



STANISLAUS COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN 2020



Stanislaus County Board of Supervisors

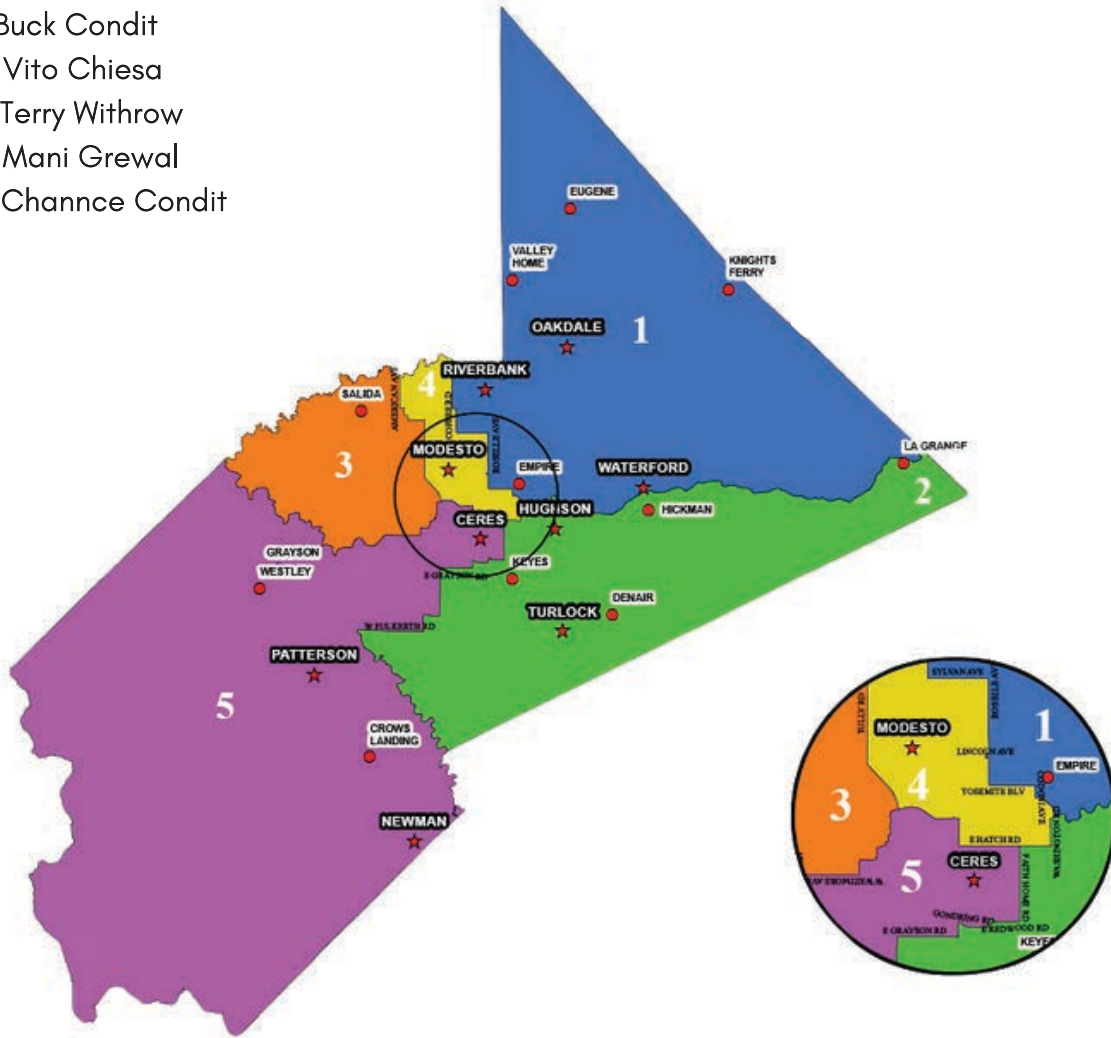
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ACKNOWLEDGEMENTS

The Community Health Improvement Plan (CHIP) has been developed by the Stanislaus County Health Services Agency with input from community members and in partnership with numerous stakeholders and community organizations. This report would not have been possible without their expertise and Stanislaus County Health Services Agency would like to give their sincerest thanks to everyone who made this plan possible. Additional thanks is owed to the residents who attended the community meetings around the county; their perceptions about the needs of their communities were vital in the development of this document.

Groups and agencies involved in the CHIP development process are listed below:

Steering Committee Agencies Represented

Area Agency on Aging	Health Plan of San Joaquin
Behavioral Health and Recovery Services	Kaiser Permanente
Catholic Charities	LGBTQ Collaborative
Center for Human Services	Livingston Health
City of Ceres	MoPride
City of Hughson	Parent Resource Center
City of Riverbank	Sierra Vista Child Family Services
Community Health Insights	Stanislaus County Children and Families
Community Services Agency	Commission
CSU Stanislaus	Stanislaus County Office of Education
Economic Development and Workforce Alliance	Stanislaus County Health Services Agency
El Concilio	Sutter Health
Focus on Prevention	United Way
Golden Valley Health Centers	Valley Children's Hospital
Health Net	West Modesto King Kennedy Center

Data Subcommittee Agencies Represented:

Area Agency on Aging	Stanislaus County Health Services Agency
Behavioral Health and Recovery Services	Mountain Valley EMS Agency
Focus on Prevention	Stanislaus County Office of Education

MESSAGE FROM PUBLIC HEALTH DIRECTOR **LORI WILLIAMS**

Stanislaus County Health Services Agency is delighted to present the 2020 Community Health Improvement Plan (CHIP). The CHIP is the culmination of sixteen months of ongoing engagement, conversations, and discussions with community partners, key stakeholders, and community residents. It reflects the concerns of the community and this organization's commitment to solve them. The strategies within the CHIP are based on the results of the Community Health Assessment (CHA), a comprehensive profile of the health status of our community that overviews the issues and concerns impacting the community as identified by stakeholders within Stanislaus County.

Based on the findings of the CHA, the CHIP outlines the steps to be taken in the next five years (2020 to 2025) to address these concerns and ultimately improve population health. In this five year time frame, CHIP progress will be monitored, evaluated, and updated to ensure the listed outcomes are achieved. The CHIP is organized around four focus areas and is meant to guide public health activities by framing each strategy through the lens of health equity and collective impact.

This plan could not have been developed without the ongoing support of the Stanislaus community. This plan is possible because of the community's ongoing commitment and willingness to share their thoughts and ideas on how to solve this Stanislaus County's greatest public health issues. With their input, the 2020 CHIP will serve as a resource and guide to building "A thriving community where all people have an opportunity to be safe and healthy".



STANISLAUS COUNTY BACKGROUND

Stanislaus County is home to more than half a million people and is a region rich in diversity with a strong sense of community. With a total land area of 1,521 square miles (approximately 973,440 acres), mild Mediterranean climate, rich soil, and progressive farming practices, Stanislaus County is a global center for agribusiness. The area is internationally recognized for agricultural innovation and is a top producer of almonds, milk, poultry, cattle, nurseries, and walnuts.

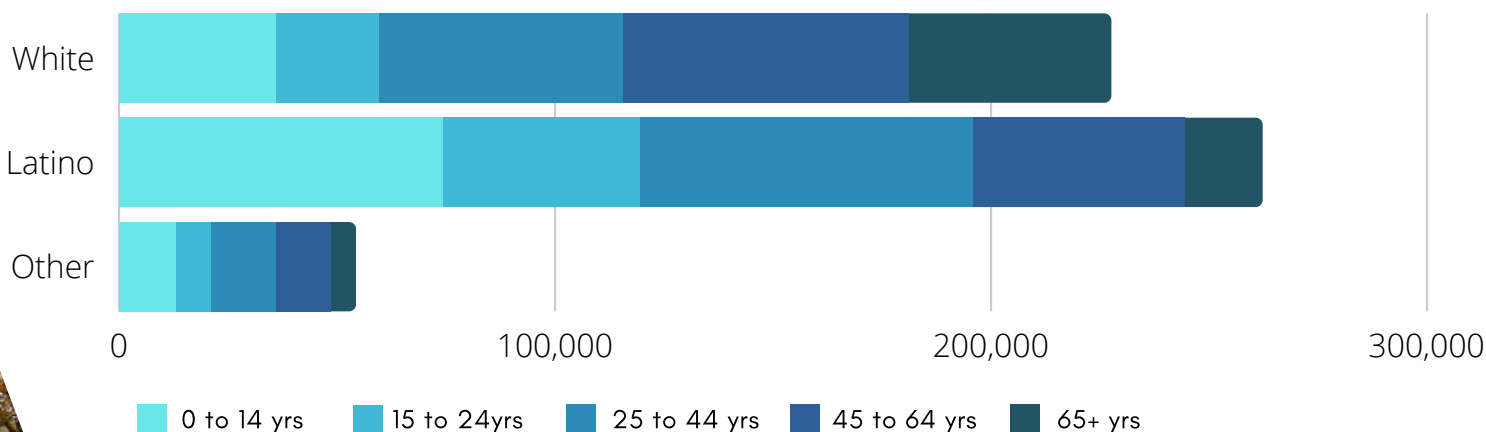
Stanislaus County is positioned in the Central Valley of California. Due to its location, ninety minutes from the San Francisco Bay area, Silicon Valley, Sacramento, the Sierra Nevada Mountains, and California's Central Coast, Stanislaus County has become one of the dominant logistics centers of the west coast. Reinforcing these connections are two major California north-south transportation routes (Interstate 5 and Highway 99) which intersect the county.

Stanislaus County promotes first-rate educational practices and is home to California State University Stanislaus and Modesto Junior College. The county benefits from the presence of these and satellite locations of other higher education institutions.

Community Demographics

The median age among Stanislaus County residents is 34.1 years old, 18% of residents are over the age of 60, and 27.2% of people are below the age of 18 years old. The two largest race/ethnicity groups in Stanislaus are Latino (47.6%) and White (40.3%). (U.S. Census Bureau, 2020).

Stanislaus County Residents by Race/Ethnicity and Age



Household Types

There are 173,898 households in Stanislaus County with an average household size of 3.09. Of these households, 8% are a single parent living with their children who are under 18 years old and 9% of households are single occupant over the age of 65. Reflecting the youth of the county, 40.6% of households have children living in them. (U.S. Census Bureau, 2020).

Education

The total number of residents enrolled in school is 152,625. Of those enrolled, 11% are in kindergarten/preschool, 44% are in elementary/middle school, and 23% are in high school. (U.S. Census Bureau, 2020).

Income

The median annual household income in Stanislaus County is \$60,704, 19% lower than the statewide median in California. Approximately 15.1% of residents live below the federal poverty level. Although Latino residents make up 47.6% of Stanislaus County, they represent 55% of residents living below the federal poverty level. (U.S. Census Bureau, 2020)

21.1% of residents aged 25 years and older do not have a high school degree
(U.S. Census Bureau, 2020).



The wealthiest 1% of men live 15 years longer than the poorest 1% of men (Chetty et al., 2016).



Health Disparities

The 2020 Community Health Assessment (CHA) documented significant health disparities based on race, ethnicity, geographic region, income, and education. (Stanislaus County Health Services Agency, 2020). Out of 58 California counties, Stanislaus County is ranked 37th for health outcomes overall, 39th for length of life, and 42nd for quality of life. Approximately 18% of Stanislaus County residents experience poor or fair health while the top U.S. performers report 12%. (University of Wisconsin Population Health Institute, 2020).

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN?

A Community Health Improvement Plan (CHIP) addresses a community's most concerning health issues by outlining an action-oriented plan to achieve a community's long-term vision of health. This plan includes an overview of the priority health issues, the strategies developed to address these concerns, and the indicators that will track the community's progress in achieving the CHIP's stated outcomes. The CHIP does not belong to a specific organization or agency but rather to the broader community. This plan is collaborative and it relies on collective partnerships to achieve agreed upon goals.

To ensure the CHIP is an action-oriented initiative, the Stanislaus County Health Services Agency-Public Health Division (HSA/PH) will act as the point of contact organization. They will provide the support and expertise needed as well as coordinate community partners and stakeholders to support the Stanislaus County CHIP's vision for, *"A thriving community where all people have the opportunity to be safe and healthy."*



WHY WAS A COMMUNITY HEALTH IMPROVEMENT PLAN DEVELOPED FOR STANISLAUS COUNTY?

The CHIP was developed to improve the health and well-being of the residents of Stanislaus County. The development of the CHIP provides an opportunity to collaborate with the community and partners across multiple sectors and disciplines to achieve better health outcomes for all residents of Stanislaus County. This CHIP is a result of strong partnerships that worked together to align the county's improvement initiatives. These collaborations are a critical component in developing policies and actions to improve county-wide health outcomes.

“

We can do an awful lot more by working with partners in the community than anything we can achieve alone.

Key Informant Interviewee

”

HEALTH EQUITY & THE SOCIAL DETERMINANTS OF HEALTH

Improving the lives of all Stanislaus County residents requires addressing many factors that influence the health and well-being of all communities. A population's health is largely influenced by the conditions in which people are born, live, work, play, and age. These drivers of health, including health care systems, are known as the social determinants of health. These factors, both positive and negative, influence a person's risk for disease, injury, and death. The social determinants of health are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. These can include everything from the sidewalks in the neighborhood where someone lives to the racism and discrimination people face on a daily basis. (Healthy People 2030, n.d.) These factors influence whether individuals have a safe place to exercise, access to buy nutritious and affordable food, a living-wage, and the necessary resources that allow them to achieve health. (Healthy People 2030, n.d.)

Social Determinants of Health



To address the root causes of health disparities in Stanislaus County, health equity must be a central focus of all public health messaging, interventions, and strategies. Health equity is achieved when "every person has the opportunity to attain [their] full potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances" (NCCDPHP, 2020). This requires action to address the inequities in health outcomes, and the removal of economic and social obstacles to health, such as poverty and discrimination (Braveman, 2017). The strategies and activities outlined within the CHIP have a health equity perspective; shifting focus from individual actions to upstream approaches that consider the effect of social, political, and economic conditions of an individual's health and well-being.

COLLECTIVE IMPACT AND RESULTS-BASED ACCOUNTABILITY

Collective Impact and Results-Based Accountability (RBA) are complementary frameworks that seek to improve the quality of life for communities by building strong partnerships, improving the performance of programs, agencies, and service delivery systems through the use of data-driven decision-making. Collective Impact is a collaborative approach that is comprised of five core components: a common agenda, shared measurements, mutually reinforcing activities, continuous communication, and a backbone support organization (Karia & Kramer, 2011). RBA monitors the success of the Collective Impact approach and ensures the five components are successfully met.



(Rural Health Information Hub, n.d.).

RBA uses data and community context to make effective decisions that promote community well-being. As these frameworks align with the CHIP's strategic planning process, they were used to guide community partners in developing CHIP strategies for each of the four focus areas. Specifically, RBA's *Turn the Curve* questions, shown on page 10, guided and facilitated the strategic planning discussions among CHIP stakeholders. These focused questions allowed stakeholders to move from "talk to action," and provided a direct method for developing CHIP strategies and activities. (Clear Impact, 2016). Additionally, this method will continue to be utilized to monitor the CHIP indicators, strategies, and activities throughout the implementation phase, reinforcing continuous quality improvement.

Accountability to the community is built into the CHIP through the implementation and monitoring phase. RBA's methodology will ensure that the CHIP is implemented, monitored, and revised as needed.



(Collective Impact, 2016).

HOW WAS THE COMMUNITY HEALTH IMPROVEMENT PLAN DEVELOPED?

The framework used to develop the CHIP is adopted from the nationally recognized model for community strategic planning, the *Mobilizing for Action through Planning and Partnerships* (MAPP). MAPP provided a process and structure for community-wide strategic planning, allowing communities to prioritize health issues, identify resources to address them, and implement strategies relevant to Stanislaus County. (NACCHO, 2013). To coordinate this process, HSA/PH adapted the six phases of MAPP that occurred through the development process from July 2017 to September 2019. The CHIP is developed as part of phases four and five of the MAPP process. The CHIP is informed by the data collected and analyzed in the four assessments completed as part of phase three in the MAPP process.

Six Phases of MAPP

1. Organize for Success and Partnership Development
2. Visioning
3. Four MAPP Assessments:
 - a. Community Themes and Strengths Assessment
 - b. Community Health Status Assessment
 - c. Local Public Health System Assessment
 - d. Forces of Change
4. Identify Strategic Issues
5. Formulate Outcomes and Strategies
6. Take Action

MAPP PROCESS AND METHODOLOGY

MAPP Phase 1: Organizing for Success and Partnership Development

In June 2017, HSA/PH staff began preparation for the county-wide Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Building on Stanislaus County's 2013 CHA and CHIP, an internal team was assembled to begin the planning phase of the MAPP process. In January 2018, HSA/PH's internal MAPP Core Team was established as the core support and backbone agency for the MAPP process. In this capacity, HSA/PH provided logistical and technical support to sustain momentum and ongoing progress through each phase of the project. Initial preparation included the identification of evidence-based processes, gathering of resources, and overall project facilitation to establish a framework and timeline of activities. The MAPP Core Team brainstormed and recruited members for the MAPP Steering Committee, consisting of community partners and stakeholders from different sectors of the local public health system.

The MAPP Steering Committee held their first meeting in April 2018 and served as the decision-making body for each phase of the MAPP process. This Steering Committee served as a supervisory board that guided the entire MAPP Process. The primary responsibilities of this committee included oversight, reviewing and approving deliverables related to each of the MAPP phases, sharing expertise for each of the four assessments, and providing input on report development.



MAPP Phase 2: Visioning

One of the first charges of the MAPP Steering Committee was to develop a vision and set of value statements to guide the work for the entire MAPP process. The development of a shared vision and set of value statements early in the process was important for providing focus and direction for the MAPP process to be completed. The shared vision also emphasized the collective movement towards a common goal for a healthy community. The MAPP Core team established a process to assist the Steering Committee with the vision and development process.



At the first visioning session, the MAPP Steering Committee members worked in groups to brainstorm ideas for a vision statement and a set of values using criteria developed by the MAPP Core Team. By the end of the first meeting, the Steering Committee proposed three vision statements and five values. The MAPP Core Team reviewed and modified the proposed vision and value statements capturing all the input brainstormed by the MAPP Steering Committee. Finally, the MAPP Core Team presented revised versions to the MAPP Steering Committee, and the final vision and value statement were selected:

Vision

A thriving community where all people have the opportunity to be safe and healthy

Values

Collaboration: Work collaboratively with the community and each other to improve the health of Stanislaus County.

Inclusiveness: Encourage broad contribution to ensure all residents of Stanislaus County can achieve optimal health.

Respect and Trust: Seek common ground to collaborate and build meaningful partnerships that keep the community voice present throughout the process.

Commitment: Collaborate and coordinate efforts to assess and improve the health of Stanislaus County.

MAPP Phase 3: Four Assessments

Phase three of the MAPP process is made up of four assessments: Community Themes and Strengths Assessment, Community Health Assessment (CHA), Forces of Change Assessment, and Local Public Health System Assessment. Each assessment provided important information for improving the health of residents in the community. The four MAPP assessments were completed by the MAPP Steering Committee, the MAPP Core Team, and key partners in the community between November 2018 and March 2019.



Community Themes and Strengths Assessment (CTSA)

The CTSA identifies assets in the community and provides a detailed understanding of issues that are important to community residents using qualitative data collection methods.

This assessment seeks to answer the questions:

- What is important to the community?
- How is quality of life perceived in the community?
- What assets can be used to improve community health?

Between December 2018 and February 2019, HSA/PH partnered with Sutter Health and Community Health Insights (CHI) to conduct eleven key informant interviews and nine focus groups. The MAPP Steering Committee identified key informants to be interviewed and helped to coordinate locations and populations for focus groups. A CHI moderator conducted the audio-recorded key informant interviews and focus groups using a research guide (Appendix A) developed by the MAPP Steering Committee and CHI. A CHI staff member also took notes during each interview and focus group meeting. HSA/PH Community Assessment, Planning, and Evaluation (CAPE) section staff manually coded the interview notes. Responses to the questions about key health needs in the community were matched to the Community Health Assessment topic categories and subcategories to identify common themes. The number of times each focus group and key informant mentioned a topic was totaled and used to represent their thoughts of what is needed in the community. These topics were compared against the Stanislaus County Community Health Assessment to identify the 11 top health needs in Stanislaus County for phase four of the MAPP process.

January 2019 - February 2019



Focus Groups

Black/African American
Hispanic/Latino
People Experiencing
Homelessness
LGBTQIA
Low-Income
Rural
Seniors
Spanish-Speaking
Veterans
Youth

December 2018 - February 2019



Key Informant Interviews

Behavioral Health and Recovery
Services
Center for Human Services
CSU Stanislaus
Golden Valley Health Centers
Stanislaus County Health
Services Agency
Memorial Medical Center
Stanislaus County Law
Enforcement
West Modesto Community
Collaborative

Community Health Assessment

The Community Health Assessment (CHA) provided quantitative information about the community's health status. The CHA identified key health needs and quality of life issues in the community through systematic and comprehensive secondary data collection and analysis. The assessment sought to answer the questions:

- How healthy is the community?
- What does the health status of the community look like?



For additional information on the CHA methodology and for the full report of the results please refer to the Stanislaus County's Community Health Assessment at www.schsa.org/cha.

Local Public Health Systems Assessment

The Local Public Health Systems Assessment (LPHSA) measures the capacity of the local public health system in providing the Ten Essential Public Health Services (CDC, 2020) which include all the fundamental activities that attribute to a community's health and well-being. This assessment assists local health departments in evaluating their systems against optimal sector standards.



HSA/PH recognizes its role in protecting and promoting the health of Stanislaus County residents, however, this work is not conducted by one agency alone. The LPHSA considers all entities that contribute to the local public health system and those that deliver essential public health services within the community, including public, private, and voluntary organizations. The LPHSA answers the following questions:

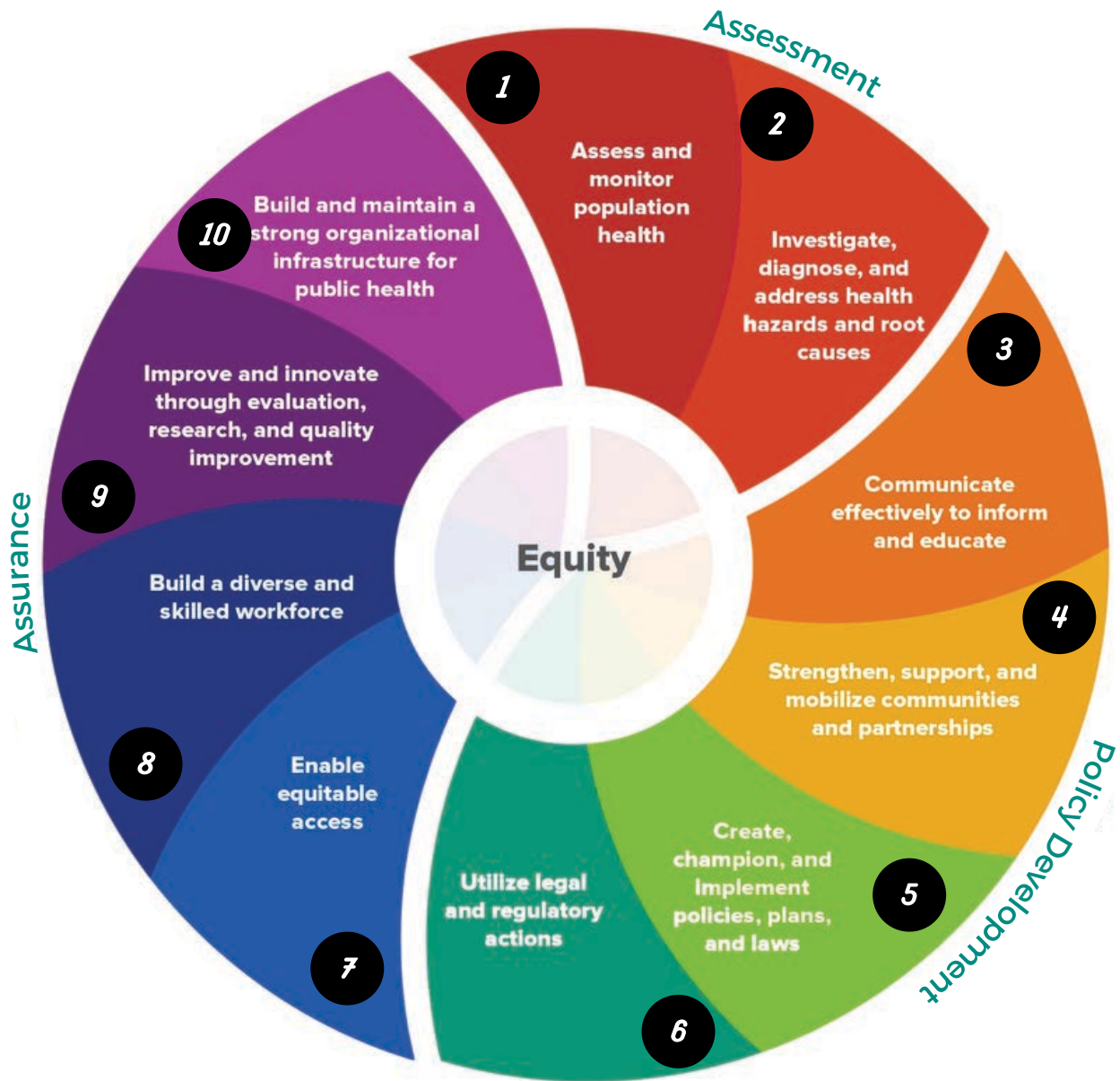
- What are the activities, competencies, and capacities of the local public health system?
- How are the Ten Essential Public Health Services being provided to the community?

The LPHSA is a self-assessment that includes 30 Model Standards serving as quality indicators organized into the ten essential public health service areas (NACCHO, 2013). It is designed to assist health departments and partners in creating a snapshot of where they are relative to the established performance standards. This assessment is intended to drive quality improvement processes and improve performance outcomes across the entirety of the public health system.



The Stanislaus County Local Public Health System Assessment workshop was held on November 1, 2018. In attendance were a group of diverse community partners representing nonprofit, private, and public organizations. In total, 60 participants attended the half-day workshop including facilitators from Mountain Valley EMS Agency, Center for Human Services, and Behavioral Health and Recovery Services. Using the National Public Health Performance Standards (NPHPS) Local Instrument, participants were preassigned to breakout groups based on their organizational role, and/or their scope as it is aligned with an Essential Service group.

The Ten Essential Public Health Services



(CDC, 2020) - Please note this diagram was updated in 2020 by the CDC, and is different from the graphic shared at the 2018 workshop.

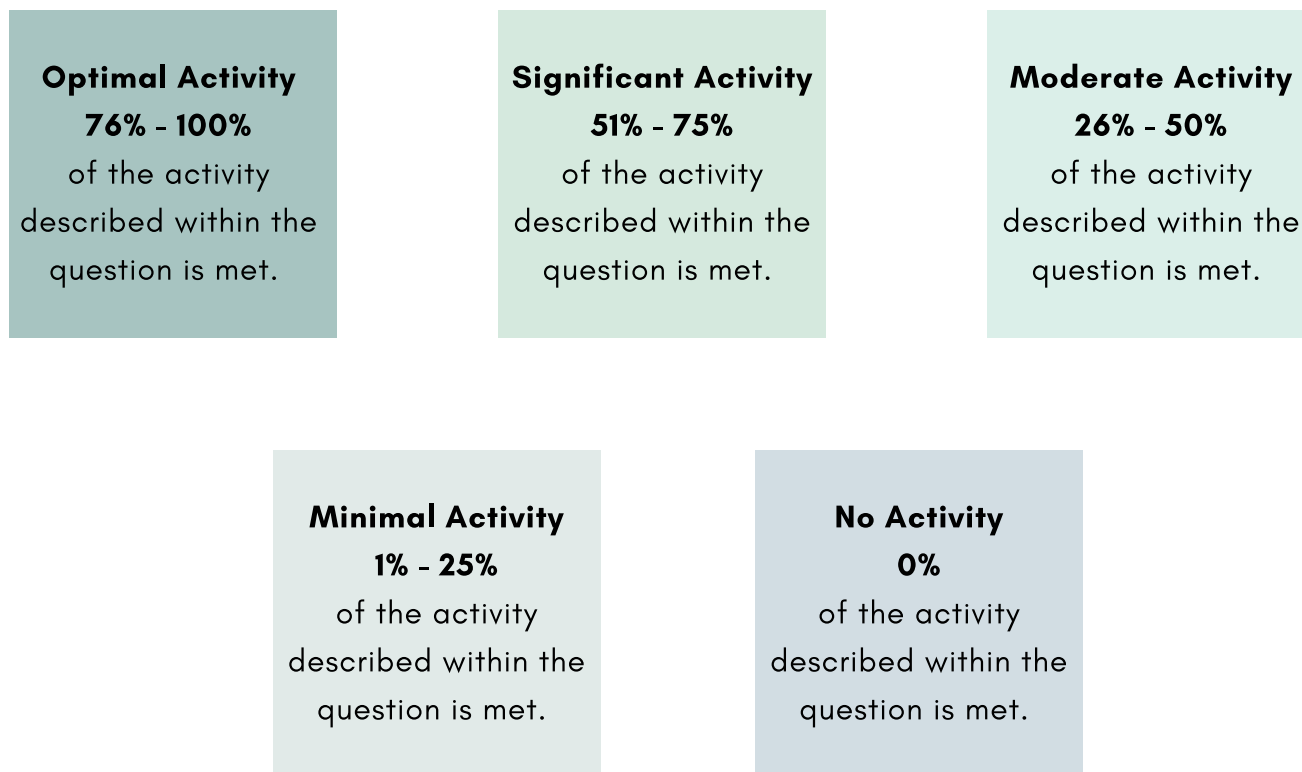
Breakout Groups

Group 1: Essential Services 1, 2, and 6

Group 3: Essential Services 7, 8, 9, and 10

Group 2: Essential Services 3, 4, and 5

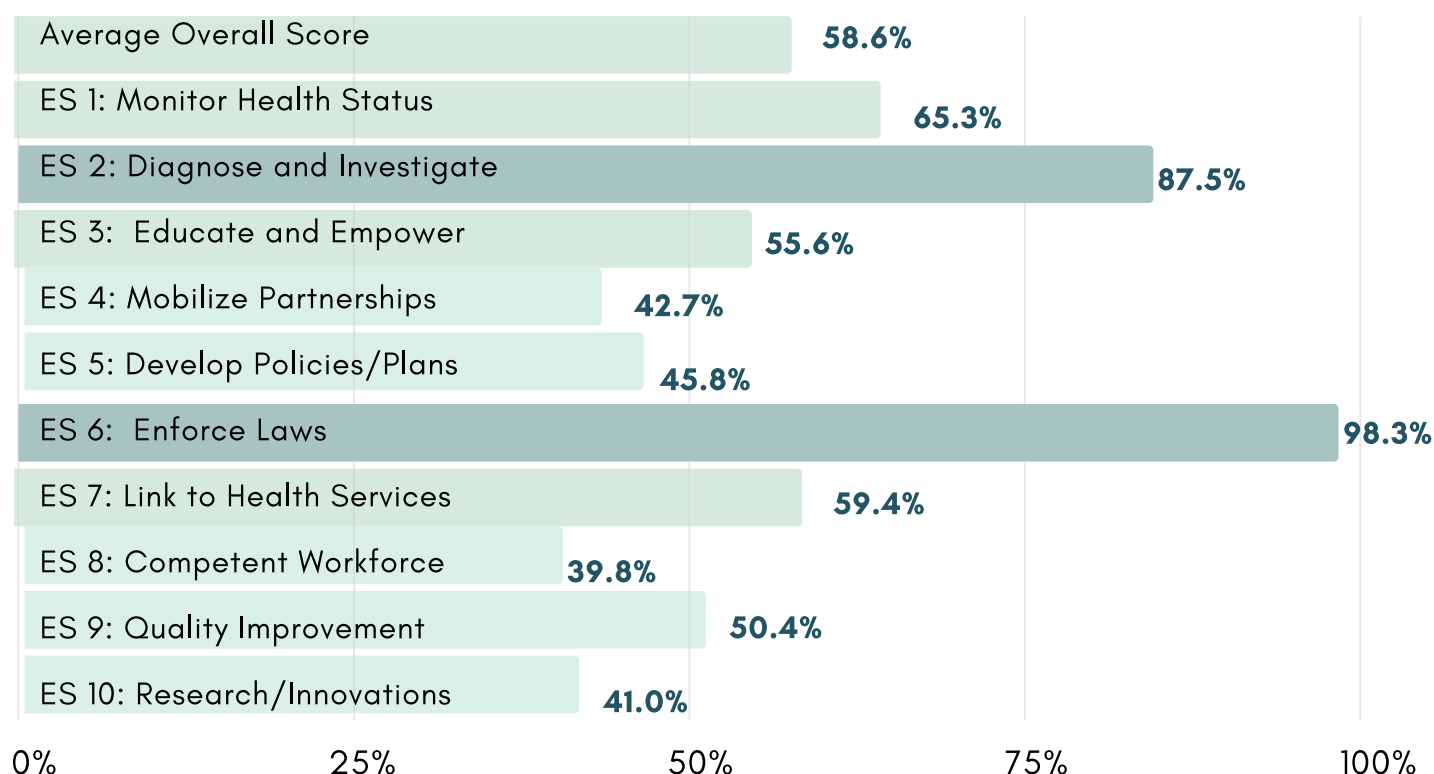
Facilitators provided instruction for reviewing model standards, scoring, and discussion. As part of the scoring system, participants were given color-coded voting cards where each color represented how well they thought an activity was being performed in the community:



Facilitators read through each of the Model Standards and participants were asked to score the level of activity of each of the associated measures being performed in Stanislaus County. Participants were asked to discuss their scores within their group and come to a common consensus about each activity's score. Final scores were captured by notetakers and analyzed using the NPHPS scoring worksheet (NACCHO, 2013). The discussion questions encouraged the group to share and brainstorm activity contributions to the specific Essential Service area and identify areas for improvement and future collaboration.

At the conclusion of the LPHSA, Stanislaus County received a performance score for each of the Ten Essential Public Health Services. Overall, Stanislaus County had an average score of 58.6% (significant activity) across the ten categories. Scores were calculated using the NPHPS scoring worksheet (NACCHO, 2013) and fall within a range of 0% (no activity performed) to 100% (optimal activity performance).

Essential Service Performance Score Summary



While the LPHSA ranks the Ten Essential Services by level of functionality, partners also provided feedback on strengths, challenges, and potential opportunities for improvement. Participants identified the following Local Public Health System's strengths: reliable and readily available health data, the ability to rapidly respond to public health threats/outbreaks, and the provision of multiple services/initiatives that are delivered throughout Stanislaus County. Participants also identified several areas for improvement including: initiatives and services that did not align with community priorities, inaccessible services, and inefficient processes. They recognized the following challenges: the building and maintenance of a competent workforce, lack of policies that address health inequity, insufficient capacity to address increasing need for mental health and substance use services, and the further need to provide linkage services for marginalized communities.

As a component of the CHIP implementation, the RBA framework will be utilized to track the improvement of the Ten Essential Services and develop performance measures and use RBA's *Turn the Curve* questions (shown on page 10) to develop effective actions and steps for continuous improvement. The summary and findings of the LPHSA were used to guide the development of the Community Health Improvement Plan (CHIP) in addition to the feedback/proposed actions of the CHIP workgroups.

Forces of Change Assessment

On February 20, 2019 and March 20, 2020, HSA/PH conducted a Forces of Change (FOC) Assessment with the MAPP Steering Committee, a multidisciplinary group of community partners and stakeholders.

The FOC Assessment identifies factors that influence the local public health systems and the communities it serves. These associated forces may influence the local public health system presently or in the future. These forces could include changes in the economy, government, technology, community infrastructure, legislation, and environment. The goal of the FOC Assessments performed in Stanislaus County was to identify external forces that may impact residents as well as the resulting opportunities and challenges that each force may bring. The assessment was conducted in three parts:

- Identification of Forces
- Determination and Categorization of Forces
- Identification of Opportunities and Challenges

In the first session, on February 20, 2019, participants were asked to answer the question, "What is occurring or might occur that affects the health of our community or the local public health system?" Examples of forces were provided to participants and three guiding questions were given to assist with brainstorming:

“Not only do we as community leaders and stakeholders need to continue to partner together, we must also work with our communities and support efforts that empower our residents.”

LPHSA participant

- What events have occurred recently that may affect our community?
- What events are likely to occur in the future?
- Are there any trends currently occurring that will have a future impact?



In a small group setting, participants identified and selected their top three most impactful forces that they identified using the guiding brainstorming questions. Each small group was provided with three sticky notes and asked to write one force. Using the MAPP guidance, each identified force was grouped into one of the seven categories:

Environmental



Economic



Legal



Ethical



Technological



Political



Social



These groupings were then discussed as a larger group and summarized to conclude the first FOC Assessment. In the second session, the group reviewed each of the forces and identified challenges and opportunities associated with each. Internally, the MAPP Core Team created a matrix to capture each of the categories, forces, opportunities, and challenges. In total, 15 potential forces and challenges were identified with related opportunities. These forces were then used to inform the strategies and activities of the CHIP.



Forces of Change Assessment Results

FORCES

- Social and mental health
- Demographic shifts
- Substance use and the opioid crisis
- Access to healthcare (lack of access to providers, services, and coverage gaps)
- Housing and homelessness (lack of affordable and quality housing)
- Uncertain government funding and resources
- Built environment

CHALLENGES

- Growing demand for public and social services
- Health disparities and health inequities
- Workforces challenges to serve changing population
- Healthcare provider shortages
- Increased homelessness
- Theft, crime, and community safety
- Continued poor health outcomes
- Gaps in services

OPPORTUNITIES

- Improve coordination and cross-collaboration across the public health system
- Increase and invest in upstream interventions
- Support community engagement efforts to empower all residents
- Collaborate across sectors to address housing and homeless efforts
- Raise public health issues in districts with poor health outcomes

MAPP Phase 4: Identifying Strategic Issues

In Phase 4 of the MAPP process, a ranked list of the most important issues facing the community was developed. The MAPP Data Subcommittee and MAPP Core Team, using the Community Health Assessment and the Community Themes and Strengths Assessment, identified 11 strategic issues that were important to Stanislaus County.

11 Strategic Issues

- Access to Care
- Asthma/Air Quality
- Chronic Disease
- Communicable Disease
- Economic Insecurity
- Education
- Housing and Homelessness
- Mental Health
- Safety
- Substance Use
- Transportation

Data trends from these 11 strategic issues were presented at five community meetings. Attendees were asked to rank each issue based on the information presented and their own personal/professional experiences. Each issue was ranked on a scale of 1 to 10 for each of the four criteria: severity, prevention, disparities, and impact. After the community meetings were completed, strategic issues were given scores using the average score of the four criteria. Then, these scores were used to rank the strategic issues and identify the top issues that would serve as the CHIP focus areas.

CHIP FOCUS AREAS



**Chronic
Disease**



**Housing and
Homelessness**



**Tobacco and
Substance Use**



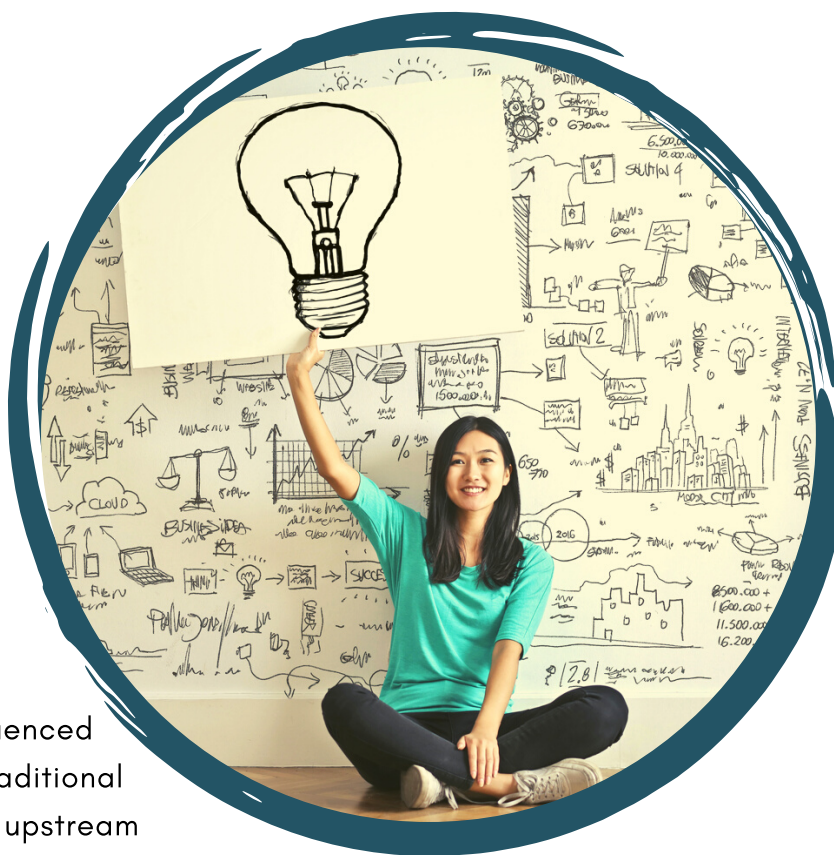
**Communicable
Disease**

MAPP Phase 5: Formulate Outcomes, Strategies, and Activities

In Phase 5, strategies and activities were developed to address the four identified focus areas. On August 29, 2019, HSA/PH held a community meeting workshop that consisted of 75 public health system partners and community members that was designed using the Results Based Accountability Framework. The workshop provided an opportunity for members of the local public health system to review data for each of the focus areas and use the data to formulate strategies and activities for the Community Health Improvement Plan.

During the first half of the workshop, all participants reviewed data sets relevant to each of the four focus areas and were familiarized with the MAPP process (NACCHO, 2013) and Results Based Accountability (RBA) framework (Clear Impact, 2016). The second half of the workshop involved breakout sessions for each of the four focus areas that were led by PH/HSA staff and community partners. Using RBA's *Turn the Curve* questions (shown on page 10) and framework, facilitators guided participants through a discussion to identify root causes that influenced the presented data as well as identified traditional and non-traditional partners in each area, upstream strategies, and key activities that include actionable steps.

To assist with the strategy and activity development, participants were provided with handouts to help frame their ideas and thoughts around health inequities, upstream population health approaches, and social determinants of health considerations.



Upon completion of the workshop, HSA/PH staff and external experts reconvened to compile and evaluate the responses and feedback from the workshop to continue developing the CHIP. During the small group discussions, strategies and activities for each of the focus areas were reviewed and expanded further to ensure alignment with local, state, and national priorities. For each focus area, goals, objectives, and indicators were chosen and key partners and root causes were identified.

MAPP Summary

The collective work outlined in these five phases cumulated in this collaborative five-year county-wide Community Health Improvement Plan. For each focus area, the CHIP overviews data trends, background overview, selected indicators, root causes, outcomes, targets, strategies, and activities. These components work together to serve as an action plan to inform and guide the collaborative MAPP implementation process within Stanislaus County. This CHIP is intended to be a living document and will continue to be revised to ensure that it continues to meet the priorities and health needs of Stanislaus County.



PUBLIC
HEALTH

Chronic
Diseases

VIRUS



SUBSTANCE
ABUSE

Community Health
Improvement Plan
FOCUS Areas

FOCUS AREA #1

CHRONIC DISEASE

Why is this important?

Chronic diseases, such as heart disease, stroke, cancer, and diabetes are among the leading causes of hospitalization and death in Stanislaus County and nationwide (Stanislaus County Health Services Agency, 2020). Many chronic diseases are caused by high risk behaviors such as tobacco use, exposure to secondhand smoke, poor nutrition, lack of physical activity, and excess use of alcohol (CDC, 2021). The burden of chronic disease is not shared equally across all communities; a person's income, race, ethnicity, and environment all impact their risk of developing and dying from a chronic disease (CDC, 2021). Marginalized groups in Stanislaus County, following the national trend, have a higher incidence of chronic disease compared to other communities. Many residents of Stanislaus County do not have the opportunity to reach their full health potential. Reducing the burden of chronic disease and the risk behaviors associated with them requires legislative action as well as policies that encourage tobacco-free living, access to affordable nutritious food, and safe environments that promote active lifestyles.

Chronic Disease in Stanislaus County

In Stanislaus County, chronic diseases are the top four leading causes of death: heart disease, cancer, Alzheimer's disease, and chronic lower respiratory disease. Heart disease and cancer were responsible for 44% of deaths among county residents from 2015 to 2017.



Twelve percent of adults in Stanislaus County have diabetes, 29% of adults have been diagnosed with high blood pressure, and 40% of adults are obese, while 44.5% of 5th graders are overweight or obese. Physical inactivity, tobacco use, poor nutrition, and alcohol use are risk factors that contribute to increased prevalence of chronic diseases like heart disease and cancer. About one in four adults in Stanislaus County are physically inactive (i.e. they do not participate in leisure time exercise). Substance use is also a predominant risk for chronic disease as among Stanislaus County adults, one in five smoke cigarettes, one in three have used an e-cigarette at least once, and one in five binge drink. (Stanislaus County Health Services Agency, 2020).

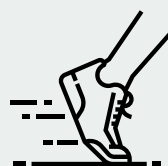
In Stanislaus County



29% of adults have been diagnosed with high blood pressure.



44.5% of 5th graders are overweight or obese.



1 in 4 adults are physically inactive.



1 in 5 adults binge drink.

Root Causes for the Community to Address

- Common modifiable risk factors such as: poor nutrition, physical inactivity, tobacco use, and high levels of chronic stress
- Underlying socioeconomic, cultural, political, and environmental determinants
- High density of fast-food outlets in low income neighborhoods
- Scarce and expensive healthy food options in low income communities
- Advertising and marketing of energy-dense, nutrient-poor options

Result Statement

All people will have the opportunity to live a long and healthy life.



Outcome: Prevent and manage chronic disease

Targets

By 2025, reduce adult obesity from 39.8% to 35.8%.

Indicator	Actual Value	2025 Target	Population Disparities
% of obese adults	39.8%	35.8%	<ul style="list-style-type: none">Latino residentsResidents living below the federal poverty level

By 2025, reduce childhood obesity from 44.5% to 40%.

Indicator	Actual Value	2025 Target	Population Disparities
% of 5th graders overweight/ obese	44.5%	40%	<ul style="list-style-type: none">Latino studentsBlack/African American students

By 2025, decrease the percentage of adults diagnosed with diabetes from 11.9% to 10.7%.

Indicator	Actual Value	2025 Target	Population Disparities
% of adults living with diabetes	11.9%	10.7%	<ul style="list-style-type: none">Latino residentsResidents living below the federal poverty level

Associated Indicators

- Heart disease mortality rates
- Percentage of physically inactive adults



STRATEGIES AND ACTIVITIES

Overarching Strategy

To increase healthy eating and active living by promoting healthy behaviors and supporting policies and environments that empower community members to attain the highest possible level of health.

Strategy 1: Improve the coordination of chronic disease management programs among health systems and community partners to prevent and manage the burden of chronic disease.

Activities



Identify and inventory successful Whole-Person-Care or Chronic Disease management and prevention programs in Stanislaus County.



Identify and analyze current coordination and communication practices among health plans, service providers and FQHC's.



Work with health systems and community resources so medical providers can refer patients to chronic disease management and prevention programs that teach self-management and empowerment techniques.



Support prevention, screening and treatment of chronic disease among at-risk populations and communities.



Establish mutually agreed-upon coordination and communication standards and methods.



Align and standardize practices through formal policies or agreements.



Provide technical assistance and support for implementation.

Strategy 2: Increase access to healthy food and opportunities for physical activity.

Activities



2.1

Create or enhance an existing resource listing opportunity for free nutrition classes and physical activity available in the county.



2.2

Identify and partner with community organizations to promote opportunities for free nutrition classes and physical activity available in the county with specific focus on groups at risk for chronic disease.



2.3

Review existing plans (sidewalks, trails, parks) to identify gaps in active transportation opportunities and connectivity.



2.4

Support and empower residents to engage city and county officials in addressing gaps identified in 2.3.



2.5

Encourage local governments to support increased enrollment in WIC, CalFRESH and other supplemental food programs.



2.6

Support the adoption of policies and practices in schools that encourage implementation of universal healthy school meals and physical activity.



2.7

Support policies that require or encourage hospitals to adopt 'Baby Friendly' practices in order to promote exclusive breastfeeding for the first 6 months of a child's life.



2.8

Support the adoption of policies and practices that limit advertising and marketing of unhealthy food and beverages to children and underserved neighborhoods.

Strategy 3: Prevent chronic disease and promote health equity through education, program developments, and policies.

Activities



Analyze factors that contribute to higher health risks and poorer health outcomes of specific populations (racial/ethnic minorities, those who live in poverty, and people with disabilities) and the development of health equity indicators.



Mobilize community partners and policy makers to address community policies, or the community environments that contributes to health inequities identified.



Implement a media campaign that establishes health outcomes as not everyone has the same opportunities and access to the most healthy choice.

Strategy 4: Develop policies and plans that support individual and community well-being.

Activities



Educate policy makers about the effects of policies and environmental factors on health outcomes.



Catalog and conduct a strengths, weaknesses, opportunities, and threats (SWOT) analysis of recent policy, systems and environment (PSE) change efforts within Stanislaus County that impact chronic diseases.



Use SWOT analysis and collaborative leverage findings to develop PSE change priorities.



Develop Health in All Policies (HiAP) Initiative action plans specific to the PSE change being pursued.



Support and foster community power to increase political will for the HiAP Initiative(s).

Alignment

This focus area aligns with the following Healthy People 2020 goals:

- Reduce the annual number of new cases of diagnosed diabetes in the population
- Reduce the diabetes death rate
- Reduce the proportion of adults who engage in no leisure-time physical activity
- Reduce the proportion of adults who are obese
- Reduce the proportion of children and adolescents who are considered obese

This focus area also aligns with the California Wellness Plan to:

- Decrease diabetes prevalence
- Reduce child obesity
- Reduce adult obesity
- Increase adult physical activity

Furthermore, this focus area aligns with the Stanislaus County 2019/2020 budget plan (community wide indicators):

- Supporting community health, including physical, mental, emotional, and spiritual health



Community Resources

- California Department of Health Care Services Whole Person Care Pilot Program key findings and lessons learned
- Centers for Medicare and Medicaid Services
- Health Plan(s) of San Joaquin
- Health Net
- Historical context of past HiAP and Healthy Eating Active Living (HEAL) efforts
- Local data
- Provider Associations
- Local Federally Qualified Health Center (FQHC) using a Whole-Person-Care or Chronic Disease Care Coordination Program
- Local Model of Cross Sectoral Partnerships (United Patterson)
- Passing of HEAL Resolutions by Stanislaus County and all 9 incorporated cities
- Public Health Advocates
- Public Health Law Center
- Public Health Institute - HiAP Technical Support



Community Partners

- Business community/large employers within Stanislaus County
- California Rural Legal Assistance-Modesto
- California State University Stanislaus
- Central California Legal Services
- City and County Governments
- County Residents
- Doctors Medical Center
- Elected Officials
- Emanuel Medical Center
- Faith-Based Organizations
- Family Resources Center
- Golden Valley Health Centers (GVHC)
- Health Plan of San Joaquin
- Health Net
- Kaiser Permanente Modesto
- Local Advocacy Groups/Grassroots Community Organizations
- Livingston Community Health (LCH)
- Modesto Bee
- Modesto Junior College
- Oak Valley Hospital
- Social Service Providers/501(c)3 Non-Profit Organizations
- Stanislaus County Office of Education
- Stanislaus Medical Society
- Sutter Gould Medical Foundation
- Sutter Memorial Medical Center
- Valley Children's Hospital



FOCUS AREA #2

HOUSING AND HOMELESSNESS

Why is this important?

Safe and affordable housing gives individuals and families a sense of privacy, security, stability, and protection from harmful exposures and environmental hazards (Taylor, 2018). Households that spend more than 30% of their gross income on housing are considered cost-burdened and may not have enough money to cover their essential needs such as medical care or nutritious food (AMCHP, 2014). Substandard housing conditions such as decayed plumbing, poor ventilation, insufficient kitchen facilities, and pest infestations have a negative impact on health. With 16.1% of Stanislaus County residents living below the federal poverty level, many residents do not have the income to pay market-rate rents which limits their access to safe and affordable housing, making housing a major public health concern.

Housing and Homelessness in Stanislaus County

In Stanislaus County, 35% of households with a mortgage and 56.2% of renting households spent more than 30% of their income on housing (U.S. Census, 2020). Stanislaus Countywide Homeless Continuum of Care conducts a one day, point-in-time census and survey of individuals experiencing homelessness. In 2018, it was estimated that there were 1,356 people experiencing homelessness in Stanislaus County, putting them at higher risk for poor physical and mental health. (U.S. Department of Housing and Urban Development, 2019).



In Stanislaus County



35% of home-owner households spend more than 30% of their income on housing.



56% of renter households spend more than 30% of their income on housing.



1356 people experiencing homelessness.

Root Causes for the Community to Address

- Lack of coordinated efforts across different programs and departments that address housing and homelessness
- Lack of affordable housing
- Lack of early screening and interventions to address the cycle of intergenerational Adverse Childhood Experiences (ACE)
- High cost of living index

Results Statement

All people will have a safe and affordable place to live.

Outcome: Increase the availability of safe and affordable housing



Targets

By 2025, decrease the number of people experiencing homelessness from 1,356 to 1,220.

Indicator	Actual Value	2025 Target	Population Disparities
People experiencing homelessness	1356	1220	<ul style="list-style-type: none"> Male residents Black/African American residents

By 2025, decrease the percentage of households with a mortgage paying more than 30% of their income on monthly housing costs from 35% to 30%.

Indicator	Actual Value	2025 Target	Population Disparities
% of homeowners that pay 30%+ on housing	35%	30%	<ul style="list-style-type: none"> Residents living in the lowest HPI quartile

By 2025, decrease the percentage of renters paying 30% or more of their income on monthly housing costs from 56% to 51%.

Indicator	Actual Value	2025 Target	Population Disparities
% of renters that pay 30%+ on housing	56%	51%	<ul style="list-style-type: none"> Residents living in the lowest HPI quartile

By 2025, increase the percentage of owner-occupied housing units from 57% to 62%.

Indicator	Actual Value	2025 Target	Population Disparities
% of housing units that are owner-occupied	57%	62%	<ul style="list-style-type: none"> Residents living in the lowest HPI quartile

Associated Indicators

- Percentage of housing units that are renter occupied



STRATEGIES AND ACTIVITIES

Overarching Strategy

To improve the health and lives of those experiencing or at risk of homelessness by designing systems to prevent homelessness for future populations, advocating for policies, and interventions that empower persons experiencing homelessness to connect with available resources, and streamlining countywide homelessness efforts.

Strategy 1: Accurately identify the homeless population and align existing housing and homeless outreach plans and strategies across Stanislaus County.

Activities



Locate and develop measures to accurately describe the population experiencing homelessness in Stanislaus County.



Conduct a gap analysis, an environmental scan, and an asset mapping activity that targets individuals experiencing homelessness, including those who lacked safe, regular, and adequate housing, as well as those imminently at risk of becoming homeless.



Assess existing resources, identify gaps, collect and analyze data, and collaborate with existing service providers.



Identify and create a comprehensive database for housing resources and homelessness trends within Stanislaus County.



Map existing services and resources to determine effective ways to collaborate and integrate persons experiencing homelessness into a coordinated system of care.



Develop data-driven analyses (i.e. Health Impact Assessments) on the potential impact of housing policies on the public's health and the availability of affordable, safe, quality housing for low-income community members.

Strategy 2: Address early life factors that place youth at risk of homelessness in adulthood; as well as engage local systems in a shared approach to prevent youth from becoming homeless.

Activities



Implement systems that identify at-risk youth through schools and wellness/well-child checks.



Infuse Adverse Childhood Experiences (ACE) informed practices into youth services delivery practices.



Identify programs for youths experiencing homelessness that increase school stability and high school graduation rates.

Strategy 3: Expand and provide housing services and coordinated approaches to increase housing stability and prevent a return to homelessness.

Activities



Implement housing programs for youths experiencing homelessness that increase school stability and graduation rates.



Engage hospitals in creating and implementing systems to comply with SB 1152 to provide coordinated care and services with required entities to prevent return to homelessness.



Engage community mental health substance use treatment centers to increase access and clinical case management to at-risk populations.



Support policies that provide rapid access to permanent housing, without pre-condition treatment, along with ongoing support services to chronically homeless families or individuals.

Strategy 3 (cont'd): Expand and provide housing services and coordinated approaches to increase housing stability and prevent a return to homelessness.

Activities



Provide training and technical assistance to community partners and youth providers on Housing First and Trauma Informed Care.



Support policies that prohibit landlords from evicting tenants without just cause.



Support housing policies that require developers to reserve a portion of housing units for low-income residents.

Alignment

This focus area aligns with the Healthy People 2020 goals:

- Proportion of households that experience housing cost burden

This focus area also aligns with the Stanislaus County Focus on Prevention Initiative:

- Address the root cause and develop strategies to intervene early to prevent homelessness

This focus area also aligns with the California Wellness Plan:

- Create healthy communities/increase neighborhood safety

This focus area also aligns with the Stanislaus County 2019/2020 Budget Plan:

- Delivering community infrastructure to benefit our residents and businesses



Community Resources

- Bethany's House
- Children's Crisis Center
- Habitat for Humanity of Stanislaus County
- Haven Women's Center
- Homeless Program (Stanislaus County Community Services Agency)
- Housing Authority County of Stanislaus
- Hutton House
- Laura's House
- Modesto Women's Mission
- Redwood Family Center
- Salvation Army
- Samaritan House
- Stanislaus County Affordable Housing Corporation
- Stanislaus County Environmental Resources
- Stanislaus County Redevelopment Agency
- Turlock Gospel Mission

Community Partners

- Behavioral Health and Recovery Services (BHRS)
- Center for Human Services
- Community Services Agency
- Aging and Veteran Services
- Community System of Care (CSOC)
- Doctor's Medical Center
- Emanuel Medical Center
- Sutter Memorial Medical Center

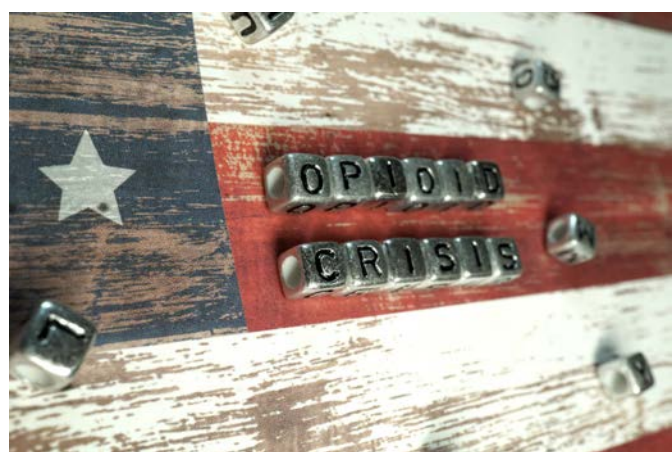
FOCUS AREA #3 TOBACCO AND SUBSTANCE USE

Why is this important?

Smoking and tobacco use are contributing factors for several adverse health conditions including: cancer, heart disease, lung disease, diabetes, and chronic obstructive pulmonary disease. Cigarette smoking is the leading cause of preventable and premature death in the U.S., resulting in more than 480,000 deaths annually. (CDC, n.d.b). Youth alcohol, tobacco, and other drug use is a significant public health concern and is associated with a wide range of academic, social, and health problems. Smoking and tobacco use primarily begin during adolescence and may lead to additional substance abuse; nearly nine out of ten adult cigarette smokers smoked their first cigarette before age 19. (CDC, n.d.c).

Tobacco and Substance Use in Stanislaus County

Stanislaus County residents report high rates of tobacco use; about one in six adults smoke cigarettes and one in three adults report engaging in binge drinking. From 2013 to 2017 there were 103 alcohol impaired driving deaths in Stanislaus County, accounting for 32% of all motor vehicle crash deaths. In 2017, there were 85 hospitalizations, 179 emergency department visits, and 18 deaths related to opioid overdose in Stanislaus County. One in five persons experiencing homelessness report drug and alcohol abuse as the cause of their homelessness. (Stanislaus County Health Services Agency, 2020).



In Stanislaus County



1 in 6 adults smoke cigarettes.



32% of motor vehicle deaths were related to alcohol-impaired driving.



1 in 3 adults engage in binge drinking.

Root Causes for the Community to Address

- Lack of policies restricting access to retail tobacco sources for adolescent youth
- Lack of coordinated access to existing substance use prevention and intervention services in the Stanislaus County
- Lack of early screening and intervention for at-risk youth
- Legislation or lack of legislation

Results Statement

A community free from the harm of tobacco and substance use.

Outcome: Reduce tobacco use and opioid prescription rates

Targets

By 2025, decrease the percent of adults who smoke tobacco from 17.2% to 12.2%

Indicator	Actual Value	2025 Target	Population Disparities
% of adults who currently smoke tobacco	17.2%	12.2%	<ul style="list-style-type: none">• Male residents• Residents living below the federal poverty level

By 2025, decrease the percent of 11th grade students who ever smoke from 14.4% to 12.4%.

Indicator	Actual Value	2025 Target	Population Disparities
% of 11th grade students who ever smoked a cigarette	14.4%	12.4%	<ul style="list-style-type: none">• Male students• Students living below the federal poverty level

By 2025, decrease the opioid prescription rate from 956.6 to 508.7 per 1,000 residents.

Indicator	Actual Value	2025 Target	Population Disparities
Rate of opioid prescriptions per 1,000 residents	956.6 /1,000	508.7 /1,000	<ul style="list-style-type: none">• Female residents• White residents

Associated Indicators
<ul style="list-style-type: none">• Rate of opioid deaths per 100,000 residents• Drug overdose deaths per 100,000 residents

STRATEGIES AND ACTIVITIES

Overarching Strategy

To improve the health and lives of Stanislaus County residents and advance health equity by reducing tobacco-related health disparities, preventing initiation of tobacco and substance use among youth and young adults, eliminating exposure to secondhand smoke, and supporting substance use interventions.

Strategy 1: Adoption of Tobacco, Alcohol, Cannabis Retail Density Ordinance across multiple jurisdictions and unincorporated areas.

Activities



Complete assessment of target jurisdictions including allies, opponents, assets, and resources.



Recruit allies as identified in 1.1 into the Healthy Retail Workgroup.



Work with community members, partners, and allies to discuss the benefits of tobacco retail licensing in communities.



Draft Tobacco, Alcohol, Cannabis Retail Licensing policy language to include density, buffer zones, and/or flavors restrictions.



Use shared data and GIS systems to create maps highlighting tobacco/alcohol/cannabis retail density by district and jurisdiction.



Conduct outreach and education campaigns with community leaders, residents, and decision makers.

Strategy 2: Completion of a fully incorporated and widely-shared Communitywide Asset and Gap Analysis for cessation, addiction, and substance use services.

Activities

2.1

Identify and create a resource database/matrix of key agencies and representatives working on tobacco/substance use prevention services related to cessation and recovery.

2.2

Convene a network of service providers, insurance providers, community groups, counselors, and other resources readily accessible to the community and those who serve the community.

2.3

Perform an asset and gap analysis of existing services organized by risk stratification levels or by service type.

2.4

Develop and annually update a shared resource list.

Strategy 3: Implementation of newly developed tobacco/substance abuse prevention programs in the community, with specific attention to schools and youth-based programs.

Activities

3.1

Identify key agencies and representatives working on tobacco/substance use prevention or direct services related to early intervention programs for youth and perinatal women.

3.2

Convene a network of service providers, insurance providers, community groups, counselors, and other resources readily accessible to the community and those who serve community members.

Strategy 3 (cont'd): Implementation of newly developed tobacco/substance abuse prevention programs in the community, with specific attention to schools and youth-based programs.

Activities

2.1

Identify curricula or training opportunities focusing on ACES, and trauma-informed care for teachers, counselors, and other individuals working with priority populations.

2.2

Update and review curricula and training opportunity list annually.

Alignment

This focus area aligns with the following Healthy People 2020 goals:

- Reduce tobacco use by adults
- Reduce tobacco use by adolescents
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Eliminate state laws that preempt stronger local tobacco control laws
- Reduce the past-year nonmedical use of prescription drugs
- Reduce the proportion of persons engaging in binge drinking of alcoholic beverages

This focus area also aligns with the California Wellness Plan:

- Reduce adult tobacco use
- Reduce adolescent tobacco use
- Reduce substance use



Community Resources

- California State University Stanislaus GIS Program
- City of Modesto GIS and Data
- Mental Health Services Act (MHSA)
- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- The Office of Child Abuse Prevention (OCAP) Coalition
- Opioid Coalition
- Prevention and Early Intervention Program
- Protecting Health and Slamming Tobacco (PHAST) Advocacy Trainings
- Public Health Law Center Policy Language
- Sierra Vista Child and Family Services
- Stanislaus County Office of Education (SCOE)
- Tobacco-Control Outreach Prevention Services (TOPS) Coalition
- UC Merced Nicotine and Cannabis Policy Center
- Young Adult Tobacco Purchase Survey Data

Community Partners

- Aegis Treatment Center
- Behavioral Health and Recovery Services (BHRS)
- Central Valley Rural Legal Assistance
- California State University Stanislaus
- Doctor's Medical Center
- HealthNet
- Health Plan of San Joaquin
- Law Enforcement Community Services Officers (CSOs)
- Nirvana
- Sheriff's Department Police Activities League (PAL)
- Stanislaus County Juvenile Probation
- Stanislaus County Health Services Agency
- Stanislaus County Office of Education (SCOE)
- Stanislaus Protection Health and Slamming Tobacco (PHAST) Youth Coalition
- Stanislaus Recovery Center
- Memorial Medical Center
- Tobacco-Control Outreach and Prevention Services (TOPS) Coalition
- TOPS Coalition Smoking Cessation Action Team
- UC Merced Nicotine and Cannabis Policy Center



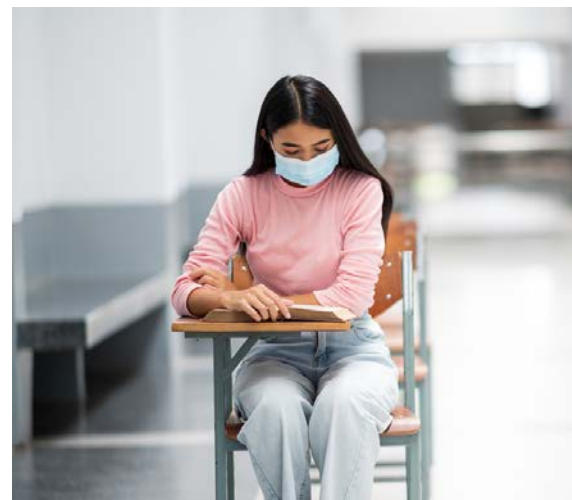
FOCUS AREA #4 COMMUNICABLE DISEASE

Why is this important?

Communicable diseases are illnesses caused by microorganisms such as bacteria, viruses, parasites, and fungi that spread from one person to another. These pathogens can be transmitted multiple ways including: ingesting contaminated food or water, breathing contaminated air, or through bites from insects (WHO, n.d.). Sexually transmitted diseases (STDs) are communicable diseases that can be passed from one person to another through sexual activity and intimate physical contact (WHO, n.d.). STDs do not always cause symptoms or may only cause mild symptoms, so it is possible to have an infection and not know it. Left untreated, STDs can lead to long-term complications including blindness, bone deformities, brain damage, cancer, heart disease, infertility, and birth defects (WHO, n.d.).

In 2019, a new communicable disease was identified: the 2019 Novel Coronavirus (COVID-19). Unlike previously identified coronaviruses that were known to circulate among humans, this virus spreads easily and sustainably in the community and can result in severe illness. While older adults and people with underlying health conditions are at highest risk for severe illness and death, there has not been an industry, region, or community that has not been impacted by COVID-19. (NCIRD, n.d.).

(cont'd on next page)



Stanislaus County had its first confirmed case of COVID-19 in March 2020. Like communities across the world, COVID-19 has placed strains on local health care systems and has disparately impacted vulnerable populations within Stanislaus County. During this global pandemic, significant public health resources have been dedicated to identifying transmission trends and implementing prevention strategies to reduce the spread of COVID-19 within the community.

Communicable Disease in Stanislaus County

Rates of sexually transmitted diseases (STDs) are increasing in Stanislaus County. In 2017, there were 2,537 cases of chlamydia (40% increase since 2013), 770 cases of gonorrhea (40% increase since 2013), and 121 cases of syphilis (112% increase since 2013) reported in Stanislaus County. Congenital syphilis rates in Stanislaus County were the 3rd highest in California in 2017. (Stanislaus County Health Services Agency, 2020).

As of December 31, 2020, Stanislaus County has had 34,465 confirmed cases of COVID-19 (approximately 6% of the county population), 1,950 hospitalized cases, and 616 deaths. In 2020, there were two observed surges of reported COVID-19 cases; the first in the month of July and second in November. Each surge of cases corresponded with limited hospital bed and staff availability (particularly within the Intensive Care Unit), a rapid increase in outbreaks within businesses and healthcare facilities, and a sizeable increase in the number of deaths among Stanislaus County residents. In December 2020, vaccines for COVID-19 became available in Stanislaus County for eligible residents based on their occupation and living condition. Expanded vaccine distribution is planned to increase in 2021.

In Stanislaus County



40% increase in chlamydia cases from 2013 to 2017.



40% increase in gonorrhea cases from 2013 to 2017.



112% increase in syphilis cases from 2013 to 2017.



3rd highest rate of congenital syphilis in California in 2017.

Root Causes for the Community to Address

- Sexual risk behaviors: having sex under the influence of alcohol or drugs, multiple sexual partners, and unprotected sex
- Lack of awareness of the importance of screening to detect asymptomatic STDs
- Lack of awareness of resources
- Lack of prenatal care
- Stigma and cultural beliefs create a barrier to health seeking behavior, engaging in care and adherence to treatment
- Lack of resources to adequately implement COVID-19 prevention strategies such as physical distancing, face coverings, isolating while sick, testing, and COVID-19 immunization.

Results Statement

A community with adequate protection against communicable disease and equitable access to treatment.

Outcome: Reduce the impact of communicable diseases in Stanislaus County



Targets

By 2025, reduce the rate of new chlamydia cases from 460 to 414 cases per 100,000 population.

Indicator	Actual Value	2025 Target	Population Disparities
Chlamydia incidence rate	460/ 100,000	414/ 100,000	<ul style="list-style-type: none">Female residentsLatino and Black/African American residents

By 2025, reduce the rate of new gonorrhea cases from 139.6 to 125.6 cases per 100,000 population.

Indicator	Actual Value	2025 Target	Population Disparities
Gonorrhea incidence rate	139.6/ 100,000	125.6/ 100,000	<ul style="list-style-type: none">Male residentsBlack/African American residents

By 2025, reduce the rate of new primary and secondary syphilis cases from 21.9 to 19.7 cases per 100,000 population.

Indicator	Actual Value	2025 Target	Population Disparities
Syphilis incidence rate	21.9/ 100,000	19.7/ 100,000	<ul style="list-style-type: none">Male residentsBlack/African American residents

By 2025, reduce the rate of new HIV cases from 9.6 to 8.6 per 100,000 population.

Indicator	Actual Value	2025 Target	Population Disparities
HIV incidence rate	9.6/ 100,000	8.6/ 100,000	<ul style="list-style-type: none">Male residents

Target (cont'd)

By 2025, increase the number of children in kindergarten who receive all vaccines required for school entry from 96% to 98%.

Indicator	Actual Value	2025 Target	Population Disparities
Kindergarten immunization rate	96%	98%	<ul style="list-style-type: none">Private Schools

Associated Indicators

- Congenital syphilis rate

STRATEGIES AND ACTIVITIES

Overarching Strategy

To improve the health and lives of Stanislaus County residents by mobilizing local data to identify persons with elevated risk of contracting diseases, designing targeted interventions to prevent disease transmission, and increasing access to quality services.

Strategy 1: Increase education and awareness of sexual health services and resources to decrease the transmission of sexually transmitted diseases in Stanislaus County.

Activities

1.1

Engage the power of key community partners to assess current sexual health education curriculum and identify opportunities and support policies to ensure culturally competent comprehensive sexual health curriculum.

1.2

Establish ongoing provider STD awareness and education (inclusive of health equity content) trainings inclusive of STD/HIV prevention, testing, and treatment.

Strategy 1 (cont'd): Increase education and awareness of sexual health services and resources to decrease the transmission of sexually transmitted diseases in Stanislaus County.

Activities

1.3

Identify non-traditional settings to conduct STD/HIV education.

1.4

Analyze local data to identify and mobilize marginalized communities to develop culturally competent sexual health services and educational materials.

Strategy 2: Improve utilization of sexual health services by increasing accessibility, availability, and quality of services.

Activities

2.1

Strengthen and optimize availability of testing in community clinics, jails, and non-traditional settings.

2.2

Identify and establish condom dispensers to increase access to condoms in non-traditional locations.

2.3

Increase linkage, engagement, and retention in HIV care for HIV positive people who are not consistently in medical care.

2.4

Increase access to Pre-Exposure Prophylaxis (PrEP) in both private and public settings.

Strategy 3: Increase the proportion of community members protected by vaccinations.

Activities

- 3.1** Increase immunization campaigns for high-risk populations and communities.
- 3.2** Determine which groups are at-risk for missing vaccines and design targeted strategies to increase awareness of what types of vaccines are locally available for low- or no-cost.
- 3.3** Hold COVID-19 vaccination clinics in areas with limited access to healthcare services.
- 3.4** Distribute COVID-19 vaccine to local hospitals and skilled nursing facilities.

Strategy 4: Strengthen community partnerships to align existing STD prevention efforts within Stanislaus County and design new targeted interventions.

Activities

- 4.1** Establish a multi-sector partnership to address STDs in Stanislaus County.
- 4.2** Analyze local data to identify groups that are high-risk of contracting a STD and design targeted interventions to prevent disease transmission.



The following activities were included in CHIP to reflect COVID-19 Pandemic and ongoing mitigation efforts related to reducing transmission and mortality rates in Stanislaus County. At the start of the pandemic, the CHIP was in its final development. The activities were formulated outside of the MAPP process due to the need to quickly address this emerging public health threat. During the upcoming implementation phase, community input will be solicited and incorporated into this section once the Communicable Disease Focus Area Workgroup launches later this summer. At that time, the current activities will be reviewed/adapted and community-wide indicators will be identified to track progress in addressing COVID-19 in Stanislaus County.

Strategy 5: Use laboratory data to enhance COVID-19 investigation, response, and prevention efforts.

Activities

5.1

Use laboratory data to initiate case investigations, conduct contact tracing/case follow-up, and implement containment measures.

5.2

Identify cases and exposures to COVID-19 in high-risk settings or within vulnerable populations to target mitigation strategies.

5.3

Implement prevention strategies in high-risk settings or within vulnerable populations including proactive monitoring for asymptomatic case detection.

Strategy 6: Coordinate and engage with partners to decrease COVID-19 transmission in the community.

Activities

4.1

Partner with the California Department of Public Health (CDPH) and community partners to establish/enhance COVID-19 testing.

4.2

Partner with local, regional, or national organizations or academic institutions to enhance capacity for infection control and prevention of COVID-19.

Alignment

This focus area aligns with the following Healthy People 2020 goals:

- Reduce the proportion of adolescents and young adults with chlamydia infections.
- Reduce gonorrhea rates
- Reduce sustained domestic transmission of primary and secondary syphilis
- Reduce congenital syphilis
- Maintain vaccination coverage levels for children in kindergarten

This focus area also aligns with the California Wellness Plan to:

- Increase child vaccination

This focus area also aligns with the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity (ELC) Paycheck Protection Program and Health Care Enhancement Act of 2020.

- Strategy 5- Use laboratory data to enhance investigation, response, and prevention
- Strategy 6- Coordinate and engage with partners

Community Resources

- California Department of Public Health
- Community Health Clinics
- Communicable Disease Taskforce
- Education Institutions
- Health Plans
- Infectious Disease Partners
- Local Data

Community Partners

- Aegis Treatment Center
- Aspiranet
- California State University Stanislaus
- Center for Human Services
- Doctor's Medical Center
- Golden Valley Health Centers
- Haven's Women's Center
- Kaiser Permanente
- LGBTQ+ Collaborative
- Livingston Community Health
- Modesto City Schools
- Modesto Junior College
- Modesto Pregnancy Center
- MoPRIDE
- Planned Parenthood Mar Monte
- Stanislaus County Community Services Agency
- Stanislaus County Office of Education
- Sutter Health
- Valley Children's Health Care
- Wellpath Care



CONCLUSION

MAPP Phase 6: Action Cycle- Implementation, Monitoring, and Evaluation

Upon the adoption of the CHIP, action workgroups will be charged with implementing and monitoring the plan (MAPP Phase 6) beginning in the Summer of 2021. To track and monitor the focus area indicators as well as progress in the implementation of the CHIP's strategies and activities, HSA/PH will utilize Results Based Accountability (RBA) framework for monitoring and tracking. Over the next five years, the following questions will be answered:

- How much of the CHIP has been completed?
- How well was the CHIP implemented?
- Is the community better off?

Each of the focus areas will have action workgroups that will be chaired by a community partner and supported by HSA/PH staff. The workgroups will be comprised of partners, organizations, and community members that have committed to participate in the CHIP's implementation. Each workgroup will focus on the strategies and activities for each of the four areas. HSA/PH will serve as the backbone agency to coordinate the action workgroups and support efforts to ensure the CHIP is implemented, monitored, and revised as needed.

Implementation for each focus area will be reviewed annually, with action workgroups reporting on CHIP progress, activities, and revisions. HSA/PH staff will capture the progress of each focus area through CHIP annual reports. The CHIP, with its associated reports, is intended to serve as a living document and may change based on data, resources, and the evolving public health landscape.



GLOSSARY

Result Statement	Conditions of well-being for entire populations; children, adults, families or communities.
Strategy	Coherent collections of actions which have a reasoned chance of improving results. Strategies are made up of our best thinking about what works, and they include the contributions of many partners. No single action by any one agency can create the improved results we want and need.
Indicator	A measure which helps quantify the achievement of a result.
Headline Indicator	A measure that quantifies the achievement of an outcome.
Associated Indicator	A measure that provides context and background to an outcome.
Root Causes	The underlying reasons that create the differences seen in health outcomes. They are the conditions in a community that determine whether people have access to the opportunities and resources they need to thrive.
Outcome	A broad description of what our county wants to accomplish under each focus area.
Actual Value	The actual level of achievement of an indicator at a point in time.
Target	A desired level of achievement for an Indicator and measurable steps towards meeting outcomes.
Population Disparity	Population-specific differences in the presence of disease, health outcomes, or access to health care. These disparities are often linked to social determinants of health impacting these populations.
Social Determinants of Health	Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Activity	Specific and defined actions accomplished in coordination with multiple partners to address strategies.

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