

HEALTH DISPARITIES 2ND ANNUAL REPORT

Annual Summary
July 2024 – June 2025



**HEALTHY
FRESNO
COUNTY**
Better Together

Transforming
Community Care
Through Care
Coordination &
Partnership



Community Health Workers (CHWs) or Promotores(as) provide care coordination services to residents of Fresno County at no-cost!

Health Disparities Overview

Fresno County's Health Disparities Program is an initiative within the Fresno County's Department of Public Health (FCDPH). The Health Disparities Program provides care coordination services through partnering agencies who deploy CHWs to provide care coordination service interventions in underserved communities throughout Fresno County. In addition, CHWs will provide health education materials in a culturally and linguistically sensitive manner on a variety of topics.

Examples of care coordination services may include assisting residents with: finding a medical provider, health insurance, transportation, employment, mental health, family planning, amongst other resources and community linkages depending on a participant's individual needs.

Partnering CHW Agencies

Listed below are the 9 partnering agencies who deploy CHWs to provide care coordination services to the underserved communities:

- Aria Community Health Center
- Black Wellness and Prosperity Center – African American Coalition
- Centro Binacional para el Desarrollo Indígena Oaxaqueño
- Centro La Familia Advocacy Services
- Cultiva La Salud
- Exceptional Parents Unlimited
- Easterseals
- Reading and Beyond
- West Fresno Family Resource Center

During the end of this reporting period, there was a significant reduction to case load per CHW due to federal funding impacts, resulting in gaps in service delivery, reduction of CHWs time and capacity, and a reduction in partnering agency agreements.

Community Impact

680

Total
Clients
Enrolled*

630

Total
Assessments
Completed**

620

Total
Outreach
Events That
CHWs
Participated
In

10,635

Total
Resources
And Direct
Services
Provided By
CHWs

3,178

Total
Engagements
Completed by
CHWs***



HOW IS DATA OBTAINED

Partnering agencies of The Health Disparities Program mobilize CHWs who develop community relationships with clients and help identify client needs through utilization of a social determinants of health (SDoH) needs assessment. Information from the assessment is entered and tracked through Care Coordination Systems (CCS), a shared and secure electronic data management system. This centralized data management system can track gaps and opportunities through person level data specific to expressed client needs.

*During this reporting period, there was a significant reduction to case load per CHW due to federal funding impacts, resulting in gaps in service delivery, reduction of CHWs time and capacity, and a reduction in partnering agency agreements.

**Total assessments completed are identified by the number of initial SDoH assessments completed by the CHWs.

***Total number of client engagements completed by CHWs which may include tele-visits, home visits, office visits, and other community locations where CHWs interact with enrolled clients.

Snapshot of the Program

- 9** Partnering agencies who provide care coordination services to the community
- 34** CHWs have been implementing SDoH screeners and providing services to clients
- 1** Centralized data management system that embeds a SDoH screener to capture person level data
- 7** Initial SDoH screening sections that collect client data on Income, Transportation, Housing, Food, Health, Personal Safety, Children and Family Planning during enrollment

Community Health Worker Snapshot

680

Total Clients
Enrolled by CHWs

CHWS IDENTIFIED CLIENTS THROUGH:

- COVID-19 related outreach and community events
- Community events and canvassing efforts
- Internal referrals from other FCDPH programs
- Internal referrals from other programs within the partnering agencies
- Community referrals sent to FCDPH and partnering agencies

CHWs provide clients linkage to services and resources.



3

The average impact of a single CHW in one year.

- 8** service needs opened per client
- 37** client engagements per client
- 3.4** months of care per client
- 9:1** client to CHW ratio



Figure 1. Client Preferred Language

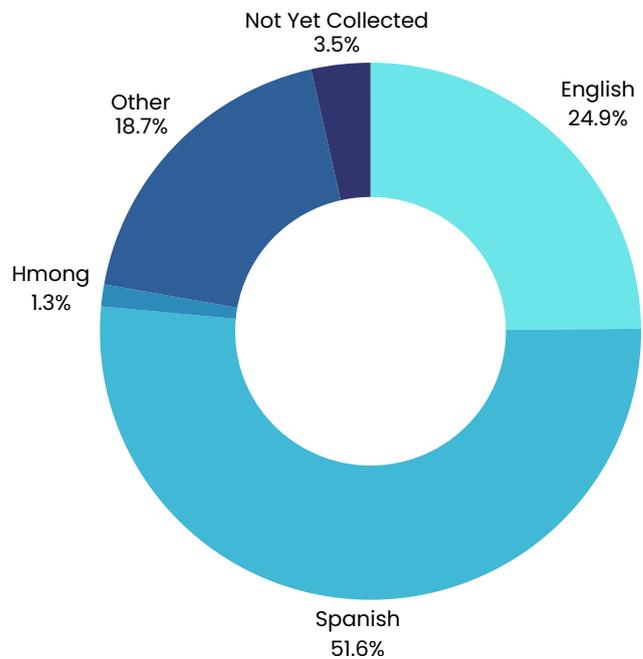


Figure 1. Language spoken is identified as the percent of enrolled clients who indicated their preferred language as Spanish (351 clients), English (169 clients), Hmong (9 clients), Other (127 clients), and Not Yet Collected (24 clients).

Partner Highlights

Aria Health Center

Aria Community Health Center is a federally qualified health center that provides medical, dental, optometry, and specialty care. One notable success involved referring a client to a medical supplies agency, which provided them with a walker equipped with a chair. Additionally, the client successfully secured an appointment for assistance with their energy bill and the client was also approved to become a paid provider for their blind spouse under the In-Home Supportive Services (IHSS) program.



BLACK Wellness and Prosperity Center - African American Coalition

The BLACK Wellness and Prosperity Center - African American Coalition provides services to Fresno's Black and African American community and promotes maternal health to enhance infant health outcomes such as the BLACK Doula Network and BLACK Fatherhood Legacy. One notable success story involved a CHW who assisted a client whose child had been bitten by a dog. The CHW provided crucial support by helping the client navigate the process of obtaining the child's medical records for their attorney, applying for Medi-Cal, and coordinating medical and dental appointments.

Health Disparities Program Client Demographics

As CHWs enroll and engage clients, they collect a release of information form and obtain demographic data that assists the enrollment process as they provide services to the client.

Demographic data collected may include race/ethnicity, gender, pregnancy, zip code, age, marital status, income, and/or insurance information. Collection of client demographic data is dependent on client consent and the amount of information shared by client is helpful in providing individualized services in a more culturally and linguistically sensitive manner.



Figure 3. Gender

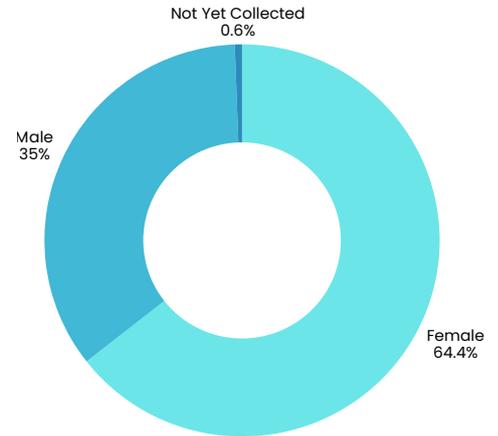


Figure 3. Gender is being presented by the percentage of enrolled clients identifying as Female (438 clients), Male (238 clients), and Not Yet Collected (4 clients).

Figure 2. Client Overview



Figure 2. 9 out of 10 clients enrolled into the Health Disparities Program are people of color and more than half (59%) are ages ranging from 25 to 49 years old.

Figure 4. Race/Ethnicity

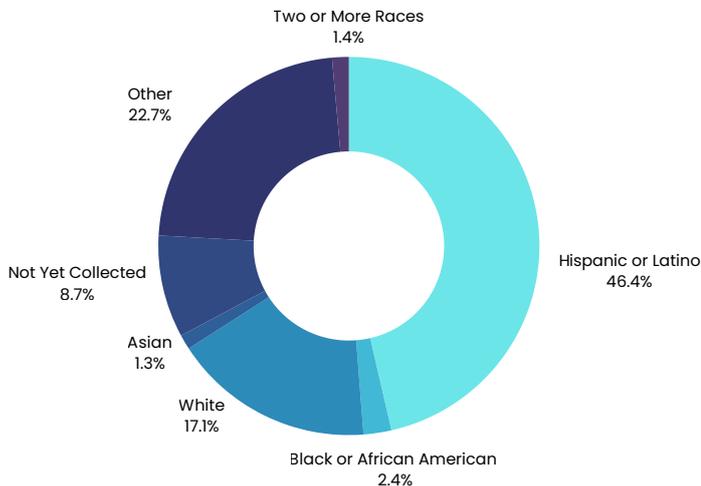


Figure 4. Race/Ethnicity is being presented as the percentage of enrolled clients identifying as Hispanic or Latino (589 clients), Black or African American (30 clients), White (217 clients), Asian (16 clients), Two or More Races (18 clients), Other (288 clients), and Not Yet Collected (111 clients).

Figure 5. Zip Codes

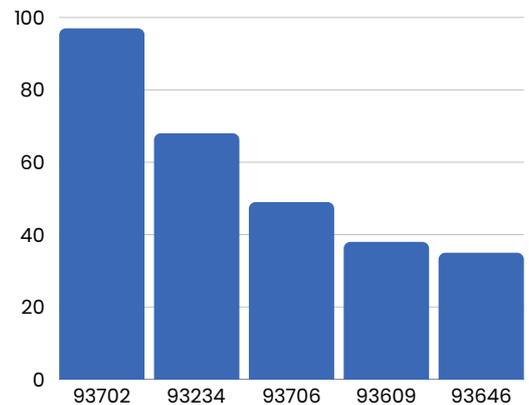


Figure 5. The top 5 zip codes of enrolled clients include 93702 (97 clients), 93234 (68 clients), 93706 (49 clients), 93709 (38 clients), and 93746 (35 clients). All zip codes are within the Fresno County's Healthy Priority Index (HPI)* Quartile 1.

*Fresno County HPI, a geographical mapping tool compiled using federal, state, and local data sources to identify the level of health burden experienced with in each census tract in the county. HPI Quartile 1 are the communities within the top 25% of the county experiencing the lowest level health opportunities and the highest level of health burden.

Partner Highlights

Centro Binacional para el Desarrollo Indígena Oaxaqueño



Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) is a community-based organization established by and for Indigenous communities. CBDIO successfully created media content in Mixteco and Indigenous languages to educate and inform community members about Medi-Cal and the importance of health coverage. CBDIO successfully assisted a client that urgently needed health insurance to assess their health. The CHW was able to assist the client in applying for Medi-Cal and by August, and the client received approval for health coverage. The CHW guided the client on how to select a health care plan, primary clinic, and doctor to initiate care. Additionally, the community member expressed gratitude for the support and the valuable information that was previously unfamiliar to them.



Centro La Familia Advocacy Services

Centro La Familia Advocacy Services (CLFA) provides services in assisting crime victims, supporting families and children, promoting health and wellness, fostering civic engagement, and offering a variety of community services. A notable achievement is one CHW delivered a presentation at a Hmong radio station to promote the Health Disparities Program and its services which successfully reached about 354 community members and listeners. Through this radio station presentation, there was one community member that reached out for assistance and enrolled into the program.

Overview of Service Outcomes

Once CHWs enroll a client, an initial assessment is conducted and based on identified SDoH needs, service need areas are then opened. Services needs are used to track the progress of each client’s service need in the centralized data system. Client service areas are dependent on what needs are being expressed by the client (i.e., food insecurity, housing, transportation, insurance, medical home, etc.).



Social Service was the largest opened and completed service need for clients.

Figure 6. Top Client Service Areas Opened and Completed

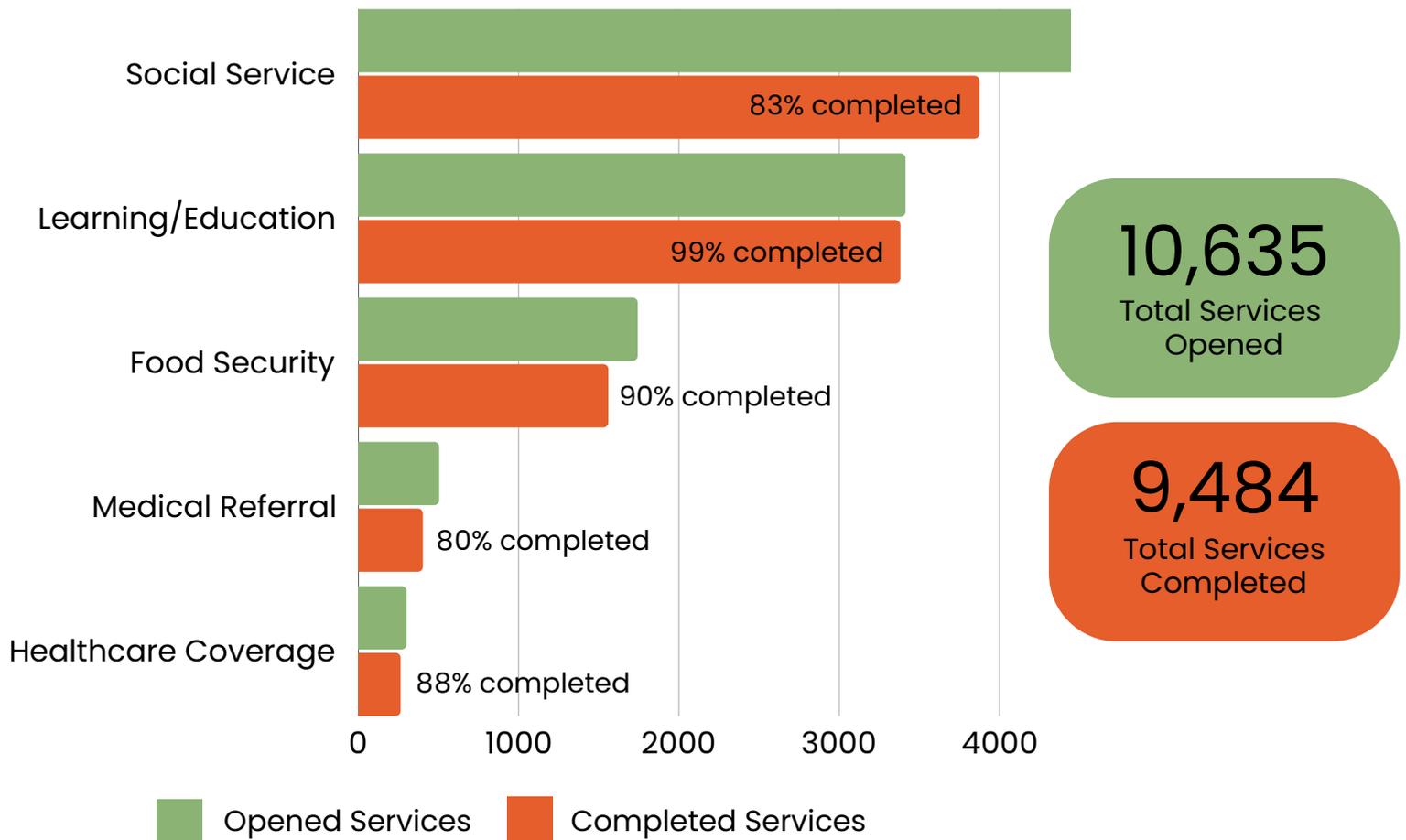


Figure 6. The top 5 opened services areas are shown by the number of client needs opened in green: Social Service (4,672), Learning/Education (3,414), Food Security (1,743), Medical Referral (505) and Healthcare Coverage (301). In comparison to the completion of the listed service areas completed shown in orange: Social Service (3,875), Learning/Education (3,382), Food Security (1,560), Medical Referral (403), and Healthcare Coverage (264).

Partner Highlights

Cultiva La Salud

Cultiva La Salud (Cultiva) supports initiatives that promote healthy eating and active living; educating community members about healthy school meals, the Immigrant Latina Women Network (which builds resilience and mitigates the risk of domestic violence), the Save The Señoras program (which assists elderly women facing food insecurity, isolation, and high levels of poverty), encourages physical activity through free Zumba classes, and in supporting farm-to-table healthy eating through their partnership with the Community Life Garden. One successful story is a 72-year-old single-person household that the CHW was able to assist with requesting for a replacement medical insurance card as well as educating the client on their insurance coverage benefits, such as the free medical transportation. Subsequently, the CHW was able to assist the same client in scheduling essential appointments for their primary care, dental, and optometry.



Exceptional Parents Unlimited

Exceptional Parents Unlimited (EPU) supports and strengthens families and children with unique needs through early learning and intervention services. One success story involves a client seeking assistance with job placement. The CHW provided support in their resume using library resources and computer access. As a result, the client applied for a job and was offered a position, enabling them to support themselves and their family.

Easterseals Central California is a CBO subcontracted partner with EPU that provides early intervention services such as behavior intervention for autism and other neurodevelopment differences, and a family empowerment program to support families with children who have a disability. A successful outcome occurred when a CHW had actively supported an elderly woman who was facing significant challenges, including a need for warm water, home painting, and additional social services. The CHW was able to provide the client with a resource folder containing information on Rural Mobile Health clinics, food support, and dental resources. Additionally, the CHW enrolled her in the Lead-Based Paint Hazard Remediation program, which allowed her home to be repainted at no cost.

Community Health Workers Outreach Efforts



9 community partners working together to provide community linkages to Fresno County residents during local events.

34,934

Community residents reached through outreach events

During these outreaching events, 34,934 community residents were reached through resources and education while visiting the CHWs information table.

346

Clients enrolled into the Health Disparities Program through outreach events

From these outreach events, 346 community residents were enrolled into the Health Disparities Program. 51% of total enrolled participants came from these outreach events to receive care coordination services, at no-cost. Additionally, CHWs were able to gauge the interest and reconnect with residents following the event.

620

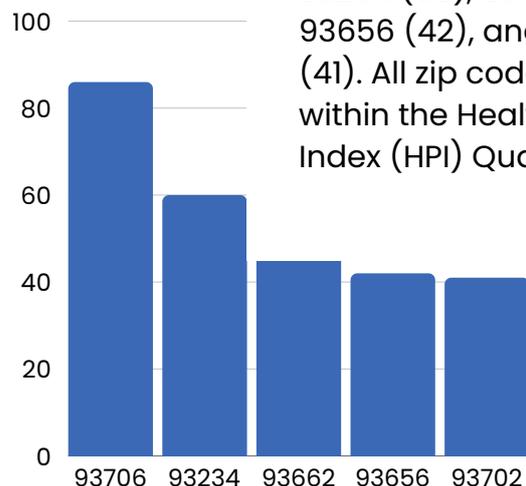
Community outreach events where CHWs were present to provide wraparound services to Fresno County residents

87,039

Health education materials provided to the community

In addition, 87,039 health education materials were provided to community residents who attended the events. The top health education materials provided during the events were COVID-19 information, Nutrition and Healthy Eating, Flu/RSV, Diabetes, Medical and Healthcare information, and Mental Health amongst other topics.

The top 6 zip codes of outreaching events include: 93706 (86), 93234 (60), 93662 (59), 93656 (42), and 93702 (41). All zip codes are within the Healthy Place Index (HPI) Quartile 1.



Partner Highlight



Reading and Beyond

Reading and Beyond (RaB) provides comprehensive, tailored case management, and two-generational programming that works well with children and families to strengthen education, health, well-being to create sustainable social and financial security, and afterschool leadership. Programs range from pre-conception to employment training and health literacy to prosperity coaching. RaB annually hosts Open House to showcase its program services, provided free health screenings and vaccinations, and to foster community engagement. This event serves as a platform for strengthening the relationship between Reading and Beyond, local neighborhoods, and the broader community.



West Fresno Family Resource Center

West Fresno Family Resource Center (WFFRC) provides on-site services such as economic empowerment, educational advancement, health and wellness, character leadership and youth empowerment. WFFRC is particularly successful in offering free CPR training, cooking classes, and fitness classes tailored for seniors and adults. A client expressed their gratitude by stating that without the CHW's support and assistance, they would not be able to understand or ask questions to their health care provider regarding their medical conditions.

"I'm very thankful for everything you have done for me and my family, without your help I wouldn't have asked my doctor all the questions I had. I hope God brings you health and many blessings. / Muchas gracias, por todo lo que has hecho por mí y mi familia, sin tu ayuda, no podría hacerle preguntas a mi doctor, que dios le de salud y que lo bendiga mucho."

Leveraging Partnerships & Sharing Syndromic Surveillance Information

The Health Disparities Program continues to work alongside FCDPH's epidemiology team to assess syndromic surveillance trends and provides information for CHWs to share out to the community. Syndromic surveillance assists in identifying emerging health trends and diseases and early detection of outbreaks that are impacting Fresno County and the utilization of emergency health services. In addition, the team has aided and leveraged with CHWs to continue to connect community members to a primary healthcare provider for non-emergency healthcare needs while also linking members to healthcare coverage when needed for on-going health needs.

Emerging Health Trends Identified and Shared by CHWs to the community:

- Avian Flu (H1N1)
- Listeria
- Tuberculosis
- Increased Emergency Room Visits
- Respiratory Syncytial Virus (RSV)
- Heat Related Illness and Heatwave
- Mental Health and Anxiety
- Hospitalization Rates
- Air Pollution/Air Quality
- COVID-19
- Mosquito Prevention
- Zika Virus
- Norovirus
- HIV/PrEP



STRENGTHENING PARTNERSHIPS

Referral Partnerships

The Health Disparities Program developed a CHW Network Referral partnership between two Fresno County Department of Public Health's Divisions to enhance program services by providing community care linkages and access to resources.

Referral Partnerships and Outcomes:

- A partnership was established in early September 2023 with the Community Health Division's Tuberculosis Clinic and 46 clients have been served to date.
- Another referral partnership was established in early June 2024 with the Public Health Nursing Division and 46 clients have been serviced to date.



Rural Mobile Health

The Fresno County Rural Mobile Health (RMH) Program provides no-cost medical services and care coordination services to Fresno County's rural communities by improving health equity through key partnerships. In partnership with the RMH Program, the University of California San Francisco School of Medicine in Fresno (UCSF-Fresno), Saint Agnes Medical Center (SAMC), and Tzu Chi Mobile Clinic, utilize mobile health units to deliver medical and/or vision services directly to residents. Additionally, the Health Disparities Program provides wraparound care coordination services by delivering culturally and linguistically appropriate health education during the RMH program events.

CHW Outcomes During RMH Events:

- 76 RMH events where CHWs were present providing services
- 24,668 health education materials were provided to residents
- 10,168 community residents were reached during RMH events
- 72 clients were enrolled into the Health Disparities Program

These efforts would not be possible without the **support from our local partners and community members.**



MEET OUR HEALTH DISPARITIES PROGRAM PARTNERS FROM 2024-2025:



Thank you!

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**To connect with Fresno County Department of
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