COMMUNITY HEALTH IMPROVEMENT PLAN FOR SAN JOAQUIN COUNTY

2019-2022

June 2019

Prepared by:
ad lucem consulting
Letter from the Healthier San Joaquin Community Health Assessment Collaborative CHNA/CHIP Core Team

This Community Health Improvement Plan (CHIP) is intended to guide collective efforts to address health throughout San Joaquin County, particularly in neighborhoods experiencing the greatest health disparities. The approach laid out in this plan builds on the priority health needs identified in the 2019 Community Health Needs Assessment (CHNA). However, this CHIP departs from previous efforts in a unique way – it focuses on just one of the priority health needs from the CHNA rather than many. It identifies one goal associated with that health need and a select number of strategies designed to be implemented collectively. Foundational to this approach is the desire to “dive deep.” That means working with and within our priority neighborhoods, coordinating efforts and resources to make a real difference. We hope that this plan will help local decision makers, key stakeholders and the community-at-large work together to improve health and address health disparities.

The CHNA and this CHIP are the products of a collaborative effort that engaged hundreds of individuals from diverse sectors and perspectives throughout San Joaquin County. County residents were essential to the process; they shared their knowledge and experience and played a key role in ranking health needs and strategies. Agency and organizational partners were critical to data collection, prioritization of health needs and building the plan, guided by residents’ expressed priorities.

We are grateful for these contributions and hopeful that our ongoing partnership strengthens existing efforts, brings new ideas and ultimately builds a healthier community in the future.

This CHIP report, as well as the 2019 CHNA are available on line at https://www.healthiersanjoaquin.org/.

We look forward to working with you.

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Executive Summary

San Joaquin County is one of California’s fastest growing counties; it includes seven cities, many small towns and a number of rural farm and ranching communities. County residents are diverse, including Latino, African American, Caucasian and Asian/Pacific Islander populations. San Joaquin is a county of contrasts, holding in one hand growth opportunities and a variety of assets and resources to support health, and in the other hand significant challenges in terms of economic security, health and health disparities.

From July 2018 through March 2019, the San Joaquin County 2019 Community Health Needs Assessment (CHNA) was conducted to present a comprehensive picture of community health, encompassing the conditions that impact health in the county. The CHNA was designed to inform and engage local decision makers, key stakeholders and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents. From data collection and analysis to the identification of prioritized needs, the development of the 2019 CHNA report was an inclusive and comprehensive process guided by a Core Team planning group and broadly representative Steering Committee, with input from hundreds of community residents. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

The 2019 CHNA report placed particular emphasis on the health issues and contributing factors that impact vulnerable populations that disproportionately have poorer health outcomes across multiple health needs. It explored disparities for populations residing in specific geographic areas referred to as “Priority Neighborhoods” as well as disparities among the county’s diverse ethnic populations. These analyses were helpful to identifying intervention strategies that promote health equity.

Building on the 2019 CHNA, San Joaquin County created its Community Health Improvement Plan (CHIP) with an approach aimed at achieving maximum collective impact. The CHIP focuses on just one priority health need and a select list of key strategies to be implemented jointly by multiple collaborators. Public agencies, hospital/health care systems and community organizations will be encouraged to coordinate and target resources in the Priority Neighborhoods identified in the CHNA.

The CHIP process was a function of the Healthier San Joaquin Community Health Assessment Collaborative and was guided by the Core Team, who engaged the Steering Committee. The Core Team included San Joaquin County Public Health Services, San Joaquin County’s nonprofit hospitals and two Medi-Cal managed care plans, Community Medical Centers (federally qualified health centers) as well as First 5 San Joaquin, a county-wide partner organization. The Core Team was responsible for planning and key decision making, including providing review and input into the CHIP report. The broadly representative Steering Committee assisted with collecting survey data, selecting priorities and building out the CHIP.
By design, the CHIP process identified **one priority health need and one goal** for strategic attention.

**Health Need: Obesity/HEAL/Diabetes**

**Goal: Help community members of all ages and abilities get more physical activity, including programs that meet language/culture needs**

With this health need selected, the Core Team and Steering Committee identified strategies, outcomes, activities and partners to address the need, which are included in this CHIP report. The CHIP will be a living document, with progress monitored and plans adjusted as San Joaquin County moves forward in implementing the CHIP through 2022 and beyond.

The CHIP is an inclusive, county-wide effort. The Core Team and Steering Committee encourage community members and community organizations to participate in implementing the priority strategies in the Priority Neighborhoods. There are a variety of opportunities for collaboration, including outreach to and engagement of community members, implementing specific interventions, or collecting feedback and data to support tracking and evaluation of CHIP progress. If the selected strategies and activities are not part of an organization’s/agency’s core mission, it is hoped they can find ways to complement CHIP efforts.

Organizations, public agencies or San Joaquin County residents seeking to contribute to the CHIP activities should contact Barb Alberson at balberson@sjcphs.org or any other Core Team member for more information.
Community Health Improvement Plan for San Joaquin County

Background: San Joaquin County

San Joaquin County, home to one of the most successful agricultural areas of the world, contains both rural and urban areas. Communities and cities maintain their unique geographic identities, separated by agriculture and open space lands. The county includes seven incorporated cities – Stockton, Tracy, Manteca, Lodi, Lathrop, Ripon and Escalon – as well as many small well-established rural communities in the unincorporated areas.

San Joaquin County is experiencing growth that brings both opportunities and challenges. Some neighborhoods have links to well-paying jobs in nearby counties, while residents in other neighborhoods struggle to find local living wage jobs and cope with high crime rates. San Joaquin County residents face challenges around economic security including homelessness and housing stability; the county compares poorly to California averages for unemployment and the percentage of adults with a post high school degree. As described in the San Joaquin County 2019 Community Health Needs Assessment, residents experience a number of disease related challenges as well as health disparities. Diabetes prevalence is higher in the county than the state average and Black and Latino populations experience higher rates of obesity than other ethnic groups. There is a shortage of health professionals in San Joaquin County, with only 190 mental health providers and 60 primary care providers per 100,000 residents. San Joaquin County residents have a higher rate of Medi-Cal/Public Insurance enrollment than the California average, 30% as compared to 22%.

Overview of the San Joaquin County Community Health Needs Assessment (CHNA)

The San Joaquin County community has a long tradition of working collaboratively and has conducted a joint triennial CHNA for many years. This collaborative effort stems...
from a desire to address local needs and a dedication to improving the health of everyone in the community. The 2019 CHNA report is available at www.healthiersanjoaquin.org.

The 2019 CHNA met federal requirements and fulfilled one of San Joaquin County Public Health Service’s requirements for national Public Health Accreditation. From data collection and analysis to the identification of prioritized needs and implementation strategies, the development of the 2019 CHNA report was an inclusive and comprehensive process guided by a Core Team planning group and a broadly representative Steering Committee (See Appendix A). As many community members as possible were engaged in the process. Opinions were sought from decision makers and key stakeholders and—more importantly—from community members whose voices are not often heard.

A social determinants of health framework was employed for the CHNA and guided examination of San Joaquin County’s social, environmental and economic conditions that impact health in addition to exploring factors related to diseases, clinical care and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the county.

A particular emphasis for the 2019 CHNA were the health issues and contributing factors with greatest impact among vulnerable populations that disproportionately have poorer health outcomes across multiple health needs. The CHNA explored disparities for populations residing in specific geographic areas referred to as Priority Neighborhoods1 as well as disparities among the county’s diverse ethnic populations. The first seven Priority Neighborhoods rank as the least healthy communities in San Joaquin County (all of which are in Stockton) and the other three are the worst performing neighborhoods in the county’s other major cities (Lodi, Tracy and Manteca). Figure 2 lists and describes the Priority Neighborhoods.

1 San Joaquin County 2019 Community Health Needs Assessment, March 2019.
The mixed-methods approach for the 2019 CHNA included a review of quantitative data available through the Kaiser Permanente CHNA data platform and additional data compiled by Public Health Services from national, statewide, and local sources to provide a more complete picture of health in San Joaquin County. These data were compared to benchmark data and analyzed to identify potential areas of need. The qualitative data collected via key informant interviews and focus groups offered a wide range of opinions on health needs with greatest impact on community members, examples of existing resources that address those health needs and suggestions for continued progress in addressing the needs. The analyzed quantitative and qualitative data were triangulated to identify the top health needs in the county and summary health need profiles were created.

A multi-step ranking process categorized the health needs into highest, medium, and lower priority. While the health need profiles developed for the CHNA provided a wealth of data and were key to the ranking process, input from community members added depth and context. This included: 1) a survey with older adults that captured their perspectives on priority health needs facing their communities; and 2) a meeting held with residents of suburban Tracy in which they reviewed quantitative and qualitative data and provided their input on priority health needs. The results of the older adult survey and Tracy community meeting were shared with the CHNA Steering Committee, along with the health need profiles, at its April 25, 2019 meeting. Final health need prioritization took place at this meeting. The Steering Committee reached consensus on the priority health needs based on criteria identified by the Core Team. This prioritization resulted in the nine ranked health needs in Figure 3.
San Joaquin County used the results of the 2019 CHNA to drive the development of a joint CHIP. In addition, each of the county nonprofit hospitals will develop an individualized implementation plan for their service area, with strategies tailored to build on a hospital’s own assets and resources. Their Implementation Strategies will be filed with the Internal Revenue Service.

### Purpose of the CHIP

The CHIP is a systematic plan to address the health needs emerging from the CHNA process.\(^2\) It serves as a guide for collaborators county-wide to align efforts, coordinating and focusing resources on agreed upon intervention objectives and strategies. The aim of the CHIP is to have a collective impact, improving the health and wellness of county residents.

Like the San Joaquin County CHNA, this CHIP takes a holistic view of health, in line with the World Health Organization definition which states that health is complete physical, mental and social well-being and not the mere absence of infirmity.\(^3\) The CHIP embodies a public health framework that defines the goal of health promotion as a combination of approaches for addressing the social determinants of health with the commitment to facilitate and encourage individuals and communities to take an active approach to achieving health.\(^4,5\)

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Ultimately, this CHIP is intended to focus on the root causes of health inequities and health disparities, and to promote equal opportunities for all people to be healthy and to seek the highest level of health possible.6

CHIP Process

The CHIP process was a function of the Healthier San Joaquin Community Health Assessment Collaborative and was guided by the Core Team, which engaged the Steering Committee. The Core Team included San Joaquin County Public Health Services, San Joaquin County’s nonprofit hospitals and two Medi-Cal managed care plans, Community Medical Centers (federally qualified health centers) as well as First 5 San Joaquin, a county-wide partner organization. The Core Team was responsible for planning and key decision making, including providing review and input into this CHIP report. The broadly representative Steering Committee (which included public agencies, community organizations, educational institutions and local leaders) assisted with collecting survey data, selecting priorities based on data collected and building out the CHIP. (See Figure 4.)

In April 2019, following the completion of the CHNA, the Core Team initiated the CHIP process. The methods for the 2019 CHIP focused on:

- Garnering substantial county resident input into the CHIP via a survey.
- Achieving maximum impact by building from the 2016 CHIP and narrowing the focus to one health need and one goal with related strategies designed to address the selected need.

Figure 4: CHIP Process Steps

Developing the CHIP was a systematic process that involved input from county residents, the Core Team and Steering Committee.

Step 1: The Core Team developed a county resident survey to identify what residents felt were the best strategies to address the CHNA highest priority health needs and then to identify just one of these health needs to address. Steering Committee members conducted the survey with residents.

Step 2: The Steering Committee convened to narrow the CHIP focus to one health need and one overarching related goal; deliberations were guided by residents' survey results. Steering Committee members identified outcomes and activities for addressing the selected need and key organizations to lead activities.

Step 3: A draft CHIP was developed, incorporating goals and objectives from the 2016 CHIP and including outcomes, strategies, activities and key organizations from the Steering Committee. The Core Team reviewed and further refined the CHIP, adding a timeline for activities.

Step 4: The CHIP was sent out for comment.

Step 5: The CHIP was revised based on input and finalized.

6 http://healthequity.sfsu.edu/content/defining-health-equity
• Planning for CHIP implementation in the Priority Neighborhoods (identified in the CHNA) to improve health and reduce health disparities experienced by community members.

• Creating a plan to align county funders, public agencies and community organizations to have a collective impact on a narrowly defined set of interventions in the Priority Neighborhoods.

CHIP Community Resident Survey

Methods
The purpose of the eight-item multiple-choice CHIP Community Resident Survey was to provide county residents with the opportunity to select strategies to address each of the highest priority health needs identified in the CHNA (Obesity/HEAL/Diabetes, Mental Health, and Economic Security) and choose just one priority health need for the CHIP.

Surveys were completed via paper and pencil (n=2111) and online (n=435) in English and Spanish; community organizations and public agencies that participate in the CHNA/CHIP Steering Committee conducted the survey. Survey collection exceeded the goal of 2000 responses with 2546 residents completing the survey. The objective of the survey sample was to be representative of the county population in terms of city of residence and ethnicity, with oversampling of communities of color; this objective was largely satisfied. Descriptive analyses were conducted to summarize results including significance testing to ascertain presence of statistically significant differences.

Limitations
While the survey was successful in reaching a large number of county residents, a few limitations can be noted. The survey was only offered in English and Spanish, not any Asian languages. Residents of rural communities, those not served by community organizations and public agencies, older adults and males were hard to reach with the survey. The survey employed only a small number of multiple-choice questions for ease of completion; a more in-depth survey might have gleaned additional data.
Survey Participant Demographics

- Geographic representation:
  - Stockton and Lodi samples exceeded goals.
  - Tracy sample met goal.
  - Manteca and rest of county were somewhat below goal.

- Ethnic representation:
  - Latino and Black samples exceeded goals. (oversampling was achieved).
  - Asian sample met goal.
  - 25% of surveys completed in Spanish.

Survey Results
Residents were asked to indicate preferred interventions for each of the top health needs identified in the CHNA (see Appendix B for detailed results):

- Obesity/HEAL/Diabetes: The largest percentage of respondents (28%) selected *Help residents of all ages get more physical activity, including programs that meet language and culture needs* as their preferred intervention.

- Mental Health: *Provide mental health services where people already get services, including schools* emerged as the preferred intervention (35%).

- Economic security: The top response for preferred intervention was *Provide more job training for adults and teens* (28%).

Survey respondents identified **Obesity/HEAL/Diabetes** as the essential need to address, with 40% of survey respondents selecting this as their top need.
Building Out the CHIP

Selecting One Health Need and Goal
At the Steering Committee convening in April 2019, approximately 45 participants reviewed progress made on the 2016 CHIP, the 2019 CHNA prioritized health needs and the 2019 CHIP Community Resident survey results to inform their votes for a single health need to address. Steering Committee members were asked to apply the criteria listed in Figure 6 and take into account the community survey findings. Obesity/HEAL/Diabetes was the health need selected.

Steering Committee members then selected one Obesity/HEAL/Diabetes goal. They broke into small groups, reviewed a menu of Obesity/HEAL/Diabetes approaches (taken from the 2016 CHIP) and discussed which goal best served the process; the large group then reconvened and voted for the top goal, selecting help community members of all ages and abilities get more physical activity, including programs that meet language and culture needs.

CHIP Strategies
At this same meeting, once the health need and goal were selected, the small groups reconvened to develop plans, identifying essential outcomes to achieve, specific strategies to address the need, activities to implement the strategies and key organizations to engage in implementing the strategies.

These plans were then synthesized by Ad Lucem Consulting, the consultants facilitating the CHIP process, to develop a cohesive draft CHIP. The draft was reviewed by the Core Team, who further refined the CHIP, adding specificity to the outcomes and measures as well as a timeline for activities. The revised CHIP was sent to select Steering Committee members for input, which was incorporated into the final CHIP.

CHIP Implementation
The CHIP will be used to align efforts, especially to encourage funders, public agencies and community organizations to have a collective impact on a narrowly defined set of interventions in the Priority Neighborhoods. The CHIP aims to guide development and implementation of policies, systems and environmental changes as well as programs for Obesity/HEAL/Diabetes that address disparities and achieve measurable change.

Figure 6: Criteria to select one health need and one related goal
- Clear disparities or inequities exist.
- Community prioritizes the issue.
- Effective, feasible, evidence informed interventions exist.
- SJC has existing efforts/resources addressing the issue that can be leveraged/built upon.
- Opportunity to intervene at the prevention level.
Policies to Support Successful CHIP Implementation

For San Joaquin County to successfully implement the strategies highlighted in this document, there is a need to develop and promote policies that drive systems and environmental changes. The CHIP includes policy strategies (described in Appendix C) that aim to obtain resources and put in place administrative structures that facilitate the CHIP strategies. The policy strategies included are:

- Implementation of existing policies and codes promoting safe routes to parks and active transportation in General Plans, Design Standards, Zoning Codes and related ordinances.
- Joint use policy activation to increase access to physical activity opportunities.
- Institutional level policy work that facilitates park improvements and beautification (e.g. park/playground maintenance; public safety protocols; subsidizing athletic team and physical activity program participation).

SJC CHIP Alignment with Other Health Improvement Initiatives

The CHIP priority health need aligns with and complements the Let's Get Healthy California initiative at the state level, and is directly in line with Healthy People 2020, CDC diabetes prevention initiatives and the Surgeon General’s call to action on improving walkability in communities. Figure 7 includes hyperlinks to the State and Federal initiatives that reflect the San Joaquin County CHIP priority health need.

<table>
<thead>
<tr>
<th>San Joaquin County Priority Health Need</th>
<th>State</th>
<th>Federal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity/HEAL/Diabetes</td>
<td><strong>Let's Get Healthy California (see Living Well, Creating Healthy Communities)</strong></td>
<td>HP2020: Nutrition, Physical Activity and Obesity</td>
</tr>
<tr>
<td></td>
<td><strong>California DPH California Wellness Plan</strong></td>
<td>Surgeon General Call to Action on Walking and Walkable Communities</td>
</tr>
<tr>
<td></td>
<td>****</td>
<td>CDC Diabetes Programs and Initiatives</td>
</tr>
</tbody>
</table>
Statement of Need: Obesity/HEAL/Diabetes

A lifestyle that includes eating healthy and physical activity improves overall health, reducing risk factors for many chronic diseases that can lead to costly and life-threatening health outcomes. Key findings on Obesity/HEAL/Diabetes from the 2019 San Joaquin County CHNA are described below.

Key Findings

- Rates of diabetes in San Joaquin County are slightly higher than state levels.
- When compared to the rest of the state, San Joaquin County fares poorly on many of the factors that contribute to obesity and diabetes, including physical inactivity among adults, walking or biking to school, food insecurity, quality of food environments, opportunities for physical activity and participation in Supplemental Nutrition Assistance Program (SNAP).
- When compared with Healthy People 2020 national adult and teen obesity statistics, adults and youth in this county have higher obesity rates.
- Although not statistically significant, obesity rates in adults and youth trend higher than the state average.

Figure 8: Obesity/HEAL/Diabetes Related Health Outcomes and Contributing Factors

<table>
<thead>
<tr>
<th>Related Health Outcomes</th>
<th>Factors that Contribute to Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicator</td>
</tr>
<tr>
<td></td>
<td>Indicator</td>
</tr>
<tr>
<td>Obesity (Adult)</td>
<td>33%</td>
</tr>
<tr>
<td>Obesity (Youth)</td>
<td>23%</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>80%</td>
</tr>
<tr>
<td>(Hemoglobin A1c Test)</td>
<td></td>
</tr>
<tr>
<td>Diabetes Prevalence</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Indicates ethnic group experiencing the greatest disparity from county averages

Source: CHNA data platform, 2018
Populations Disproportionately Impacted

- Black residents have slightly worse rates of diabetes management when compared to the rest of the county.
- Obesity disproportionately affects Black and Latino adults and youth. In particular, Black residents have the highest obesity rate among the county’s adult population and Latinos have the highest rate among youth.
- Black and Latino youth have lower rates of physical activity, with the lowest rates experienced by Black residents.
- Asian, Black and Latino residents have higher rates of SNAP participation, an indicator of poverty, with Black residents experiencing the greatest disparity.

Primary Data: What San Joaquin County Stakeholders Say About this Health Need

- Almost all key informants mentioned Obesity/HEAL/Diabetes as a top (8) or medium (2) health need.
- Most (24 of 31) focus groups mentioned Obesity/HEAL/Diabetes as a top (15) or medium (9) health need.
- Obesity/HEAL/Diabetes affects all income levels but low-income people struggle most with buying healthy food and access to physical activity.
- Factors contributing to Obesity/HEAL/Diabetes: poverty; lack of access to healthy food (few grocery stores); easy access to cheap unhealthy food (fast food, liquor stores, unhealthy food at schools and food banks); few safe places for physical activity; little understanding of healthy lifestyle and how to prepare healthy foods.

“We have high rates of [chronic disease]. All of that stems from not eating healthy and getting enough exercise, especially in children.”
-- Key Informant

CHIP Priority Issue and Strategies

Figure 9 presents the goal and objectives for the CHIP priority health need, Obesity/HEAL/Diabetes, including corresponding performance measures, baseline data and targeted improvements. Note that the objectives below focus on improving physical activity for community members of all ages. The objectives provide a framework for monitoring long-term change in population health over time and not the success of specific CHIP activities. The baseline data source is not updated frequently and is not appropriate to evaluate the success of CHIP activities. In addition, changes in physical activity frequency may not be realized at the county level; tracking changes at the census tract level in the Priority Neighborhoods receiving interventions may be more informative.
Appendix C presents the 2019–2022 CHIP matrix for Obesity/HEAL/Diabetes, including strategies, activities, outcomes, progress measures and responsible organizations. These strategies are cross-cutting, simultaneously addressing Objectives 1.1–1.3 (Figure 9).

Next Steps: From Planning to Action

The CHIP will guide community health improvements from 2019–2022. This CHIP will serve as a living document, as these efforts grow and evolve to take advantage of emerging opportunities. Next steps include:

- Build out detailed work plans with Priority Neighborhood community members for implementing key activities in their neighborhoods.
- Identify how each Steering Committee organization/agency will contribute. There are a variety of opportunities for collaboration, including outreach and engagement for community members, implementing specific interventions, collecting feedback and data to support progress tracking and evaluation of CHIP progress.
- Align funder investments around specific activities and Priority Neighborhoods.
- Put in place an ongoing process to ensure efforts are aligned and progress is tracked.

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7 https://www.hhs.gov/fitness/be-active/physical-activity-guidelines-for-americans/index.html
Working Together to Improve Community Health in San Joaquin County

The CHIP belongs to all of San Joaquin County; the more public agencies, community organizations and community members engaged in CHIP implementation, the more likely it is that CHIP outcomes—and visible improvements in Priority Neighborhoods—will be achieved. Organizations, public agencies or San Joaquin County residents seeking to contribute to the CHIP activities should contact Barb Alberson at balberson@sjcphs.org or any other Core Team member for more information.
Appendix A. Steering Committee, Core Team

The Steering Committee member organizations are listed below. Organizations that are also part of the Core Team, which guided the CHIP process, are indicated with an asterisk.

- Adventist Health Lodi Memorial*
- Assembly Member Eggman's District Office
- Asian Pacific Self Development and Residential Association (APSARA)
- Beyond our Gates, University of the Pacific
- Business Forecasting Center, University of the Pacific
- Catholic Charities Diocese of Stockton
- Child Abuse Prevention Council
- Community Medical Centers*
- Dameron Hospital*
- Delta Health Care
- Dignity Health St. Joseph’s Medical Center*
- El Concilio
- Emergency Food Bank Stockton/San Joaquin
- Family Resource and Referral Center
- Fathers & Families of San Joaquin
- First 5 San Joaquin*
- Golden Valley Health Center
- Greenlining Institute
- HealthForce Partners
- Health Net*
- Health Plan of San Joaquin*
- Kaiser Permanente*
- Lao Family Community Empowerment, Inc.
- Little Manila
- Office of the Mayor, City of Stockton

- Office of Violence Prevention – City of Stockton
- Public Health Advocates
- Reinvent South Stockton Coalition
- San Joaquin Council of Governments
- San Joaquin County Behavioral Health Services
- San Joaquin County Data Co-Op
- San Joaquin County Health Care Services Agency
- San Joaquin County Housing Authority
- San Joaquin County Office of Education
- San Joaquin Delta College
- San Joaquin Hispanic Chamber of Commerce
- San Joaquin County Public Health Services*
- Sutter Health*
- Stocktonians Taking Action to Neutralize Drugs (STAND)
- St. Mary's Dining Room
- Stockton Chamber of Commerce
- Stockton City Council
- Stockton Police Department
- The Amelia Ann Adams Whole Life Center
- Third City Coalition
- UC Cooperative Extension
- United Cerebral Palsy of San Joaquin County
- University of the Pacific
- Women's Center Youth and Family Services
- Wallach & Associates
Appendix B. CHIP Community Survey Results

**SURVEY OVERVIEW AND SAMPLING**
- Purpose: Community residents select top strategies to address CHINA priority health needs and identify one top priority health need
- Sample goal: Sample representative of county population – city of residence, ethnic breakdown; oversample communities of color
  - Target sample size of 2000
  - 8 multiple-choice items
  - Offered in English and Spanish
  - Administered by CBOs

**SURVEYS COLLECTED**
- # surveys received: 2546
  - Paper: 2111
  - Online: 435

**Geographic representation:**
- Stockton and Lodi samples exceed goals
- Tracy sample meets goal
- Manteca and rest of county below goals

**Ethnic representation:**
- Latino and Black samples exceed goals (oversampling was achieved)
- Asian sample meets goal

**SURVEY SAMPLE PROFILE**

**SAMPLE DEMOGRAPHICS: CITY OF RESIDENCE (% OF SAMPLE)**

```
<table>
<thead>
<tr>
<th>City</th>
<th>Stockton</th>
<th>Lodi</th>
<th>Tracy</th>
<th>Manteca</th>
<th>Escalon</th>
<th>Lathrop</th>
<th>Unincorporated</th>
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<tr>
<td></td>
<td>67</td>
<td>12</td>
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<td>3</td>
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Appendix C. 2019–2022 CHIP Matrix

OVERALL GOAL: HELP COMMUNITY MEMBERS OF ALL AGES AND ABILITIES GET MORE PHYSICAL ACTIVITY, INCLUDING PROGRAMS THAT MEET LANGUAGE AND CULTURAL NEEDS

Outcome A: Enhanced implementation of at least one county code or policy* in at least four Priority Neighborhoods, pushing funding toward environmental and programmatic improvements to support safe routes to parks and active transportation in the Priority Neighborhoods

Key Strategy A: Implement existing health-related language promoting safe routes to parks and active transportation in General Plans, Design Standards, Zoning Codes and related ordinances

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Activities</th>
<th>Measures</th>
<th>Responsible Organizations</th>
<th>Partners</th>
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</thead>
<tbody>
<tr>
<td>Jul–Dec 2019</td>
<td>A1 Develop process and criteria to select Priority Neighborhoods/parks that will be focus of interventions</td>
<td>Environmental/programmatic improvements made in selected Priority Neighborhoods</td>
<td>• CBOs/non-profits in the Priority Neighborhoods</td>
<td>• Priority Neighborhood community members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Funding/resources allocated to safe routes to parks/active transportation in selected Priority Neighborhoods</td>
<td>• Public Health Services</td>
<td>• City governments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• City/County Planning and Public Works Departments</td>
<td>• Council of Governments</td>
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<td>• Trust Builders</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Schools in the Priority Neighborhoods</td>
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<td>• Faith-based organizations, Catholic Charities</td>
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<td>• Departments of Parks &amp; Recreation</td>
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<td>• Bicycle Coalitions</td>
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<td>• Local elected officials</td>
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<td>• Community centers/senior programs</td>
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<td></td>
<td>• Transportation partners</td>
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<tr>
<td>Plan: Jul–Dec 2019</td>
<td>A2 Conduct community engagement process in selected Priority Neighborhoods to identify community members’ top safe routes/active transportation improvements:</td>
<td></td>
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<tr>
<td>Implement: Jan–Jun 2020</td>
<td>• Connect with existing organizations working in the Priority Neighborhoods to engage community members/build volunteer base</td>
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<td></td>
<td>• Assist selected Priority neighborhoods to form committees/neighborhood councils to address safe routes/active transportation county code/policy implementation</td>
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<td></td>
<td>• Recruit, train and engage community members in selected Priority Neighborhoods on advocacy and leadership</td>
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<td></td>
<td>• Provide translation/interpretation services to ensure voices of diverse community members are heard</td>
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<td>• Identify 1–2 safe routes to parks/active transportation priorities to advocate for</td>
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<td>• Incorporate education on importance of physical activity into community engagement strategy</td>
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<tr>
<td>Jul 2020–ongoing</td>
<td>A3 Engage community members and organizations to advocate for equitable policy/code implementation for priorities</td>
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<tr>
<td>Jul 2020–ongoing</td>
<td>A4 Support City/County officials to seek funding for prioritized improvements</td>
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</tbody>
</table>

*Code/policy implemented will be selected based on community member identification of Priority Neighborhood needs; may be the same or different code/policy in each Priority Neighborhood
OVERALL GOAL: HELP COMMUNITY MEMBERS OF ALL AGES AND ABILITIES GET MORE PHYSICAL ACTIVITY, INCLUDING PROGRAMS THAT MEET LANGUAGE AND CULTURAL NEEDS

Outcome B: A minimum of one new or improved place/opportunity for physical activity in at least four Priority Neighborhoods

Key Strategy B: Park activation to increase park safety and encourage increased use by community members of all ages and abilities

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Activities</th>
<th>Measures</th>
<th>Responsible Organizations</th>
<th>Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul–Dec 2019</td>
<td>B1 Develop process and criteria to select Priority Neighborhoods/parks for interventions</td>
<td>Joint use policies cover selected Priority Neighborhoods and selected Priority Neighborhood schools have active joint use agreements</td>
<td>• County/City Parks and Recreation Departments</td>
<td>• Priority Neighborhood community members</td>
</tr>
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<td></td>
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<td>New/expanded programming in selected Priority Neighborhoods</td>
<td>• School districts and schools</td>
<td>• Office of Violence and Injury Prevention</td>
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<td></td>
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<td>Youth from selected Priority Neighborhoods enrolled in programs/athletic leagues</td>
<td>• CBOs/non-profits in the Priority Neighborhoods</td>
<td>• County Public Works Department</td>
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<td>Park improvements (e.g. new/repaired equipment or infrastructure) or beautifications (e.g. trash cleaned up, landscaping refreshed, benches painted) in selected Priority Neighborhoods</td>
<td>• YMCA and other youth programming providers</td>
<td>• Public Health Services</td>
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<tr>
<td></td>
<td>B2 Assess selected Priority Neighborhood joint use policies/agreements, parks and city park plans to identify needs/gaps and inform community engagement</td>
<td></td>
<td>• Youth sports leagues</td>
<td>• Health care providers, hospitals, clinics</td>
</tr>
<tr>
<td>Jan 2021–ongoing</td>
<td>B3 Joint use • Engage parents, youth and community members in selected Priority Neighborhoods to work for joint use policy adoption among school districts and parks and recreation departments • Provide community members training on advocacy and leadership • Public agencies/community organizations provide technical assistance and expertise for developing policy language • Work to activate joint use agreements in selected Priority Neighborhoods</td>
<td></td>
<td>• County Sherriff</td>
<td>• Council of Governments</td>
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<tr>
<td></td>
<td>B4 Park programming/youth athletic leagues • Engage parents, youth and community members in selected Priority Neighborhoods to assess desired physical activity programming for different ages/abilities (use steps outlined in row A2 for community engagement) • Work with organizations providing physical activity programing to expand offerings to locations within selected Priority Neighborhoods • Provide free enrollment/equipment for Priority Neighborhood community members participating in physical activity programs • Employ community members and youth to staff programs</td>
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<td>• City police departments</td>
<td>• Trust Builders</td>
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<td>• Faith-based organizations</td>
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<td>• Local elected officials</td>
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<td>• Community centers/senior programs</td>
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<td>• Business sector</td>
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</tbody>
</table>
**OVERALL GOAL:** HELP COMMUNITY MEMBERS OF ALL AGES AND ABILITIES GET MORE PHYSICAL ACTIVITY, INCLUDING PROGRAMS THAT MEET LANGUAGE AND CULTURAL NEEDS

**Outcome B:** A minimum of one new or improved place/opportunity for physical activity in at least four Priority Neighborhoods

**Key Strategy B:** Park activation to increase park safety and encourage increased use by community members of all ages and abilities

<table>
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<th>Timeline</th>
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<th>Partners</th>
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</thead>
<tbody>
<tr>
<td>Jan 2020–ongoing</td>
<td><strong>B5</strong> Park improvement/beautification</td>
<td></td>
<td>Priority Neighborhoods</td>
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<td></td>
<td>• Conduct community engagement in selected Priority Neighborhoods to identify priorities for park improvement/beautification (use steps outlined in row A2 for community engagement) and build volunteer base</td>
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<td></td>
<td>• Guide park improvement processes with best practices and existing models/plans to serve all ages and abilities</td>
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<td>• Work with public safety officials to establish protocols to enhance safety</td>
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<td>• Engage local businesses to adopt parks, supporting improvements and beautification</td>
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<td>• Engage communities through events, volunteer days and skills training</td>
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<td>• Create and implement a sustainability plan to maintain park improvements and new/enhanced programming</td>
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### OVERALL GOAL: HELP COMMUNITY MEMBERS OF ALL AGES AND ABILITIES GET MORE PHYSICAL ACTIVITY, INCLUDING PROGRAMS THAT MEET LANGUAGE AND CULTURAL NEEDS

**Outcome C:** Increased Priority Neighborhood community member awareness of available parks/programming that promotes physical activity in at least four Priority Neighborhoods

**Key Strategy C:** Conduct effective, narrowly cast campaign to promote physical activity in selected Priority Neighborhoods that are the focus of improvements and new/enhanced programming

<table>
<thead>
<tr>
<th>Timeline</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Oct 2021– Dec 2022</td>
<td><strong>C1</strong> Develop and implement an evaluation to assess campaign impacts</td>
<td>Campaign activities conducted</td>
<td>• City Parks and Recreation Departments; Stockton Departments of Public Works and Libraries</td>
<td>Priority Neighborhood community members</td>
</tr>
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<td></td>
<td><strong>C2</strong> Conduct promotional events and engagement activities in selected Priority Neighborhoods to make community members of all ages and abilities aware of available parks and programming</td>
<td>Pre- and post-campaign community member surveys to assess changes in awareness of parks/physical activity programming</td>
<td>• First 5</td>
<td>Office of Violence and Injury Prevention</td>
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<td></td>
<td></td>
<td>Program enrollment</td>
<td>• Public Health Services</td>
<td>Reinvent South Stockton Coalition</td>
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<td>Observational studies of park use</td>
<td>• City visitor centers</td>
<td>City governments</td>
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<td>Local elected officials</td>
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<td>Jan–Dec 2022</td>
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<td>Community and cultural organizations</td>
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<td>Faith-based organizations</td>
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