

Community Benefits Needs Assessment in South Fresno



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The California Endowment and Fresno Building Healthy Communities commissioned this project to bring perspective from the urban south Fresno neighborhoods. In particular, BHC sought to better understand how community residents understand the health challenges captured by the Central California Hospital Council's health needs assessment. The California Endowment contracted with the Central Valley Health Policy Institute (CVHPI) at Fresno State to train Building Healthy Communities to collect data and to analyze and report the findings. This report is the findings of 8 focus groups of 100 participants who were residents of South Fresno. The findings have been reported back to the participants, who will also take part in a larger community even that reports on the findings. We would also like to acknowledge the contribution of many CVHPI staff including: Yesenia Silva, Jacqueline Cortez, Guadalupe Corona and Karina Corona.

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INTRODUCTION

The nine not-for-profit community medical centers in the four-county central San Joaquin Valley region recently completed a Community Health Needs Assessment to identify the health status and needs of residents in the regions they serve. Over the next several years, each of these hospitals will initiate community benefit activities based on the priorities emerging from the assessment. The broad array of potential actions related to these priorities and the competing forces shaping hospital community engagement create daunting challenges for planning. Decision-making can be facilitated by understanding the perspectives of low-income and underserved urban residents about how hospitals can best address population health improvements. In this report, the Central Valley Health Policy Institute at Fresno State share the findings of focused group interviews with residents of south Fresno neighborhoods. Based on these data, the report describes a number of potentially cost-effective, patient-centered and culturally responsive community benefit investments to further the health of Fresno residents.

Background: Non-profit Hospital Community Benefits

The majority of hospitals in the United States operate as nonprofit organizations and, as such, are exempt from most federal, state, and local taxes. State and federal law require hospitals to earn this favored tax status by investing in the health of their communities, known as the “community benefit” obligation. In 1969, the Internal Revenue Service (IRS) extended hospitals’ community benefit obligations from their own patients to the “community as a whole”; since 2009, the IRS has required all nonprofit hospitals to report their community benefit expenditures on a “Schedule H” worksheet. This worksheet, which is appended to the Form 990 that all tax-exempt organizations must file annually with the IRS, effectively creates a publicly accessible, facility-specific, nationwide reporting system that enables an assessment of how individual hospital community benefit investments are linked to

community needs identified in Community Health Network Areas¹ and it provides a singular opportunity to compare hospital investments geographically and (when merged with other data) by other variables such as size, location, and patient mix. It also raises important questions for state policy makers and health professionals.

Schedule H expressly delineates certain types of activities that are considered a community benefit, such as (1) provision of “financial assistance” consisting of “free or discounted health services provided to persons who meet the organization’s criteria for financial assistance and are unable to pay for all or a portion of the services”; (2) hospital costs in connection with hospital participation in Medicaid and other means-tested entitlement programs; and (3) multiple subcategories of activities, including “community health improvement” services, defined as “activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services.”

The IRS recognizes evidence-based “community building” activities as a community benefit. These activities represent an important set of federally recognized activities because they rest squarely on the social conditions of health, such as physical improvements and housing, economic development, community support, environmental improvements, leadership development, and training for community members, among others.

The IRS also draws a clear delineation between what it considers community benefits, as described above, and how it treats bad debt and losses associated with hospitals’ Medicare participation. Neither is considered a community benefit under federal law. The IRS expressly defines “bad debt” as “uncollectible charges that the organization recorded as revenue but wrote off due to a patient’s failure

¹ coalitions of public, nonprofit and private sectors working together to build healthier communities through community-based prevention planning and health promotion.

to pay.” California law, on the other hand, allows hospitals to count charity care, discounted care and costs of government programs as community benefit expenses; bad debt is not included, nor explicitly excluded.

Public controversy over whether nonprofit hospitals provided community benefits sufficient to justify their favored tax status gave rise to Congressional scrutiny during 2005–09 and culminated in the inclusion of new community benefit requirements in the Affordable Care Act (ACA). Among other reforms, the ACA requires that nonprofit hospitals conduct community health needs assessments (CHNAs) and develop implementation strategies that clearly tie hospital investments to community needs. In the current healthcare access context where ACA is in question, it is imperative that community benefits beyond charity care are at the forefront of investments to improve health and wellbeing.

Central California Community Health Needs Assessment 2015-2016

A Community Health Needs Assessment (CHNA) is a guiding document for spending community benefit funds. Stoto and Smith (2015) explain the critical function the CHNA performs in ensuring hospitals’ community benefit spending actually improves community health: “all not-for-profit hospitals are required to work with public health agencies and other organizations to conduct a CHNA at least every three years and adopt an implementation strategy describing how identified needs will be addressed (Rosenbaum, 2013). By aligning and leveraging the efforts and resources of the health care delivery sector, public health agencies, and other community organizations, the new CHNA requirements create a shared interest in improving population health (Stoto, 2013).” A CHNA must draw widely on newly-available data relating to environmental, economic, and educational factors that may affect community health, and must solicit input from historically marginalized populations as well as from public health professionals.

Nine nonprofit Medical Centers serving the four County region of Central California participated in the 2015-2016 Central California Hospital Council's community health needs assessment (CHNA):

1. Community Medical Centers, which operates four hospitals — Community Regional Medical Center, Clovis Community Medical Center, Fresno Heart & Surgical Hospital and Community Behavioral Health Center — as well as several long-term care, outpatient, and other health care facilities.
2. Adventist Health Central Valley Network, which operates more than 60 sites in Kings, Tulare, Kern and southern Fresno counties, including four hospitals: Adventist Medical Center – Hanford, Adventist Medical Center – Selma, Adventist Medical Center – Reedley, and Central Valley General Hospital in Hanford.
3. Children's Hospital Central California serves as the only pediatric hospital in Central California. Its service area extends from Modesto in the north to Bakersfield in the south and covers 9 counties—Fresno, Kern, Kings, Madera, Mariposa, Merced, Stanislaus, San Luis Obispo, and Tulare.
4. Kaiser Permanente Fresno Medical Center is a general medical and surgical hospital. Kaiser Foundation Hospital Fresno Service Area includes eastern Fresno County, most of Madera County, northeast Kings County, and northwest Tulare County.
5. Serving Tulare County are the Kaweah Delta Health Care District's Tulare Regional Medical Center located in Tulare County.
6. Madera Community Hospital serves Madera County residents, and also operates two rural health care clinics and a home health agency.
7. Coalinga Regional Medical Center
8. Sierra View District Hospital serves the Southern Sequoia region of California's Central Valley.
9. St. Agnes Medical Center (SAMC) is a general medical and surgical hospital located in Fresno

and serves Fresno, Madera, Kings, and Tulare counties.

The 2015-2016 effort included quantitative and qualitative analysis of multiple data sources, and used both a survey and focus groups to identify priorities for action. The Hospital Council's consultant originally intended to conduct only two focus groups, both scheduled for far North Fresno during the middle of a workday; promotional materials did not mention interpreter services. Community groups gave feedback about the obstacles Fresno residents faced to participate, from language access to getting transportation to attend focus groups. In response to these objections, the consultant organized one additional focus group in a downtown Fresno location. Survey methodology did not appear to have been tested for reliability or language and translation accuracy. Further, the survey questions were heavily focused on individual behaviors and did not inquire about structural barriers to healthy living, environmental contributors to illness/disease, or other social determinants of health.

Despite these methodological questions, the Hospital Council's CHNA yielded an impressively coherent set of quantitative and qualitative findings and identified multiple priorities for action. At the top of the list were the following 5 barriers to individual and population health for the hospitals to address through community benefits spending: 1) Access to care, 2) Breathing Problems (asthma), 3) Diabetes, 4) Mental Health, and 5) Obesity.

In reviewing the CHNA process and results, Fresno Building Healthy Communities (BHC), came to believe that the overall priorities were an adequate reflection of community needs, but that there was a dire need to bring perspective from the urban south Fresno low-income and primarily people of color neighborhoods. In particular, BHC sought to better understand how community residents understand the health challenges captured by these five priorities and their recommendations about actions that medical centers could take to address these challenges. BHC contracted with the Central Valley Health Policy Institute (CVHPI) at Fresno State to conduct a series of focus groups with BHC residents. The purpose of these focus groups was to: 1) ascertain the needs and barriers to health and wellbeing of the residents living in Southwest and Central Fresno; 2) hear from the residents how to best address their needs and

overcome the barriers to health and wellbeing; and 3) provide a data-based perspective on the adequacy of the Hospital Council's 2015 CHNA. Armed with this deeper understanding of the community's needs, community members can knowledgeably support hospitals' appropriate community benefits expenditures, and advocate where necessary to refocus hospitals' initiatives to address social determinants of health as "health needs."

METHODS

The Central Valley Health Policy Institute trained BHC team leaders on focus group protocol and data collection. With input from BHC team leaders, a focus group questionnaire guide was developed by CVHPI. Each focus group was facilitated by BHC team leaders with a note taker and a recorder. Eight focus groups were convened from November 5, 2016 to December 16, 2016. Focus group participants represented the Fresno BHC Place in language, ethnicity, and age, ensuring substantial representation of historically marginalized populations. Focus groups demographics included youth, adult African American, adult Latino, and adult Hmong groups who resided in Southwest, Southeast, and Central Fresno. Focus groups were conducted in English, Spanish and Hmong. A total of 100 residents were involved in the focus groups.

The health priorities from the Hospital Council's CHNA were also introduced to the groups and they were encouraged to engage in thinking about how these priorities can be addressed in their community. CVHPI conducted a qualitative analysis using codes and themes. Experiences from participants were quoted to support themes and recommendations.

RESULTS

ACCESS TO CARE

THE STORY OF DELAYED CARE

“Sometimes it’s much easier to call 911 in order to see the physician instead of waiting for [an] appointment” Hmong Focus Group Participant

Access to care is the ability to be able to get health care that is needed in a timely manner to achieve the best health outcomes (Healthy People 2020, 2015). Focus group participants reported an inability to access care due to the traditional barriers such as cost, language, and lack of insurance. Most focus groups identified the lack of timely care as the most common barrier to accessing care. This is a complex issue tied to availability of providers with resources available, shortage of providers in or around their neighborhoods, and the long wait times while at the doctor. The consequence of this fractured and wanting health system is that people do not get the preventative care they need, and the delays and shortage of care leaves the doctor-patient interaction prime for a breakdown in communication, thus further diminishing the quality of care.

Long waits to get an appointment

Participants in all focus groups identified long waits as the primary barrier to seeking care. When people needed care such as a routine check-up, the nearest appointment was at least a month away, and can be up to three months away. This is from people who have already determined they have sufficient resources to access care, such as through health insurance coverage, such as Medi-Cal or paying a sliding fee scale at a Federally Health Qualified Clinic. For those who do not have the resources, there is only one option for medical care: the emergency room.

“People go into ER who don’t need ER care, but don’t have insurance so they can only get ER services”
-Southwest Focus Group Participant

The narrative in all of the focus groups, regardless of insurance status, is that participants delay care as long as possible. The issue is not only money, rather, the expected barriers they will have to face. For those who can access care but choose to wait, they cite long wait times to see a doctor. The inability

to see a doctor in a timely manner for a time-sensitive issue is perceived as equivalent to not being able to see a doctor at all. As one Southwest focus group participant notes, “people [who are] sick and can’t get to the doctor but have insurance, they go to the ER.” The inability to get a timely appointment is an important and often overlooked finding. Every demographic of the focus groups identified a delay of care, and several pointed out having to wait as much as three months for a basic care visit with a doctor.

For those needing to see a specialist, this wait becomes even longer. Many pointed to circumventing their primary provider when they were directly able to access specialist care. For those who could not circumvent a primary provider, seeing a specialist became the most challenging aspect of getting care. The primary provider is not perceived as an ally in helping participants get the care they need, rather, they are the gatekeepers. Once a provider has agreed to refer a patient to a specialist, focus group participants noted that many specialties are not available locally, leaving them with an additional barrier of finding the resources to travel.

The poor people’s doctor appointment: lack of transportation, rude service, and long waits

“..had to buy and pay for assisted transportation services to the MD—a lot of the cab companies don’t accept these—end up being worthless” Southwest Focus Group Participant

Getting to an appointment may be taken for granted by many. However, in Southeast and Southwest Fresno there are numerous transportation issues that are unique to these communities. While living in a city with more than 20 routes of public transportation, much of that system is inaccessible to residents in these communities. These residents must resort to additional ways of finding transportation, including paying someone for a ride or taking costly cabs. Some programs have aimed at addressing these issues by offering special transportation service vouchers for doctors at a low cost, but as one participant noted, those are often worthless because cab companies will not accept them.

Experiencing bad treatment at the doctor’s office is an important factor in the care system for Latinos with health care access issues in the Central Valley (Pacheco, Ramirez, Capitman, 2012). Perceived discrimination often a consequence of larger policy level decisions that limit resources for those who need them. This bad treatment then results in patients experiencing care in a system that cannot

get them the complete care they need on time. This was pervasive for participants that were seeking primary care or emergency room services. One focus group sums up the experience expressed in most of the groups:

“Attitude of ER—fell and broke hand, no xray in ER, treated her as though she were there because she didn’t want to pay for services—by the time she got to specialist (delay of 2 weeks), specialist said hand already healing, no point in doing anything” -Southwest Focus Group Participant

Breakdown in communication: the sum of the barriers leads to inadequate (and sometimes dangerous) care

“They sent her to waiting room for 4 hours and miscarried and she was in pain and felt embarrassed ...she was told that she had to wait her turn. Waited 7 hours to and when the doctor saw her he automatically discharged her, gave her a pill and that was it.” Southeast Focus Group Participant

Continuity of care is also part of the breakdown that happens in health care for participants. Being able to visit the same provider over time is crucial. For those who can only get emergency Medi-Cal, the gap between eligibility can come at a crucial time for care. One focus group participant discussed a case of a woman who received breast cancer screening and monitoring while pregnant, but that care ended with her pregnancy eligibility.

“She felt some small bumps on her breast. The provider checked and referred her to a specialist for a mammogram. After the pregnancy they didn’t want to provide services to her because she did not have Medi-Cal...at the beginning they provide health [care] then it is stopped”

While the financial case for not providing care after insurance is there, county systems must ensure continuity of care whenever possible for patients who do not qualify for medical insurance through the county’s safety net system.

Lack of continuity of care is at best inconvenient and at worst life threatening. One participant recalled that she kept seeing different doctors for a cough that was repeatedly dismissed. When she requested to see a resident at the health center, the doctor doing his residency found that the patient was allergic to the medication she had been prescribed, and quickly prescribed another. The lack of continuity of care, along with other barriers in communication with health providers left focus group participants

feeling unheard. In the end, the care experience may feel unfinished, as in the case of one participant from the Calwa focus group:

“My child’s pediatrician says that all the health concerns that I notice are normal; that what my child is experiencing is normal. At the end of the appointment I still have the same concerns and no answers”

GETTING ACCESSIBLE CARE: PARTICIPANTS PAVE PATH TO CARE THEY CAN ACTUALLY USE

Focus groups presented numerous challenges to getting the care they need. However, they also knew there were better ways to access care based on past personal experiences or experiences of people they knew. In addition, participants were asked to frame their solutions under what they saw the purview of community benefits could do. It was made clear that while community benefits models could not solve all health problems in a community, they could leverage resources in ways that were responsive to existing community needs in creative and also evidence-based ways.

Patients at the Margins

Many focus groups identified their own position of race, class, and health insurance coverage as the reason for receiving for subpar care. It is therefore crucial that healthcare providers spend considerable amount of time and resources in knowing what care and services these patients need to receive, as well as generally being represented at the services level. On one hand, as one Hmong focus group participant noted, the marginalization may come from self-censoring:

Hmong elders who go to the hospital, if they feel that they are causing a nuisance or trouble for the hospital then they may feel that they don't want to start any problems and may not ask/demand for resources that they need.

Nevertheless, participants also identified lack of competent translation services and poor treatment because of their race when attempting to seek care.

Most focus groups identified the need for more affordable healthcare as a strong need. They had concrete solutions as to how to get more affordable health care in innovative ways that seek to have more access to what is already available. For example, participants wanted to be made aware of all financial

options available to them. In addition, they suggested access to more localized health care to answer basic questions about their health. As a Southwest focus group participant put it, somewhere where people do not necessarily get health care, but “where you could go in and sit down and talk about your problem, actually listen to you and try to answer your question or...find someone who can help you.”

Accessibility by proximity: The need for local health education centers

The need for neighborhood centered, neighborhood based health education and infrastructure was persistent in all focus groups, across various issues discussed. Whether talking about access to care, obesity, diabetes, or mental health, focus groups identified the need to have readily accessible permanent places that could help them in achieving a healthier lifestyle. One focus group identified that “clinics should be built within [the] neighborhood. It could be in the schools available to all the community.”

Participants identified the need for wellness centers near them that are not dependent on just one program. For example, one Latino focus group stated that such a center should have doctors there weekly. A Southwest focus participant group even identified where the center could be located:

“...Maybe over by the new library—where you could go in and sit down and talk about your problem, where someone could actually listen to you and try to answer your question or direct you to help you find someone who can help you.”

The idea of wellness centers extends not only to places where participants receive health information, but also where they are able to participate in group physical activity, access health-related materials and information in their own language, as well as learn about nutrition, food resources, healthy eating and cooking information. This finding speaks to the community’s own willingness to bring an innovative solution to the larger access to care and city infrastructure issues that community benefits has the potential to support.

Top 5 Priorities for health care Access

Table 1 is a list of the top five priorities that were presented by participants as crucial access to care solutions that hospital community benefits could support.

Table 1. Summary of Suggested Use of Community Benefits for Access to Care

<p>1) The need for consistent, local contact with health providers is a theme identified by all focus groups. This was a consistent need across health care topics, whether discussing asthma or diabetes. The need for increased neighborhood access to care is crucial to participants.</p>	<p>Health Care Coverage</p> <ul style="list-style-type: none"> ● Health care access regardless of income or immigration status ● More preventive care access ● Share of cost programs <p>Health Centers</p> <ul style="list-style-type: none"> ● Extended provider hours ● Neighborhood wellness centers
<p>2) Better streamlining of services and personal contact that informs community members about where to go for help, what they qualify for, and someone to check in with about their health.</p>	<p>Navigation of the Health Care System</p> <ul style="list-style-type: none"> ● Information about how to navigate the health care system ● Information about how to set up an appointment ● How to research relevant and reliable information ● Eligibility awareness throughout the health care process (before appointment, when recommending treatment, after care) <p>Stigma</p> <ul style="list-style-type: none"> ● Decreasing stigma of patients who: use public health insurance, need language assistance, and/or receive care in an emergency room setting
<p>3) Continuity is seen as a path to better outcomes for participants as patients, and a key aspect to continuity is receiving care within their own community.</p>	<p>Elderly</p> <ul style="list-style-type: none"> ● Sensitive care for elderly patients <p>Youth</p> <ul style="list-style-type: none"> ● More health and wellness education for youth <p>Language</p> <ul style="list-style-type: none"> ● Language appropriate material <p>Cultural Humility</p> <ul style="list-style-type: none"> ● Staff that has been trained in cultural humility
<p>4) Accessibility to health care within neighborhoods or access to reliable transportation to appointments.</p>	<p>Transportation</p> <ul style="list-style-type: none"> ● Vans or vouchers to health providers
<p>5) Improved safety when accessing care</p>	<p>Safety</p> <ul style="list-style-type: none"> ● Safe settings at provider locations, as well as in the direct areas surrounding health care settings

The solutions identified in table 1 range from help with getting medical care to more investment

in disadvantaged communities. These communities lack the resources to travel beyond their neighborhoods for care and often do not receive information in a way that they can understand. There is also need for systematic training of doctors and staff on how to work with historically disadvantaged populations like those needing public assistance and racial/ethnic minorities. These identified solutions could be funded through community benefits models that extend beyond charity care.

OBESITY

Social engineering for an unhealthy lifestyle

There was an overwhelming consensus from the focus groups that their surrounding environments were not engineered or created for its local residents to engage in a healthy lifestyle. Structures that support health living include physical structures such as sidewalks and lighting, as well as local economic structures like grocery stores. Living an active life and eating nutritious food takes a combination of individual agency and structures that allows that agency to come to fruition. Agency is complex, and participants felt like sometimes they are brushed off as being not interested in their health when that is not the case. And while they have the agency to want to do better for themselves, they feel that there are no structures supporting their desires to attain their healthy lifestyle goals. Most focus groups reported that there are no healthy lifestyle structures in their neighborhoods. One Latino focus group participant noted, “Depending where we live with no stores just liquor stores, we are limited to our choices.” This lack of neighborhood structures is seen as a major barrier for healthy eating and physical activity.

Focus groups identified that they know this lack of structures is not a city-wide issue. In fact, several pointed to the disparate access to amenities of healthy living that they know exist in other places. Focus groups reported their lack of resources as having a direct impact on their health.

During the summer, we do like to go out and exercise. It would encourage us if we also had an environment and culture that encourages everyone in the community to go out and exercise. We would be more willing to go out there and be active if there is more people out there doing it.”

—Hmong Focus Group Participant

There was a sense from some participants that those who are crafting healthy neighborhoods do not care about them. Some mentioned that hospitals did not care about their health, only when they were sick. Others mentioned that when they would attempt to walk in their neighborhood they felt unsafe, and police were unresponsive to their needs. The unequal structures identified as barriers to achieving a healthy lifestyle are the in the same vein as those that produce barriers in access to care.

Healthy Food as Inaccessible Food

As health information and healthy food go hand and hand, a holistic approach to healthy food is needed. Participants of focus groups said that advertisements, and the type of food available in their neighborhoods was mostly junk food. In talking about the challenges to eating healthy, one Latino focus group participant noted, "...being able to easily access junk food/fast food. The advertisements draw you in." Others noted that fast food places were closer to them than grocery stores. At the end of the day, affordability is a key factor to food accessibility. Some noted that living paycheck to paycheck does not leave much room to experiment with new foods. One noted that the transportation cost to purchase healthy food was itself a deterrent, saying, "It can take multiple buses to get there."

Envisioning the Way to Healthier Neighborhoods

Focus groups see the path to a healthier community paved by the potential of community benefits money. This begins with systemic, culturally appropriate information that is readily available in the neighborhoods they live in about health and the important role it plays in the daily lives of community members. The youth focus group noted that holding healthy living community forums would begin to give people a sense of what should they should be eating and ways they can be healthier. Other groups gave similar suggestions in the way of resources fairs, mobile health information units, and navigators that could potentially help with questions. The overall sentiment was that if they knew that their neighborhoods did not look like those in which people are healthy, they needed to be transformed in order to make it easier to create a culture of healthy living.

Access to healthy eating leads to healthy living

Participants reported a variety of solutions to bring more food to their communities. Since the fundamental problem for many is that healthy food is not attainable in their current built environment, focus groups identified ways to have the food be brought to them. In order to address the mobility issues due to lack of transportation for all and mobility issues of elders, one Hmong focus group participant had the following idea:

“What may help is if groceries can be delivered to people's home. Hospitals should give stipends to grocery delivery businesses that our residents can receive delivered healthy foods”

In addition, others thought that hospitals could help by “sponsoring healthy food giveaways.” The African American focus group thought that hospitals could also help bring food to their community that was “affordable organic food that’s not [filled] with all these chemicals and stuff.”

The need for a systemic solution to healthier food options is crucial for sustainability. One-off food giveaway programs that rely solely on volunteers can only last as long as there are those who can help. In addition, funding for more comprehensive programs that do anything more than provide food giveaways are often short term. One Latino focus group noted that “programs like WIC help because they give only healthy food and tips on how to cook and prepare them.” However, the lack of universal access to WIC gives only those with small children access to this information.

Community that promotes activity

Achieving a healthy lifestyle takes a village. Focus groups saw the role of community benefits as interjecting where perhaps more traditional frameworks would utilize local government and school systems as the leaders. There was a strong sense from focus groups including the youth, Hmong, Latino and African American focus groups that spaces for physical activity, like gyms, could be of great help. Youth said they were too expensive, and others reported them being currently inaccessible. However, youth also noted that community benefits could provide equipment for recreational programs at their local parks.

One Hmong participant noted that gyms have the potential to be actual prescriptions for health

that make a difference. The participant said, “My father was able to use his Medi-Cal to get access to a Gym for certain hours of time. This helps.” A Latino focus group also proposed the idea of hospitals giving free gym memberships to community. There is a strong sense that reimagining their community spaces can lead to more physical activity, and that in other places like Clovis, investment leads to making physical activity more desirable:

“The Clovis bike lane has a trail and exercise equipment. Maybe if we have safe nice trails with adult workout equipment, more people might be active.” -Hmong Focus Group Participant

Age Appropriate Spaces for Healthy Living

Half of the focus groups reported that elders have unique needs when it comes to living a healthy lifestyle. Their mobility and language issues limit them to places of close proximity for both physical activity and grocery shopping. The African American focus group noted that some of the school-based activities do not take into account that older residents may not feel welcome. When it comes to spaces for older people, there was a need for their structure to be more socially oriented. A participant shared: “Be more social. Have access to green spaces where people can spend time together.” However, one Hmong focus group noted the need to have age appropriate physical activity for people of all ages:

“Parks are mostly made for children and not make for elders/adults -- we would like to see parks with exercise equipment for kids and adults -- this might make us want to visit the park more.”

Top 5 Priorities for Obesity and Physical Activity:

Table 2 is a list of the top five priorities that focus groups thought hospital community benefits could play a role in helping to solve. On the left hand side are the overall systemic synthesized goals from all of the data and on the right column are specific examples identified in the focus groups.

Table 2. Summary of Suggested Use of Community Benefits for Obesity

<p>1) Better community access to safe parks to support physical activity for community members of all ages</p>	<p>Revitalize and Invest in Parks</p> <ul style="list-style-type: none"> ● Invest in infrastructure of parks such as equipment, fitness programs, and maintenance ● Walking trails <p>Age-Friendly Exercise Spaces</p> <ul style="list-style-type: none"> ● Exercises spaces for the elderly
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<p>2) Increased local access to affordable, healthy foods that communities know how to use</p>	<p>Cooking Classes</p> <ul style="list-style-type: none"> ● Recipe-based cooking classes with a focus on nutrition
<p>3) Systemic, local, culturally and age appropriate physical activity programming in groups</p>	<p>Inclusive Fitness Program</p> <ul style="list-style-type: none"> ● Cultural exercise Programs ● Exercise programs for mothers and children ● Structural activities that include the entire community <p>Collective Physical Activities</p> <ul style="list-style-type: none"> ● Opportunities for physical activities in groups ● Zumba Activities
<p>4) Wellness-based nutrition education that is systemic, local, culturally and age appropriate</p>	<p>Nutritionist for Parents and Children</p> <ul style="list-style-type: none"> ● Bilingual ● Provide information to parents and children ● Funding <p>Collective Education</p> <ul style="list-style-type: none"> ● Community meetings
<p>5) Strong partnerships between communities, schools, and hospitals to provide better nutrition and physical activity opportunities for children</p>	<p>Partnerships with Schools</p> <ul style="list-style-type: none"> ● Healthy food for schools ● Create afterschool programs ● Programs that encourage families to walk together, in which children receive physical education credit for it ● Increase safety around schools so children feel they have a safe place to walk <p>Partnerships with Hospitals</p> <ul style="list-style-type: none"> ● Space where the hospitals can learn about community health education needs ● Gym memberships sponsored by hospital <p>Access to Exercise Areas within Neighborhoods</p> <ul style="list-style-type: none"> ● Public access to green spaces in schools ● Increased fitness opportunities and supporting infrastructure in parks ● Afterschool programs ● Exercise equipment at the West Fresno Family Resource Center ●

	<p>Inclusion of Exercise in Schools</p> <ul style="list-style-type: none"> ● Exercise before exams
Other priorities	<p>Incentives to go to the hospital</p> <ul style="list-style-type: none"> ● Food access ● Mobile food unit ● More water fountains

DIABETES

Diabetes is an epidemic in Fresno County, and Latinos, African American, and Hmong residents feel the impact the most (CDC 2015). Management of diabetes is one of the biggest challenges for this population. The aforementioned access to care is an issue for late diagnosis, but also in terms of management. Focus groups identified feeling like the management resources available for people in their community are limited, education resources are not widely available, and that there are particular segments of their community that fall through the cracks and do not get adequate treatment.

Limited services available

Focus groups reported that when it comes to diabetes, one of the principal challenges is getting access to consistent, accurate information about diabetes management. Many reported that diabetes diagnosis is difficult because there is a “lack of education” about what care resources are available. However, there are also prevention issues, such as knowledge about prevention resources about recognizing signs and symptoms of diabetes. Many of the previous themes around physical activity and access to healthy foods that were brought up during the obesity portion of the focus group also re-emerged during the diabetes discussion.

For those that do get to see the doctor, they experienced a lack of continuity of care. For example, one focus group participant in the Calwa focus group talked about only getting prevention information for diabetes when she was pregnant. Particularly, she got recommended to a nutritionist. She said that helped her and she was able to lose 40 pounds, but after her pregnancy she was longer longer referred to a nutritionist. Another participant recalled her neighbor not qualifying for Medi-Cal, and due to the fact that she could not afford her labs, her doctor was not willing to continue to see her. The

participant reported the neighbor was very worried about having diabetes and not being able to get checked.

Accessible resources essential for management

Since one of the key issues to prevention and management is information, focus groups reported several systematic ways in which hospital community benefits could help people in their community. Many of the previous themes of solutions were echoed in this section of the focus group discussion. These included localized, age-appropriate centers were people like seniors, and those with diabetes could receive information about setting up doctor appointments, nutrition education, and information on resources available for help. One Hmong focus group participant noted that from her previous experience, she had seen this work:

“In Minnesota, we have a Hmong charter school that has a health clinic that helps young people to learn about diabetes and healthy nutrition.”

Focus group participants noted structural ways their neighborhoods could change to help them better manage their diabetes and prevent diabetes for children. These included better nutrition programming and access to healthier food in their neighborhood. They noted more for physical activity that were accessible and safe could also lead them to do more physical activity which they knew helped them manage diabetes better.

Top 5 Priorities for Diabetes:

Table 3 outlines the changes suggested by participants that hospital community benefits could invest in to improve diabetes prevention and management for people in their neighborhoods. They pinpointed systemic changes to diabetes education that is responsive to their cultural and systemic barriers. They not only want education in their language, but also physically accessible to them. In addition, they would like to close the gap between what doctors prescribe to them for prevention and management and what they actually have access to in their neighborhood. Investments in safe accessible places to exercise are needed as well as access to healthy food in their community.

Table 3. Summary of Suggested Use of Community Benefits for Diabetes

<p>1) Diabetes education that is local, systemic, language, age, and culturally appropriate</p>	<p>Education</p> <ul style="list-style-type: none"> ● Preventive education tailored for children, adults and pregnant women ● Culturally-gearred classes ● Exercise and Food <p>Nutritionist</p> <ul style="list-style-type: none"> ● Bilingual and community oriented ● Nutrition classes for children, adults and pregnant women
<p>2) Local center where residents can receive prompt diabetes management information</p>	<p>Clear and Direct Information</p> <ul style="list-style-type: none"> ● Resources available for diabetes management ● Available programs for treatment and management ● Contact person for programs and services <p>Locally Available Health Care</p> <ul style="list-style-type: none"> ● Mobile Units
<p>3) Streamlining available resource and programming information</p>	<p>Capitalization of Established Communication Pathways</p> <ul style="list-style-type: none"> ● Broadcasted in Hmong and Spanish speaking networks ● Integrated in school system
<p>4) Safe and accessible places for physical activity</p>	<p>Clean and Safe Exercise Areas</p> <ul style="list-style-type: none"> ● Increased lighting ● Free from animals, such as stray dogs ● Access to walking trails ● Located within their neighborhood ● Fitness equipment on trails
<p>5) Low-cost/no-cost access to healthy food</p>	<p>Access to food</p> <ul style="list-style-type: none"> ● Fresh fruits and vegetable available within communities
<p>6) Other priorities</p>	<p>Health Coverage and Access for All</p> <ul style="list-style-type: none"> ● Health care for individuals with and without health insurance <p>Reach Out to Patients</p> <ul style="list-style-type: none"> ● Appointment reminders <p>Transportation</p> <ul style="list-style-type: none"> ● Bus passes for patients

ASTHMA

Fresno County faces a very unique challenge in the nation when it comes to pollution. There are a combination of factors that make our air quality poor, some which are outside of the local control, and some that are exacerbated by inequalities in exposure to health hazards (CVHPI, 2014). While focus groups reported challenges that are shared by many Fresnans, like access to information about asthma, and general air exposure information, they also pointed to unique challenges given where they live such as industrial pollution and vehicle idling at schools. Focus groups identified similar challenges to accessing care for asthma that were mentioned when asked about diabetes and obesity.

Lack of management of outdoor pollution

When asked about what the main source of asthma was in the neighborhood, a Calwa participant replied, “the big *fabricas*,” the factories. Focus groups agreed that when they step outside their house, they are faced with uncertainty about what they will be exposed to, and do not have enough support to mitigate the exposure factors. For example, one Southwest Focus group participant noted that buses outside of Edison High School make the pollution so bad in that neighborhood throughout the week that it feels “like you’re sitting in the middle of the blowback from the buses.” In addition, focus groups highlighted secondhand smoking, nearby freeways, trash burning, and overall heavy air pollution as examples of things that cause breathing problems in their neighborhoods.

Lack of adequate medical prevention (diagnosis, correct treatment)

Focus groups stressed that prevention is difficult because of access to care and information. For example, the Hmong focus group identified that many times people in their community do not “understand signs, symptoms, and long term effects on their health.” Others said they do not get consistent, accurate information on treatment options for breathing problems. One Southeast focus group participant said, “Hospitals don’t treat people, they send them away to a different hospital.” In addition, once people in the community do get care, they do not always have sufficient information to follow through with care.

“My father received an inhaler and he didn't know what it was for” – Hmong Group Participant

Building a neighborhood that is breathable

Participants identified several strategies that hospitals can use to help mitigate the effects of air pollution on individuals living in their neighborhoods. Those in Southwest Fresno thought that education should be localized in their neighborhood to make it more accessible. Other focus groups also talked about localized information on prevention through resource centers where they could get information on what programs were available both for clinical care, air pollution reduction, such as buying or fixing vehicles, smoking laws, and housing and industry codes. In addition, several focus groups established the need to have more access to doctors, pharmacists, and clinics that could answer questions and treat patients that have challenges to accessing care.

Top 5 Priorities for Asthma:

Table 4 summarizes asthma solutions that hospitals can invest in that communities in South Fresno think would be priorities in their communities. The first is a streamlined and localized way to have education on asthma and breathing problems in general, both from an education outreach perspective but also follow up management help after receiving care. Something that all of the focus groups clearly identified was the need to have a broader conversation and investment into what outside polluters are making breathing more difficult for their community. These broader efforts having to do with regulations and neighborhood infrastructure may need broader hospital-government partnerships to accomplish improvements in air quality.

Table 4. Summary of Suggested use of Community Benefits for Asthma

<p>1) Systemic, streamlined asthma information on prevention, diagnostics, and management</p>	<p>Education</p> <ul style="list-style-type: none"> ● Information on what asthma is, how to recognize and treat it, as well as its symptoms ● The effects of secondhand smoke
<p>2) Cultural and language appropriate staff and resources on asthma symptoms, health care, and management</p>	<p>Language Appropriate and Accurate Information</p> <ul style="list-style-type: none"> ● Available in multiple languages, including Hmong and Spanish ● Should be broadcasted across various networks, including existing Hmong and

	<ul style="list-style-type: none"> Spanish networks ● Resource availability list ● Trained staff to provide information ● Training for doctors
3) Improved neighborhood infrastructure that reduces air pollution	<p>Neighborhood Regulations</p> <ul style="list-style-type: none"> ● Enforce laws on burning refuse ● Enforce laws on wood burning ● Ensure that community members do not throw trash on streets or in alleys ● Secure open alleys with key access to decrease dumping
4) Regulatory bodies to ensure: 1) patients are able to access insurance coverage for needed care and; 2) automobile emittances are more closely monitored	<p>Regulatory Oversight</p> <ul style="list-style-type: none"> ● Oversight to prevent insurance provider asthma-coverage discrimination <p>Regulation of Car Circulation</p> <ul style="list-style-type: none"> ● Regulate car circulation in the city by license plate numbers. For example: the “Hoy No Circula,” Mexico City’s program
5) Home improvement subsidies and policy changes that would reduce indoor and outdoor pollution sources	<p>Improvements in Home Environments</p> <ul style="list-style-type: none"> ● Programs to access home-equipment that decreases pollution ● Access to humidifiers <p>Energy Efficient Products</p> <ul style="list-style-type: none"> ● Electric Heaters ● Solar Panels

MENTAL HEALTH

“A neighbor of ours has said that she feels depressed and I think that is because she is lonely”-Calwa
Focus Group Participant

When communities do not have infrastructure investments such as parks, public spaces, and accessible health prevention such as the classes and programs, social isolation is a key result of this neglect. Research has identified that this is especially true for communities of color such as Latinos and African Americans (Krivo, Washington, Peterson, Browning, Calder, & Kwan, 2013). Focus groups resoundingly agreed more mental health services in their communities are needed. While participants of focus groups did identify challenges and opportunities for community benefits investments in mental health, this complex issue filled with stigma needs specific, culturally appropriate conversations that are given more time than the focus groups could give the topic given time constraints.

Focus groups reported a deep deficit in services that people in their community can access due to

language, availability, and transportation. They also felt like affordability of mental health care was an issue. One Southeast focus group captured this sentiment that resonated in other focus groups about being left with few options for care, “Insurances aren’t helping, not enough practitioners, [there is] not enough mental health [care].” Some felt like medicating was not enough to treat long term. In addition, there is a blame culture when it comes to mental health in the care community, as well as a lack of adequate assessment of individuals with mental health issues.

Top 5 Priorities for Mental Health:

Table 5 shows the solutions identified by focus groups that hospitals could adopt when dealing with mental health access and care challenges in Fresno. As the Calwa focus group said, there needs to be more availability at the local level, that are “Community centers for the elder, children and parents.” Due to the feeling of isolation and that insurances and providers are not always on their side or prioritizing prevention over medication treatment, some pointed to the need for advocates to help them navigate the mental health service system. According to the Southwest focus group, this prevention approach could also be accomplished through “motivation, support groups, and stress management.”

Table 5. Summary of Suggested Use of Community Benefits for Mental Health

<p>1) Need for more direct mental health services that effectively respond to the economic, cultural, and linguistic challenges of the community</p>	<p>Available Interpreters</p> <ul style="list-style-type: none"> ● Information in all languages ● Language appropriate health education ● Bilingual educators who share information about health issues and diseases affecting the community, and how to prevent them ● Allow for interpreters (family or formal staff) to be present during the medical visit ● Improve translation services with providers <p>Education</p> <ul style="list-style-type: none"> ● Education packets about services. Available resources shared with community through radio, television, direct mail, and videos ● Information about mental health access points and options
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	<ul style="list-style-type: none"> ● Preventive treatment ● Nutrition management
2) Localized mental health services in existing infrastructures such as schools	<p>Care at Schools</p> <ul style="list-style-type: none"> ● Mental health professionals at schools <p>Exercise Integrated in Schools</p> <ul style="list-style-type: none"> ● Exercise classes at schools ● No-cost positive activity opportunities, such as exercise classes for youth in schools
3) Investment in infrastructure that makes access to services possible such as transportation and sliding-scale care	<p>Access</p> <ul style="list-style-type: none"> ● Extended office hours ● House calls, including the Hmong community ● Informal therapeutic groups ● Sliding-scale payment options ● Increase number of providers <p>Transportation</p> <ul style="list-style-type: none"> ● Free bus passes for patients
4) Investment in a strong mental health prevention model that begins at the schools	<p>Preventive Models at Schools</p> <ul style="list-style-type: none"> ● Early education about mental health ● Increase the number of afterschool programs
5) Patient navigators that provide culturally and linguistically appropriate information about how to access mental health services	<p>Health Care System Navigators</p> <ul style="list-style-type: none"> ● Provide community members with information about how to navigate the health care system both inside and outside of the medical site ● Education that enables agency for community and for individuals ● Informs patients about mental health care options ● Hmong health educators

Mapping the Way to Community Benefits that Works for Community

Building on the work of the Fresno hospitals' CHNA, focus groups were conducted with diverse 100 residents in south Fresno to explore perceptions and recommendations for action regarding the five top priorities areas: Access to Care, Diabetes, Obesity, Asthma (breathing problems) and Mental Health. Residents expressed a strong consensus. Race/ethnicity, class, language, location within Fresno, and health insurance coverage remain significant barriers to care and wellness. Community care and wellness could be improved through neighborhood-level access to culturally-responsive health care;

access to safe parks/other spaces with physical activities programming; family-based health education and self-care programming; culturally appropriate and inclusively targeted educational media; new models for community-supported healthy eating; and expansion of in-person health care system navigation.

It is important to note that those people who were looking for care and did not get it have many reasons, not just because they did not know the right place for care. Lack of getting care is also not solely due to a lack of efficiency among the existing Federally Qualified Health Clinics that are in the neighborhoods already. Rather, it is a complex issue that includes the fact that there are few care options in the neighborhoods of participants, and those FQHCs that are there have to take on most of the burden of care with limited resources. Taking bus rides that can take up to two hours is not a feasible option for many.

A summary of the common sense consensus reached among south-Fresno residents across the five priorities is found in Table six. The table shows that in each of the five hospital priority areas, residents believe that relatively simple and affordable changes in practice could improve their access to care, self- management and health outcomes. Although residents highlighted a number of social determinants of health and large scale infrastructure projects that would improve their lives, their focus was on highly feasible potential projects such as establishing a nursing presence within key locations within existing community centers, as well as developing organized self-management and health-improvement activities at these locations, where the family and community can come together, would address the broader neighborhood health access issues impacting south-Fresno residents.

Table 6. Summary of South-Fresno Resident Consensus across Priorities

Access to Care	Obesity	Diabetes	Asthma	Mental Health
Consistent, local contact with health providers is a theme	Local access to safe places for physical activity for all ages	Local, consistent/ongoing, language, age, and culturally appropriate diabetes education	Systemic, streamlined information on prevention, diagnosing, and asthma management	Mental health directly responding to the economic, cultural, and linguistic challenges of the community
Better streamlining of services and personal contact/Systems Navigation aides	Access to affordable, healthy food that community know how to use	Local center where residents can receive prompt information on diabetes management	Cultural and Language appropriate/responsive staff and resources on asthma	Local, accessible mental health services in existing infrastructures such as schools, community centers
Continuity is better care in their own community.	Systemic, local, culturally and age appropriate physical activity group programming	Streamlining and language/cultural tailoring of information on resources and programming available	Improved neighborhood infrastructure that reduces air pollution	Make access to services possible (transportation and sliding fee scale care)
Accessibility to health care in my own neighborhood or have a way to get there.	Local, consistent, culturally and age appropriate wellness education	Safe and accessible places for physical activity	Regulatory bodies ensure patients can get coverage and care they need and auto emissions are reduced	Develop a strong mental health prevention model that begins at the schools
Safely being able to access care	Inclusive partnerships to increase child nutrition and physical activity	Low-cost/no cost access to healthy food	Home improvement subsidies and policy changes to make homes produce less indoor and outdoor pollution	Culturally and linguistically appropriate mental health care access navigators

Neighborhood-Level Access to Health Care Services and Program

Residents indicated that the ability to visit a neighborhood wellness center in their own community, regardless of insurance status was essential to achieving a healthier lifestyle. This would also address obesity, diabetes, asthma, and mental health issues the community faces. Such a center should be equipped with both clinical and preventative health services, and which provided staff with training in cultural humility and language translation services, as well as offer opportunities for fitness, nutrition education and access to healthy foods. This would remove many of the reported structural barriers, including transportation, while providing direct health benefits.

Safe Parks and Exercise Spaces and Programs

The solutions drawn from the focus groups took on the pattern of local-based health concerns surrounding community infrastructure. Foremost, is the lack of available space in their local neighborhood that can accommodate all who live there, from children to elders. The infrastructure that does exist is inadequate, lacking safe and maintained fitness spaces, equipment, and walking trails. Existing fitness spaces within communities such as parks, school facilities, and areas around the immediate health care facilities were also reported to have safety concerns. Examples of threats to safety

were inadequate lighting and unattended stray animals. However, the need for investment towards adequate space was the overarching theme.

Family-based strategies and programs

It should also be noted that respondents often reported solution strategies that were inclusive of families. Access to family-oriented fitness education and activities, both within the community as well as in school sites, was a high priority. Activity, nutrition education and food access programs specifically focused on integrating family and community. There was a need to make everyone feel welcome by having age appropriate services. The children should have a place to play while parents get nutrition education and elders have a group exercise class.

Culturally and Language Appropriate Communication

A need was reported for available health care services, education and resources to be communicated to communities in culturally-appropriate mediums, such as through Spanish and Hmong-speaking media networks. This need for improvement to communication spanned from the clinical realm, to appointment setting, to eligibility service information as well as educational and outreach campaigns.

Access to healthy food and cooking classes

While residents shared that there is a need to improve access points to healthy foods, another need emerged around the implementation of healthy foods in meal planning. Residents reported that family-friendly cooking classes would enable communities to integrate healthy foods into routine meal preparation while simultaneously providing the opportunity for families to receive multi-generational nutrition education.

Health Care System Navigation

While there is documented need for investment in communities that focuses on physical infrastructure, such as transportation, there is also evidence that there is a need for a health care navigation infrastructure as well, that creates a health care pathway from program eligibility and appointment setting to the clinical environment and treatment options. Throughout this pathway, there is also a call for access to current and reliable information that is framed in culturally accessible formats.

APPENDIX A. Comparing Community Benefits Assessments Plans and Findings

Appendix A in this document identifies a way in which hospitals can take the information captured in the community focus groups to inform their needs assessments and the implementation plans for the priorities they will work on. On the first column of the appendix table is the perspective of focus groups as they talked about each of the health priorities. The middle column represents the systemic infrastructure comments as well as the summarized analysis of Central Valley Health Policy institute on how to invest community benefits money to tackle the issues identified by the focus groups. The last column represents the implementation priorities as identified by Community Regional Medical Center. We chose this plan over other hospital plans to compare due to the thoroughness of their implementation plan, however, other hospitals and groups of hospitals can also adopt the first two columns as they see applicable with their health priorities. We found repetition in what community asked for, which actually fits with a social determinants of health framework that says that investment in infrastructure such as parks, transportation, and local access to resources like health care lead to improved health outcomes.

Access to Care		
South Fresno Focus Groups' Identified Priorities	Health Infrastructure and Supports	Community Medical Centers Community Health Needs Priorities
<p>Local Wellness Centers <i>"They should have medical walk-in clinic, [wellness center] in the neighborhood—maybe over by the new library—where you could go in and sit down and talk about your problem. Where they actually listen to you and try to answer your question or direct you to help you find someone who can help you. Sometimes people go to their doctor, but never go back because there isn't good communication with medical staff."</i> --Southwest Fresno Focus Group Participant</p> <p>Health Care Coverage <i>"People go into the emergency room who don't need emergency room care, but don't have insurance so they can only get emergency room services."</i> --Southwest Fresno Focus Group Participant</p> <p><i>"Patients do not go to a provider earlier because they do not have insurance and cannot qualify for any assistance program."</i> -- Southeast Focus Group</p> <p>Health Care System Navigation <i>"It is hard to navigate the system to even set up the appointments because you don't know how to set one up."</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p>	<p>Local Wellness Centers</p> <ul style="list-style-type: none"> • A system of neighborhood-based facilities that provide comprehensive health prevention services, such as access to an in-office doctor one day per week, as well as access to fitness equipment and dietary counseling services <p>Health Care Coverage</p> <ul style="list-style-type: none"> • Access to health care services, regardless of income or immigration status • Preventative Care coverage • Share of cost programs <p>Health Care System Navigation</p> <ul style="list-style-type: none"> • Investing in systems that provide accurate information about how to navigate the health care system, including: <ul style="list-style-type: none"> o Program eligibility o Appointment setting o Access to reliable service and treatment related informational materials o Language Translation Services and language appropriate materials that are up to date 	<p><u>Community Medical Centers</u> Developing Health and Housing Pilot Project CMC, in partnership with the Fresno City and County Housing Authority, will pilot a place-based health project in a low-income, subsidized housing complex in Central Fresno. The project will assess for the specific health needs and/or challenges faced by families, including drivers behind their higher-than average emergency room utilization for low-acuity complaints. <u>Community Regional Medical Center</u> Navigating Medi-Cal Eligibility CRMC admitting staff will continue efforts to link uninsured patients who visit our hospital with much needed Medi-Cal coverage. Through a partnership with Fresno County Department of Social Services (DSS), admitting staff will "presumptively" enroll patients that meet Medi-Cal eligibility requirements. Presumptive eligibility grants patients 60-day coverage—Medi-Cal coverage becomes permanent once the patient completes the enrollment process with DSS.</p> <p>Supporting Fresno Medical Respite Center In partnership with the Fresno Rescue Mission, CRMC will support this respite service to provide homeless patients with a safe place for them to continue their recovery and receive additional home health, social service, and other support services after their hospital stay. The</p>

<p><i>“What I see is that our Hmong community, when they go to the hospital, they don’t want to demand for translators or interpreters. Hmong patients are always trying to bring their own translator so then the hospitals begin to feel like there is no need for the language and culture translators in the hospital.”</i> <i>--Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</i></p> <p>Health Care Setting <i>“Hmong patients may pretend that they know what’s going on and rely on the hospital task to figure out what is needed for those Hmong.”</i> <i>--Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</i></p> <p><i>“Feel a lack of compassion, a lack of professionalism.”</i> <i>-- Southeast Focus Group</i></p>	<p>Health Care Setting</p> <p>Stigma</p> <ul style="list-style-type: none"> • A health system culture that respects patients who visit the emergency room, as well as patients with public health insurance and who need language assistance <p>Elderly</p> <ul style="list-style-type: none"> • Sensitive care for elderly patients that is age appropriate <p>Youth</p> <ul style="list-style-type: none"> • Investment in systems that provide health prevention education to youth <p>Cultural humility & Language Services</p> <ul style="list-style-type: none"> • Staff trained in cultural humility • Language translation services and language appropriate materials <p>Safety</p> <ul style="list-style-type: none"> • Ensuring that provider locations are safe for community members to visit <p>Transportation</p> <ul style="list-style-type: none"> • Vans, vouchers and bus pass programs 	<p>Medical Respite Center will serve patients from all hospitals in the Fresno metropolitan region.</p> <p>Establishing first hospital-based MAP Point Project at Community’s Ambulatory Care Center In collaboration with Kings View Corporation, Centro La Familia Advocacy Services and the Poverello House, the MAP (Multi-Agency Access Partnership) Point housed near our Ambulatory Care Center will provide our patients, their families and neighborhood residents with much-needed linkages to social services upon leaving the hospital, including additional outpatient treatment, substance abuse treatment, mental health treatment and health care insurance enrollment.</p> <p>Strengthening Chronic Disease Medical Homes CRMC will continue to provide a team-based health care approach in its chronic disease medical homes. The team-based care model consists of a physician, nurse practitioner, nurse, case manager and outreach worker.</p> <p>Ensuring Seamless Care Transition Services Care transition services will ensure that patients who lack a designated primary care provider and yet require continuing care after discharge receive ‘seamless’ care and assistance in establishing primary, specialty and home health care ‘homes.’ Care transition services will also help patients set-up follow-up appointments, help with transportation services, and other help to address a patient’s barriers to continuing care.</p>
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Diabetes

South Fresno Resident Identified Priorities	Health Infrastructure and Supports	Community Medical Centers
<p>Education <i>“We need diabetes information for everyone not just people who have diabetes. We are not informed enough.”</i> <i>--Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</i></p> <p><i>Early education at schools (Both Southeast Fresno Focus Groups)</i></p> <p>Clean and Safe Exercise areas <i>Safe, Lighted, Free from stray dogs, Access to walking trails, Close to their neighborhood, Equipment on trails.</i></p> <p>Nutritionist</p>	<p>Education</p> <ul style="list-style-type: none"> • Preventative education tailored for children, adults and pregnant women. • Broadcasted in Hmong and Spanish speaking networks • Integrated in school system • Culturally gear classes • Exercise and Food <p>Clean and Safe Exercise areas</p> <ul style="list-style-type: none"> • More lighting • Free from animal stray dogs • Access to walking trails • Within their neighborhood 	<p style="text-align: center;"><u>Community Medical Centers</u></p> <p>Lead Fresno County Diabetes Collaborative Community Medical Centers will continue its leadership role in Fresno County Health Improvement Partnership’s diabetes collaborative. The workgroup seeks cross-sector collaboration in addressing rising diabetes rates in the county, aims to increase diabetes and pre-diabetes awareness, screenings and linkages to continuing care. The collaborative will align interventions and public outreach/education with measurable health outcomes among health care providers, schools, non-profit organizations and public</p>

<p>Nutritionist coach or liaison to work with the community.</p> <p>Access to food <i>“Healthy food that include cultural ingredients and dishes.”</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p> <p>Nutritionist coach or liaison to work with the community.</p> <p>Management of Diabetes <i>“I don’t know who to turn to if I had the disease”</i> -- Southeast Focus Group</p> <p><i>Space where personal challenges and emotions after been diagnosed with diabetes can be shared.</i></p> <p><i>“Might now know they have diabetes and when they find out might have a feeling of disgust.”</i> --Central Fresno Adult Latinos</p> <p><i>“My community is not aware of the help and are afraid to ask for help... If there is someone who can advocate and guide them then it is easier to get the help.”</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p>	<ul style="list-style-type: none"> • Equipment on trails <p>Locally Available health care</p> <ul style="list-style-type: none"> • Mobile Units <p>Transportation</p> <ul style="list-style-type: none"> • Bus passes for patients <p>Clear and direct information and communication</p> <ul style="list-style-type: none"> • Resources available • Programs available • Contact person <p>Nutritionist</p> <ul style="list-style-type: none"> • Bilingual and that will work with the community • Classes about nutrition for children, adults and pregnant women <p>Access to food</p> <ul style="list-style-type: none"> • Fresh fruits and vegetable available within their community <p>Management of Diabetes</p> <ul style="list-style-type: none"> • Health care for individuals with and without health insurance • Appointment reminders • Support groups 	<p>health.</p> <p>Diabetes Information Campaigns CMC will actively engage with the broader community around diabetes prevention, awareness and education through online communication platforms, campus and community health activities. Community will continue to provide diabetes and pre-diabetes prevention and awareness education through partnerships with local non-profit organizations, parent support groups and schools.</p> <p style="text-align: center;"><u>Community Regional Medical Center</u></p> <p>Continue Diabetes Care Center CRMC’s Diabetes Care Center will continue to provide care, education and interventions through its high-risk diabetes in pregnancy program. The program will continue to provide patients and their families with diabetes self-management education, healthy eating habits and controlling diabetes during pregnancy.</p> <p>Strengthen Diabetes Medical Home CRMC’s diabetes medical home provides coordinated care for patients from a multi-disciplinary team consisting of a physician, nurse practitioner, nurse, case manager and outreach worker. Team members ensure that patients diagnosed diabetes receive appropriate and timely care, medications and transportation to appointments. Intense case management is provided to patients facing hardships, including directly linking patients to community resources.</p>
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Obesity

South Fresno Resident Identified Priorities	Health Infrastructure and Supports	Community Medical Centers
<p>Inclusion of Exercise in Schools <i>“Exercise before an exam.”</i> -- (Central Fresno Focus Group)</p> <p>Inclusive Fitness Programs <i>“Cultural exercise classes.”</i> -- (Southeast Fresno Focus Group)</p> <p><i>“Simultaneous exercise program for children and mothers”</i> -- (Southeast Fresno Focus Group)</p> <p><i>“Structural activities that the community can join.”</i> --Central Fresno Focus Group</p> <p>Community Education & Activities</p>	<p>Inclusion of Exercise in Schools</p> <ul style="list-style-type: none"> • Ensure that physical education components remain within schools • Employ health-based education strategies, such as the opportunity for students to exercise before an exam • Opportunities for parents to be involved in fitness education, such as student credit for family fitness activities • Ensure schools and the areas near schools are safe for students and families <p>Inclusive Fitness Programs</p> <ul style="list-style-type: none"> • Community exercise programs that are language and culturally accessible, 	<p style="text-align: center;"><u>Community Medical Center</u></p> <p>Celebrate Food Day at Community Medical Centers’ Campuses Community Medical Centers will continue its commitment to provide patients and families with increased opportunities for nutrition, health and access to healthy, locally grown produce. Community will continue to host and sponsor activities and events centered on healthy eating and nutritious recipes. Food Day events will be celebrated throughout Community campuses and will be open to patients, their families and community members at large.</p> <p>Explore community-based collaborative opportunities around obesity CMC will research and ultimately</p>

<p><i>“Structural activities that the community can join.”</i> -- Central Fresno Focus Group</p> <p>Access to Exercise Areas within Neighborhoods <i>“Have the green areas or gym from schools open to the public”</i> --Central Fresno Focus Group</p> <p><i>“Parks are mostly for children and not make for elders/adults- we would like to see parks with exercise equipment for kids and adults- this might make us want to visit the park more.”</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p> <p><i>“Gym and pool for elderly by hospital.”</i> --Southwest Fresno Focus Group</p> <p>Nutrition Information & Food Access <i>“Healthy food is more expensive than unhealthy food. Tomatoes are more expensive than chips, water is more expensive than soda.”</i> --Youth Focus Group</p> <p>Community Infrastructure <i>“Invest in the infrastructure of parks such as</i></p> <ul style="list-style-type: none"> ● Equipment ● Fitness programs ● Maintenance ● Walking trails ● Drinking Fountains.” <p>-- Central Fresno Focus Group and Youth Focus Group</p> <p>Hospital Community Forums <i>“From my experience of coming from Minnesota—we saw that there were Hmong community forums hosted by hospitals to lean about what the community would like to have to improve their health. Health insurance, gave elders heart monitors that they can use to do physical activities.”</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p>	<p>including programs for mothers and children, with structured activities that allow for the entire community to participate</p> <p>Community Education & Activities</p> <ul style="list-style-type: none"> ● Community meetings ● Opportunities for group-based physical activities, such as Zumba ● Community cooking classes that provide the community with health-based recipes and food preparation techniques <p>Access to Exercise Areas within Neighborhoods</p> <ul style="list-style-type: none"> ● Neighborhood-based exercise spaces that are safe and friendly to all ages, that provide exercise equipment, or membership to already existing fitness facilities ● Expanded access to green spaces at local schools as well as expanding and incorporating afterschool programs <p>Nutrition Information & Food Access</p> <ul style="list-style-type: none"> ● Bilingual nutritionists to work directly with the community ● Nutrition classes for children, adults and pregnant women ● Programs that improve access to fresh fruit and vegetables <p>Community Infrastructure</p> <ul style="list-style-type: none"> ● Parks and walking trails ● Providing an expansion of water fountains within communities <p>Hospital Community Forums</p> <ul style="list-style-type: none"> ● A space where the hospitals can learn what the community wants to learn 	<p>implement at least three community-based physical activity/obesity prevention programs in neighborhoods surrounding CRMC.</p> <p>Engage in Collaborative Efforts on Obesity CMC will continue to participate in broad, community-wide efforts to address obesity through partnerships with the Fresno County Public Health Department, non-profit organizations and schools.</p> <p style="text-align: center;"><u>Community Regional Medical Center</u></p> <p>Support Diabetes Nutrition and Weight Management Group As a complimentary service to patients being served in the Diabetes Medical Home, Community Regional will continue to host support groups to assist patients in managing diabetes through nutrition label education, diet and exercise counseling. The support groups are led by CRMC’s case management team members and are available in both English and Spanish. Support groups are free and open to patients and their families.</p>
Breathing Problems/Asthma		
South Fresno Resident Identified Priorities	Health Infrastructure and Supports	Community Medical Centers
<p>Education Infrastructure <i>“Information sheet on what is asthma, and how to do to manage asthma, how to recognize symptoms.”</i> --Southwest Fresno Focus Group</p>	<p>Education Infrastructure</p> <ul style="list-style-type: none"> ● Multi-language awareness education programs that: <ul style="list-style-type: none"> ○ Explain asthma ○ How to Manage it ○ How to recognize it ○ What are the symptoms? 	<p style="text-align: center;"><u>Community Medical Centers</u></p> <p>Engage in Regional Clean Air Collaborative Efforts CMC will continue to participate in collaborative local and regional efforts addressing clean air quality initiatives such</p>

<p><i>"In communities where we live, inform us about all programs, make it known that it exists. Resources that are available are not well known in the community." --Southeast Fresno Focus Group</i></p> <p>Cultural Humility & Language Translation Services <i>"Family relationships are very important. If family members are informed they can be the best advocates and health educators for their elders and community members." --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</i></p> <p>State Regulatory Committees Insurance <i>"Access: state regulating insurance so that there isn't any discrimination." --Southeast Fresno Focus Group</i></p> <p>Air & Environmental Pollution <i>"Restriction of factories near neighborhoods." --Youth Focus Group</i></p> <p>Neighborhood Regulations <i>"Burning wood would contaminate and pollute the air, so instead of burning wood for warmth to have electric heaters." --Southeast Fresno Focus Group</i></p> <p>Home Environment Improvement Programs <i>"...indoor air quality due to smokers (smoke gets into clothing, when they smoke outside they still blow smoke in the door)." --Southwest Fresno Focus Group</i></p> <p><i>"It was hard to breathe for my child when there was someone who smoked and lived next to us. The child had red eyes and hard to breathe because of the neighbor's smoking fumes. It came to effect the child's insides." --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</i></p>	<ul style="list-style-type: none"> ○ What are the available resources? ○ The effects of second hand smoke <ul style="list-style-type: none"> • Communications strategy that provides asthma education to the community via Hmong and Spanish speaking network media segments <p>Cultural Humility & Language Translation Services</p> <ul style="list-style-type: none"> • Language translation trained staff • Training for doctors <p>State Regulatory Committees Insurance</p> <ul style="list-style-type: none"> • Oversight to ensure that insurance providers do not discriminate against asthma-related conditions <p>Air & Environmental Pollution</p> <ul style="list-style-type: none"> • Regulate car circulation in the city by the car plate number. Example the "Hoy No Circula" Mexico City's program <p>Neighborhood Regulations</p> <ul style="list-style-type: none"> • Oversee that trash is not burned within neighborhoods • Ensure that community members do not burn wood during non-burn days • Lock alleyways with the goal of decreasing dumping and littering within communities <p>Home Environment Improvement Programs</p> <ul style="list-style-type: none"> • Programs for low-cost humidifiers • Electric Heaters • Solar Panels 	<p>as Fresno County Health Improvement Partnership's Land Use and Planning group.</p> <p style="text-align: center;"><u>Community Regional Medical Center</u></p> <p>Sustain Chronic Lung Disease Program CRMC, in partnership with UCSF Fresno, will continue its evidence-based, in-home intervention program for patients with chronic lung disease. The program re-establishes linkages to care for patients with severe asthma. The team-based program consists of a medical director, nurse practitioner, registered nurse, respiratory therapist and outreach worker. The care team provides patients with an in-home assessment of potential asthma triggers, lung function test and education on asthma and inhaler use.</p> <p>Launch Pediatric Asthma Education Program CRMC's Pediatric Asthma Education Program will focus on providing education to young patients that are newly-diagnosed or have issues with adherence to clinical visits and/or medications. The program will provide patients and families with self-management health information aimed at preventing asthma episodes, hospitalizations and visits to the emergency room. Goals: Increase the number of physician referrals to the Pediatric Asthma Education Program; reduce ER visits and hospitalizations due to asthma complications; increase medication compliance and proper medication use.</p>
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Mental Health

South Fresno Resident Identified Priorities	Health Infrastructure and Supports	Community Medical Centers
<p>Access to Mental Health Care <i>"Limited access to care results in delayed care." --Central Fresno Focus Group, Southeast Fresno Focus Group</i></p>	<p>Access to Mental Health Care</p> <ul style="list-style-type: none"> • Extended office hours • House call programs as culturally appropriate, including the Hmong community 	<p style="text-align: center;"><u>Community Medical Centers</u></p> <p>Leading Mental Health Advocacy In February 2016, Community's Vice President for Population Health &</p>

<p><i>“Expensive to get treatment or access to talk to a counselor.”</i> --Central Fresno Focus Group</p> <p><i>“Informal, therapeutic groups.”</i> --Central Fresno Focus Group</p> <p>Mental Health Care System Navigation <i>“Navigating health care system so patient can become their own advocate.”</i> --Central Fresno Focus Group, Southeast Fresno Focus Group</p> <p><i>“Guidance counselor to help navigate the health system and inform of the different options.”</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p> <p>Education Infrastructure <i>“About packets, services, available resources through the radio, television, mail, videos. Make available resources known and accessible so the community can utilize them.”</i> --Southeast Focus Group and Youth Focus Group</p> <p>Mental Health Care in Schools <i>“Schools as a place for early education, prevention about mental health.”</i> --Southeast Fresno Focus Group</p> <p><i>“Positive activities free: exercises, kids’ classes.”</i> --Southeast Fresno Focus Group</p> <p>Exercise Integrated in Schools <i>“Have more after school programs, rec centers, and not medicate right away.”</i> --Southeast Fresno Focus Group</p> <p>Culturally-Appropriate Communication <i>“Language appropriate health education and health educators to talk about health issues / diseases affecting the community and how to prevent them. Allow for interpreters (family or formal employee) to be present during the medical visit.”</i> --Southeast/Central Fresno Focus Group Participant (Hmong Speakers)</p> <p>Transportation <i>“Set up a program for doctor clinics to send out bus passes / free of charge to the clinic if it is necessary by the patient.”</i> --Central Fresno Focus Group</p> <p><i>“Transportation infrastructure where they will be able seek care without depending on some else. “</i> --Southeast Fresno Focus Group</p>	<ul style="list-style-type: none"> • Informal therapeutic groups • Sliding scale pay system • Increased number of providers • Care that is tailored across the lifespan <p>Mental Health Care System Navigation</p> <ul style="list-style-type: none"> • Investing in systems that provide accurate information about how to navigate the health care system, including: <ul style="list-style-type: none"> ○ Program eligibility ○ Appointment setting ○ Access to reliable service and treatment related informational materials ○ Language translation services and language appropriate materials <p>Education Infrastructure</p> <ul style="list-style-type: none"> • Education packets, services, available resources communicated through radio, television, direct mail, videos, that include information on: <ul style="list-style-type: none"> ○ Access points and treatment options ○ Preventative treatment ○ Nutrition management ○ <p>Mental Health Care in Schools</p> <ul style="list-style-type: none"> • Mental health professionals at schools • Early education about mental health • Expand afterschool programs <p>Exercise Integrated in Schools</p> <ul style="list-style-type: none"> • Exercise classes at schools • Opportunities for family exercise activities at schools <p>Culturally-Appropriate Communication</p> <ul style="list-style-type: none"> • Multi-language translation services and language appropriate materials • Language appropriate health education • Allow for interpreters (family or formal employee) to be present during visit <p>Transportation</p> <ul style="list-style-type: none"> • Vans, vouchers and bus pass programs 	<p>Community Engagement was appointed by California Governor Brown to the state’s Mental Health Services Oversight & Accountability Commission (Proposition 63). The commission’s goal is to oversee statewide implementation of the Mental Health Services Act, advise the Governor and Legislature on mental health policy and develop strategies to overcome the stigma associated with mental illness. CMC will continue its commitment to advocate for improved coordinated care, access and resources for families and individuals suffering with mental health disorders on a local, regional and state-wide level.</p> <p>Leading Community Conversations: Mental Health</p> <p>CMC will continue to lead this cross-sector discussion and collaboration to facilitate access and service coordination for individuals affected by mental illness. CMC will support the expansion of the Multiagency Access Partnership (MAP) across Fresno County, including the MAP site to be located at the Community Regional campus. Community Conversations on mental health will seek to address mental health services for children and substance abuse issues/services related to physical health.</p> <p style="text-align: center;"><u>Community Regional Medical Center</u></p> <p>Integrating Primary Care and Mental Health Care</p> <p>CRMC will partner with Fresno County Department of Behavioral Health to develop primary care medical homes for patients with mental illness. The medical homes will provide timely, team-based care to address patient’s physical and mental health.</p> <p>Community Behavioral Health Center</p> <p>Community Regional will continue to operate the Community Behavioral Health Center— a 61-bed, inpatient facility providing 24-hour care to adults in need of acute psychiatric care.</p>
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APPENDIX B. California Community Benefit Code and Definition

State Statute	Definition of Community Benefit
California Health and Safety Code §127345	<p>“Community benefit” means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:</p> <ol style="list-style-type: none"> 1) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Children Services Program, or county indigent programs. 2) The unreimbursed cost of services included in subdivision (d) of Section 127340. 3) Financial or in-kind support of public health programs. 4) Donation of funds, property, or other resources that contribute to a community priority. 5) Health care cost containment. 6) Enhancement of access to health care or related services that contribute to a healthier community. 7) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services. 8) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

APPENDIX C. California Community Benefit Reporting Summary and Reporting Elements

What reporting is required of	What reporting is required of	What reporting is required of	What reporting is required of
<p>Private nonprofit hospitals must submit a community benefit plan to the Office of Statewide Health Planning and Development in the State Department of Health Services. Certain elements are defined as community benefit, such as charity care and the unreimbursed costs of government programs. There is no standardized format for hospital plans.</p>	<p>Charity care, discounted care and costs of government programs are included in the statute's definition of community benefit expenses, but not required to be itemized separately. Bad debt is not included, nor explicitly excluded.</p>	<p>Goods and services that increase access, promote health, or meet a community need are included in the statute's definition of community benefit, but not required to be itemized separately</p>	<p>The Office of Statewide Health Planning and Development makes individual hospital reports available to the public, but does not aggregate data.</p>

REFERENCES

- Central Valley Health Policy Institute. "A Fair and Healthy Fresno: Community Voices on the 2035 General Plan Update. 2014. Fresno, CA. Accessed January 15, 2017
<http://www.csufresno.edu/chhs/cvhpi/documents/A-Fair-and-Healthy-Fresno-Online-Format.pdf>
- Krivo, L., Washington, H.M., Peterson, C.R., Browning, C.A., Calder, & M. Kwan. 2013. "Social Isolation of Disadvantage and Advantage: The Reproduction of Inequality in Urban Space." *Social Forces*, 92(1): 141-164.
- Patient Protection and Affordable Care Act, Public Law No. 111-148, §9007, 124 Stat. 855, (March 2010): 737-741.
- U.S. Department of Health and Human Services. "Healthy People 2020: Access to Care. 2014. Washington, DC. Accessed December 17, 2016 <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services#1>
- Internal Revenue Service, Schedule H (Form 990) 2011: Hospitals (Revised 2012), accessed August 2, 2012, <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>
- 2011 Instructions for Schedule H.
- Stoto, M. A., and Smith, C. R. (2015). Community Health Needs Assessments- Aligning the Interests of Public Health and the Health Care Delivery System to Improve Population Health. *National Academy of Sciences*.
- Stoto, 2013. Population health in the Affordable Care Act era. *AcademyHealth*. Issue Brief.
- Rosenbaum, S. 2013. Update: Treasury/IRS proposed rule on community benefit obligations of nonprofit hospitals. *AcademyHealth*. Issue Brief.