KERN COUNTY PUBLIC HEALTH

Grounded in Health

2023 COMMUNITY HEALTH IMPROVEMENT PLAN

crescendo

Contents

2023 Community Health Improvement Plan

Kern County Public Health's mission is to protect and promote the health and safety of the community they serve, spanning the entire county. They strive to achieve their mission and vision – that the communities of Kern will play, eat, work safely and have accessible health services for all – through a variety of specialized programs and services.

Kern County Public Health remains oriented towards its mission, vision, and goals by periodically assessing community need through the Community Health Assessment (CHA) process, followed by strategic planning centered on developing a Community Health Improvement Plan (CHIP). **The purpose of the CHIP is to describe how Kern County Public Health and its partners will work together to improve the health of the populations they serve.** The pairing of the CHA and CHIP processes allow for timely assessment of prevailing health issues, incorporating perspectives and opinions gathered from community stakeholders during the CHA. Emphasis is given to integrating the input of community stakeholders and members from underserved and underrepresented populations.

Methodology

Between July and December of 2023, Crescendo Consulting Group ("Crescendo") worked in collaboration with Kern County Public Health to conduct a CHA and CHIP. A mixed-methods approach consisting of quantitative and qualitative research methods was implemented during the CHA, with findings directly applied to development of the CHIP. Specifically, information gathered was used to facilitate identification of priority health issues, developing realistic strategies, and specifying goals and monitoring plans to maintain accountability over time.

CHIP workshop participants engage in focused discussions of community health needs.

Upon completion of the CHA, Crescendo conducted a multi-phase process. First, the priority needs identified from the CHA were finalized. Second, a CHIP survey was administered, providing community stakeholders a platform to identify potential strategies, barriers, and community resources that correspond with each priority need category identified through the CHA. Additionally, Crescendo conducted a review of promising practices related to the specific identified community health topics identified in the Kern County CHA. Finally, Kern County Public Health held a four-hour, on-site "Prioritization Day" CHIP workshop on November 21, 2023. The on-site workshop began with small group discussions of potential strategies to address the community health needs identified and prioritized through the CHA process, followed by a voting session in which all attendees voted on their preferred strategies for each category of need. The result of this process is a set of prioritized strategies for each CHA priority, providing Kern County Public Health and its partners with priorities in which to address across Kern going forward.

The CHA report is available to you at kernpublichealth.com.

Overview of Health Priorities

Community Health Assessment Prioritized Needs

The needs prioritization process provided Kern County Public Health with an opportunity to review key findings and categorize identified needs that fall within the agency's purview to address. The needs featured in the table below were prioritized (categories of need and specific identified needs are not in any priority order).

Exhibit 1: Prioritized Categories of Need and Specific Identified Needs

CATEGORY OF NEED	SPECIFIC IDENTIFIED NEEDS
Expanded chronic disease and communicable disease prevention and surveillance efforts	Expansion of STI prevention and testing efforts to mitigate county-level trends in incidence of STIs like syphilis
	Efforts to prevent and address chronic health conditions such as diabetes, asthma, and heart disease
Enhanced behavioral health programs and services for children/youth and adults	Counseling services for children/youth and adults for mental health issues such as depression, anxiety, and others
	Crisis or emergency care programs for behavioral health issues
	Substance use prevention programs, particularly for methamphetamines and fentanyl
	Culturally competent mental health programs that aim to reduce stigma and to promote awareness of early signs of mental illness
	More primary and specialty health and behavioral healthcare providers, particularly in outlying areas of the county
Improved access to care through increased capacity and enhanced navigation support	Efforts to streamline health and behavioral healthcare services to increase accessibility and ease navigation
	Appropriate use of services across the continuum of community health and behavioral healthcare resources in order to reduce use of acute care facilities for non-emergent care.
	Affordable dental care services and navigation support for individuals regardless of insurance status, including support for those paying out-of-pocket
Promotion of equitable access to health and behavioral health services and resources	Outreach to raise public awareness of available health and behavioral health services and resources, specifically to populations encountering obstacles related to factors such as language, culture, and/or immigration status
	Culturally competent public health prevention programs and resources, such as for farming families and non-English-speaking communities across the county
	Equitable access to prenatal care, including expanded availability of ultrasounds, to close the maternity care disparity for Black and Native American persons
Better support to assist community members to meet basic needs	More safe public recreational spaces for children and adults, including enhancement of existing spaces through maintenance of public bathrooms and water fountains, particularly in underserved areas, such as farmworker communities
	Expanded transportation services across the county, such as for residents of outlying communities and for populations like older adults who require additional assistance
	Resources to address hunger and food insecurity, including support for food pantries and other sources of emergency food

Community Health Improvement Plan Survey

The purpose of the CHIP survey was to comprehensively evaluate stakeholder insights on each priority need category in preparation for the CHIP workshop. The five priority need categories are listed alphabetically in the table below.

The CHIP survey instrument can be found in Appendix B.

Exhibit 2: Prioritized Categories of Need Featured in CHIP Survey

Priority Need Category	Brief Explanation
Access to Care	Improved access to care through increased capacity and enhanced navigation support
Basic Needs	Better support to assist community members to meet basic needs
Behavioral Health	Enhanced behavioral health programs and services for children/youth and adults
Chronic Disease and Communicable Disease	Expanded chronic disease and communicable disease prevention and surveillance efforts
Equitable Access to Services and Resources	Promotion of equitable access to health and behavioral health services and resources

In addition to laying the groundwork for the CHIP workshop, the survey also provided an avenue for stakeholders who were unable to attend the in-person prioritization session to convey their ideas for strategies, barriers, and keys to success. These contributions were included in forming the strategies considered by CHIP workshop attendees.

Survey respondents were asked to identify one to three strategies, and any corresponding barriers, for each of the five priority need categories. A total of 48 participants completed the survey, representing a variety of organizations throughout Kern County.

A list of all strategies and barriers identified by survey respondents can be found in Appendix C.

Exhibit 3: Participant Organizations Represented in CHIP Survey

Organization Name	Organization Name
Anthem Blue Cross	Kern County Department of Human Services
Arvin Union School District	Kern County Hispanic Chamber of Commerce
Bakersfield American Indian Health Project	Kern County Network for Children
Bakersfield College Launchpad	Kern County Public Health
Bakersfield Memorial Hospital – AIDS Project	Kern County Superintendent of Schools
Bakersfield Pregnancy Center	Kern Health Systems
Bee Kind – Counseling	Kern High School District
Black Infant Maternal Health Initiative	LESD Family Resource & Learning Center
Cirugía Sin Fronteras (DBA CSF Surgery; CSF Medical Non-Profit Foundation)	Mercy Hospitals – Bakersfield
City of Bakersfield Recreation & Parks	ShePOWER Leadership Academy
Community Action Partnership of Kern	The Open Door Network
Dolores Huerta Foundation	United Way of Central Eastern California (formerly, United Way of Kern County)
First 5 Kern	Vision y Compromiso
Hall Ambulance Service, Inc	WIC Kern County Breastfeeding Coalition
Kern Behavioral Health & Recovery Services	Womens Center-High Desert, Inc.

Key Findings

Across all five need categories, 179 strategies and corresponding barriers were identified by participants. The chronic disease and communicable disease need category received the most strategy responses (47), followed by the behavioral health need category (42). The equity, basic needs, and access to care need categories each received approximately 30 strategy responses.

Two optional final questions were presented to all survey participants, in addition to collecting participants' priority need category insights. The first question provided survey participants with an opportunity to share other issues they believe Kern County Public Health is able to address:

Regardless of the tactics and barriers listed above, are there other issues we need to address?

- → **"Addressing gaps** in our coverage of Kern County."
- → **"Affordable housing** and an easy way to **access the information** on how to obtain it."
- → **"Healthier food** options, better **walking trails**, plant more **trees for better air quality**, encourage **outdoor activities."**
- → **"Homelessness."**
- → "Improved **data sharing and collection**."
- → **"Medi-Cal managed OB Providers** to help address factors such as food insecurity, mental health needs, addition health education, nutrition education, etc."

- → **"Infant mortality rate** in Kern, and **lactation support** after being discharged from the hospital."
- → **"Lack of competent medical providers in our county for individuals with insurance**. Increasing the **health literacy** of our community."
- → "Lack of **resources and referrals being provided to patients by private** and the **lack of OBGYNs** in Kern County."
- → "We need to **work more closely with Kern County's Native American populations**, including going to the reservations for services if needed."

The second question provided a space for survey participants to share advice and "keys to success" in addressing these top needs throughout Kern County. Twenty survey participants responded, with responses including the following:

If you had to share one or two "keys to success" to improve health and well-being in the county, what advice would you give?

- → "**Expand mobile health clinic use** and **prioritize funding in mental health."**
- → "Better **health equity across** our **county**."
- → "Continued **collaboration** and **engagement**."
- → "Creating more **digital marketing** to **serve areas strategically**."
- → "**De-centralize** a portion of **services and locations out of Bakersfield city**, create **greater presence** and **awareness** in **outlying communities**."
- → **"If someone's basic needs aren't being met (food, shelter, clothing) then nothing else takes priority over that--even their health.** This is a very grassroots community and in order to reach them we have to **meet them where they are at**, **in person**, and show up with **real resources they can use**--not a website, not a flyer, but real resources. The community has lots of stakeholders and advisory board who talk about the problems but do little to help solve them. Less is more--**less talk, more action**."
- → "In order to affect change, we must all **work together as a united county** to **address these significant issues**."
- → **"Know your "why"**. Why are these services or programs being offered? **Find people who are passionate about the why** to participate in the program."
- → "The Keys to Success would include **all entities working in collaboration**. **This is OUR community** so we all have to participate and work collectively together."
- → "We need to be **providing the community what it is asking for**, not swag, but **items that are really needed**. Secondly, we need to be **doing outreach in the communities we serve**, in the **specific neighborhoods** that are being **affected**."

A list of all responses can be found in Appendix C.

Promising Practices Review

In addition to eliciting strategy ideas from Kern County stakeholders, Crescendo conducted a high-level review of promising practices to use to supplement strategy lists for each identified category of need in preparation for the CHIP workshop session. Identified practices are briefly summarized below, by category of need. References to source literature, where appropriate, are included in Appendix A.

Access to Care

- Enhance interagency and interdepartmental data sharing, including up-to-date sharing of available programs
- Create accurate and data-driven messaging for the general public – Awareness media campaigns and events
- Provide access to a local hotline where residents may be connected with qualified clinicians (RNs, MDs, etc.)
- Implement a local media campaign promoting and explaining community resources
- Link primary care clinics in rural areas with centralized health systems for training and mutual support through telehealth
- Establish a uniform, warm-hand off protocol to link care processes and clinical services between county providers
- Pilot community health care worker credentialing programs
- Create an entry system that coordinates between county providers and community resources
- Integrate oral health care into overall health care, either by creating a referral and tracking system that connects clinics and primary care to dental providers or by training nondental health care professionals in assessing risk for oral disease for earlier detection
- Provide incentives to dental health care professionals that implement a sliding scale for noninsured patients
- Educate community members in the use of primary care vs. acute care facilities
- Encourage emergent care facilities to implement a screening at initial patient entry, so as to re-route nonemergent cases to local urgent cares, clinics, and primary cares (including follow through after screening process to ensure patient accessed the necessary services)

Basic Needs

- Mobile food pantries to reach rural areas of the community
- Monthly vouchers to spend at local farmers' markets and invited to engage in a variety of community activities

- Establish community-based program developed to increase access to local, healthy foods
- Implement food insecurity screenings in clinical settings and community resource point-of-contact, using the Hunger Vital Sign (a two-question, validated tool that is widely used in clinical and community-based settings across the nation)
- Provide toolkits (Addressing Food Insecurity: A Toolkit for Pediatricians) with more details on strategies for effectively addressing food insecurity in clinical settings.
- Enhance existing recreational spaces through maintenance of public bathrooms and water fountains, particularly in underserved areas, such as farmworker communities
- Improve and/or develop public meeting spaces in rural communities
- Promote equitable park programs and policies that make it safe and easy for community members to be physically active (including activities that are accessible for all ability levels)
- Encourage employee-sponsored transit passes for employment locations near transit
- Increase connectivity among neighborhoods and communities via expanded bus route hours of operations and service areas
- Implement a coordinate fare and schedule system for county-wide transit

Behavioral Health

- Establish digital clinics using smartphone apps to augment and extend mental health care
- Support and expand prevention programming such as harm reduction services
- Promote and disseminate opioid abatement and intervention materials such as the Regrounding our Response (RoR) curriculum
- Bolster recovery community Infrastructure
- Create partnerships with medical institutions that have well-established opioid use disorder treatment programs
- Implement CME opportunities for evidence-based substance use interventions

Chronic Disease and Communicable Disease

- Establish a Community Advisory Board that reflects at-risk groups for communicable diseases, to engage in decision-making and partnerships surrounding STI prevention efforts
- Incorporate and pilot HIV/STI testing during point-of-contact with specifically identified community resources and partners (for example: shelters, CAP agencies, community health worker appointments, etc.)
- Incorporate and pilot HIV/STI testing during point-of-contact with specifically identified health care entities (for example: substance use treatment providers, emergency departments, etc.)

- Integrate syphilis and other STI screenings of mother at prenatal appointments
- Implement a local education campaign for STI prevention targeting adult populations
  Provide Diabetes Prevention Program (DPP) in rural communities through connections with community centers and/or health clinics, including patient payment relief via a sliding scale
- Provide Diabetes Self-Management Training (DSMT) in rural communities through connections with community centers and/or health clinics, including patient payment relief via a sliding scale
- Educate community members in how to incorporate exercise into daily life (including chores inside and outside the home, errands, etc.)
- Implement heart healthy education through materials (Public Service Announcements, TV ads, flyers, etc.) created for the Million Hearts initiative (millionhearts.hhs.gov)
- Expand access to and delivery of asthma self-management education (AS-ME), including home and workplace visits
- Pilot home visit program for trigger reduction and asthma self-management education
- Create, maintain, and disseminate county-wide surveillance dashboard for pre-diabetes, diabetes, heart disease, stroke, and asthma diagnoses
- Conduct annual education campaigns aimed at reducing exposure to wildfire smoke

Equitable Access to Services and Resources

- Implement multi-lingual education campaigns for chronic diseases and communicable diseases (specifically in Spanish and Punjabi)
- Promote on-site translators at acute care and primary care facilities
- Provide health clinics throughout county with cultural competency training tailored to the specific communities the health clinics serve
- Encourage and support rural community members receiving health education and returning to community for work (e.g., nursing training, midwifery training, medical training, dental training, community health worker training, etc.)
- Recruit and retain minority staff from underrepresented communities
- Provide community health worker credentialing programs in rural areas
- Incorporate preconception and prenatal education during point-of-contact with specifically identified community resources and partners
- creating a referral and tracking system that connects clinics and primary care
- Train health care providers located at primary care clinics and other health services in the available resources for maternity care
- Create a network connecting rural healthcare providers with OBGYN physicians throughout the county

- Establish a traveling OBGYN physician program to bring maternity care to rural health clinics
- Pilot bi-annual health care screenings at employment locations to reach migrant farmers
- Coordinate with traditional healers
- Expand hours of operation to include evening and weekend hours to meet the needs of community members that are unable to attend due to their regular working hours Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials
- Employ methods to assess literacy levels including the use of screening instruments that test for certain skills related to functional literacy or less formal tools that allow health care professionals to determine a person's comfort level with various modes of communication.
- Utilize nationally recognized curriculums such as Building Bridges: Mental Health Interpreter Training for Interpreters of Southeast Asian Languages to provide training for interpreters, trainers, and health providers, as well as a mental health interpreter certification process

Strategy Prioritization: The CHIP Workshop

Stakeholders from across Kern County were invited to participate in a CHIP workshop, held in Bakersfield on November 21, 2023. Kern County Public Health and Crescendo facilitated the four-hour workshop session to examine strategies, identify barriers, and discuss potential measures for each priority need category. Forty-four (44) stakeholders participated, representing 20 agencies.

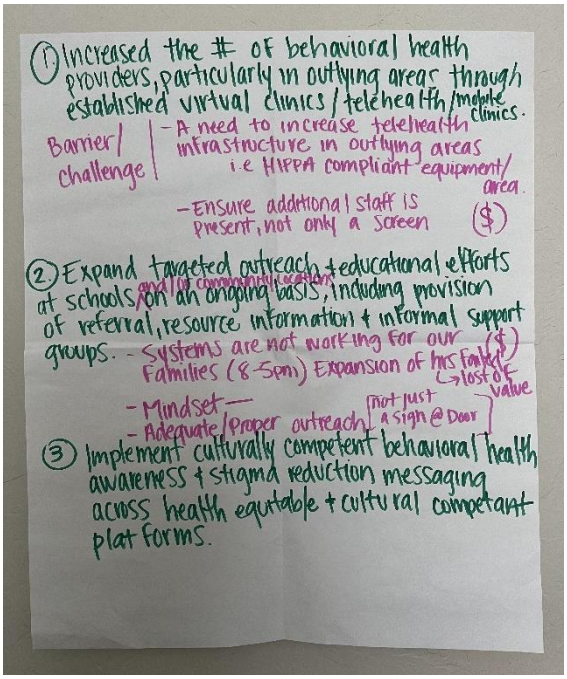
The CHIP workshop agenda can be found in Appendix D.

Exhibit 4: Participant Organizations Represented in CHIP Workshop

Organization Name	Organization Name
Anthem Blue Cross	Kern County Network for Children
Arvin Union School District	Kern County Public Health
Bakersfield American Indian Health Project	Kern Health Systems
Bakersfield Pregnancy Center	Kern High School District
Cirugía Sin Fronteras (DBA CSF Surgery; CSF Medical Non-Profit Foundation)	Kern Medical
City of Bakersfield Recreation & Parks	Kern Regional Center
Community Action Partnership of Kern	LESD Family Resource & Learning Center
Dolores Huerta Foundation	Native Star Foundation
Kaiser Permanente	United Way of Central Eastern California (formerly, United Way of Kern County)
Kern Behavioral Health & Recovery Services	Vision y Compromiso

During the four-hour working session, participants engaged in the following:

- **Background.** Participants were provided with a brief overview of the CHA and CHIP processes, including a brief overview of CHA findings, as well as goals of the CHIP workshop session.
- **Small Group Discussions.** Participants were assigned to small groups based on their area of expertise, with each group assigned one priority need category. Table leaders identified prior to the workshop led each small group in reviews of the list of strategies generated through the pre-workshop CHIP survey and promising practice research, as well as the opportunity to add ideas to the list of strategies. Each small group then identified a list of the top three to five strategies within the assigned priority need category, determined from participants' agreement of what will be most impactful, help community members, and address health disparities. Discussants were free to re-word, merge, split, or otherwise modify the strategies as originally presented in order to arrive at a final list of three to five strategies. Identification of top strategies was followed by dialogue of corresponding top barriers and possible measures to gauge progress. A full list of strategies considered by each group is featured below.



- **Strategy Prioritization.** Small groups reconvened into one larger group to vote on the top strategies identified for all need priority categories. Each participant was given three votes per need priority category: first choice, second choice, and third choice. To record scores and rank strategies, each first-choice vote was assigned a score of five points, each second-choice vote was assigned a score of three points, and each third-choice vote was assigned a score of one point. Total scores for each strategy were calculated, and the top three votes in each of the five categories were presented to the group.

The following sections delve into the CHIP workshop outcomes for each need priority category.

Appendix E contains top strategies chosen for large group voting and corresponding barriers.

The complete workshop polling strategy scores can be found in Appendix F.

Prioritized Strategies: Access to Care

Strategies in this category are intended to promote **improved access to care through increased capacity and enhanced navigation support**. Specific needs identified and prioritized in the CHA include:

- Efforts to streamline health and behavioral healthcare services to increase accessibility and ease navigation
- Appropriate use of services across the continuum of community health and behavioral healthcare resources in order to reduce use of acute care facilities for non-emergent care
- Affordable dental care services and navigation support for individuals regardless of insurance status, including support for those paying out-of-pocket

Workshop participants deliberating strategies

Exhibit 5: Strategies Reviewed by 'Access to Care' Group

Strategies (three highest priority strategies in green)
Creation of new facilities, such as school/community-based health centers and/or behavioral health facilities in outlying areas
Promotion of electronic resources to assist with care needs (e.g., telehealth/e-consult) and/or resource navigation (e.g., a comprehensive website)
Public awareness campaigns to increase knowledge of differences between emergent, urgent, and routine health care needs and resources
Better information for clinical staff and social services providers on available services and referral pathways (e.g., to behavioral health resources)
A uniform, warm-hand off protocol to link care processes and clinical services between providers
More health, behavioral health, and dental health care resources that are accessible to all community members regardless of income
Public awareness campaigns on dental health and affordable care/treatment options
Addition of more dental providers and facilities across the county, including mobile units, to expand availability geographically and beyond 'normal' business hours

COMMUNITY HEALTH NEED CATEGORY:	Improved access to care through increased capacity and enhanced navigation support
GOAL:	**By December 31, 2026, improve access to health and behavioral health services by co-locating health services, including a list of resources that can be distributed throughout the communities of Kern by trusted promotoras, community health workers, and social service providers.**
OBJECTIVES:	By December 31, 2026, increase access to care by creating telehealth infrastructure to co-locate health services in at least three (3) non-traditional care settings, such as churches, school districts, senior centers, libraries, community rooms, or veteran's halls, with extended hours to better serve families experiencing geographical barriers in outlying areas. By December 31, 2026, create an updated list of health, behavioral health, and dental health care resources that are accessible to communities throughout Kern that consider underserved community groups such as the working class, low-income, middle-class, immigration status, farmworkers, etc.; provide lists to promotoras, community health workers, and social service providers.
KEY PARTNERS, ASSETS, & RESOURCES:	Including but not limited to Kern County Public Health, Kern Health Equity Partnership, Kern Health Systems, Kern County Superintendent of Schools, Kern County Network for Children, Vision y Compromiso, Dolores Huerta Foundation, Building Healthy Communities, and Family Resource Centers.
ANTICIPATED BARRIERS TO SUCCESS:	Funding; jurisdiction; facility/building availability; utilization of services; geographical identification for areas; confidentiality between providers

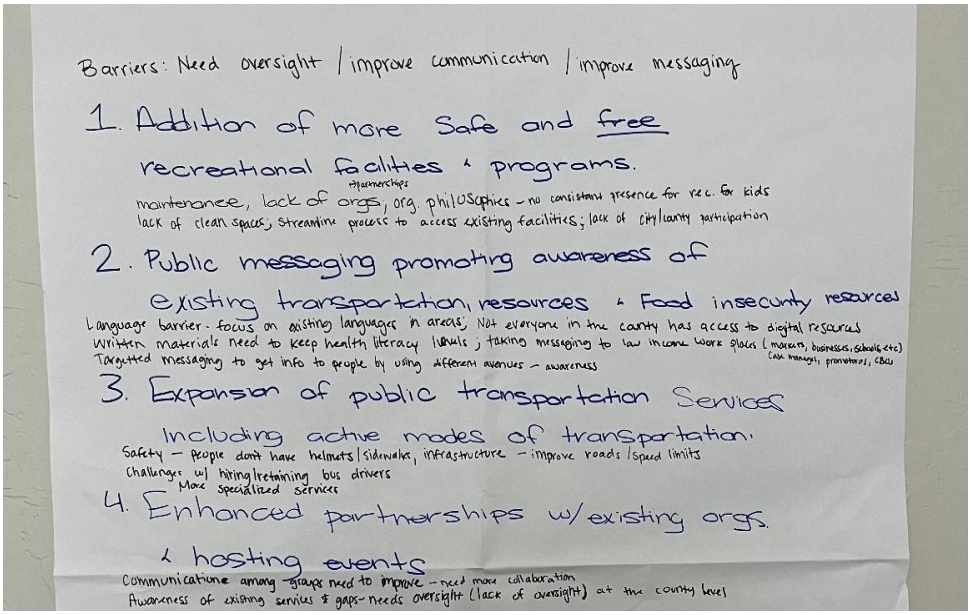
Prioritized Strategies: Basic Needs

Strategies in this category are intended to promote **better support to assist community members to meet basic needs**. Specific needs identified and prioritized in the CHA include:

- More safe public recreational spaces for children and adults, including enhancement of existing spaces through maintenance of public bathrooms and water fountains, particularly in underserved areas, such as farmworker communities
- Expanded transportation services across the county, such as for residents of outlying communities and for populations like older adults who require additional assistance
- Resources to address hunger and food insecurity, including support for food pantries and other sources of emergency food

Exhibit 6: Strategies Reviewed by 'Basic Needs' Group

Strategies (three highest priority strategies in green)
Increased maintenance of amenities in public spaces (e.g., bathrooms and water fountains), particularly in underserved areas,
Increased patrolling of public spaces and parks
Addition of more safe and free recreational facilities and programs
Subsidies and allowances for transportation beyond what is currently offered
Public messaging promoting awareness of existing transportation resources and food insecurity resources
Expansion of public transportation service, including active modes of transportation (walking, bicycling, etc.)
Enhanced partnerships with existing organizations, including hosting collaborative events
Community events in which resources and assistance (e.g., food giveaways) can be provided



'Basic Needs' strategies and barriers

COMMUNITY HEALTH NEED CATEGORY:	Better support to assist community members to meet basic needs
GOAL:	**By December 31, 2026, address meeting basic needs of the communities of Kern with a focus on making available more safe and free recreational facilities and programs in areas of highest need by organizing monthly meetings and creating a plan to expand active modes of transportation.**
OBJECTIVES:	By July 1, 2025, create an updated list of safe and free recreational programs throughout Kern. By July 1, 2026, add at least two (2) new safe and free recreational facilities and programs to the county. By December 31, 2026, convene recreational facilities, program, and county leadership quarterly to review community needs and discuss available services that meet those needs. By December 31, 2026, leverage a gap analysis of transportation to develop a plan to expand active modes of transportation such as walking paths, bike lanes, or bus stops.
KEY PARTNERS, ASSETS, & RESOURCES:	Including but not limited to Kern County Public Health, Kern Health Equity Partnership, Kern Health Systems, Kern County Superintendent of Schools, Kern County Network for Children, Family Resource Centers, Parks and Recreation.
ANTICIPATED BARRIERS TO SUCCESS:	Maintenance; limited currently existing partnerships; transportation; location availability; no consistent presence for kids' recreational services

Prioritized Strategies: Behavioral Health

Strategies in this category are intended to promote **enhanced behavioral health programs and services for children/youth and adults.** Specific needs identified and prioritized in the CHA include:

- Counseling services for children/youth and adults for mental health issues such as depression, anxiety, and others
- Crisis or emergency care programs for behavioral health issues
- Substance use prevention programs, particularly for methamphetamines and fentanyl
- Culturally competent mental health programs that aim to reduce stigma and to promote awareness of early signs of mental illness
- More primary and specialty health and behavioral healthcare providers, particularly in outlying areas of the county

Reporting out to the full workshop group on 'Behavioral Health' strategy discussions

Exhibit 7: Strategies Reviewed by 'Behavioral Health' Group

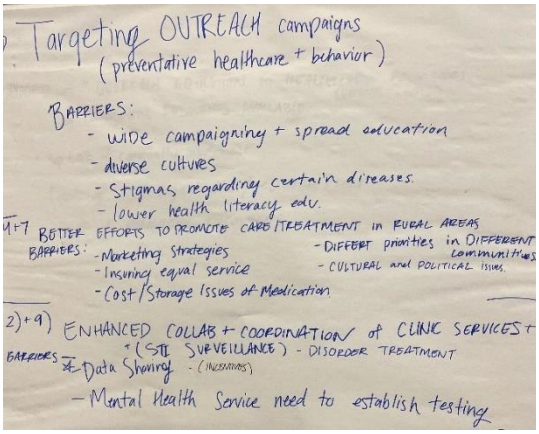
Strategies (three highest priority strategies in green)
Expand outreach and educational efforts at schools and community locations on an ongoing basis, including provision of referral and resource information and informal support groups
Create new behavioral health facilities or mobile units (or expand offerings at existing facilities) to focus on specific populations (such as adolescents) and geographies (such as the county's rural communities)
Ensure that behavioral health information and services are equitably available to people regardless of income or geographic location
Increase the number of behavioral health providers, particularly in outlying areas, through established virtual clinics, telehealth, and mobile clinics
Implement culturally competent behavioral health awareness and stigma reduction messaging across health equitable and culturally competent platforms
Engage community leaders, particularly in outlying areas, in efforts to promote community awareness and action on issues like child mental health
Enhance local capacity by adding sobering center and crisis system beds in order to divert those in need of behavioral health care away from emergency rooms
Provide needed support while people are waiting for appointment openings, such as through a 24-hour mental health line in English and Spanish
Establish virtual clinics or otherwise use telehealth to extend existing behavioral health care

COMMUNITY HEALTH NEED CATEGORY:	Enhanced behavioral health programs and services for children/youth and adults
GOAL:	**By December 31, 2026, enhance behavioral health services for children, youth, and adults by increasing behavioral health providers in outlying areas and/or under resourced communities, raising awareness by sharing culturally competent behavioral health and stigma reduction messaging and providing outreach at schools and areas that the community visits frequently.**
OBJECTIVES:	By July 1, 2026, collaborate with behavioral health partners to facilitate at least three (3) meetings for community members to provide culturally competent behavioral health and stigma reduction messaging. By December 31, 2026, collaborate with behavioral health partners and providers to increase the number of behavioral health providers in outlying areas and/or underserved communities of Kern by at least 10 virtual clinics, telehealth, and mobile clinics. By December 31, 2026, provide at least five (5) targeted outreach and educational efforts at schools and community locations on behavioral health provision of referral and resource information, informal support groups, and available resources.
KEY PARTNERS, ASSETS, & RESOURCES:	Including but not limited to Kern Behavioral Health and Recovery Services, Kern County Public Health, Kern Health Equity Partnership, Kern Health Systems, Kern County Superintendent of Schools, Kern County Network for Children, and Family Resource Centers.
ANTICIPATED BARRIERS TO SUCCESS:	Lack of telehealth infrastructure; lack of HIPAA-compliant equipment; staffing shortages to provide present physical staff

Prioritized Strategies: Chronic Disease and Communicable Disease

Strategies in this category are intended to promote **expanded chronic disease and communicable disease prevention and surveillance efforts.** Specific needs identified and prioritized in the CHA include:

- Expansion of STI prevention and testing efforts to mitigate county-level trends in incidence of STIs like syphilis
- Efforts to prevent and address chronic health conditions such as diabetes, asthma, and heart disease



'Chronic disease and communicable disease' strategy and barrier brainstorming

Exhibit 8: Strategies Reviewed by 'Chronic Disease and Communicable Disease' Group

Strategies (three highest priority strategies in green)
Outreach education to healthcare providers on community resources available
Enhanced collaboration and coordination between clinical and social service providers, such as through data sharing to better guide individual-level care, including integration of STI surveillance alongside substance use treatment and mental health services
More diabetes programming, such as one-on-one education for those living with the condition and/or integration into childhood dental health education
Better efforts (including partnerships with primary care clinics and mobile clinics) to ensure that expansion of preventive/treatment resources are equitably available to people in rural areas and/or with lower incomes
Increased healthcare capacity to improve timeliness of appointments and availability of specialize services, such as long-term treatment and monitoring of HIV patients
STI prevention and testing awareness and outreach campaigns, including through news media (e.g. local TV) and social media (e.g., TikTok)
Partnerships with primary care clinics and/or use of mobile clinics to expand access to STI testing, in locations like parks and libraries as well as in remote areas of the county
Promotion of preventative measures, such as by making condoms more readily and discretely available at nightclubs and bars
Integration of STI surveillance alongside other efforts, such as substance use disorder treatment programs and/or mental health services
Establishment of a Community Advisory Board reflecting those most at risk for communicable diseases

COMMUNITY HEALTH NEED CATEGORY:	Expanded chronic disease and communicable disease prevention and surveillance efforts
GOAL:	**By December 31, 2026, enhance collaboration and coordination between clinical and social service providers to better guide individual-level care by creating a framework, achieve equitable distribution of mobile clinics and mobilized health services, and establish and maintain communications of available social, health and behavioral health services across the communities of Kern.**
OBJECTIVES:	By January 1, 2025, primary care clinic and mobile clinic leads will meet to assess available prevention and treatment resources to develop a shared location calendar that supports equitable availability of services to people in rural areas or underserved communities. By December 31, 2026, collaborate with social service providers, healthcare providers, and staff to create a framework that integrates sexually transmitted infection (STI) surveillance, substance use treatment, and mental health services in individual-level care. By December 31, 2026, provide monthly education to clinical and social providers on available health and behavioral health services and other resources so that they may share to communities they serve across Kern County.
KEY PARTNERS, ASSETS, & RESOURCES:	Including but not limited to Anthem Blue Cross, Community Action Partnership of Kern, Kaiser Permanente, Kern Behavioral Health and Recovery Services, Kern County Public Health, Kern Health Equity Partnership, Kern Health Systems, Family Resource Centers, Healthcare clinics and Hospitals throughout Kern.

ANTICIPATED BARRIERS TO SUCCESS:	Data sharing; ensuring HIPAA compliance; establishing testing at mental health services

Prioritized Strategies: Equitable Access to Services and Resources

This strategy aims to address the state Department of Health Care Services' (DHCS) Comprehensive Quality Strategy (CQS) "Bold Goal" to "close maternity care disparity for Black and Native American persons by 50% at the state level by 2025. In partnership with Kern County's Medi-Cal insurance providers, Kern County Public Health and its partners will seek to leverage Medi-Cal payor data and resources to better understand and address maternity care disparities among the Black and Native American population.

Strategies in this category are intended to promote **equitable access to health and behavioral health services and resources.** Specific needs identified and prioritized in the CHA include:

- Outreach to raise public awareness of available health and behavioral health services and resources, specifically to populations encountering obstacles related to factors such as language, culture, and/or immigration status
- Culturally competent public health prevention programs and resources, such as for farming families and non-English-speaking communities across the county
- Equitable access to prenatal care, including expanded availability of ultrasounds, to close the maternity care disparity for Black and Native American persons

Exhibit 9: Strategies Reviewed by 'Equitable Access to Services and Resources' Group

Strategies (three highest priority strategies in green)
Cultural competency training for providers and staff, including focus on the unique and distinct challenges encountered by specific groups across the county
A countywide Health Equity task force to coordinate work towards equitable health and behavioral health care
Expanded mobile services targeting outlying areas, including focus on specific identified needs such as OB and maternal health
Creation of more channels to enable farmworkers to engage with services and resources, such as through community health workers and forums with local leaders
Educational efforts focused on raising awareness among providers on the nature and scale of specific health disparities in Kern County
Efforts to cultivate a diverse clinical and social service provider workforce that is reflective of local communities
Targeted outreach to increase awareness of available prevention and care resources, particularly among underserved communities
Development of a "green book" for patients seeking equitable access to care
Programs to enhance prenatal and postpartum care for Black and Native American persons (e.g., a doula program serving these populations)

'Equitable access to services and resources' discussion

COMMUNITY HEALTH NEED CATEGORY:	Equitable access to health and behavioral health services and resources
GOAL:	**By December 31, 2026, disparities in maternity care among African American/Black and Native American persons in Kern will be addressed through creating a doula program, facilitating provider trainings, and working collaboratively with partners to address barriers and enhance prenatal and postpartum care.**
OBJECTIVES:	By December 31, 2024, create a committee addressing maternal care to coordinate work, share resources and education, and share gaps, particularly among African American/Black and Native American populations and under resourced communities throughout Kern to address barriers collaboratively. By December 31, 2026, at least 24 non-duplicative in-county doulas will be available to provide services by creating a doula program aimed to address infant and maternal health disparities. By December 31, 2026, provide at least two (2) cultural competency trainings for providers and staff to include a focus on distinct challenges identified through the maternal care committee.

KEY PARTNERS, ASSETS, & RESOURCES:	Including but not limited to Anthem Blue Cross, Black Infant Maternal Health Initiative, Kaiser Permanente, Kern Behavioral Health and Recovery Services, Kern County Public Health, Kern Health Equity Partnership, and Kern Health System.
ANTICIPATED BARRIERS TO SUCCESS:	Trust; engagement; buy-in; access; education; long-term commitment; capacity; post-partum support; depression; need for incentives

Monitoring & Annual Updates

In order to track progress in addressing the community health needs identified in the CHA through strategies identified in the CHIP process, Kern County Public Health endeavors to conduct ongoing monitoring of its implementation efforts, as well as of those of its partners across the county who are identified in this report. This will include an annual review process to revisit the CHIP and implement revisions to the plan as needed, based on progress towards articulated goals, unforeseen public health priorities or challenges, or other substantive events that have implications for this plan as originally composed. Updates on progress towards goals, as well as to the plan itself, will be shared with the community, including the partners who contributed to the original CHIP plan and others across Kern who have an interest in the CHA/CHIP process and its objectives.

Appendices

Appendix A: Identified Promising Practices Across Need Categories

Access to Care

Best practices for improving access to care include the hub and spoke model, increasing e-consult services, integration of oral health and primary healthcare, and integration of social needs and primary healthcare. The hub and spoke model utilizes healthcare entities located in urban and suburban areas to create partnerships with facilities in outlying areas, allowing for continuity of services and resources in communities that otherwise might not have access to specialty care.[1] Increasing e-consult services, such as telehealth for patients and audiovisual educational opportunities for healthcare providers, has been shown to decrease both direct and indirect patient and staffing costs, and increase education among patients and healthcare providers, and improve overall access to care.[2] The integration of oral health and primary healthcare acts as a bridge to earlier oral disease prevention and intervention, without requiring patients to schedule and attend appointments outside of primary care practice.[3] Addressing social needs in the primary healthcare setting could increase marginalized communities' access to care, such as through hiring social workers in primary care offices and/or referring patients (with follow-up) to social services.[4]

Basic Needs

Nationally recognized best practices for addressing community members' basic needs encompass access to parks, access to recreational and green spaces, expansion of transportation services, and the integration of social needs into healthcare settings. Access to parks, as well as access to recreational and green spaces, can provide safe opportunities for community members to

[1] Elrod, J.K. & Fortenberry, Jr., J.L. (2017). The hub-and-spoke organization design revisited: A lifeline for rural hospitals. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5751794/

[2] Butzner, M., & Cuffee, Y. (2021). Telehealth interventions and outcomes across rural communities in the United States: Narrative review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8430850/

[3] Committee on Oral Health Access to Services; Board on Children, Youth, and Families; and Board on Health Care Services. (2011). Improving access to oral health care for vulnerable and underserved populations. https://www.hrsa.gov/sites/default/files/publichealth/clinical/oralhealth/improvingaccess.pdf

[4] Levins, H. (2021). Integrating social needs into health care practice: Evidence and barriers. https://ldi.upenn.edu/our-work/research-updates/integrating-social-needs-into-health-care-practice-evidence-and-barriers/

Omerov, P., Craftman, A.G., Mattsson, E., Klarare, A. (2019). Homeless persons' experiences of health- and social care: A systematic integrative review. https://onlinelibrary.wiley.com/doi/10.1111/hsc.12857

increase physical activity and social connectedness regardless of income level.[5] Expansion of transportation services can increase connectivity across neighborhoods and connect rural communities to urban and suburban services and resources.[6] Expanding of transportation services can include public bus lines and light rails, together with increasing the walkability and bikeability of communities. Similar to improving access to care, the integration of social needs in healthcare settings (such as through hiring primary care-based social workers and referring patients with follow-up) can aid in meeting community members' basic needs which otherwise might prevent community members from receiving vital services and resources.[7]

Behavioral Health

Best practices for behavioral health programs and services include mobile care units, diverting patients after initial emergency room use, mental health promotion and education through social media, and school- and community-based interventions. Mobile behavioral health clinics can improve accessibility and result in higher treatment rates for communities that otherwise have difficulty accessing behavioral healthcare.[8] As the emergency room commonly treats substance use-related crisis needs, health systems throughout the U.S. have found success in providing patients with immediate transitional care (same day or next day), which in turn help prevents emergency services overload while providing quality care.[9] Social media is an effective tool for reaching a variety of populations (especially youth and young adults) for mental health promotion and education opportunities.[10] School- and community-based interventions and prevention programs, including behavioral health education and skills training for families, has been shown to reduce stigma, improve identification of behavioral health needs, and increase seeking services and resources.[11]

[5] Centers for Disease Control and Prevention. (2022). What's your role? Parks, recreation and green spaces. https://www.cdc.gov/physicalactivity/activepeoplehealthynation/everyone-can-be-involved/parks-recreation-and-green-spaces.html
[6] Centers for Disease Control and Prevention. (2011). Transportation health impact assessment toolkit. https://www.cdc.gov/healthyplaces/transportation/expand_strategy.htm
[7] Omerov, P., Craftman, A.G., Mattsson, E., Klarare, A. (2019). Homeless persons' experiences of health- and social care: A systematic integrative review. https://onlinelibrary.wiley.com/doi/10.1111/hsc.12857
[8] Carpenter-Song, E., Jonathan, G., Brian, R., & Ben-Zeev, D. (2019). Perspectives on mobile health versus clinic-based group interventions for people with Serious Mental Illnesses: A qualitative study. https://pubmed.ncbi.nlm.nih.gov/31615368/
[9] University of Kentucky. (2019). UK's first bridge clinic offers immediate access to opioid treatment. https://www.research.uky.edu/news/uks-first-bridge-clinic-offers-immediate-access-opioid-treatment
[10] O'Reilly, M., Dogra, N., Hughes, J., Reilly, P., George, R., & Whiteman, N. (2019). Potential of social media in promoting mental health in adolescents. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6904320/
[11] Castillo, E.G., et al. (2019). Community interventions to promote mental health and social equity. https://pubmed.ncbi.nlm.nih.gov/30927093/

Chronic Disease and Communicable Disease

Chronic disease and communicable disease prevention and surveillance best practices involve community partnerships, training of primary care and behavioral health providers, and expanding screening availability. Building and maintaining community partnerships, alongside collaboration between community-based programs and healthcare providers, can strengthen capabilities to provide prevention and surveillance efforts.[12] Training primary care, behavioral health, and other providers who are not typically involved in providing services for communicable disease creates the opportunity for earlier detection and intervention.[13] The expansion of screening availability (such as providing screenings during emergency room visits and behavioral health appointments) could increase disease prevention.[14]

Equitable Access to Services and Resources

Best practices for equitable access to services and resources include professional language interpreters, cultural competency training for healthcare providers, the Black Infant Health (BIH) program, and use of health equity task forces. Accessibility of appropriate professional interpreters can positively impact the accessibility and usability of services and resources.[15] Requiring cultural competence training for healthcare providers leads to better health equity in both medical care and behavioral healthcare.[16] California Department of Public Health's BIH program addresses poor birth outcomes for Black women through an empowerment-focused interventions.[17] Health equity task forces (such as the Office of Minority Health's Health Equity Task Force) provides a purposeful space for planning community-specific needs to advance health equity.[18]

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[12] Centers for Disease Control and Prevention. (2023). Community approaches to reducing STDs. https://www.cdc.gov/std/health-disparities/cars.htm
Centers for Disease Control and Prevention. (2021). How we prevent chronic diseases and promote health. https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm

[13] National Academies of Sciences, Engineering, and Medicine. (2021). Sexually transmitted infections: Adopting a sexual health paradigm. https://www.ncbi.nlm.nih.gov/books/NBK573165/

[14] Jenkins, W.D. (2019). Chlamydia and gonorrhea screening in the emergency department setting: Increasing evidence of utility and need for further research. https://www.sciencedirect.com/science/article/abs/pii/S0735675718308477?via%3Dihub

[15] Gerchow, L., Burka, L.R., Miner, S., & Squires, A. (2021). Language barriers between nurses and patients: A scoping review. https://pubmed.ncbi.nlm.nih.gov/32994104/

[16] Chae, D., Kim, J., Kim, S., Lee, J., & Park, S. (2020). Effectiveness of cultural competence educational interventions on health professionals and patient outcomes: A systematic review. https://pubmed.ncbi.nlm.nih.gov/32030876/
McGregor, B., Belton, A., Henry, T.L., Wrenn, G., & Holden, K.B. (2019). Improving behavioral health equity through cultural competence training of health care providers. https://pubmed.ncbi.nlm.nih.gov/31308606/

[17] California Department of Public Health. (2023). Black Infant Health (BIH). https://www.cdph.ca.gov/Programs/CFH/DMCAH/BIH/Pages/default.aspx

[18] Office of Minority Health, U.S. Department of Health and Human Services. (2021). Health equity task force. https://www.minorityhealth.hhs.gov/health-equity-task-force

Appendix B: Pre-Workshop Survey Instrument

KERN COUNTY PUBLIC HEALTH

Kern County Community Health Improvement Plan - Strategy Development

Introduction and Background

Kern County Public Health is hosting a Community Health Improvement Plan (CHIP) workshop in collaboration with Crescendo Consulting Group on Tuesday, November 21, 2023.

To use our time together on the 21st as efficiently as possible, we are asking for you to complete a brief exercise.

As background, over the past several months, you have participated in Kern County's Community Health Assessment by helping to identify community health resources and challenges in the County. Based on your input and other research, we grouped the needs into the following five "priority categories":

- **Expanded chronic disease and communicable disease prevention and surveillance efforts**
- **Enhanced behavioral health programs and services for children/youth and adults**
- **Improved access to care through increased capacity and enhanced navigation support**
- **Promotion of equitable access to health and behavioral health services and resources**
- **Better support to assist community members to meet basic needs**

The next step is to generate a list of specific actions to address the Priority Categories. Specifically, we want you to BRIEFLY list up to three specific actions / tactics to help address each of the three Priority Categories. For each, also list barriers. Examples are shown within the survey.

The results of this query will be presented for discussion at the November 21st workshop (9:00am to 1:00pm, Larry E. Reider Education Center).

The Workshop results will help Kern County to align its resources and collaborating relationships in its Community Health Improvement Plan, which will guide action aimed at addressing the identified Priority Categories in the coming years.

* 1. What is your name? Please note that your individual responses will be confidential. We ask your name only to assure that we engage a broad spectrum of participants.

2. What organization(s) are you associated with (if any)?

3. Will you be attending the CHIP workshop on Tuesday, November 21, 9:00am to 1:00pm, at the Larry E. Reider Education Center?

- ◯ Yes
- ◯ No

Comments:

KERN COUNTY PUBLIC HEALTH

Kern County Community Health Improvement Plan - Strategy Development

Priority: Expanded chronic disease and communicable disease prevention and surveillance (1 of 5)

'Expanded chronic disease and communicable disease prevention and surveillance efforts' refers to needs such as:

- **Expansion of STI prevention and testing efforts to mitigate county-level trends in incidence of STIs like syphilis**
- **Efforts to prevent and address chronic health conditions such as diabetes, asthma, and heart disease**

An example of tactics and barriers may be something such as -

Tactic: Combine existing STI testing outreach and promotion through a new PR campaign

Barriers: In the past, stigma with regards to STIs have been a significant barrier in promoting use of testing resources.

In the spaces below, please provide 1 tactic and 1 associated barrier. You can include up to 3 tactics and/or barriers if desired but not required.

FIRST

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

FIRST

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

Kern County Community Health Improvement Plan - Strategy Development

Priority: Enhanced behavioral health programs and services for children/youth and adults (2 of 5)

'Enhanced behavioral health programs and services for children/youth and adults' refers to needs such as:

- Counseling services for children/youth and adults for mental health issues such as depression, anxiety, and others
- Crisis or emergency care programs for behavioral health issues
- Substance use prevention programs, particularly for methamphetamines and fentanyl
- Culturally competent mental health programs that aim to reduce stigma and to promote awareness of early signs of mental illness
- More primary and specialty health and behavioral healthcare providers, particularly in outlying areas of the county

An example of tactics and barriers may be something such as -

Tactic: Creation of a public awareness campaign aimed at encouraging youth and young adults to seek out counseling services.

Barriers: Lack of community awareness of mental health provider availability, particularly for children and youth.

In the space provided below, please share UP TO three actions or "TACTICS" and associated "BARRIERS."

FIRST

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

FIRST

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

Kern County Community Health Improvement Plan - Strategy Development

Priority: Improved access to care through increased capacity and enhanced navigation support (3 of 5)

'Improved access to care through increased capacity and enhanced navigation support' refers to needs such as:

- Efforts to streamline health and behavioral healthcare services to increase accessibility and ease navigation
- Appropriate use of services across the continuum of community health and behavioral healthcare resources in order to reduce use of acute care facilities for non-emergent care
- Affordable dental care services and navigation support for individuals regardless of insurance status, including support for those paying out-of-pocket

An example of tactics and barriers may be something such as -

Tactic: Implement expanded dental health screening programs across the county.

Barriers: Variable dental insurance coverage, including lack of coverage and/or coverage with substantial limitations, has previously been identified as a deterrent to care-seeking behaviors.

In the space provided below, please share UP TO three actions or "TACTICS" and associated "BARRIERS."

FIRST

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

FIRST

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

Kern County Community Health Improvement Plan - Strategy Development

Priority: Promotion of equitable access to health and behavioral health services/resources (4 of 5)

'Promotion of equitable access to health and behavioral health services and resources' refers to needs such as:

- Outreach to raise public awareness of available health and behavioral health services and resources, specifically to populations encountering obstacles related to factors such as language, culture, and/or immigration status
- Culturally competent public health prevention programs and resources, such as for farming families and non-English-speaking communities across the county
- Equitable access to prenatal care, including expanded availability of ultrasounds, with focus on closing the maternity care disparity for Black and Native American persons

An example of tactics and barriers may be something such as -

Tactic: Initiation of programming aimed at addressing access to care disparities experienced by the region's farmworker communities.

Barriers: There have been historical trust issues between area farmworker communities and local government that have challenged past attempts to implement similar programs.

In the space provided below, please share UP TO three actions or "TACTICS" and associated "BARRIERS."

FIRST

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

FIRST

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

Kern County Community Health Improvement Plan - Strategy Development

Priority: Better support to assist community members to meet basic needs (5 of 5)

'Better support to assist community members to meet basic needs' refers to needs such as:

- More safe public recreational spaces for children and adults, including enhancement of existing spaces through maintenance of public bathrooms and water fountains, particularly in underserved areas, such as farmworker communities
- Expanded transportation services across the county, such as for residents of outlying communities and for populations like older adults who require additional assistance
- Resources to address hunger and food insecurity, including support for food pantries and other sources of emergency food

An example of tactics and barriers may be something such as -

Tactic: Expansion of public transit services targeting residents of outlying communities

Barriers: An obstacle identified by residents of outlying communities, beyond existence of public transit routes, is how to get from remote residences to and from bus stops.

In the space provided below, please share UP TO three actions or "TACTICS" and associated "BARRIERS."

FIRST

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

FIRST

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

SECOND

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

TACTIC:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

THIRD

BARRIER:

Please be brief, as there is a limit of 300 characters -- about one or two sentences.

Kern County Community Health Improvement Plan - Strategy Development

Final Questions

1. Regardless of the TACTICS and BARRIERS listed above, are there other issues we need to address?

2. If you had to share one or two "KEYS TO SUCCESS" to improve health and well-being in the county, what advice would you give?

Appendix C: Pre-Workshop Survey – Identified Strategies and Barriers

The following tables display all identified strategies and barriers for each priority need category.

Exhibit 10: Identified Strategies and Barriers for ACCESS TO CARE Priority Need Category

Strategy/Tactic	Barrier
Increase the number of providers.	Appointment accessibility is currently really bad in Kern County. For mental and behavioral health the waiting time can be a few months.
Flu shots and dental cleaning in rural areas	Cater to the most marginalized cities in Kern.
Expand programs like Kern Medical's Whole Person Care to include more BH services.	Difficulty hiring and retaining staff across both medical and behavioral health
Increase access to behavioral health by expanding the current structure of geographic providers	Difficulty managing many providers. Increase in options would create improved service through competition
Increase awareness within the community about the link between dental health and physical health.	Educational awareness materials in multiple languages across all of Kern County.
Expand services through the weekend vs Monday-Friday only.	Employee schedules and funds.
Consider a school-community based health center	Facilities, lack of infrastructure for a community and school wide continuum of care
Create facility and infrastructure in outlying areas such as Arvin that do not have access to local behavioral health services	Find and build facilities, create infrastructure for a continuum of care
Public information campaigns on what are emergent, urgent, and routine healthcare	Funding
Implement (bilingual, multilingual) lactation support volunteers (peer counselors) throughout the county.	Funding 45-hour lactation educator courses.
Discuss our community needs with large dental schools that have mobile treatment centers.	Funding, partnership
Create a comprehensive website that helps people navigate their options based on needs.	Historically, attempts at having a Community Resource listing are not comprehensive of the entire county and quickly become outdated as they are updated annually (at most).
More media/PSA about dental health and affordable options	How expensive dental care is

Strategy/Tactic	Barrier
Expand physical health screenings for people of all ages	Insurance coverage
Affordable medical centers to support individuals regardless of insurance status	Lack of health insurance coverage with substantial limitations and there are many instances of claims being rejected or the compensation amount being reduced due to certain clauses of the policy.
Variable dental coverage and variable hours offered in outlying areas.	Lack of services provided during extended hours.
We need more funds for dental referrals.	Many insurance companies don't cover the need and put strict limitations on what will be covered.
Get a dentist on site to provide care.	Missing teeth cause the diet to change, decreasing the food choices.
Implement free healthcare insurance to the poor and old folks; with life being inherently unpredictable, being prepared for uncertainties can be the best protection against them.	Most people purchase a life insurance policy when they are young. This makes sense since the premium amounts are low for young policyholders. One thing that you need to know about premium calculation is that there are various factors that impact it, including the policyholder's age, medical condition, family medical history, etc.
Gauge patient's understanding of care and treatment	Patients leave provider office leave unsure/unclear of care received, treatment, and next steps
Telehealth/e-consult	Reimbursement and adoption, digital divide
Provide dental health screenings and support at schools.	School coordination.
Provide health and behavioral healthcare services campaign and outreach program; to raise awareness, provide support, or create positive change to the community.	Shortage of community support attributed to absence of knowledge, not lack of care
Ensuring "appropriate use of services across the continuum of community health" may imply we need to include some case management efforts with regard to the dental programs we offer.	Staffing shortages and low wages for HEA's make that position hard to fill.
Providing informational classes for providers and organizations on referrals to behavioral health.	The different areas or BH can make it difficult for some to know where to refer clients,
Entice more dental providers to come to Kern.	There is a shortage of dental providers in Kern County, especially those who accept Denti-Cal.

Strategy/Tactic	Barrier
Education of what is available and how to access services	Time and funding
Offer services or extend services 5 p.m. -8p.m.	Variable Urgent Care hours for patients that have an unscheduled doctor's appointment. Urgent Care would have the ability to treat less serious illnesses. Most locations do not offer extended hours.
Implement a mobile dental unit for traveling around Kern County for care	Very expensive to implement a mobile dental care unit and hiring a dentist and other dental workers

Exhibit 11: Identified Strategies and Barriers for BASIC NEEDS Priority Need Category

Strategy/Tactic	Barrier
Community events in outlying areas that allow for resources and assistance to be provided	Space and transportation to events.
Developing a local foodbank in the south valley	Getting appropriate community partners to co-locate or invest in facilities and staffing in the area.
Enhance transit systems into Bakersfield	Cost, availability,
Expand food giveaways during the holiday times.	Funds and space to give out food that allows families to take it home
Expand information and knowledge on resources	[Participant left question blank]
Expand the Waste Hunger Not Food program into all outlying areas of Kern County.	Food insecurity is a major issue in Kern County and many of our outlying areas are food deserts.
Expanding public transportation to residence living in outlying communities.	An obstacle that outlying residence face is little to no public transit routes and very limited to/from their destination.
Expansion of affordable transportation	Cost
Expansion of public transport for outlying areas	Increase is not cost effective
Implementing Telehealth options for all Kern County residents.	An obstacle is lack of access to a smart phone/computer and/or being able to navigate these devices to connect to Telehealth.
Increase awareness of how residents can advocate for improvements in their community	Residents are used to status quo of their environment and unsure how they can make improvements

Strategy/Tactic	Barrier
Increasing the number of bus routes and routes	Making sure the bus stops are covered due to Bakersfield's extreme weather. (Extreme heat in summer and cold and rain in the winter)
Leveraging the Food is Medicine program, and medically tailored meals.	Low participation rates, need to promote the program better.
Mail to specific Zip Code areas informational material in different languages. Specifically, a magnet for the fridge with the resources we are trying to promote.	When you are experiencing a need/distress your brain doesn't always reason the best options, therefore if we are able to provide the community with the proper resources in their languages, for them to have on their fridge, it will increase their ability to access the services they need.
Media campaign on the benefits of using public transportation	Some people have issues with feeling safe on public transit
Mobile food pantries, such as a contract with DoorDash, Uber Eats, etc., to deliver food baskets.	Not everyone has the transportation to obtain a food basket if ordered.
Mobile Health Units to go to the outlying communities, including indigenous and immigrant populations.	Lack of transportation/services to our outlying areas including indigenous and immigrant populations.
Offer more bus passes for public health and educational Programs (Connecting with the schools and colleges)	Funding for the said bus passes
Partner with similar CBOs to address gaps in care we experience at Public Health for our residents.	Can be difficult to align values and funding with other organizations in the community
Promote Food Feeding Program to address hunger and food insecurity	The study revealed different challenges hindering the effectiveness of the school feeding program in basic education schools, including insufficient food served to the students in quantity and quality, inadequate materials and infrastructure, and unaffordable prices of required groceries from the market
Promoting Medi-Cal transportation services.	Dissatisfaction with current contracted transportation vendor. Challenging for members and providers to navigate transportation requests.
Promotion of available food resources	Funding for marketing and canvasing.
Provide more patrolling of public spaces and parks to increase safety.	Lack of resources to provide more patrolling.

Strategy/Tactic	Barrier
Provide more transportation allowances, not just medical appointments	Provide assistance with grocery shopping for the elders or unable.
Reduce the amount of homeless in recreational spaces.	Families stop using public areas when there are homeless. E.I. parks, downtown area.
Revitalize parks and enhance recreation services	Funding and city/county governance
Safe and free recreational facilities for children; Parks provide intrinsic environmental, aesthetic, and recreation benefits to our cities.	Lack of recreational facilities should take into account all difficulties that limit the access to these facilities when preparing management policy of sports and recreation infrastructure and it's functioning especially for children. The range of sports and recreation facilities' offer should be very wide in order for all social groups of the examined environment to have access to sports and recreation facilities.
The availability of reliable transportation and affordable fare	Lack of transportation services may vary and compromise the following: - Older adults - People with disabilities - Low-income individuals and families - Veterans - People with special healthcare needs, who often must travel long distances to access care
Utilizing the PH website to list Waste Hunger distribution locations and information	The website is not "user friendly" and most people are using a phone--we would be better served with an app for this purposes. Also, the locations of the distribution sites are more often than not a hit-or-miss, meaning there is lack of consistency in participating distributors.
Working with schools to provide direct linkage for food pantries and other sources of food.	Collaboration from schools including but not limited to space, MOU needed, etc.

Exhibit 12: Identified Strategies and Barriers for BEHAVIORAL HEALTH Priority Need Category

Strategy/Tactic	Barrier
Expand BH workforce.	Access to educational programs and the expediency of making a sustainable wage.
Outreach events at public schools	Anything that deals with sexual information could be seen as controversial

Strategy/Tactic	Barrier
Hire enough staff to accommodate for patients to get seen soon.	Appointments are made too far out creating a barrier for patients.
Partner with local school district and bridge campaign into SBHIP and Community Schools	Confidentiality, lack of facilities, lack of continuum of care, stigma
Develop and create substance adolescent facility.	Confidentiality, legal and liability barriers for adolescents.
Enhance services through family childcare providers	Connecting with CCCC to get the warm handoff
Increased classroom presentations on use of coping skills, warning signs, and how to access care.	Continued stigma of those who receive BH treatment.
Work with youth to develop campaign messaging around mental health	Creating messages without the focus population in mind may lead to lost messaging
Media/Info graphics that show diversity, inclusion and cultural awareness supporting seeking counseling services	Cultural Barries for individuals seeking counseling services
Enhanced collaboration around MHP BH MOU	Developing and implementing screening and transition tool processes, lack of data exchange platform.
Culturally competent awareness campaign for mental health.	Each cultural group has different taboos about mental health. Is important to generate individual awareness campaigns designed for each cultural group we are targeting.
Increased monetary action focused toward mental health stigma and counseling for those in need that may not have the resources to afford it	Finding counselors to perform these actions for the large number of individuals who need them and can't pay
Create crisis facilities for adolescents.	Funds, confidentiality, liability and legal all barriers.
Tak a grassroots approach and speak to young adults at the jr. Highs, middle schools, and high schools in person.	Getting approval from the district can be difficult for certain "topics" of Public Health, but the schools are taking a more forward approach with mental health services these days.
Address stigma among different groups	In some cultures, older generations may not be open to talk about mental health.
Expand public awareness of mental health issues amongst children, especially in rural Kern.	Lack of community awareness of childhood mental health issues in rural Kern.

Strategy/Tactic	Barrier
Promote Guidance and Counselling to the youth to provide healthy mental wellbeing.	Lack of guidance to children and youth may cause the increase of drug addiction and suicide.
Establish locations for services and service providers	Lack of providers. No locations available
Create safe spaces in the schools for students to vocalize their mental health needs and be guided to the proper programs or services.	Lack of safe spaces limits the ability of children and adults to express their need to access mental health resources.
Create a 24 hour effective mental health line in English and Spanish	Language Barrier and someone must answer the phone at all times
Provide referral and resource information in all schools	Large number of schools, bandwidth to accomplish this is tough
Increase providers in outlying areas	Limited providers available - telehealth not best for remote areas due to internet connection
Advertising free or low cost accessible services	Most counseling services are expensive and if they are low cost or free, there aren't any immediate, nor near future visits (too far out)
Give presentations on services to high-risk youth, like those who participate in AFLP classes w/ Clinica Sierra vista, NFP, etc.	No barrier identified other than possible scheduling conflicts.
Create a facility in Arvin to deliver behavioral health services	No current facility or infrastructure present in city limits, stigma, limited inventory or viable space
Linking patients/participants to free/low cost counseling services by referral forms from multiple partners in community health, healthcare, child care agencies etc.	Not enough no cost/low cost counseling services.
Child Care Consultation Program; Promote mental health and social emotional well-being	Research has shown that children who engage in persistent challenging behavior in the early years are at a greater risk of emotional and behavioral disorders as they grow older
Engage leadership in outlining communities of Bakersfield	Scheduling, personnel limitations,
More preventative services in schools beginning in elementary. Services should be ongoing and not only once a year.	Schools do not have the time to prioritize ongoing prevention services or do not believe they are needed, especially at the elementary level.
[Participant left question blank]	Schools do not know what services are available to them (often free of charge) through various community resources such as Kern BHRS, public health, and others.

Strategy/Tactic	Barrier
Expand services at Psychiatric Evaluation Center (PEC). Including but not limited to: bed space so not consistently on diversion, allowing patients with catheters.	Space and lack of properly trained employees.
Establish youth substance abuse treatment throughout the county utilizing mobile units.	Staffing and cost
Establish more primary and specialty health and behavioral healthcare providers, particularly in outlying areas of the county	Staffing and costs associated with in person clinics. One option that has been explored is telehealth however many outlying areas do not have the wifi available for families
Create messaging in all neighborhoods	Stigma
Creating a digital campaign and serving ad impressions to cell phone I.Ds to create more awareness on mental health and substance abuse. Creating a geofence and targeting specific areas strategically.	Substance abuse isn't top of mind for the majority. Due to more people being connected more digitally than ever before.
Increase crisis system capacity in Kern County.	The crisis system infrastructure capacity, including bed space and staffing, in Kern County does not meet the current need.
PSAs explaining the benefits of seeking and obtaining counseling services	The stigmas surrounding seeking counseling services
Create a community awareness campaign to destigmatize mental health challenges.	There are cultural stigmas associated with accessing mental health services.
Increase sobering center beds in Kern County and divert overdoses to sobering centers via ambulance instead of sending them to hospitals.	There is currently only one licensed sobering center in Kern County, which does not provide enough capacity to make significant changes in our EMS system.
Create availability of first-time behavioral health appointments within 2-3 days.	There is lack of appointments within this timeframe.
Promotion of what is available and how to access services	Time and funding
Supporting the families in need of services until appointments.	Wait time for appointments.
Promote and build Emotional Fitness Centers	When emotional issues cannot be address it may lead to mental breakdowns and depression.

Exhibit 13: Identified Strategies and Barriers for CHRONIC DISEASE AND COMMUNICABLE DISEASE Priority Need Category

Strategy/Tactic	Barrier
A public campaign addressing HIPPA and confidentiality	Some people may be embarrassed or hesitant of fear of judgement and exposure
Collaborate with Primary Care Clinics to expand Testing and education.	Resistance from Clinics to make time for training and education. Too many potential appointments. Insurance reimbursement barriers
Collaboration with LHD MOU	Limited publicly available data due to entering the county 1/1/24.
Combine diabetes and childhood dental health education as one affects the other.	Lack of education in multiple languages that explains the link of diabetes and dental health.
Combine efforts of STI surveillance with SUD programs including MAT services, needle exchanges, and other residential and outpatient services.	Coordination would be extensive as there are multiple SUD providers and services are often siloed and lack communication between providers.
Condom programs	Not enough convenient testing sites, extended hours.
Create more outreach opportunities in high-risk areas by going in as unidentifiable community members, rather than government health workers.	Historically, people who engage in multiple high-risk behaviors have not wanted to be seen associating with or engaging with government agencies.
Create outreach material that can be easy to understand and attractive to the audiences. That the images also represent the community we would like to reach.	Even though stigma may be significant barrier if we incorporate well know community leaders (Promotoras de Salud) this may produce better outcome.
Creating a digital campaign and serving ad impressions to cell phone I.Ds to create more awareness on STIs. Creating a geofence and targeting specific areas strategically.	STI's testing areas aren't top of mind for the majority. Due to more people being connected more digitally than ever before.
Educate providers in our community on the importance of routine testing and education at annual visits	Provider engagement
Education services in multiple languages	Partner with CBOs throughout the county to assist in obtaining languages and proving information
Encourage preventative healthcare, including screenings, for early diagnosis of chronic conditions through community outreach campaigns.	Cost, appointment availability, childcare, transportation, etc. All have been barriers to our community accessing preventative healthcare services.
Enhance healthy eating campaign in high schools and colleges.	Ensuring this campaign is mandated for all students to ensure they receive the information

Strategy/Tactic	Barrier
Expand knowledge at all k-12 schools, private, charter and public	Stigma and funding
Expand prevention efforts to weekend events around community.	Cost and work schedule of employees. As well as stigma of STI's at family events.
Expansion of use of mobile health clinic for STI health screenings in remote parts of Kern County where individuals may be far from a clinic	Long drive for mobile clinic, fewer clients, time consuming and expensive for gas
I personally am not aware of any outreach or promotion.	Men, for some reason men are not interested or comfortable getting tested. Maybe we can have men only clinics. Maybe offer testing during routine check ups.
Increase community collaboration with all service providers.	There are currently no collaborations between service providers as there is no checks and balances or client forum where the people can voice opinions and hold service providers accountable as what they would like to see happen in their communities or how to better engage their populations.
Increase data sharing among healthcare and social services providers so that frontline staff can encourage clients in seeking testing or assessments/screenings at any touchpoint. (i.e. "You're due for certain health screenings" when speaking to their dentist)	Use any opportunity to reach and remind clients of preventive care.
Offer Free STI testing mobile clinic in public locations like park, libraries.	Transportation to testing clinics, afraid of judgement.
Outreach for the community including prevention ideas to address Chronic Health Conditions in Kern	Developing impactful and cost effective outreach
Physical Activity Program; Regular physical activity is proven to help prevent and manage noncommunicable diseases	Unhealthy living can cause noncommunicable disease diabetes and heart diseases.
Post flyers at existing medical offices to promote STI testing..	Patients may not be aware of testing dates and can learn about it where they currently go for medical care.
Provide basic technology education for individuals to access the existing online health and prevention resources.	There is a lot of digital educational material that cannot be accessed by individuals with low levels of education or lack of technological knowledge.

Strategy/Tactic	Barrier
School education	Parent refusal
Supply condoms to local nightclubs and bars to be discreetly available in the restrooms, either through a "vending machine" style or laid out in a bowl.	Stigma to use of contraceptives due to religious reasons.
Highlight county level trends regarding communicable conditions and accessible treatment options	Buy in from the community
A universal "enrollment" form	Clients get frustrated having to fill forms that request the same/similar information to receive services.
Community testing events	Coordination of providers and location for event
Awareness and promotional campaigns to promote existing services/programs and ways to access them.	Currently the community knows too little of where to call to access resources/aid. This lack of knowledge leads to misinformation and the inability to access existing resources/programs from those who need them the most.
Awareness Campaign that engages all three local TV News stations for one week or one month	Finding people to share their stories, scheduling, scripting the information that the news stories share.
Promotion Campaign of Sweeteners; strive in helping food brands develop products with a reduced sugar solution and healthy sweetening alternatives without sacrificing taste and quality.	Food intake that can gain weight when you take in more calories than your body needs, and sugary foods and drinks contain a lot of calories that causes diabetes
Correction facilities	Funding
Increasing programs that provide education one on one for residents with diabetes.	Funding, time, participation
Provide virtual classes	Get access to outlying areas
Heart Awareness Outreach Program; a great time to commit to a healthy lifestyle and make small changes that can lead to a lifetime of heart health	Heart disease is the leading cause of death for both men and women. More than half of the deaths due to heart disease in 2009 were in men. When we do not take care of our hearts as part of our self-care, we cannot set an example for others.
Allow for prevention medicines and alternative methods to be more accessible to low income	Insurances might not cover prevention. Costs of most prevention medicines or techniques is not reimbursable or billable. Transportation to and from these locations is a barrier.

Strategy/Tactic	Barrier
[Participant left question blank]	Judgmental people
Identify appropriate channels and timelines to share health messages.	Messages may come in sporadic phases...an alignment among all organizations may be beneficial (i.e. Sponsoring radio, tv, bus wraps, CHWs, health educators, etc.
Improve timeliness of medical appts	Overwhelmed system, lack of providers
Maybe TikTok videos about safe sex or the importance of safe sex that is teenage friendly.	Parents not being realistic that their teenagers or younger could be having intercourse.
Schedule testing days in the evening	Patients may not be available for testing during the day and/or prefer evening hours.
Working with MCP's HEDIS/MCAS measures as they relate to STIs	STI limited HEDIS measures
Provide automatic referral to mental health services to help with acceptance of STI and to address reasons (if any) for engaging in risky behaviors that may lead to spreading of STI.	Stigma may keep people from accessing services and/or they may not meet medical necessity for specialty services.
Entice infectious disease healthcare professions to Kern County to assist with long-term treatment and monitoring of HIV patients.	There is a lack of qualified healthcare professionals to care for our HIV patients, meaning newly diagnosed patients have to wait weeks, or sometimes months, for appointments.
Expand opt out testing for STDs and HIV for early identification and treatment.	There is still a stigma associated with STDs and HIV and many of our community members live in denial and don't think they are "at risk" for STDs or HIV.
Ensure rural and low income communities receive the care	Transpiration
Mail to specific Zip Code areas informational material in different languages. Specifically, a magnet for the fridge with the resources we are trying to promote.	When you are experiencing a need/distress your brain doesn't always reason the best options, therefore if we are able to provide the community with the proper resources in their languages, for them to have on their fridge, it will increase their ability to access the services they need.

Exhibit 14: Identified Strategies and Barriers for EQUITY Priority Need Category

Strategy/Tactic	Barrier
Access to care offering extended hours.	There have been challenges in getting to doctor appointments due to farmworkers commuting, unable to miss work and clinic/resources do not open after 5 p.m.
Attempting to attract more OBGYNs to our county through campaigns at Kern Medical and by actively recruiting providers	Funding, geographical barriers.
Create a green book for patients seeking equitable access to care with a list of providers that have met the criteria's. Ex) BIMHI	Distribution of this information and on-going revisions of green book as needed.
Create a TDM or IDT process across community and school based health providers	Confidentiality, lack of facilities and infrastructure
Create/increase outreach to raise awareness of dental and behavioral health services within indigenous and immigrant communities.	Lack of communication/outreach to our indigenous and immigrant communities
Cultural comp training for staff	Time and funding
Culturally competent awareness campaign for health behavioral health.	Each cultural group has different taboos/cultural variers and impressions about health and behavioral health. Is important to generate individual awareness campaigns designed for each cultural group we are targeting to break those taboos.
Develop a countywide Health Equity taskforce so that all healthcare agencies are working towards equitable healthcare.	Not all Kern County healthcare agencies are prioritizing health equity.
Education and training, changing clinical environments can also be key to purposeful change in behavior.	People who lack education and training have trouble getting ahead in life, have worse health and are poorer than the well-educated. Major effects of lack of education include: poor health, lack of a voice, shorter lifespan, unemployment, exploitation and gender inequality.
Expanded use of the mobile health clinic with more services offered and more often around remote parts of Kern County where care is sparse	Expensive use of funding and resources for Publix Health to expand care and time commitment to the field
Farmworkers need folks to assist them with healthcare	When people look and talk like farmworkers, they feel comfortable receiving healthcare resources.

Strategy/Tactic	Barrier
Have our own OBG doctor onsite to care for the unborn child	Have options for the home birthing that is also covered. Midwives
Having a forum with local government and farmworkers to hear out farmer workers	Cost, transportation for farmworkers and a facilitator for this forum
Identify community leaders and diverse medical providers to build connections with them.	Many communities stay within their own populations and do not seek additional services on their own.
Implementing community health workers to help build the rapport between farmworkers and local government	Fear of deportation
Improve access to health services	Poor quality health services are holding back progress on improving health in countries at all income levels. The reasons for inadequate availability of healthcare vary from country to country and include political, financial, and physical barriers, especially the lack of an adequate infrastructure to deliver the benefits of drugs.
Improving Cultural Competence to Reduce Health Disparities for Priority Populations	A lack of conceptual clarity around cultural competence persists in the field and the research community. This confusion leads to disagreement regarding the topic areas and practices in which a provider should train to attain cultural competence.
Increase awareness through outreach of available resources through schools and community based organizations	Establishing the partnerships needed and costs
Increase culturally competent programming for all cultures	Disconnect
Increase options for providers available in rural communities.	Often there is only one provider with limited availability in outlying communities.
Increase outreach in all neighborhoods, MHFA	Number of staff it will take to do so is a challenge
Initiation of programs further aimed at reducing disparities for Black/Native American persons.	With regard to "closing the maternity care disparity for Black and Native American persons", we need to identify and begin to work at the root of some of those social determinants of health, which is a decades long effort.
Mobil clinics for outlying areas	Funding, staffing, equipment

Strategy/Tactic	Barrier
Patients have negative attitudes towards healthcare, unwanted pregnancy, transportation, financial barriers.	It will be important to listen to and get feedback from the patients experience and do everything possible to make them feel comfortable in accessing services.
Promotion of doula program and services to enhance prenatal and postpartum care for Black and Native American persons.	Not enough racially and culturally concordant contracted doulas with MCP.
Provide a healthcare provider symposium educating them on the local statistics for birth outcomes in our Black and native American residents.	Many of Kern County's healthcare providers are not from Kern County and may not be knowledgeable in our local outcome statistics. Awareness of our outcomes will help them make better decisions when providing services to our local population.
Provide health literacy training to service providers	Documents and information provided to patients and caregivers is at a high literacy level not allowing patients to make appropriate and adequate healthcare decisions
Provide mobile preventative healthcare services.	Kern County is geographically large with diverse communities. Preventative healthcare services are not consistently available in all Kern County communities.
Provide more support and education to outlying communities.	Cost and getting information distributed for success.
Provide ultrasounds through HOC or Mobile health unit, or purchase a unit for OB and maternal health purposes.	Funding can be an issue, as well as appropriate staffing for mobile units and/or HOC.
Utilize the Family Resource Centers to help promote awareness	[Participant left question blank]

If you had to share one or two "KEYS TO SUCCESS" to improve health and well-being in the county, what advice would you give?

- → Expand mobile health clinic use and prioritize funding in mental health.
- → Availability of providers, hours of operations to meet the needs of individuals that need services after 5 p.m., and compassion/care for individuals.
- → Better health equity across our county.
- → Clean it up, make it safer to go outdoors, walk and exercise, eat better, practice cultural rituals at liberty.

- → Continued collaboration and engagement.
- → Create contracts and incentives for healthcare workers to keep them in Kern County.
- → Creating more digital marketing to serve areas strategically.
- → De-centralize a portion of services and locations out of Bakersfield city, create greater presence and awareness in outlying communities.
- → Educating the public on their rights and how to utilize systems.
- → Engage a variety of stakeholders. Identify resident leaders in each community.
- → Find people who care, to speak with the people that act. A lot of time you need people of action to ensure a new measure actually takes shape and comes to life, but they need the input of those who care. Invest in your content development. Good content remains in the kitchen drawer, in the fridge, in the important information folder, etc. Develop something of quality that families will keep.
- → If someone's basic needs aren't being met (food, shelter, clothing) then nothing else takes priority over that--even their health. This is a very grassroots community and in order to reach them we have to meet them where they are at, in person, and show up with real resources they can use--not a website, not a flyer, but real resources. The community has lots of stakeholders and advisory board who talk about the problems but do little to help solve them. Less is more--less talk, more action.
- → In order to affect change, we must all work together as a united county to address these significant issues.
- → Increase both the public's and agencies' knowledge of what community resources are available and how to access them. Often there are resources to help, but only a limited group of people know about them or know how to access them. People often get frustrated and give up because they have to call so many different agencies and it can be overwhelming and confusing.
- → Increasing number of providers in the county.
- → Instead of simply asking, "What does success look like for me?" I want you to make a slight change to the question. Ask yourself, "What would a successful life look like for me?" To get your mind jogging, here are a few follow-up questions that can help you paint a mental picture of your successful life: -What kind of legacy do I want to leave behind? What will people say when they describe my life? -How much influence do I want and what will I do with it? -Who do I want to impact and how will I go about it? -How much time do I want to spend with my family? You don't need a definitive answer before you read any further, but keep this in mind as you continue. Once you can define your successful life, these two keys to success will give you a blueprint to living it. Discipline is important. Without discipline, a successful life is impossible to reach. Positivity: When you think about people you love being around, chances are they're not

"glass half empty" type people. The most influential people are positive by choice, and understand how to balance it appropriately with realism rather than negativity.

- → Know your "why". Why are these services or programs being offered? Find people who are passionate about the why to participate in the program.
- → Make an impact to begin and the community will take note and support.
- → The Keys to Success would include all entities working in collaboration. This is OUR community so we all have to participate and work collectively together.
- → We need to be providing the community what it is asking for, not swag, but items that is really needed. Secondly, we need to be doing outreach in the communities we serve, in the specific neighborhoods that are being affected.

Appendix D: CHIP "Prioritization Day" Workshop Agenda

Time	Item	Lead
8:30 – 9:00am	Participant arrival, table assignments *(Coffee and light refreshments)*	Kern County Public Health
9:00 – 9:20am	Welcome, Introductions, and Agenda Overview	Kern County Public Health; Crescendo
9:20 – 9:35am	Background ➢ Overview of CHA/CHIP Process ➢ Summary of CHA Findings	Crescendo
9:35 – 9:45am	Break	
9:45 – 10:55am	Small Group Discussions – Strategy Prioritization and Data Brainstorming	Table Leads
10:55 – 11:15am	Reporting Out by Table Leads	Crescendo; Table Leads
11:15 – 11:40am	Break *(Lunch arrives)*	
11:40 – 12:20pm	Strategy Voting *(Working lunch)*	Crescendo
12:20 – 12:30pm	Break	
12:30 – 12:50pm	Review of Results	Crescendo
12:50 – 1:00pm	Wrap-Up and Next Steps	Kern County Public Health

Appendix E: Top Strategies & Corresponding Barriers, by Category

Access to Care

The small group assigned priority need category "Access to Care" identified the following top five strategies – and corresponding barriers – for the large group voting session.

- Creation of new facilities, such as school/community-based health centers & behavioral health facilities in outlying areas, with extended hours.
    - Barriers:
        - → Funding
        - → Jurisdiction
        - → Facility/building availability
        - → Utilization of services
        - → Geographical identification for areas
        - → Confidentiality between providers
- Better information for clinical staff, promotoras, CHWs, & social services providers on available services & referral pathways (e.g., to behavioral health resources).
    - Barriers:
        - → Communication
        - → Sustainability
        - → Updated information
        - → Language accessibility
        - → Cultural appropriation
        - → Red tape
- More health, behavioral health, & dental health care resources that are accessible to all community members regardless of income (including working class, low-income, middle-class, immigration status, etc.).
    - Barriers:
        - → No local medical or dental schools
        - → Lack of culturally competent behavioral health providers
        - → Language accessibility
        - → Reaching people over federal state poverty line
- Addition of (and raising awareness of) more dental providers & facilities across the county (including mobile units) to expand geographic availability and beyond 'normal' business hours.
    - Barriers:

        - → Jurisdiction
        - → Funding
        - → Transportation
        - → Consistency of mobile unit schedule
- Assess transportation needs and find solutions for outlying areas.
    - Barriers:
        - → Jurisdiction
        - → Funding
        - → Geography

Basic Needs

The small group assigned priority need category "Basic Needs" identified the following top five strategies – and corresponding barriers – for the large group voting session.

- Addition of more safe & free recreational facilities & programs.
    - Barriers:
        - → Maintenance
        - → Limited currently-existing partnerships
        - → Transportation
        - → Location availability
        - → No consistent presence for kids recreational services
- Public messaging promoting awareness of existing transportation resources & food insecurity resources.
    - Barriers:
        - → Language accessibility
        - → Lack of access to digital resources and technology
        - → Reaching low income work places (e.g., markets, businesses, schools, etc)
        - → Geography
- Expansion of public transportation services, including active modes of transportation (walking, bicycling, etc.).
    - Barriers:
        - → Language accessibility
        - → Technology knowledge and comfort
        - → Safety and access to equipment (e.g., helmets)
        - → Difficulty accessing and maintaining bus drivers
        - → Poor infrastructure

- Enhanced partnerships with existing organizations, including hosting collaborative events.
    - Barriers:
        - → Poor communication
        - → Lack of collaboration
        - → Limited variety of current events
        - → Lack of awareness of existing services
        - → Lack of oversight
- More mobile food pantries to serve all of Kern.
    - Barriers:
        - → Lack of oversight and collaboration
        - → Inaccessible hours
        - → Community members needing to meet eligibility for services
        - → Information provided by organizations is always changing
        - → Food safety
        - → Transportation
        - → Consumer knowledge (e.g., education on "best by" dates)
        - → Difficulty accessing information on available resources

Behavioral Health

The small group assigned priority need category "Behavioral Health" identified the following top four strategies – and corresponding barriers – for the large group voting session.

- Increase the number of behavioral health providers (particularly in outlying areas) through established virtual clinics, telehealth, & mobile clinics.
    - Barriers:
        - → Lack of telehealth infrastructure
        - → Lack of HIPAA-compliant equipment
        - → Staffing shortages to provide present physical staff
- Expand targeted outreach and educational efforts at schools & community locations on an ongoing basis, including provision of referral, resource information, & informal support groups.
    - Barriers:
        - → Current systems not working for families
        - → Inaccessible hours
        - → Lack of adequate and personable outreach

- Implement culturally competent behavioral health awareness & stigma reduction messaging across health equitable & culturally competent platforms.
    - Barriers:
        - → Lack of safe and consistent spaces
        - → Lack of high-quality translators
        - → Geography
        - → Lack of trust in telehealth (telehealth trauma)
        - → Difficulty navigating systems
- Enhance capacity by adding sobering center & crisis system beds locally in order to divert those in need for behavioral health care away from emergency rooms.
    - Barriers:
        - → Geography
        - → Communication between behavioral health providers and referring agency
        - → Inadequate infrastructure
        - → Families mindset

Chronic Disease and Communicable Disease

The small group assigned priority need category "Chronic Disease and Communicable Disease" identified the following top five strategies – and corresponding barriers – for the large group voting session.

- Understandable and targeted outreach campaigns encouraging preventative healthcare (e.g., screenings) and behaviors (e.g., physical activity and healthy eating).
    - Barriers:
        - → Difficult for wide campaigning and widespread education
        - → Diverse cultures (language and culture accessibility)
        - → Stigmas regarding certain diseases
        - → Lower health literacy education
- More diabetes programming, such as one-on-one education for those living with the condition and/or integration into childhood dental health education.
    - Barriers:
        - → Lack of support groups
        - → Lack of knowledge regarding primary provider care
        - → One-one-one education and communication
        - → Not enough access to health educators

- Enhanced collaboration & coordination between clinical & social service providers to better guide individual-level care, including integration of STI surveillance alongside substance use treatment & mental health services.
    - Barriers:
        - → Data sharing
        - → Ensuring HIPAA compliance
        - → Establishing testing at mental health services
- Better efforts (including partnerships with primary care clinics & mobile clinics) to ensure that expansion of preventive/treatment resources are equitably available to people in rural areas and/or with lower incomes.
    - Barriers:
        - → Different priorities in different communities
        - → Cultural and political issues
        - → Ensuring equal service access
        - → Cost of medication
        - → Storage of medication
        - → Medication shortages
        - → Adequate marketing strategies
- Outreach education to healthcare providers on community resources available.
    - Barriers:
        - → Lack of community involvement
        - → Lack of lead organization or a committee lead
        - → Lack of provider resources

Equitable Access to Services and Resources

The small group assigned priority need category "Equitable Access to Services and Resources" identified the following top four strategies – and corresponding barriers – for the large group voting session.

- Cultural competency training for providers and staff, including focus on the unique and distinct challenges encountered by specific groups across the county.
    - Barriers:
        - → Participation
        - → Limited local access
        - → Lack of incentives to change behavior
        - → Digital divide
        - → Internal structures

        - → Building sensibility
        - → Advocacy
        - → Need for relationship building within communities
- A countywide Health Equity task force to coordinate work towards equitable health and behavioral health care.
    - Barriers:
        - → Supports/incentives for providers to stay
        - → Need for health equity work implemented within agencies beyond task force members
        - → Financial support
        - → Business development
        - → National support
- Targeted outreach to increase awareness of available prevention and care resources, particularly among underserved communities.
    - Barriers:
        - → Turn over rate
        - → Lack of diverse workforce (cultural and language)
        - → Outreach materials not representative/readable
        - → Financial support
        - → Trust
        - → Lack of video options (education for digital users)
- Programs to enhance prenatal and postpartum care for Black and Native American persons (e.g., a doula program serving these populations).
    - Barriers:
        - → Trust
        - → Engagement
        - → Buy-in
        - → Access
        - → Education
        - → Long-term commitment
        - → Capacity
        - → Post-partum support
        - → Depression
        - → Need for incentives

Appendix F: Top Strategies & Voting Results, by Category

ACCESS TO CARE	# of green	# of yellow	# of red	Total Score	Rank
A) Creation of new facilities, such as school/community-based health centers & behavioral health facilities in outlying areas, with extended hours.	95 (19 votes)	21 (7 votes)	7 (7 votes)	**123**	1
B) Better information for clinical staff, promotoras, CHWs, & social services providers on available services & referral pathways (e.g., to behavioral health resources).	20 (4 votes)	30 (10 votes)	3 (3 votes)	**53**	3
C) More health, behavioral health, & dental health care resources that are accessible to all community members regardless of income (including working class, low-income, middle-class, immigration status, etc.).	45 (15 votes)	45 (15 votes)	5 (5 votes)	**95**	2
D) Addition of (and raising awareness of) more dental providers & facilities across the county (including mobile units) to expand geographic availability and beyond 'normal' business hours.	20 (4 votes)	12 (4 votes)	7 (7 votes)	**39**	4
E) Assess transportation needs and find solutions for outlying areas.	10 (2 votes)	6 (2 votes)	16 (16 votes)	**32**	5

BASIC NEEDS	# of green	# of yellow	# of red	Total Score	Rank
A) Addition of more safe & free recreational facilities & programs.	55 (11 votes)	24 (8 votes)	11 (11 votes)	**90**	1
B) Public messaging promoting awareness of existing transportation resources & food insecurity resources.	25 (5 votes)	18 (6 votes)	7 (7 votes)	**50**	4
C) Expansion of public transportation services, including active modes of transportation (walking, bicycling, etc.).	15 (3 votes)	48 (16 votes)	9 (9 votes)	**72**	3
D) Enhanced partnerships with existing organizations, including hosting collaborative events.	65 (13 votes)	12 (4 votes)	5 (5 votes)	**82**	2
E) More mobile food pantries to serve all of Kern.	30 (6 votes)	12 (4 votes)	6 (6 votes)	**48**	5

BEHAVIORAL HEALTH	# of green	# of yellow	# of red	Total Score	Rank
A) Increase the number of behavioral health providers (particularly in outlying areas) through established virtual clinics, telehealth, & mobile clinics.	75 (15 votes)	30 (10 votes)	3 (3 votes)	**108**	1
B) Expand targeted outreach and educational efforts at schools & community locations on an ongoing basis, including provision of referral, resource information, & informal support groups.	40 (8 votes)	18 (6 votes)	12 (12 votes)	**70**	3
C) Implement culturally competent behavioral health awareness & stigma reduction messaging across health equitable & culturally competent platforms.	50 (10 votes)	48 (16 votes)	5 (5 votes)	**103**	2
D) Enhance capacity by adding sobering center & crisis system beds locally in order to divert those in need for behavioral health care away from emergency rooms.	20 (4 votes)	15 (5 votes)	17 (17 votes)	**52**	4

CHRONIC DISEASE & COMMUNICABLE DISEASE	# of green	# of yellow	# of red	Total Score	Rank
A) Understandable and targeted outreach campaigns encouraging preventative healthcare (e.g., screenings) and behaviors (e.g., physical activity and healthy eating).	5 (1 vote)	18 (6 votes)	17 (17 votes)	**40**	4
B) More diabetes programming, such as one-on-one education for those living with the condition and/or integration into childhood dental health education.	5 (1 vote)	12 (4 votes)	4 (4 votes)	**21**	5
C) Enhanced collaboration & coordination between clinical & social service providers to better guide individual-level care, including integration of STI surveillance alongside substance use treatment & mental health services.	80 (16 votes)	33 (11 votes)	6 (6 votes)	**119**	1
D) Better efforts (including partnerships with primary care clinics & mobile clinics) to ensure that expansion of preventive/treatment resources are equitably available to people in rural areas and/or with lower incomes.	55 (11 votes)	42 (14 votes)	4 (4 votes)	**101**	2
E) Outreach education to healthcare providers on community resources available.	40 (8 votes)	6 (2 votes)	6 (6 votes)	**52**	3

EQUITABLE ACCESS TO SERVICES	# of green	# of yellow	# of red	Total Score	Rank
A) Cultural competency training for providers and staff, including focus on the unique and distinct challenges encountered by specific groups across the county.	40 (8 votes)	36 (12 votes)	11 (11 votes)	**87**	2
B) A countywide Health Equity task force to coordinate work towards equitable health and behavioral health care.	60 (12 votes)	9 (3 votes)	8 (8 votes)	**77**	3
C) Targeted outreach to increase awareness of available prevention and care resources, particularly among underserved communities.	20 (4 votes)	42 (14 votes)	13 (13 votes)	**75**	4
D) Programs to enhance prenatal and postpartum care for Black and Native American persons (e.g., a doula program serving these populations).	65 (13 votes)	24 (8 votes)	5 (5 votes)	**94**	1