2024-2028
COMMUNITY HEALTH IMPROVEMENT PLAN

KINGS COUNTY, CALIFORNIA

2024

DELIVERED BY: Moxley PUBLIC HEALTH

Kings County
Department of Public Health

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A NOTE FROM
KINGS COUNTY DEPARTMENT OF PUBLIC HEALTH

Kings County Department of Public Health strives to bring together people and organizations to improve community wellness. The community health assessment process is one way the health department and its partners can live out its mission. In order to fulfill this mission, these partners must be intentional about understanding the health issues that impact residents and work together to create a healthy community.

A primary component of creating a healthy community is assessing the community's needs and prioritizing those needs for impact. In 2023, Kings County Department of Public Health partnered with Moxley Public Health and community-based organizations to conduct a comprehensive Community Health Assessment (CHA) to identify priority health issues and evaluate the overall current health status of the health department's service area. These findings were then used to develop an Improvement Plan (CHIP) to describe the response to the needs identified in the CHA report.

The 2024-2028 Kings County CHIP would not have been possible without the help of numerous Kings County organizations, acknowledged on the following pages. It is vital that assessments such as this continue, so partners know where to direct resources and how to use them in the most advantageous ways.

The goals of public health can only be accomplished through community members' commitment to themselves and to each other. The Department believes that together, Kings County can be a thriving community of health and well-being at home, work, school, and play.

Importantly, this report could not exist without the contributions of individuals in the community who participated in interviews and completed the community member survey. The Department is grateful for those individuals who are committed to the health of the community, and took the time to share their health concerns, needs, behaviors, praises, and suggestions for future improvement.

Sincerely,

Rose Mary Rahn
Director, Public Health,
Kings County Department of Public Health

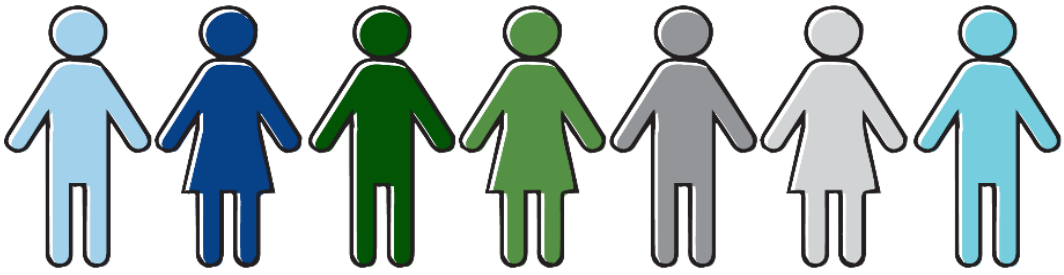
ACKNOWLEDGEMENTS

This Improvement Plan (CHIP) was made possible thanks to the collaborative efforts of Kings County Department of Public Health, community partners, local stakeholders, non-profit partners and community residents (listed below). Their contributions, expertise, time and resources played a critical part in the completion of this strategic plan.

KINGS COUNTY DEPARTMENT OF PUBLIC HEALTH WOULD LIKE TO RECOGNIZE THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS FOR THEIR CONTRIBUTIONS TO THIS REPORT:

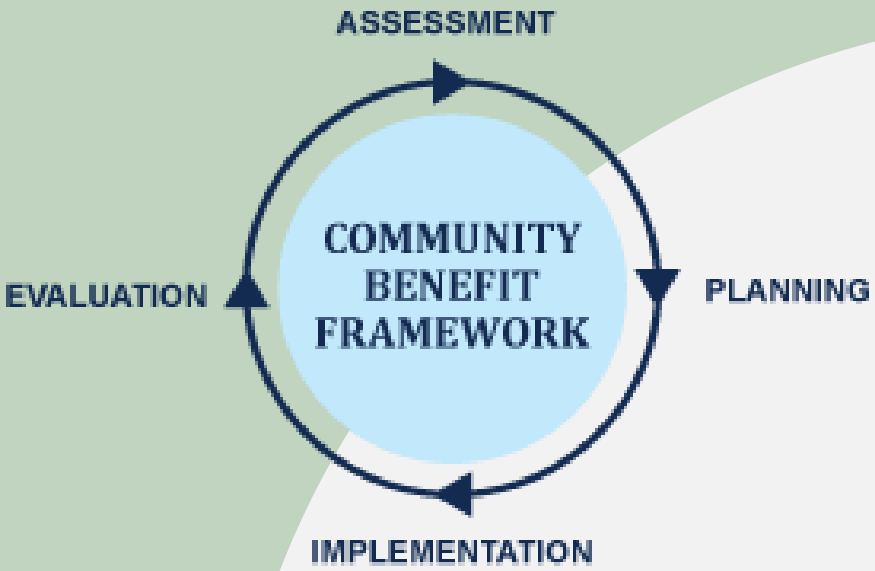
Adventist Health
Aria Community Health Center
Armona Community Services District
California Health Collaborative
Champions Recovery Alternative Programs
City of Corcoran
Community residents
Corcoran Unified School District
Duchess of Doula
Family HealthCare Network
Hanford Public Library
Kings Community Action Organization
Kings County Commission on Aging
Kings County Health Equity Advisory Panel (KCHEAP)
Kings County Latino Round Table
Kings County Office of Education
Kings County Behavioral Health Veterans Support Group
Kings View Community Services
Lily of the Valley Church
National Association for the Advancement of Colored People
Re-establishing Stratford
Restore 180
Santa Rosa Rancheria Department of Education
Tachi-Yokut Tribe
United Health Centers
Valley Voices
WestCare

The 2024-2028 Improvement Plan (CHIP) report was prepared by Moxley Public Health, LLC, (www.moxleypublichealth.com) an independent consulting firm that works with hospitals, health departments, and other community-based nonprofit organizations both domestically and internationally to conduct Community Health Assessments (CHAs)/Community Health Needs Assessments/CHNAs and Improvement Plans (CHIPs)/Implementation Strategies.



INTRODUCTION

WHAT IS AN IMPROVEMENT PLAN (CHIP)?



An **Improvement Plan (CHIP)** is part of a framework that is used to guide community benefit activities - policy, advocacy, and program-planning efforts. For health departments, the Improvement Plan (CHIP) fulfills the mandates of the Public Health Accreditation Board (PHAB).

Kings County
Department of Public Health

OVERVIEW
OF THE PROCESS

In order to develop an Improvement Plan (CHIP), Kings County Department of Public Health followed a process that included the following steps:

STEP 1: Plan and prepare for the CHIP.

STEP 2: Develop goals/objectives and identify indicators to address health needs.

STEP 3: Consider approaches/strategies to address prioritized needs, health disparities, and social determinants of health.

STEP 4: Select approaches with community partners.

STEP 5: Integrate CHIP with community partners and health department plans.

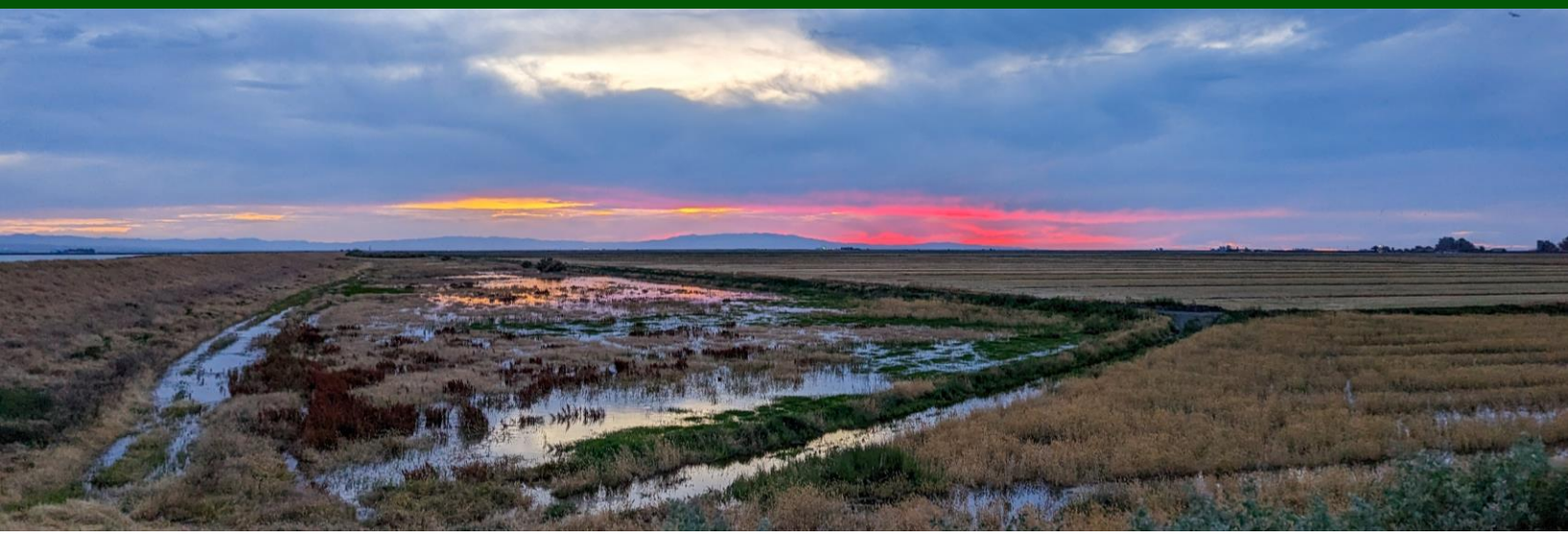
STEP 6: Develop a written CHIP.

STEP 7: Adopt the CHIP.

STEP 8: Update and sustain the CHIP.

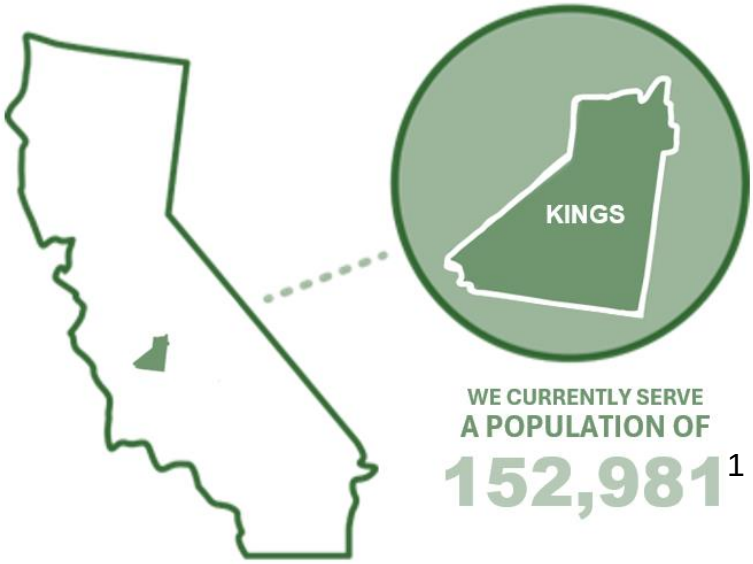
Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

THE 2024-2028 KINGS COUNTY CHIP MEETS ALL PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REGULATIONS.



DEFINING THE KINGS COUNTY
SERVICE AREA

For the purposes of this report, Kings County Department of Public Health defines their primary service area as being made up of Kings County, California. The CHA and this resulting Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This CHIP plans to address the selected priority health needs identified by the CHA.



[1]

The population of Kings County is slowly increasing, while the California population has slightly decreased in the past 3 years[1]

0.3%
KINGS COUNTY

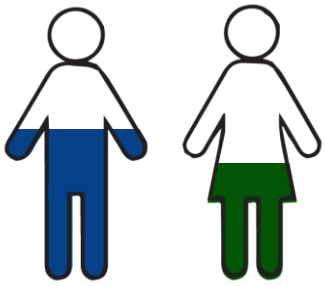
-1.3%
CALIFORNIA

KINGS COUNTY SERVICE AREA			
GEOGRAPHIC LOCATION	**ZIP CODE**	**GEOGRAPHIC LOCATION**	**ZIP CODE**
Armona	93202	Lemoore	93245
Avenal	93204	Lemoore	93246
Corcoran	93212	Lost Hills	93249
Hanford	93230	Stratford	93266
Hanford	93232	Waukena	93282
Kettleman	93239	Kingsburg	93631
Laton	93242	Riverdale	93656

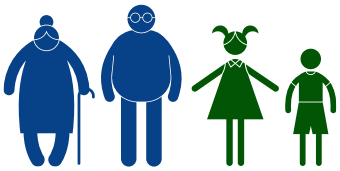
KINGS COUNTY

DEMOGRAPHICS AT-A-GLANCE

There is a **higher percentage of men than women** in Kings County[3]



56% **44%**



Youth ages 0-19 and seniors 65+ make up

41% of the population

in Kings County[5]

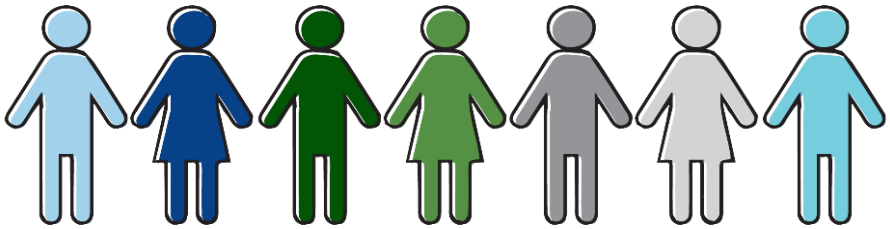
1 in 10

Kings County residents are aged 65+, lower than 1 in 7 in California[6]

6% of Kings County residents are **veterans**, higher than the state rate of 4%[4]

More than two-thirds of the veterans in the service area are under age 55[4]

More than half (57%) of the population in Kings County identifies as Hispanic or Latino/a, higher than the California proportion of 40%[1]



57% HISPANIC OR LATINO/A

29% NON-HISPANIC WHITE

7% BLACK/ AFRICAN AMERICAN

4% ASIAN

0.6% AMERICAN INDIAN/ AK NATIVE

0.2% NATIVE HI/PACIFIC ISLANDER

2% MULTI RACIAL/ OTHER

59% of the population in the Kings County service area speaks English at home; 37% speaks Spanish at home, higher than the California rate of 28%

19% are foreign-born, compared to 27% of Californians. Of those who are foreign-born, 63% are not U.S. citizens[7]

Californians can expect to live nearly 3 years longer on average than Kings County residents[4]

The age-adjusted mortality rate in Kings County of **719 per 100,000** population is higher than California's rate of 631 per 100,000[8]

1 in 278
Kings County residents will die prematurely, which is higher than the 1 in 345 California rate[9]

According to the county health ranking program, Kings County is ranked in the **top 50% of healthiest counties in California** based on social factors that impact health[9]

PRIORITY HEALTH NEEDS
FOR KINGS COUNTY

1 ACCESS TO HEALTHCARE

Kings County has **less access** to both **primary and dental care** providers than California[10]

1 IN 3
Kings County and California residents **did not have a routine checkup** in the past year[8]

2 FOOD INSECURITY

13% of Kings County residents (vs. 9% of Californians) experience **food insecurity**[6]

While **87%** of Kings County residents report that **fruits and vegetables** are usually or always **available**, only **76%** say there are usually or always **affordable**[6]

3 ENVIRONMENTAL EXPOSURES

In 2019, Kings County had **worse air quality than California overall** (12.3 vs. 7.1 micrograms of particulate matter per cubic meter of air)[11]

In 2021, at least **1 community water system** in Kings County, California reported a health-based **drinking water violation**[12]

4 CHRONIC DISEASES

HEART DISEASE AND CANCER are the leading causes of death in kings county[8]

26% of Kings County adults rate their health as **fair or poor**, compared to 18% for California[9]

5 MATERNAL, INFANT, AND CHILD HEALTH

Kings County's **teenage birth rate** (17 per 1,000 women) is nearly **twice** that of California's (9 per 1,000 women)[8]

Kings County has a **higher infant mortality rate** than California (5 vs. 4 per 1,000 live births)[8]

STEP 1

PLAN AND PREPARE FOR THE IMPROVEMENT PLAN (CHIP)

IN THIS STEP, KINGS COUNTY DEPARTMENT OF PUBLIC HEALTH:

- DETERMINED WHO WOULD PARTICIPATE IN THE DEVELOPMENT OF THE CHIP
- ENGAGED BOARD AND EXECUTIVE LEADERSHIP
- REVIEWED COMMUNITY HEALTH ASSESSMENT

Kings County
Department of Public Health

PLAN AND PREPARE FOR THE 2024-2028 KINGS COUNTY IMPROVEMENT PLAN (CHIP)

Secondary and primary data were collected to complete the 2023 Kings County Community Health Assessment (CHA) report. (Available at https://www.kcdph.com/). Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Primary data was collected through key informant interviews with **27** experts from various organizations serving the Kings County service area and included leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies. A *community member survey* was distributed via a QR code and link with **986** responses (629 English responses and 357 Spanish responses). The survey responses (from community members) were used to prioritize the health needs, answer in-depth questions about the health needs in the county, and to identify health disparities present in the community. Finally, there were **6** focus groups held across the county, representing a total of **61** community members from priority populations. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs, and prioritize health needs. More detail on methodology can be found in the 2023 Kings County CHA Report.

> **The improvement plan (CHIP) deals with the "how and when" of addressing needs. While the community health assessment considers the "who, what, where and why" of community health needs, the CHIP takes care of the how and when components.**
>
> ***- Catholic Health Association***

STEP 2

DEVELOP GOALS AND OBJECTIVES AND IDENTIFY INDICATORS FOR ADDRESSING COMMUNITY HEALTH NEEDS

IN THIS STEP, KINGS COUNTY DEPARTMENT OF PUBLIC HEALTH:

- DEVELOPED GOALS FOR THE IMPROVEMENT PLAN (CHIP) BASED ON THE FINDINGS FROM THE CHA
- SELECTED INDICATORS TO ACHIEVE GOALS

Kings County
Department of Public Health

PRIORITY HEALTH NEEDS

GOALS, OBJECTIVES, AND INDICATORS

The following graphic shows the health improvement framework that this report followed while adhering to Public Health Accreditation Board (PHAB) requirements and the community's needs.

Health Improvement Framework

Equity Health equity is achieved when all people in a community have access to affordable, inclusive, and quality infrastructure and services that, despite historical and contemporary injustices, allow them to reach their full health potential.

Priorities Priorities identify health needs (both social determinants of health and health outcomes) that affect the overall health and well-being of children, families, and adults of all ages.

What shapes health and well-being in Kings County?

Many factors, including improving social determinants of health such as:

Community conditions
- Housing and homelessness
- Education/student success
- Adverse childhood experiences
- Economic stability (income/poverty, employment, food security, transportation, etc.)
- Internet/Wi-Fi access
- Access to childcare
- Crime/violence
- Environmental conditions

Health behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to care
- Health insurance coverage
- Local access to healthcare providers
- Access to mental healthcare
- Preventive care and practices

What are signs that health is improving in Kings County?

Improve health outcomes such as:

Mental health/addiction
- Depression
- Suicide
- Youth and adult drug use
- Drug overdose deaths

Chronic and infectious diseases
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead exposure)
- HIV/AIDS and sexually transmitted infections (STIs)

Maternal and infant health
- Preterm births
- Infant mortality
- Maternal morbidity and mortality

All Kings County residents achieve their full health potential
- Improved health status
- Reduced premature death

Vision:
Kings County is a model of health, well-being, and economic vitality

Strategies Choose effective activities, policies, and programs to improve performance on these priorities.

Next, with the data findings from the community health needs assessment process, Kings County Department of Public Health used the following guidelines/worksheet to choose priority health factors and priority health outcomes (worksheet/guidelines continued to next page).

ALIGNMENT WITH PRIORITIES AND INDICATORS

STEP 1: Identify at least one priority factor and at least one priority health outcome.

PRIORITY FACTORS	PRIORITY HEALTH OUTCOMES
☑ Community Conditions	☐ Mental Health and Addiction
☑ Health Behaviors	☑ Chronic Disease
☑ Access to Care	☑ Maternal and Infant Health

STEP 2: Select at least 1 indicator for each identified priority factor.

PRIORITY FACTORS	
COMMUNITY CONDITIONS	
TOPIC	**INDICATOR NAME**
Housing Affordability and Quality	☐ Affordable and Available Housing Units
Poverty	☐ Child Poverty
	☐ Adult Poverty
K-12 Student Success	☐ Chronic Absenteeism (K-12 students)
	☐ Kindergarten Readiness
Adverse Childhood Experiences	☐ Adverse Childhood Experiences (ACEs)
	☐ Child Abuse and Neglect
Food Insecurity	☑ Food Insecurity
Environmental Conditions	☑ Air Quality
	☑ Water Quality
HEALTH BEHAVIORS	
TOPIC	**INDICATOR NAME**
Tobacco/Nicotine Use	☐ Adult Smoking
	☐ Youth All-Tobacco/Nicotine Use
Nutrition	☑ Fruit Consumption
	☑ Vegetable Consumption
Physical Activity	☐ Child Physical Activity
	☐ Adult Physical Activity
ACCESS TO CARE	
TOPIC	**INDICATOR NAME**
Health Insurance Coverage	☑ Uninsured Adults
	☑ Uninsured Children
Local Access to Healthcare Services	☑ Primary Care Health Professional Shortage Areas
	☑ Mental Health Professional Shortage Areas
Unmet Need for Mental Health Care	☑ Youth Depression Treatment Unmet Need
	☑ Adult Mental Health Care Unmet Need

ALIGNMENT WITH PRIORITIES AND INDICATORS (CONTINUED)

STEP 2 (continued): Select at least 1 indicator for each identified priority health outcome.

PRIORITY HEALTH OUTCOMES	
MENTAL HEALTH AND ADDICTION	
TOPIC	**INDICATOR NAME**
Depression	☐ Youth Depression
	☐ Adult Depression
Suicide Deaths	☐ Youth Suicide Deaths
	☐ Adult Suicide Deaths
Youth Drug Use	☐ Youth Alcohol Use
	☐ Youth Marijuana Use
Drug Overdose Deaths	☐ Unintentional Drug Overdose Deaths
CHRONIC DISEASE	
TOPIC	**INDICATOR NAME**
Heart Disease	☑ Coronary Heart Disease
	☑ Premature Death – Heart Disease
	☑ Hypertension
Diabetes	☑ Diabetes
Harmful Childhood Conditions	☑ Child Asthma Morbidity
	☑ Child Lead Poisoning
MATERNAL AND INFANT HEALTH	
TOPIC	**INDICATOR NAME**
Preterm Births	☑ Preterm Births
Infant Mortality	☑ Infant Mortality
Maternal Morbidity/Mortality	☑ Severe Maternal Morbidity/Mortality

ADDRESSING THE **HEALTH NEEDS**

The 2023 Community Health Assessment (CHA) identified the following significant health needs from an extensive review of the primary and secondary data. The significant health needs were ranked as follows through the community member survey (986 responses from community members).

HEALTH NEEDS RANKED IN THE COMMUNITY MEMBER SURVEY:	
#1 (tied) Access to healthcare (e.g. doctors, hospitals, specialists, medical appointments, etc.)	**#1 (tied)** Crime and violence
#3 Mental health and access to mental healthcare	
#4 Housing and homelessness	
#5 (tied) Income/poverty	**#5 (tied)** Substance use/drug use
#7 Employment	
#8 Food insecurity (e.g. not being able to access and/or afford healthy food)	
#9 Environmental conditions (e.g. air and water quality)	
#10 (tied) Access to childcare	**#10 (tied)** Education (e.g. early childhood education, elementary school, post-secondary education)
#12 Chronic diseases (e.g. heart disease, diabetes, cancer, asthma)	
#13 Adverse childhood experiences (e.g. child abuse, mental health, family issues, trauma)	
#14 Nutrition and physical health/exercise	
#15 Transportation (e.g. public transit, cars, cycling, walking)	
#16 Preventive care and practices (e.g. mammograms, vaccinations)	
#17 Tobacco and nicotine use/smoking	
#18 Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal mortality)	
#19 Internet/Wi-Fi access	
#20 HIV/AIDS and sexually transmitted infections (STIs)	

ADDRESSING THE **HEALTH NEEDS**

From the significant health needs, Kings County Department of Public Health chose health needs that considered the health department's capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health department's priorities.

THE 3 PRIORITY HEALTH NEEDS THAT WILL BE ADDRESSED IN THE 2024-2028 IMPROVEMENT PLAN (CHIP) ARE:

Priority Area 1: Access to Healthcare
Priority Area 2: Food Insecurity
Priority Area 3: Environmental Exposures
Priority Area 4: Chronic Diseases
Priority Area 5: Maternal, Infant, and Child Health

STEPS 3 & 4

CONSIDER AND SELECT APPROACHES/STRATEGIES TO ADDRESS PRIORITIZED NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY PARTNERS

IN THESE STEPS, KINGS COUNTY DEPARTMENT OF PUBLIC HEALTH:

- SELECTED APPROACHES/ STRATEGIES TO ADDRESS KINGS COUNTY SERVICE AREA PRIORITIZED HEALTH NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH
- DEVELOPED A WRITTEN IMPROVEMENT PLAN (CHIP) REPORT

Kings County
Department of Public Health

#1 PRIORITY AREA
ACCESS TO HEALTHCARE

(will help with preventative healthcare)

IMPROVEMENT PLAN (CHIP) GOALS

Develop a public health workforce that practices cultural humility and trauma-informed care.	Establish an infrastructure to better serve rural and underserved communities in Kings County.

SMARTIE* OBJECTIVES

By 2028, increase the use of Community Health Workers (CHWs) (e.g., Promotoras, connect and refer to services).	By 2027, ensure 80% of health care staff are trained on principles of cultural humility and trauma informed care.	Identify locations and resources (i.e. provider clinics, mobile units) to provide Telehealth services in Avenal, Corcoran, Home Garden, Stratford, Kettleman City and other rural or underserved communities by 2026.	Establish a Kings County Network of Care by 2027.

STRATEGIES

Recruit and train CHWs. Expand reimbursement for CHWs.	Engage with regional and state associations and experts to explore strategies.	Determine improvement needs for outlying clinics. Create welcoming and comfortable space for clients to conduct virtual appointments. Identify clinics and mobile units for potential partnerships.	Increase Medi-Cal rates/payments in Central California. Educate the community on proper use of the healthcare system. Increase access to reliable transportation for health visits.

PARTNERS

Kings County Department of Public Health (KCDPH), Adventist Health, Aria Health Community Health Center (CHC), United Health Center, Family Healthcare, Valley Voices, CalViva Health/Health Net, other Managed Care Plans (MCPs), Kings Community Action Organization (KCAO), Champions Recovery, Fresno Metro Ministries	KCDPH, Adventist Health, Aria CHC, United Health Center, Family Healthcare, Valley Voices, CalViva Health/Health Net, other managed care plans, KCAO, Champions Recovery, California Department of Health Care Services (DHCS)	KCDPH, California Health Collaborative (CHC), Senior Center, school nurse, Reef-Sunset School District	KCDPH, Health Net, Medical providers, MCPs, specialty care providers, school districts, health care agencies, Kings Area Regional Transit (KART), DHCS

PRIORITY POPULATIONS

Monolingual non-English speakers, recent immigrants, low-income population, asylum seekers, uninsured population, people with disabilities, LGBTQIA+ community	Healthcare employees, monolingual non-English speakers, recent immigrants, low-income population, asylum seekers, uninsured population, people with disabilities, LGBTQIA+ community	Residents of Avenal and Corcoran, mono-lingual Spanish speakers, uninsured population, seniors, low-income individuals	Individuals with chronic health conditions, low income, limited or no broadband access, parents

DESIRED OUTCOMES OF STRATEGIES

- ↑ Increase access and utilization of non-emergency healthcare services and existing healthcare resources
- ↑ Access to primary care, screening, and routine checkups
- ↑ Access to culturally and linguistically appropriate care
- ↓ Delayed care

OVERALL IMPACT OF STRATEGIES

- ↑ Health status
- ↑ Quality of life
- ↑ Prevention and management of chronic diseases
- ↓ Emergency department visits and hospitalizations
- ↓ Unmet care needs
- ↓ Premature mortality and morbidity

ALL KINGS COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

Kings County Department of Public Health

**SMARTIE goals are specific, measurable, attainable, realistic, time-phased, inclusive, and equitable.*

#2 PRIORITY AREA
FOOD INSECURITY

(will help with obesity and nutrition)

IMPROVEMENT PLAN (CHIP) GOALS

Increase affordable access to healthy foods.	Create a comprehensive approach to increasing awareness and education on healthy eating, ultimately leading to healthier communities.

SMARTIE* OBJECTIVES

By 2028, increase the number of Food Banks and number of monthly distributions offered in Kings County by 50%.	By 2028, increase the availability of fruits and vegetables offered at local food banks.	By 2028, provide healthy eating workshops/education in all Kings County schools.	By 2028, provide regular free and accessible healthy eating workshops to Kings County residents.

STRATEGIES

Develop partnerships with Community-based Organizations (CBOs) and existing food banks. Collaborate with partners on joint funding opportunities and community assessment of needs.	Develop partnerships between local food banks, local retailers, farmers, and community partners to increase access to fruits and vegetables.	Develop partnerships with the Kings County Office of Education and school site administration. Develop and implement healthy eating training materials.	Utilize partnerships with CBOs, Managed Care Plans (MCPs), and public health department to provide workshops.

PARTNERS

Women, Infants, and Children (WIC) - Kings County Department of Public Health (KCDPH), Kings Partnership (KPFP), Kings Community Action Organization (KCAO), Kings County Commission on Ageing (KCCOA), School Districts	WIC - KCDPH, KCAO, Kings County Human Services Agency, KCCOA, CalViva, Anthem Blue Cross, Kaiser	WIC - KCDPH, KCDPH (MCAH, School liaison nurse), KPFP, KCAO, KCCOA, United Cerebral Palsy of Central California Inc. (UCCP), Healthy Eating Active Living Workgroup, Tachi-Yokut Tribe	WIC - KCDPH, KPFP, KCAO, KCCOA, UCCP), Tachi-Yokut Tribe

PRIORITY POPULATIONS

Low-income individuals and families, infants, children, seniors, rural areas of Kings County	Low-income individuals and families, infants, children, seniors, rural areas of Kings County	Low-income households, rural communities, children	Low-income individuals and families, infants, children, seniors, rural areas of Kings County

DESIRED OUTCOMES OF STRATEGIES

- ↑ Access to affordable, healthy food
- ↑ Access to food banks
- ↑ Access to fruits and vegetables
- ↑ Healthy eating education

OVERALL IMPACT OF STRATEGIES

- ↑ Mental health
- ↑ Quality of life
- ↑ Nutrition
- ↓ Food insecurity
- ↓ Chronic conditions
- ↓ Obesity

ALL KINGS COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

Kings County Department of Public Health

**SMARTIE goals are specific, measurable, attainable, realistic, time-phased, inclusive, and equitable.*

#3 PRIORITY AREA ENVIRONMENTAL EXPOSURES

IMPROVEMENT PLAN (CHIP) GOALS

Increase access to safe and clean drinking water in Kings County.	Improve air quality in Kings County by reducing exposure to particulate matter in the air.

SMARTIE* OBJECTIVES

Manage exposure to environmental contaminants in drinking water by 2028 by testing for household wells in Kings County for nitrates.	Create or support 1 piece of legislation that requires public health input in the review of planning and development proposals in Kings County.

STRATEGIES

Provide water quality, education to the community (including on nitrate levels, arsenic).

Increase community awareness of water accessibility programs and resources in Kings County.

PARTNERS

Kings River Conservation District, Women Infants and Children (WIC) - Kings County Department of Public Health (KCDPH), Self Help Enterprises, Community Water Center, school districts and teachers, Kings Water Alliance, Regional Water Quality Control Board	KCDPH, San Joaquin Valley Air Control District, Transportation Collaborative, City development and planning - Planning Commission meetings

PRIORITY POPULATIONS

Rural populations/populations dependent on well water, pregnant/nursing people, infants, and elderly folks.	Rural populations, people who work outside, people living with asthma, incarcerated individuals, uninsured individuals.

DESIRED OUTCOMES OF STRATEGIES

- ↓ Particulate matter in air
- ↑ Water quality testing
- ↓ Exposure to environmental contaminants in drinking water
- ↑ Education and awareness of environmental exposures

OVERALL IMPACT OF STRATEGIES

- ↑ Air quality
- ↑ Water quality
- ↓ Environmental exposures
- ↓ Adverse health effects of environmental conditions

ALL KINGS COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

*SMARTIE goals are specific, measurable, attainable, realistic, time-phased, inclusive, and equitable.

#4 PRIORITY AREA CHRONIC DISEASES

IMPROVEMENT PLAN (CHIP) GOALS

Prevent and manage rates of chronic disease in Kings County.

SMARTIE* OBJECTIVES

By December 31, 2025, improve the prevention and management of chronic diseases by conducting 30 educational workshops and distributing 5,000 educational materials on chronic disease prevention and management.	Enhance community awareness of healthcare providers and their services in Kings County	Increase health literacy for Kings County residents living with or at high risk of chronic diseases.

STRATEGIES

Build connections with and train trusted messengers. Partner with local health organizations and leverage community resources to enhance knowledge and self-management skills among residents. Link Kings County residents to resources and services designed to prevent and treat chronic diseases.	Develop 1 multi-lingual, web-based platform of providers and resources for people living with or at high-risk of chronic disease by 2028. Implement community outreach to bridge the gap between providers and the community.	Achieve a 20% increase in the number of residents who demonstrate improved understanding of chronic disease management, as measured by pre- and post-program health literacy assessments.

PARTNERS

Kings County Department of Public Health (KCDPH - MCAH), Managed Care Plans (MCPs) [diabetes management care plans, data from Federally Qualified Health Centers (FQHCs)], United Way - 211, Kings Partnership (KPFP), Libraries, Kings County Commission on Aging (KCCOA), Local churches (Episcopal Church, Lily of the Valley), Avenal Senior Center, school districts, California Health Collaborative (CHC) - Diabetes Coalition, tobacco prevention, Community-based Organizations (CBOs) working with youth, families, and priority populations	KCDPH, MCPs - CalAIM, CBOs with Community Health Workers (CHWs), California Health Collaborative (CHC), Kings Community Action Organization (KCAO)	Santa Rosa Rancheria - Health Liaison, KCDPH, Adventist Health

PRIORITY POPULATIONS

Outlying areas (Corcoran, Avenal, Kettleman City, etc.), MediCal recipients and eligible members, dual-eligible population (MediCal, MediCare), Indigenous communities Latino/ Hispanic population, uninsured	MediCal recipients and currently uninsured eligible members, rural communities within Kings County, mono-lingual Spanish speakers	Indigenous Communities, Latino/ Hispanic population, populations with high rates of diabetes-related amputations, adults over the age of 65, minority racial and ethnic groups, recent refugees and immigrants, people with less than a high school degree or GED, mono-lingual Spanish speakers

DESIRED OUTCOMES OF STRATEGIES

- ↑ Education on chronic diseases & risk factors
- ↑ Chronic disease prevention, screening & management
- ↓ Sedentary youth & adults
- ↑ Opportunities for physical activity
- ↓ Food insecurity
- ↑ Nutrition, including fruit and vegetable consumption

OVERALL IMPACT OF STRATEGIES

- ↑ Mental and physical health
- ↑ Mental and physical health
- ↑ Quality of life
- ↑ Health status
- ↓ Overweight & obesity
- ↓ Chronic disease
- ↓ Premature mortality

ALL KINGS COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

Kings County Department of Public Health

**SMARTIE goals are specific, measurable, attainable, realistic, time-phased, inclusive, and equitable.*

#5 PRIORITY AREA
MATERNAL, INFANT & CHILD HEALTH

IMPROVEMENT PLAN (CHIP) GOALS

Increase access to pre- & postnatal services among birthing persons.		Increase health literacy among birthing persons.	Provide culturally relevant services to birthing persons.		
SMARTIE* OBJECTIVES					
Increase breastfeeding rates in Kings County amongst Women, Infants, and Children (WIC) participants by 5% by 2028.	Expand Community Baby Shower events to 6 per year.	Achieve a 20% increase in the number of pregnant or parenting persons who demonstrate improved understanding of how to enroll in MediCal, how to schedule a doctor visit, telehealth appointments, questions to ask during health visits, importance of prenatal care, education on US prenatal care/ healthcare systems, and how to advocate for self as measured by pre- and post-program health literacy assessments.	Partner with at least three community-based organizations and cultural leaders to co-develop culturally relevant materials and training for healthcare providers by 2028.	Build awareness of importance of doula services & interventions (addressing Black maternal mortality).	Address provider bias through training and resources.
STRATEGIES					
Provide culturally relevant breastfeeding education for priority populations in Kings County. Increase awareness of and access to free and low-cost breastfeeding resources for Medi-Cal eligible birthing parents.	Increase partnerships to expand community awareness of and resources for Kings County Baby Showers.	Implement community-based education programs that utilize partnerships with healthcare providers and Community Health Workers (CHWs). Develop a health literacy toolkit for birthing parents.	Provide culturally relevant outreach through community health workers (CHWs) and CBO partnerships. Provide training for healthcare providers and groups that serve birthing parents on culturally relevant pre and postnatal practices and educational materials.	Partner with five local organizations, community leaders, and healthcare providers to co-host educational events and distribute informational materials about the benefits of doula services for Black women and birthing parents by 2028. Reach 1,000 Black women & birthing parents with doula education by 2028.	Educate 50 providers on cultural birthing practices/ care needs by 2028.
PARTNERS					
Duchess of Doula, WIC - Kings County Department of Public Health (KCDPH), Adventist Health, 211, CalViva, Federally Qualified Health Centers (Aria Community Health Center (CHC), United Health Center, Kings Tulare Breastfeeding, Family Healthcare network), Kings Community Action Organization (KCAO), home visitation programs, parent programs, First 5 Kings County, local schools, regional breastfeeding liaisons, support groups, Family Resource Centers (FRCs)	Anthem Blue Cross, CalViva, Central California Food Bank (diaper distribution), University of Southern California (interns), United Health Centers (interns), KCAO	KCDPH, KCAO, Dutchess of Doula, Anthem Blue Cross, CalViva, Kaiser, Restore 180, Lily of the Valley	KCDPH, KCAO, Dutchess of Doula, Anthem Blue Cross, CalViva, Kaiser, Restore 180, Lily of the Valley, National Association for the Advancement of Colored People (NAACP)		

PRIORITY POPULATIONS

Women of color, Black women/ birthing persons moms/ birthing persons, Rural Areas, Low-income population, Uninsured, Immigrants, Monolingual Spanish Speakers

DESIRED OUTCOMES OF STRATEGIES

- ↑ Access to pre- and post-natal care
- ↑ Access to primary care, screening, and routine checkups
- ↑ Access to culturally and linguistically appropriate care
- ↑ Breastfeeding
- ↓ Delayed care

OVERALL IMPACT OF STRATEGIES

- ↑ Health status
- ↑ Quality of life
- ↓ Unmet care needs
- ↓ Infant mortality
- ↓ Maternal mortality and morbidity
- ↓ Low birth weight and pre-term births

ALL KINGS COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

**SMARTIE goals are specific, measurable, attainable, realistic, time-phased, inclusive, and equitable.*

CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

DEVELOPMENTAL & PHYSICAL DISABILITIES/SENIOR CITIZENS

Kings County Commission on Aging Council
Kings/Tulare Area Agency on Aging
Special Needs Support Group of Kings County
United Cerebral Palsy Central California

DOMESTIC/CHILD ABUSE & VIOLENCE, SEXUAL ASSAULT

Barbara Saville Shelter
CASA of Kings County
Kings County Child Abuse Prevention Coordinating Council/Family Preservation Support Board
Kings County Domestic Violence Services
Kings County Elder Abuse Services
Kings County Human Sex Trafficking Support
Kings County Domestic Violence/Victim Witness Program
Kings County 24-Hour Crisis Line
Kings County Rape Crisis Program

ECONOMIC STABILITY

American Red Cross Central California Region
Electric and Gas Bill Assistance and Water Bill Assistance
Greater Kings County Chamber of Commerce
Kings Area Rural Transit
Kings Community Action Organization
Kings County Human Service Agency
Kings County Job Training Office
Kings Partnership for Prosperity, Progress and Prevention
Kings United Way
Kings/Tulare Homeless Alliance (CoC)
Proteus Inc.
Self-Help Enterprises
St. Brigid Catholic Church
The Salvation Army Hanford
Volunteer Income Tax Assistance (VITA)
Water Tank Program
Weatherization Program

EDUCATION

Cal-Learn
College of the Sequoias
Corcoran Joint Unified School District
Hanford Joint Union High School District
Kings County Office of Education
Kings County Special Education
Learn4Life Hanford
Lemoore Union High School District
Santa Rosa Rancheria Department of Education
State Center Community College District
West Hills College Lemoore

HEALTHCARE

Adventist Health
American Cancer Society
American Heart Association
Anthem Blue Cross Blue Shield
Aria Community Health Center
Avenal Community Health Center
CalAIM: Enhanced Care Management
California Health Collaborative
Central California Public Health Consortium
COVID Education Program
Duchess of Doula
Every Woman Counts Program
Family Healthcare Network
Health Net
Kings County Department of Public Health
Leukemia & Lymphoma Society
March of Dimes Central Valley Division
OMNI Health Centers
Tachi Clinic - Central Valley Indian Health, Inc.
United Health Centers
Valley Children's Healthcare
Valley Health Team

HEALTHY FOOD, PHYSICAL ACTIVITY & NUTRITION

Central California Food Bank
Central California Regional Obesity Prevention Program
Senior Nutrition Program
Summer Food Services Program (SFSP)
University of California Cooperative Extension Office

CURRENT RESOURCES

ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

HOUSING, HOMELESSNESS, SOCIAL SERVICES & ADVOCACY

211 Kings County
ANCHORS Supportive Housing
Armona Community Services District
Barbara Seville Women's Shelter
CalFresh Healthy Living Program
Corcoran Emergency Aid
Day Care Homes Food Program
Episcopal Church of the Savior
Equity in Black
Facilitating Accountability Victim Offender Restoration (F.A.V.O.R)
Habitat for Humanity
Hanford Public Library
Housing Authority of Kings County
Kings County Housing Assistance
Kings County Latino Roundtable
Kings County Library
Kings County Veterans Services
Kings Gospel Mission
Kings/Tulare Homeless Alliance
Latin American Assembly of God
Lighthouse Rescue Mission
Lily of the Valley Church
NAACP Kings & Tulare County
PATH Program Kings County
Re-establishing Stratford
Restore 180
Valley Voices

MATERNAL, INFANT & CHILD HEALTH/ACCESS TO CHILDCARE

Aspiranet Hanford
Breastfeeding Support Program
California Alternative Payment Program (CAPP)
California Child Care Initiative Project
California Personal Responsibility Education Program (CA PREP)
CalWORKs
Crossroads Pregnancy Center
First 5 Kings County
Head Start
Home Visiting Program
Kettleman City Family Resource Center
Kings County CareConnect
Kings County Child and Adult Care Food Program
Kings County Community Resource Center

MATERNAL, INFANT & CHILD HEALTH/ACCESS TO CHILDCARE (CONTINUED)

Kings County Emergency Child Care Bridge Program for Foster Children
Kings County Resource & Referral
Kings County Toy Lending Library
Refuge Armona
Regional Perinatal Programs of California (RPPC)
Safe Kids Kings County
Support, Outreach, and Leadership (SOL) for Youth Program
TrustLine
WIC - Women, Infant, & Children

MENTAL HEALTH & SUBSTANCE USE

Champions Recovery
Cornerstone Recovery System
Collaborative Justice Treatment Court
Family Member Support Group
Kings Community Action Crisis Center
Kings County Assertive Community Treatment (ACT)
Kings County Crisis Line
Kings County Department of Behavioral Health
Kings County Local Outreach to Suicide Survivors (LOSS) Team
Kings County Mental Health Taskforce
Kings County Veterans Support Group
Kings County Wellness Bridge
Kings/Tulare County Warmline
Kings View Community Services
Lemoore Naval Fleet & Family Support
Mental Health Systems/TURN
National Alliance on Mental Illness
Oak Wellness Center
Peer-to-Peer Non-Crisis Warm Line
Perinatal Mental Health Integration Project (PMHIP)
Fresno, Madera, and Kings Counties
Sister Speak
The Kind Center
WestCare
Young Minds Kings County

TOBACCO & NICOTINE USE

Kings County Tobacco Control
Regional Advocates Countering Tobacco (ReACT)
RISE – Statewide Rural Coordinating Center
Unidos Por Salud

STEPS 5-8

INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPROVEMENT PLAN (CHIP)

IN THIS STEP, KINGS COUNTY DEPARTMENT OF PUBLIC HEALTH WILL:

- INTEGRATE CHIP WITH COMMUNITY PARTNERS AND HEALTH DEPARTMENT PLANS
- ADOPT THE CHIP
- UPDATE AND SUSTAIN THE CHIP

Kings County
Department of Public Health

KINGS COUNTY

NEXT STEPS

The Community Health Assessment (CHA) and this resulting Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This CHIP explains how Kings County Department of Public Health plans to address the selected priority health needs identified by the CHA.

This CHIP report was adopted by Kings County Department of Public Health leadership in 2024.

This report is widely available to the public on the health department website: https://www.kcdph.com/

Written comments on this report can be made by contacting the Kings County Department of Public Health: Everardo.Legaspi@co.kings.ca.us.

EVALUATION OF IMPACT

Kings County Department of Public Health will monitor and evaluate the programs and actions outlined above. We anticipate the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. Kings County is committed to monitoring key indicators to assess impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. A review of the impact of Kings County's actions to address these significant health needs will be reported in the next scheduled CHA.

ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED

Since Kings County Department of Public Health cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our region given our areas of focus and expertise. Taking existing organization and community resources into consideration, Kings County will not directly address the remaining health needs identified in the CHA, including but not limited to crime and violence, mental health, housing and homelessness, income, poverty, and employment, substance use, access to childcare, education, adverse childhood experiences (ACEs), transportation, tobacco and nicotine use, internet access, HIV/AIDS and STIs, and COVID-19. We will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that the health department cannot independently lead in order to address the other health needs identified in the 2023 CHA.

APPENDIX A

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) CHECKLIST: IMPROVEMENT PLAN (CHIP)

MEETING THE PHAB REQUIREMENTS FOR THE CHIP

The PHAB Standards & Measures serve as the official guidance for PHAB national public health department accreditation, and includes requirements for the completion of Community Health Assessments (CHAs) and CHIPs for local health departments. The following page demonstrates how this CHIP meets the PHAB requirements.

Kings County
Department of Public Health

APPENDIX A:
PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
		MEASURE 5.2.1 A: Engage partners and members of the community in a community health improvement process.	
✓		1. A collaborative process for developing the community health improvement plan (CHIP), which includes:	
	4	a. A list of participating partners involved in the CHIP process. Participation must include: i. At least 2 organizations representing sectors other than public health. ii. At least 2 community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes.	
✓	7-25	b. Review of information from the community health assessment.	
✓	19-23	c. Review of the causes of disproportionate health risks or health outcomes of specific populations.	
✓	12-17	d. Process used by participants to select priorities.	
		The CHIP process must address the jurisdiction as described in the description of Standard 5.2.	
		MEASURE 5.2.2 A: Adopt a community health improvement plan.	
		1. A community health improvement plan (CHIP), which includes all of the following:	
✓	19-23	a. At least two health priorities.	
✓	19-23	b. Measurable objective(s) for each priority.	
✓	19-23	c. Improvement strategy(ies) or activity(ies) for each priority. i. Each activity or strategy must include a timeframe and a designation of organizations or individuals that have accepted responsibility for implementing it. ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities.	A detailed work plan (living document) has been developed that included strategies, SMART objectives, annual activities, indicators, partners, and priority populations.
✓	24-25	d. Identification of the assets or resources that will be used to address at least one of the specific priority areas.	
✓	27	e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.	
		The CHIP must address the jurisdiction as described in the description of Standard 5.2.	

APPENDIX A:

PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST (CONT.)

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓ ✓ ✓	N/A	**MEASURE 5.2.3 A: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.** 1. Community health improvement plan (CHIP) activity or strategy implemented. 2. Annual review of progress made in implementing all strategies and activities in the community health improvement plan (CHIP). 3. Revisions to the community health improvement plan (CHIP) based on the review in Required Documentation 2 (above).	The 2024-2028 CHIP will be evaluated and examples of implementation will be provided to PHAB. Any revisions will be noted.
✓ ✓	19-23	**MEASURE 5.2.4 A: Address factors that contribute to specific populations' higher health risks and poorer health outcomes.** 1. A policy or procedure that demonstrates how health equity is incorporated as a goal into the development of programs that serve the community. 2. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. The documentation must define the health department's role in the strategy as well as the roles of stakeholders, partners, or the community.	All CHIP strategies are specifically tied to health equity and indicate which priority population(s) the strategy will focus on and the social determinants of health and barriers that will be addressed.

APPENDIX B

REFERENCES

Kings County
Department of Public Health

APPENDIX B:
REFERENCES

1. U.S. Census Bureau, Decennial Census, P1, 2010-2020. http://data.census.gov/
2. U.S. Census Bureau, American Community Survey, DP05, 2021. http://data.census.gov/
3. U.S. Census Bureau, American Community Survey, K202101, 2021. http://data.census.gov/
4. U.S. Census Bureau, American Community Survey, S0101, 2020 & 2021. http://data.census.gov/
5. U.S. Census Bureau, American Community Survey, S1601, 2020. http://data.census.gov/
6. U.S. Census Bureau, American Community Survey, DP02, 2020. http://data.census.gov/
7. U.S. Census Bureau, American Community Survey, K9S01, 2021. http://data.census.gov/
8. U.S. Centers for Disease Control (CDC), Behavioral Risk Factor Surveillance System (BRFSS), via 2023 County Health Rankings, 2020 data. http://www.countyhealthrankings.org
9. County Health Rankings & Roadmaps, 2023 Data Set, http://www.countyhealthrankings.org/
10. Health Resources and Services Administration (HRSA). (2023). Find shortage areas. https://data.hrsa.gov/tools/shortage-area/
11. California Air Resources Board, Air Quality Data Statistics, 2019 data, from Dec. 2020 via http://www.kidsdata.org
12. State Water Resources Control Board, Annual Compliance Report Dataset, 2021 https://www.waterboards.ca.gov/drinking_water/certlic/drinkingwater/Publications.html

Moxley
PUBLIC HEALTH

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