.1:** Increase the number of people who participate in physical activity opportunities provided by diabetes coalition and partners each year by 5% through December 2028. **Goal 7:** Increase consumption of healthy food and beverages. **Objective 7.1:** Increase the number of sites in Tulare County where healthier food and beverages are readily accessible through December 2028.

Description of Alignment

Engagement with the community enables the Public Health Branch to promote programs and services that meet the needs and expectations of the community. They can in turn inform their partners on how to scope their programs and services to meet community needs, especially for the vulnerable populations. Community engagement will also be used to identify they locations and types of physical activities they would like to participate in. In addition, placing produce in locations within a community would benefit from knowing what types of fresh food is preferred among the community members. This is done by including the community voice in the implementation of program services and activities

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

Community Mobilization and Health Promotion

Public Health Strategic Plan	Tulare County CHIP
Goal 3: Promote Health **Objective3.1:** Ensure health literacy is considered when developing prevention program materials by: • Requiring 1-2 staff per prevention program to complete a health literacy training by 2025. • Implementing a literacy level screening tool to be used across all prevention programs by 2025. **Objective 3.3:** Identify a minimum of six health issues per year, based on the selected national awareness months	**Goal 2:** Ensure the public knows how and when to access care. **Objective 2.1:** Reduce the use of emergency rooms (ER) visits for nonemergency care to no more than xx% of ER visits by 2028. **Goal 3:** Help people get recommended health care services, including prevention. **Objective 3.1:** Increase the number of organizations providing populationbased primary prevention services. **Goal 5:** Improve Identification and management of prediabetes and diabetes. **Objective 5.1:** Ensure prediabetics and diabetics are appropriately managing their condition by screening XX (number) of people annually through 2028. **Objective 5.2:** Increase the number of individuals who manage their diabetes or prediabetes to reduce diabetesrelated hospitalization in Tulare County by xx% by December 2028.

Description of Alignment

The Public Health Branch plans to promote six health issues each year during the 5-year period of this strategic plan. With appropriate timing, they will align topics with CHIP objectives to maximize the community's effort of achieving those goals. Topics would include the appropriate use of emergency rooms, recommended health care prevention and detections (e.g., health screenings), and educating or encouraging diabetics to manage their condition as recommended by the health care provider.

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

Equity, Diversity, and Inclusion

Public Health Strategic Plan	Tulare County CHIP
Goal 4: Include Health Equity throughout the Department **Objective 4.2:** Incorporate standard health equity (cultural competency) language (boiler plate language) within partner agreements or contracts starting in 2024. **Objective 4.3:** Address health inequities through data-driven decision-making by using data to identify disparities in the community that have been marginalized and have been disproportionately impacted by reviewing program data according to their cadence for program data review. **Objective 4.4:** By 2028 Develop infrastructure to receive referrals from ECM providers related to CalAIM that will include: • Building capacity to receive referrals. • Developing a referral process. • Creating a data framework. • Integrating services (connection to	**Goal 1:** Ensure all providers and staff receive cultural humility training in conjunction with diversity, equity, and inclusion practice. **Objective 1.1** Ensure that 100% of participating facilities implement a training plan by 2024. **Goal 5:** Improve Identification and management of prediabetes and diabetes. **Objective 5.1:** Ensure prediabetics and diabetics are appropriately managing their condition by screening 80-100 of people annually through 2028. **Objective 5.2:** Increase the number of individuals who manage their diabetes or prediabetes to reduce diabetesrelated hospitalization in Tulare County by xx% by December 2028. **Goal 6:** Increase opportunities for physical activity. **Objective 6.1:** Increase the number of people who participate in physical activity opportunities provided by diabetes coalition and partners each year by 10% through December 2028. **Goal 7:** Increase consumption of healthy food and beverages. **Objective 7.1:** Increase the number of sites in Tulare County where healthier food and beverages are readily accessible through December 2028.

Description of Alignment

This goal is more inward facing, but as internal capacity is built, the County will be positioned to support their community partners with their equity initiatives. This work will support reducing any disparities by addressing diversity, equity, and inclusion. It can be used to support the partnership's desire to ensure all those working the in the public health and healthcare system are trained in cultural humility.

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

Equity, Diversity, and Inclusion
Description of Alignment
This has the potential to also reduce barriers to care that are associated with a reluctance to obtain healthcare services because of the perception that providers are not as caring or understanding as they could be. The incorporation of a Health Equity framework will also be useful in identifying areas where physical activity opportunities could be increased. Lastly, some communities are still considered food deserts, places where buying fresh produce is challenging due to availability and/or cost. Incorporating strategies to address equity had the potential of reducing or eliminating these barriers.

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

Organizational Excellence

Public Health Strategic Plan	Tulare County CHIP
Goal 5: Build a Skilled and Competent Workforce	**NA**

Description of Alignment

This one is inward facing, but as internal capacity is built, the County will be positioned to support their community partners.

Public Health Strategic Plan	Tulare County CHIP
Goal 6: Create a Culture of Continuous Quality Improvement and Results-based Accountability	**NA**

Description of Alignment

This one is inward facing, but a QI opportunity could be identified with the CHIP work in the future.

Appendix C: Alignment Between the Public Health Strategic Plan and the Tulare County Community Health Improvement Plan

Health Informatics

Public Health Strategic Plan	Tulare County CHIP
Goal 7: Advance Information and Data Management for the Public Health Branch **Objective 7.1:** Participate with Agencywide efforts in building a data management system for CalAIM. **Objective 7.2:** Explore data management systems and tools to share data with partners by: • Refreshing 20% of CHA data each year and publish on the PH website for public access. • Ensuring public access for data related to specific program activities (e.g., STD data with schools).	**Goal 3:** Help people get recommended health care services, including prevention. **Objective 3.1:** Increase the number of organizations providing populationbased primary prevention services. **Goal 4:** Provide care to people where they are at. **Objective 4.1:** Increase the ability of primary care and behavioral health professionals to provide more highquality care to vulnerable populations. **Goal 5:** Improve Identification and management of prediabetes and diabetes. **Objective 5.1:** Ensure prediabetics and diabetics are appropriately managing their condition by screening 80-100 of people annually through 2028. **Objective 5.2:** Increase the number of individuals who manage their diabetes or prediabetes to reduce diabetesrelated hospitalization in Tulare County by xx% by December 2028.

Description of Alignment

The intent of this goal is to position the public health branch to provide health informatics for its programs and community partners to make data-driven decisions. The information can be used to track health care services received by the Medi-Cal population via the CalAIM informatics system. This system may be able to track the diabetic patients and their ability to manage their condition. It also supports maintaining the data found in the Community Health Assessment.

Appendix D: Monitoring Tools

Appendix D: Status Update Report Template

Tulare County TAME Diabetes (Subcommittee Name)	
Name/Organization:	Meeting Date:
Goal:	
Objective:	

Process Measure	Outcome Measure
Data graphic showing trend	*Data*

Progress	Opportunities/Accomplishments
Add	*Add*

Collaboration with other organizations

Next Steps

Questions

Tulare County Health and Human Services Agency
Public Health Branch

HHSA Public Health

Accredited 2020

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