
# SUTTER AMADOR HOSPITAL

## 2022 Community Health Needs Assessment

**Mission**
We enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in healthcare services.

**Vision**
Sutter Health leads the transformation of healthcare to achieve the highest levels of quality, access, and affordability.

**Community Health Needs Assessment**
The following report contains Sutter Amador Hospital's 2022 Community Health Needs Assessment (CHNA), which is used to identify and prioritize the significant health needs of the communities we serve. CHNAs are conducted once every three years, in collaboration with other healthcare providers, public health departments and a variety of community organizations. This CHNA report guides our strategic investments in community health programs and partnerships that extend Sutter Health's not-for-profit mission beyond the walls of our hospitals, improving health and quality of life in the areas we serve.

# 2022 Community Health Needs Assessment

Conducted on behalf of

**Sutter Amador Hospital**
**200 Mission Boulevard**
**Jackson, CA 95642**

Conducted by

COMMUNITY HEALTH INSIGHTS

May 2022

# Acknowledgments

We are deeply grateful to all those who contributed to the community health needs assessment conducted on behalf of Sutter Amador Hospital. Many devoted community health experts and members of various social service organizations serving the most vulnerable members of the community gave their time and expertise as key informants to help guide and inform the findings of the assessment. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Sutter Amador Hospital. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. This joint report was authored by:

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# Report Summary

## Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs (SHNs) of the Sutter Amador Hospital (SAH) service area. The priorities identified in this report help to guide nonprofit hospitals' community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com).

## Community Definition

The definition of the community served included the primary service area of the hospital, which consists of 19 ZIP codes across Amador, Calaveras, and Tuolumne Counties. The main area used for this assessment were the ZIP codes and county rates for Amador and Calaveras county as most data indicates to these two counties are the main area of which Sutter Amador Hospital provides services for.

## Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included 10 one-on-one and group interviews with 20 community health experts, social service providers, and medical personnel. Furthermore, 18 community residents or community service provider organizations participated in 2 focus groups across the service area. Finally, 9 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including SAH's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were

[1] Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/.

incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

## Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize SHNs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as SHNs. These SHNs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

## List of Prioritized Significant Health Needs

The following SHNs identified for Sutter Amador Hospital are listed below in prioritized order.

1. Access to Quality Primary Care Health Services
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Basic Needs Such as Housing, Jobs, and Food
4. Access to Specialty and Extended Care
5. Access to Functional Needs
6. Increased Community Connections
7. Active Living and Healthy Eating
8. Injury and Disease Prevention and Management
9. Safe and Violence-Free Environment

## Resources Potentially Available to Meet the Significant Health Needs

In all, 128 resources were identified in the service area that were potentially available to meet the identified SHNs. The identification method included starting with the list of resources from the 2019 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

## Conclusion

This CHNA details the process and findings of a comprehensive health assessment to guide decision-making for the implementation of community health improvement efforts using a health equity lens. The CHNA includes an overall health and social examination of SAH's service area and highlights the needs of community members living in parts of the county where the residents experience more health disparities. This report also serves as a resource for community organizations in their effort to improve health and well-being in the communities they serve.

# Introduction and Purpose

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the SHNs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)" (p. 78963).[2]

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Sutter Amador Hospital (SAH), located at 200 Mission Boulevard, Jackson, CA 95642. SAH's primary service area includes 19 ZIP codes across Amador, Calaveras, and Tuolumne Counties. The main area used for this assessment were the ZIP codes and county rates for Amador and Calaveras county as most data indicates to these two counties are the main area of which Sutter Amador Hospital provides services for. The total population of the service area was 59,877.

SAH is an affiliate of Sutter Health, a nonprofit healthcare system. The CHNA was conducted over a period of three months, beginning in March 2022, and concluding May 2022. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that nonprofit hospitals conduct a community health needs assessment at least once every three years.

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA on the behalf of SAH. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

# Findings

## Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the SHNs in the SAH service area. In all, nine SHNs were identified. Primary data were then used to prioritize these SHNs.

Prioritization was based on three measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last measure was the percentage of community provider survey respondents that identified a health need as a top priority. Table 1 shows the value of these measures for each significant health need.

[2] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

*Table 1: Health need prioritization inputs for SAH service area.*

| Prioritized Health Needs | Percentage of Key Informants and Focus Groups Identifying Health Need | Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority | Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority |
|---|---|---|---|
| Access to Quality Primary Care Health Services | 100% | 27% | 78% |
| Access to Mental/Behavioral Health and Substance Use Services | 100% | 20% | 67% |
| Access to Basic Needs Such as Housing, Jobs, and Food | 100% | 25% | 44% |
| Access to Specialty and Extended Care | 92% | 5% | 33% |
| Access to Functional Needs | 100% | 8% | ~ |
| Increased Community Connections | 75% | 4% | ~ |
| Active Living and Healthy Eating | 33% | 2% | 11% |
| Injury and Disease Prevention and Management | 17% | 4% | ~ |
| Safe and Violence-Free Environment | 17% | ~ | 11% |

~ Health need not mentioned as a top priority

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and were more frequently identified among the top priority needs.[3] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

[3] Further details regarding the creation of the prioritization index can be found in the technical report.

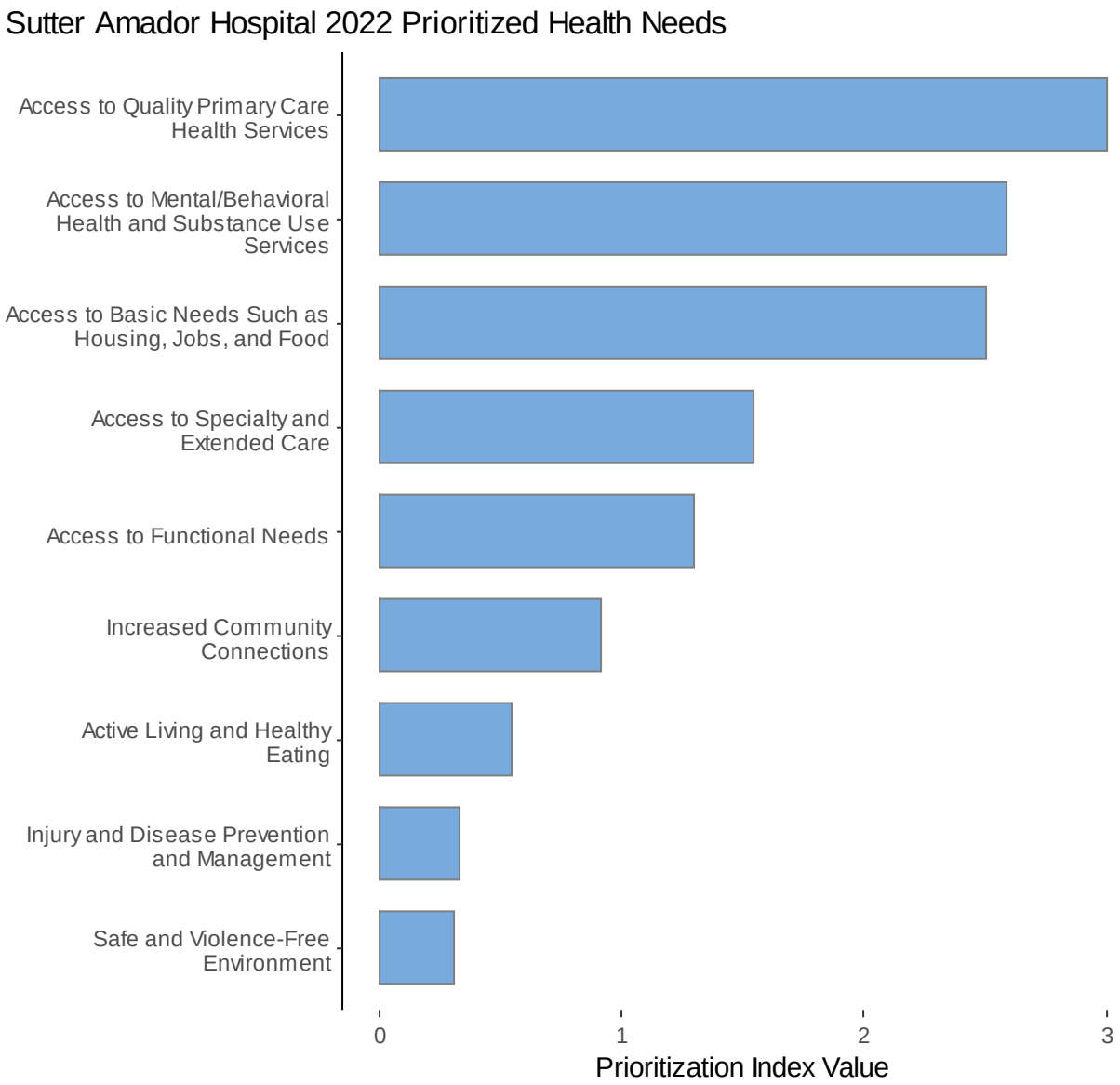


*Figure 1: Prioritized significant health needs for SAH service area.*

While COVID-19 was top of mind for many participating in the primary data collection process, feedback regarding the impact of COVID-19 confirmed that the pandemic exacerbated existing needs in the community.

The SHNs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health ordered by their relationship to the conceptual model used to guide data collection for this report. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of this report).

***1. Access to Quality Primary Care Health Services***

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Community Service Provider Survey Responses</td></tr>
<tr><td>• Need for primary care providers for those with insurance, Medi-Cal, Medi-Care and the uninsured.<br>• Need for increased access to technology for primary care via telehealth.<br>• Long wait times for primary care.<br>• Consider alternative approaches to care to account for rural nature of the county. Take the care to the people, implement house calls.<br>• Need for more care providers that specialize in senior health.<br>• Directed and incentivized recruitment to bring more primary care providers to the county.<br>• Need more health care and support services in Fiddletown and River Pines.<br>• Integration of COVID-19 testing and treatment into general medical practice.<br>• Great need for more pediatrics care providers and facilities.<br>• Need for a pediatric provider at Wellspace Clinic.<br>• Increased implementation of street nursing, street medicine for the unsheltered population of the county.<br>• Improve community trust in local federally qualified health care (FQHC) clinics.</td><td>• It is difficult to recruit and retain primary care providers in the region.<br>• There aren't enough primary care service providers in the area.<br>• Too few providers in the area accept Medi-Cal.<br>• Patients have difficulty obtaining appointments outside of regular business hours.<br>• Wait-times for appointments are excessively long.<br>• Patients seeking primary care overwhelm local emergency departments.<br>• Out-of-pocket costs are too high.<br>• Quality health insurance is unaffordable.<br>• Primary care services are available but are difficult for many people to navigate.<br>• Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).<br>• The quality of care is low (e.g., appointments are rushed, providers lack cultural competence).</td><td>• Child Mortality<br>• Life Expectancy<br>• Premature Age-Adjusted Mortality<br>• Premature Death<br>• Stroke Mortality<br>• Chronic Lower Respiratory Disease Mortality<br>• Diabetes Mortality<br>• Heart Disease Mortality<br>• Cancer Mortality<br>• Liver Disease Mortality<br>• Alzheimer's Disease Mortality<br>• Influenza and Pneumonia Mortality<br>• Diabetes Prevalence<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Poor Physical Health Days<br>• Frequent Physical Distress<br>• Lung Cancer Prevalence<br>• Asthma ED Rates<br>• Primary Care Shortage Area<br>• Medically Underserved Area<br>• Primary Care Providers<br>• COVID-19 Cumulative Full Vaccination Rate<br>• Homelessness Rate</td></tr>
</table>

***2. Access to Mental/Behavioral Health and Substance Use Services***

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Not enough mental health and behavioral health providers in the county.<br>• Need a psychiatrist that is located in Amador County.<br>• Most mental health care is occurring via telehealth, need more in person provider visits.<br>• Many community members experiencing homelessness in the county struggle with severe mental illness and substance use.<br>• Limited shelter beds in the community.<br>• Need another sober home in the county.<br>• Use mobile mental health services to reach people in crisis.<br>• Opioids (Heroine, Oxycodone, Fentanyl) easier to get than weed in the county.<br>• Vaping and tobacco usage is high in both area youth and adults.<br>• There are minimal options for substance abuse treatment for those without insurance or who are on Medi-Cal.<br>• Integration of mental health in area schools to increase | • Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.<br>• The area lacks the infrastructure to support acute mental health crises.<br>• There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).<br>• Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).<br>• There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers).<br>• Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools).<br>• It's difficult for people to navigate for mental/behavioral healthcare.<br>• Treatment options in the area for those with Medi-Cal are limited.<br>• There aren't enough services here for those who are homeless and dealing with substance-abuse issues.<br>• The cost for mental/behavioral health treatment is too high. | • Life Expectancy<br>• Premature Age-Adjusted Mortality<br>• Premature Death<br>• Liver Disease Mortality<br>• Suicide Mortality<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Poor Physical Health Days<br>• Frequent Physical Distress<br>• Excessive Drinking<br>• Drug Induced Death<br>• Adult Smoking<br>• Primary Care Shortage Area<br>• Medically Underserved Area<br>• Mental Health Providers<br>• Psychiatry Providers<br>• Firearm Fatalities Rate<br>• Disconnected Youth<br>• Homelessness Rate |

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| access to care for youth and their families.<br>• Not enough therapists in the county to help people with depression and anxiety.<br>• Quality of therapist serving Amador County is very inconsistent.<br>• Not enough therapists to deal with mild to moderate behavioral and mental health issues, which results in an escalation.<br>• Significant lack of services for suicide prevention.<br>• County does not have a medically assisted treatment facility for those battling drug addiction.<br>• Create a residency program at the hospital to help recruit mental health practitioners to the county. | • Mental/behavioral health services are available in the area, but people do not know about them.<br>• The stigma around seeking mental health treatment keeps people out of care.<br>• Substance-abuse is an issue among youth in particular.<br>• The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community.<br>• Awareness of mental health issues among community members is low.<br>• Substance-use treatment options for those with Medi-Cal are limited.<br>• There are substance-abuse treatment services available here, but people do not know about them. | |

***3. Access to Basic Needs Such as Housing, Jobs, and Food***

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[4] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.[5]

[4] McLeod, S. 2020. Maslow's Hierarchy of Needs. Retrieved 31 Jan 2022 from http://www.simplypsychology.org/maslow.html.

[5] Robert Wood Johnson Foundation, and University of Wisconsin, 2022. Research Articles. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale.

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Lack of access to needed technology and technology literacy.<br>• County infrastructure for technology needs improvement.<br>• There are limited shelter beds in the community.<br>• Housing costs in the area have drastically increased.<br>• Inadequate housing for the unsheltered, veterans and seniors.<br>• Lack of low income housing or rentals in the county.<br>• Bring in other housing options, "boarding houses".<br>• Homelessness is a concern in the county.<br>• Rent is increasing for many seniors in the area on a fixed income, pushing them out of the county.<br>• Lack of jobs in the county for area youth.<br>• Food insecurity is an issue for some seniors, especially in rural areas.<br>• Food deliveries to those in need that cannot come to food distribution locations.<br>• There are not enough affordable assisted living options for seniors.<br>• Need for hygiene opportunities (showers, restrooms) for homeless residents.<br>• Lack of affordable childcare in the county, especially for those that are low income.<br>• Need childcare with longer hours for parents that work later shifts.<br>• Families are struggling with the excessive cost of food and gas. | • It is difficult to find affordable childcare.<br>• Lack of affordable housing is a significant issue in the area.<br>• The area needs additional low-income housing options.<br>• Many residents struggle with food insecurity.<br>• Services for homeless residents in the area are insufficient.<br>• Educational attainment in the area is low.<br>• Employment opportunities in the area are limited.<br>• Many people in the area do not make a living wage.<br>• Poverty in the county is high.<br>• Services are inaccessible for Spanish-speaking and immigrant residents. | • Child Mortality<br>• Life Expectancy<br>• Premature Age-Adjusted Mortality<br>• Premature Death<br>• Diabetes Prevalence<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Poor Physical Health Days<br>• Frequent Physical Distress<br>• COVID-19 Cumulative Incidence<br>• Asthma ED Rates<br>• Drug Induced Death<br>• Adult Obesity<br>• Limited Access to Healthy Foods<br>• Food Environment Index<br>• Medically Underserved Area<br>• COVID-19 Cumulative Full Vaccination Rate<br>• Some College<br>• Disconnected Youth<br>• Third Grade Reading Level<br>• Third Grade Math Level<br>• Median Household Income<br>• Homelessness Rate<br>• Long Commute - Driving Alone |

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Area fire danger has created basic needs concerns. Electricity outages result in the need to rely on a generator, which many families don't have.<br>• Amador County lacks opportunity to access college classes.<br>• Partner with colleges to bring satellite classrooms/campuses to the county.<br>• High number of children being raised by their grandparents. | | |

***4. Access to Specialty and Extended Care***

Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • There are not enough specialists to meet the needs of the population.<br>• There are not enough affordable assisted living options for seniors.<br>• Need specialists in the community such as oncology, orthopedics, and urology to help meet the needs of the senior population. | • It is difficult to recruit and retain specialists in the area.<br>• Not all specialty care is covered by insurance.<br>• People have to travel to reach specialists.<br>• The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). | • Life Expectancy<br>• Premature Age-Adjusted Mortality<br>• Premature Death<br>• Stroke Mortality<br>• Chronic Lower Respiratory Disease Mortality<br>• Diabetes Mortality<br>• Heart Disease Mortality<br>• Cancer Mortality<br>• Liver Disease Mortality |

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Dialysis and cancer treatment are desperately needed in the county.<br>• County has no specialist for ENT (ears, nose, and throat), urology, psychiatry, dermatology, or podiatry.<br>• Senior help transitioning from independent living, to living with family or in assisted living.<br>• Lack of eye care services in the county.<br>• Patients must travel as far as an hour or more to see a specialist.<br>• Skilled nursing facility and extended care for seniors needed.<br>• More respite beds in the emergency room.<br>• Having a wheelchair reasonably priced for patients at home.<br>• Long term care facilities needed.<br>• Need a place for homeless and vulnerable to recuperate safely once discharged from the emergency department or hospital. | • Too few specialty and extended care providers accept Medi-Cal.<br>• Out-of-pocket costs for specialty and extended care are too high.<br>• The area lacks a kind of specialist or extended care option not listed here.<br>• There isn't enough OB/GYN care available.<br>• Wait-times for specialist appointments are excessively long.<br>• Additional hospice and palliative care options are needed. | • Alzheimer's Disease Mortality<br>• Diabetes Prevalence<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Poor Physical Health Days<br>• Frequent Physical Distress<br>• Lung Cancer Prevalence<br>• Asthma ED Rates<br>• Drug Induced Death<br>• Psychiatry Providers<br>• Specialty Care Providers<br>• Homelessness Rate |

***5. Access to Functional Needs***

Functional needs refers to needs related to adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Bus system in the county difficult to use with a physical disability.<br>• Roads difficult to walk on, no shoulder or sidewalk.<br>• Bus system needs more stops and more convenient times.<br>• Concerns among older community members to drive in severe weather, which results in not receiving care when needed sometimes.<br>• Provide more transportation vouchers to those experiencing homelessness.<br>• School bus system does not provide transport for kids in afterschool activities.<br>• More transportation services are needed to help people access care outside of the county.<br>• Roads in the county need repair.<br>• More transportation services for seniors to navigate in and outside the county.<br>• No transportation available via Uber, Lyft, or taxis. | Survey respondents did not indicate this as a priority need for the service area. | • Disability<br>• Frequent Mental Distress<br>• Frequent Physical Distress<br>• Adult Obesity<br>• COVID-19 Cumulative Full Vaccination Rate<br>• Homelessness Rate<br>• Long Commute - Driving Alone<br>• Access to Public Transit |

***6. Increased Community Connections***

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[6] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Further, healthcare and community support services are more effective when they

[6] Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved 31 Jan 2022 from https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

are delivered in a coordinate fashion, where individual organizations collaborate with others to build a network of care.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
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<tr><td>Key Informant and Focus Group Responses</td><td>Community Service Provider Survey Responses</td></tr>
<tr><td>• More engagement activities for youth.<br>• Need increased opportunities for people to connect.<br>• Expansion of library hours to allow community to gather.<br>• Cost of youth activities is a barrier for many to participate.<br>• More opportunities for seniors to gather and socialize.<br>• Increased engagement with seniors in rural areas living in isolation.<br>• Enhance collaboration with non-profit organizations in the county.<br>• Increased community engagement to reduce vaccine hesitancy.<br>• More community outreach about available resources.<br>• Increased partnerships among organizations to address provider shortages.</td><td>Survey respondents did not indicate this as a priority need for the service area.</td><td>• Child Mortality<br>• Life Expectancy<br>• Premature Age-Adjusted Mortality<br>• Premature Death<br>• Stroke Mortality<br>• Diabetes Mortality<br>• Heart Disease Mortality<br>• Suicide Mortality<br>• Unintentional Injuries Mortality<br>• Diabetes Prevalence<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Poor Physical Health Days<br>• Frequent Physical Distress<br>• Excessive Drinking<br>• Drug Induced Death<br>• Physical Inactivity<br>• Access to Exercise Opportunities<br>• Primary Care Shortage Area<br>• Medically Underserved Area<br>• Mental Health Providers<br>• Psychiatry Providers<br>• Specialty Care Providers<br>• Primary Care Providers<br>• COVID-19 Cumulative Full Vaccination Rate<br>• Homicide Rate<br>• Firearm Fatalities Rate<br>• Some College<br>• Disconnected Youth<br>• Homelessness Rate<br>• Long Commute - Driving Alone<br>• Access to Public Transit</td></tr>
</table>

***7. Active Living and Healthy Eating***

Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Increase access to fruits and veggies in rural areas.<br>• More walking and hiking trails in the county.<br>• Increase access to more affordable healthy foods countywide.<br>• Provide more opportunities to purchase produce from local farmers.<br>• Bring more farmers markets to Amador County.<br>• Many areas in the county lack access to grocery stores.<br>• Lack of access to outdoor activities<br>• A lot of land, but little available for recreation due to property rights. | • Food insecurity is an issue here.<br>• Fresh, unprocessed foods are unaffordable.<br>• Homelessness in parks or other public spaces deters their use.<br>• Students need healthier food options in schools.<br>• There are food deserts in the area where fresh, unprocessed foods are not available. | • Life Expectancy<br>• Premature Age-Adjusted Mortality<br>• Premature Death<br>• Stroke Mortality<br>• Diabetes Mortality<br>• Heart Disease Mortality<br>• Cancer Mortality<br>• Diabetes Prevalence<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Poor Physical Health Days<br>• Frequent Physical Distress<br>• Asthma ED Rates<br>• Adult Obesity<br>• Physical Inactivity<br>• Limited Access to Healthy Foods<br>• Food Environment Index<br>• Access to Exercise Opportunities<br>• Homelessness Rate<br>• Long Commute - Driving Alone<br>• Access to Public Transit |

***8. Injury and Disease Prevention and Management***

Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g.,

sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Community Service Provider Survey Responses</td></tr>
<tr><td>• More primary prevention programs in the county focused on injury and disease prevention.<br>• Provide incentives for community members that engage in primary prevention.<br>• Need for more smoking cessation programs.<br>• Increased COVID-19 educational resources.<br>• High obesity in the county, need more obesity prevention efforts in the county.<br>• More drop in vaccine clinics.<br>• Increased messaging around the benefits of vaccine coverage.</td><td>Survey respondents did not indicate this as a priority need for the service area.</td><td>• Child Mortality<br>• Stroke Mortality<br>• Chronic Lower Respiratory Disease Mortality<br>• Diabetes Mortality<br>• Heart Disease Mortality<br>• Liver Disease Mortality<br>• Suicide Mortality<br>• Unintentional Injuries Mortality<br>• Alzheimer's Disease Mortality<br>• Diabetes Prevalence<br>• HIV Prevalence<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Frequent Physical Distress<br>• COVID-19 Cumulative Incidence<br>• Asthma ED Rates<br>• Excessive Drinking<br>• Drug Induced Death<br>• Adult Obesity<br>• Physical Inactivity<br>• Adult Smoking<br>• COVID-19 Cumulative Full Vaccination Rate<br>• Firearm Fatalities Rate<br>• Motor Vehicle Crash Death<br>• Disconnected Youth<br>• Third Grade Reading Level<br>• Third Grade Math Level<br>• Homelessness Rate</td></tr>
</table>

***9. Safe and Violence-Free Environment***

Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Further, research has demonstrated that individuals

exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[7]

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| • Increased theft of catalytic converters.<br>• Vagrancy in the area makes people feel unsafe.<br>• Increased child abuse cases in the county. | • The current political environment makes some concerned for their safety.<br>• Youth need more safe places to go after school. | • Life Expectancy<br>• Premature Death<br>• Poor Mental Health Days<br>• Frequent Mental Distress<br>• Frequent Physical Distress<br>• Physical Inactivity<br>• Access to Exercise Opportunities<br>• Homicide Rate<br>• Firearm Fatalities Rate<br>• Motor Vehicle Crash Death<br>• Disconnected Youth<br>• Homelessness Rate |

# Methods Overview

## Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[8] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

## Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. SAH requested written comments from the public on its 2019 CHNA and most recently adopted Implementation Strategy through SHCB@sutterhealth.org.

[7] Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.
[8] Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/.

At the time of the development of this CHNA report, SAH had not received written comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, and the service provider survey. SAH will continue to use its website as a tool to solicit public comments and ensure that these comments are considered as community input in the development of future CHNAs.

## Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 10 interviews with 20 community health experts, 2 focus groups conducted with a total of 18 community residents or community-facing service providers, and 9 responses to the Community Service Provider survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize SHNs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet, exercise, and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 86 different health-outcome and health factor indicators were collected for the CHNA.

## Data Analysis

Primary and secondary data were analyzed to identify and prioritize the SHNs within the SAH service area. This included identifying 12 PHNs in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA, including primary and secondary data collection, analysis, and results, see the technical section of this report.

# Description of Community Served

The definition of the community served was the primary service area of SAH. This area was defined by 20 ZIP Codes—95225, 95226, 95232, 95245, 95248, 95252, 95254, 95255, 95257, 95601, 95629, 95640, 95642, 95665, 95666, 95669, 95675, 95685, 95689, and 95699. This service area was designated because the majority of patients served by SAH resided in these ZIP Codes. Geographically, the majority of the SAH service area resides in Amador County, CA. Amador County is located approximately 45 miles southeast of Sacramento, CA. Amador County has a total area of 606 square miles, of which 11.4 square miles is water. Sutter Amador Hospital is located in the city of Jackson, which is also the county seat and

home to approximately 4,500 area residents. The total population of the service area was 59,877. The service area is shown in Figure 2.

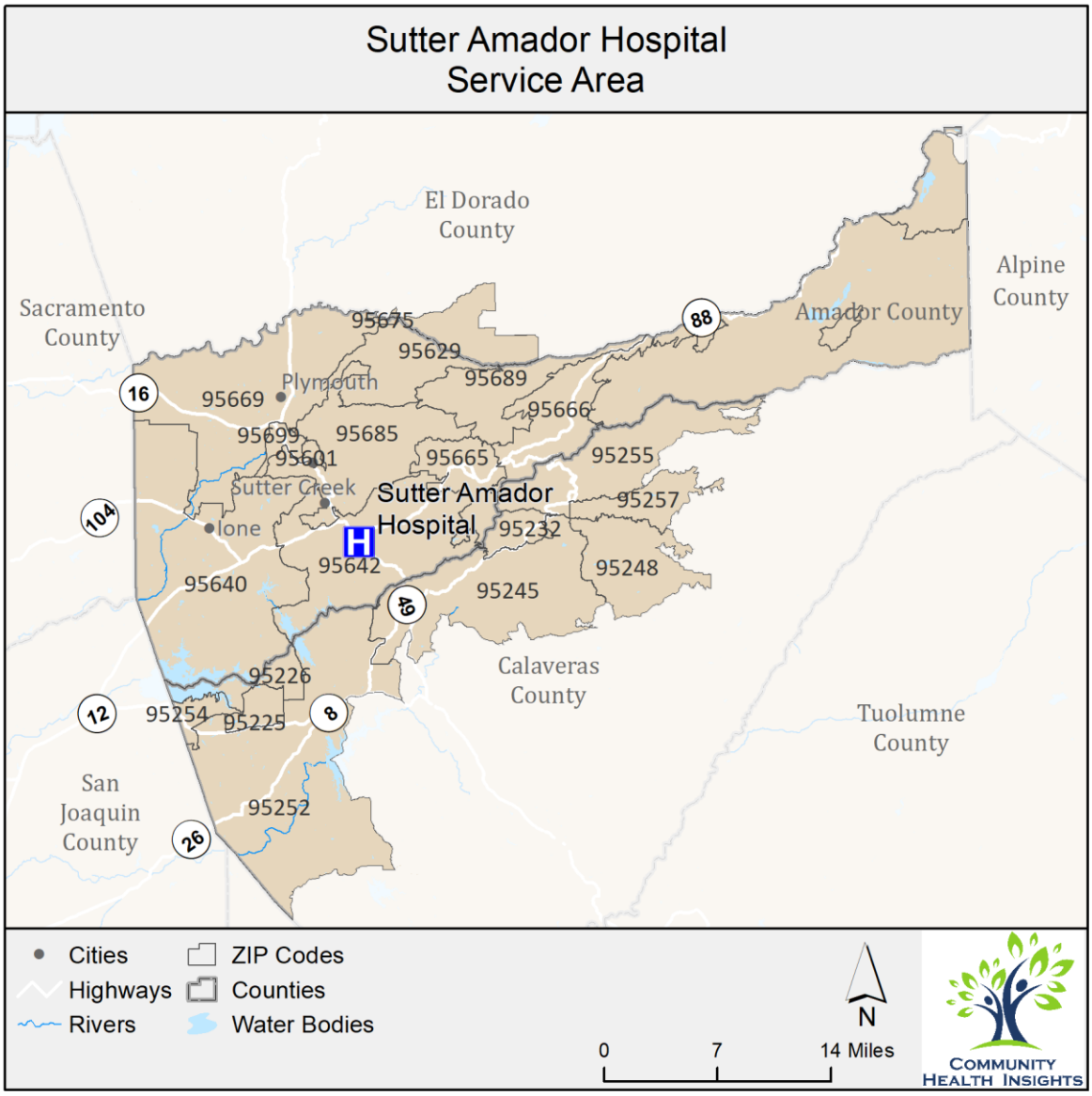



*Figure 2: Community served by SAH.*

Population characteristics for each ZIP Code in the service area are presented in Table 2. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively to the state or county is highlighted.

*Table 2: Population characteristics for each ZIP Code located in the SAH service area.*

| ZIP Code | Total Population | % Non-White or Hispanic\Latinx | Median Age (yrs.) | Median Income | % Poverty | % Unemployment | % Uninsured | % Without High School Graduation | % With High Housing Costs | % With Disability |
|---|---|---|---|---|---|---|---|---|---|---|
| 95225 | 378 | 29.6 | 43.7 | $68,750 | 32.3 | 0 | 0 | 8.6 | 35.6 | 7.7 |
| 95226 | 0 | ~ | ~ | ~ | ~ | ~ | ~ | ~ | ~ | ~ |
| 95232 | 161 | 0 | 64.5 | $55,500 | 10.6 | 24.3 | 0 | 0 | 56 | 13.7 |
| 95245 | 1,717 | 26.6 | 55.3 | $51,830 | 22.4 | 17.5 | 12.2 | 8.2 | 19.5 | 28.1 |
| 95248 | 106 | 0 | 58 | ~ | 21.7 | 28.9 | 0 | 0 | 51.7 | 43.4 |
| 95252 | 16,262 | 21.4 | 47.4 | $79,618 | 6 | 4.6 | 5 | 10.3 | 42.3 | 17.8 |
| 95254 | 1,035 | 24.7 | 55.3 | $103,559 | 0 | 7.6 | 0 | 17.4 | 15.2 | 18.5 |
| 95255 | 1,289 | 13 | 58.8 | $35,169 | 22.5 | 0 | 6.5 | 6.7 | 46.7 | 27.3 |
| 95257 | 407 | 25.8 | 53.8 | $54,390 | 30 | 0 | 6.4 | 19 | 36.8 | 11.8 |
| 95601 | 151 | 26.5 | 37.9 | $29,722 | 7.3 | 13.5 | 0 | 5.8 | 38.3 | 11.3 |
| 95629 | 940 | 12.8 | 56 | $66,176 | 14.9 | 0 | 9 | 2.3 | 21.2 | 14.5 |
| 95640 | 11,598 | 30.6 | 46 | $67,922 | 11.3 | 3.6 | 3.6 | 15.7 | 33.9 | 15.4 |
| 95642 | 7,101 | 15.9 | 54.4 | $62,083 | 8.3 | 6 | 5.6 | 8.4 | 34.4 | 19.9 |
| 95665 | 4,303 | 24.2 | 53 | $82,215 | 4.7 | 6.7 | 2.9 | 3.4 | 34.8 | 18.8 |
| 95666 | 5,164 | 17.4 | 56.5 | $61,128 | 13.3 | 12.1 | 7 | 8.1 | 31.7 | 23.8 |
| 95669 | 2,315 | 29.2 | 44.6 | $79,464 | 9.8 | 4 | 6.7 | 13.4 | 27.4 | 13.1 |
| 95675 | 566 | 24.9 | 46.4 | $40,670 | 0 | 36.4 | 17.7 | 31.4 | 26.3 | 58.1 |
| 95685 | 4,665 | 12.4 | 50.7 | $57,420 | 11.3 | 6 | 2.9 | 6.8 | 37.9 | 18 |
| 95689 | 1,698 | 12.8 | 57.8 | $52,700 | 8.7 | 17.6 | 0.8 | 4 | 27.7 | 18.9 |
| 95699 | 21 | 0 | 72.4 | ~ | 90.5 | 0 | 4.8 | 0 | 90 | 0 |
| Amador | 38,429 | 21.8 | 50.5 | $62,772 | 9.9 | 6.9 | 4.7 | 10 | 33.4 | 19 |
| Calaveras | 45,514 | 19.1 | 52 | $63,158 | 11.4 | 6.4 | 4.4 | 9.8 | 39.2 | 21.1 |
| California | 39,283,497 | 62.8 | 36.5 | $75,235 | 13.4 | 6.1 | 7.5 | 16.7 | 40.6 | 10.6 |

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

## Health Equity

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a mutual understanding for the concept of health equity.

"*Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including*

*powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*"[9]

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[10]

In the US, and many parts of the world inequities are most apparent when comparing various racial and ethnic groups to one another. Using these comparisons between racial and ethnic populations, it's clear that health inequities persist across communities, including Amador, Calaveras Counties.

This section of the report shows inequities in health outcomes, comparing these between race and ethnic groups. These differences inform better planning for more targeted interventions.

## Health Outcomes - the Results of Inequity

The table below displays disparities among race and ethnic groups for the HSA for life expectancy, mortality, and low birthweight.

*Table 3: Health outcomes comparing race and ethnicity in the SAH service area.*

| Health Outcomes | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|---|---|---|---|---|---|---|---|
| **Amador** | | | | | | | |
| Life Expectancy | Average number of years a person can expect to live. | ~ | ~ | ~ | 83 | 80.1 | 80.5 |
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | ~ | ~ | ~ | 237.2 | 307.7 | 294.1 |
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | ~ | ~ | ~ | 4,919.7 | 6,540.2 | 6,203.9 |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | ~ | ~ | ~ | 6.9% | 6.3% | 6.5% |
| **Calaveras** | | | | | | | |
| Life Expectancy | Average number of years a person can expect to live. | ~ | ~ | ~ | 86.4 | 79.1 | 79.6 |

[9] Robert Wood Johnsons Foundation. 2017. What is Health Equity? And What Difference Does a Definition Make?. Health Equity Issue Brief #1. Retrieved 31 Jan 2022 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf .

[10] Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.

| Health Outcomes | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|---|---|---|---|---|---|---|---|
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | ~ | ~ | ~ | 207.2 | 364.2 | 348.1 |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | ~ | ~ | ~ | 6.7% | 5.8% | 6% |

~ Data Not Available
Data sources included in the technical section of the report.

Health outcome data by race and ethnicity was only available for the Hispanic and White population groups in both Amador and Calaveras Counties. In Amador County, Whites had lower life expectancy, higher premature age-adjusted mortality, higher premature death of years of potential life lost, but a lower percentage of low birthweight babies compared to Hispanics. The same pattern was also true in Calaveras County, with the exception of data of premature death, as this was not available by race and ethnicity for this county.

## Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the HSA, such as education attainment and income. These health factors are displayed in the table below and are compared across race and ethnic groups.

*Table 4: Health factors comparing race and ethnicity in the SAH service area.*

| Health Factors | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|---|---|---|---|---|---|---|---|
| **Amador** | | | | | | | |
| Some College[a] | Percentage of adults ages 25 and over with some post-secondary education. | 58.8% | 62% | 35.3% | 48% | 65.3% | 62.5% |
| High School Completion[a] | Percentage of adults ages 25 and over with at least a high school diploma or equivalent. | 84.7% | 87.7% | 65.9% | 75.4% | 93.1% | 90% |
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | ~ | ~ | ~ | 2.5 | 2.8 | 2.7 |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | ~ | ~ | ~ | 2.3 | 2.5 | 2.5 |
| Children in Poverty | Percentage of people under age 18 in poverty. | ~ | ~ | ~ | 16.5% | 11.1% | 12.5% |

| Health Factors | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|---|---|---|---|---|---|---|---|
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | ~ | $85,893 | ~ | $84,821 | $61,164 | $62,640 |
| Uninsured Population[b] | Percentage of the civilian non-institutionalized population without health insurance. | 20.8% | 23.4% | 0% | 5.2% | 4.1% | 4.7% |
| **Calaveras** | | | | | | | |
| Some College[a] | Percentage of adults ages 25 and over with some post-secondary education. | 54.2% | 43.2% | 61% | 52.4% | 64.2% | 62.2% |
| High School Completion[a] | Percentage of adults ages 25 and over with at least a high school diploma or equivalent. | 75.2% | 73.4% | 67.3% | 77.5% | 92.2% | 90.2% |
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | ~ | ~ | ~ | 2.6 | 2.7 | 2.7 |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | ~ | ~ | ~ | 2.2 | 2.4 | 2.4 |
| Children in Poverty | Percentage of people under age 18 in poverty. | ~ | ~ | ~ | 26.5% | 14.5% | 19.6% |
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | ~ | ~ | ~ | $69,696 | $63,324 | $68,248 |
| Uninsured Population[b] | Percentage of the civilian non-institutionalized population without health insurance. | 0% | 0.4% | 0% | 5.2% | 4.1% | 4.4% |

~ Data Not Available

Unless otherwise noted, data sources included in the technical section of the report.

[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.

[b]From 2019 American Community Survey 5-year estimates table S2701.

Health factor data by race and ethnicity for Amador County reveal that the Black and Hispanic population groups had the lowest percentage of some college and high school completion. Hispanics have a lower third grade reading and math level compared to Whites in the county, and the largest percentage of population uninsured is among the American Indian/Alaska Native and Asian. Data by race and ethnicity for Calaveras County show that Asians have the lowest percentage of some college and high school completion, with Whites having the largest percentage for both. Hispanics in Calaveras

County have the lowest reading and math levels, higher percentage of children living in poverty and highest percentage of population uninsured in comparison to Whites in the county.

## Population Groups Experiencing Disparities

The figure below describes populations in the SAH service area identified through qualitative data analysis that were identified as experiencing health disparities. Interview participants were asked, "What specific groups of community members experience health issues the most?" Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group two or more times as one experiencing disparities. Figure 3 displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

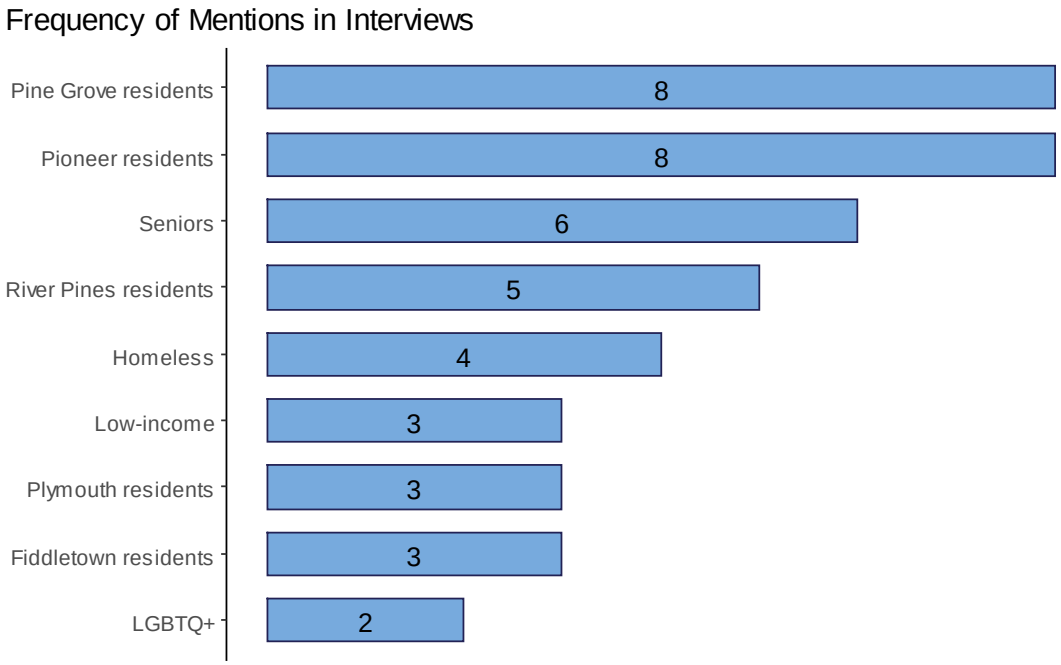



*Figure 3: Populations experiencing disparities the SAH service area.*

# California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)[11] values for the SAH service area. The HPI is an index based on 25 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between

[11] Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from https://healthyplacesindex.org/about/.

communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

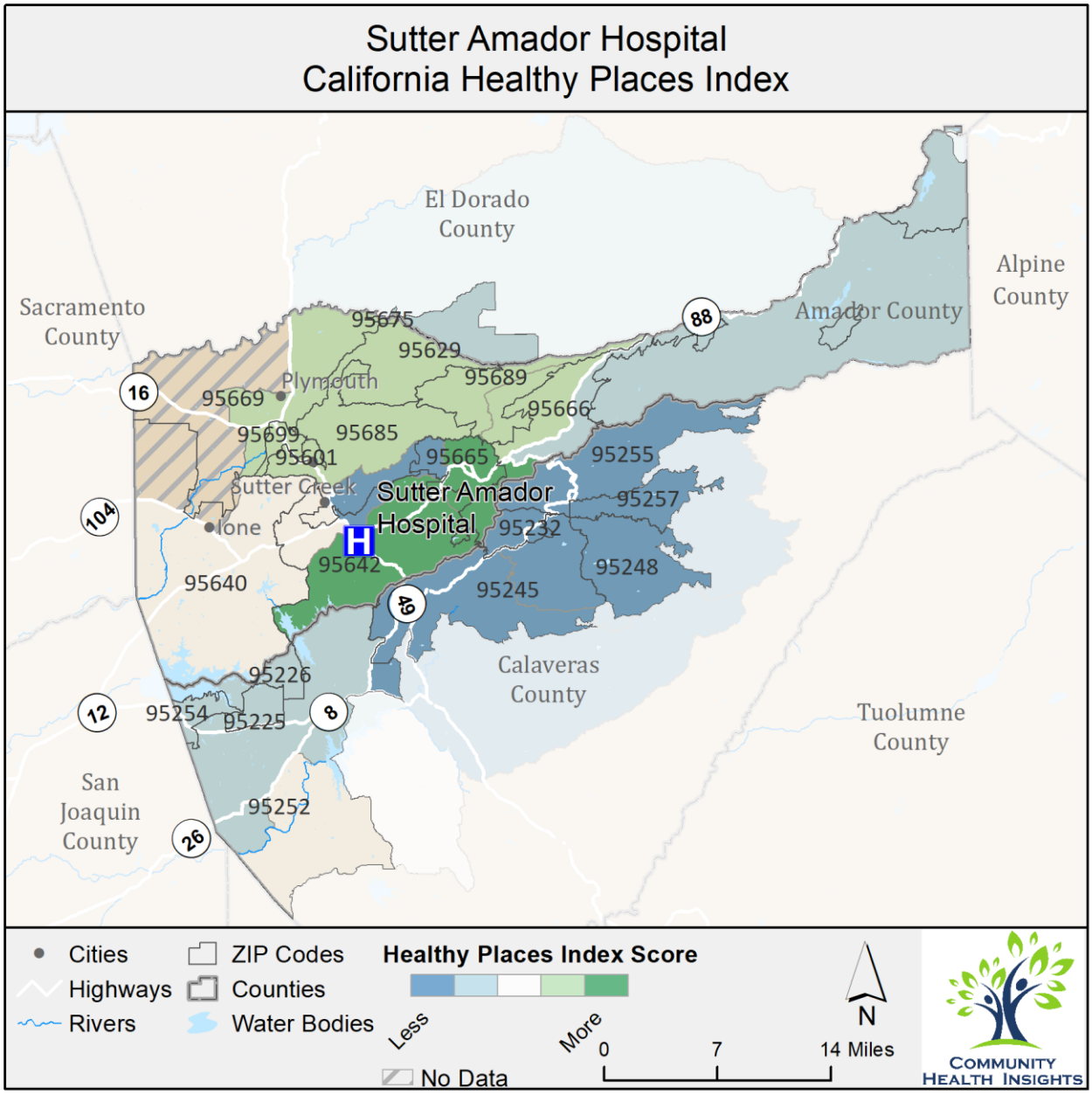



*Figure 4: Healthy Places Index for SAH.*

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. The area between Sutter Creek and Pine Grove and upcountry area of Amador County towards Pioneer and West Point are likely to have a higher concentration of residents in these locations experiencing health disparities.

# Communities of Concern

Communities of Concern are geographic areas within the service area that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 4 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 5, with the census population provided for each, and are displayed in Figure 5.

*Table 5: Identified Communities of Concern for the SAH service area.*

| ZIP Code | Community\Area | Population |
|---|---|---|
| 95642 | **Jackson** | 7,101 |
| 95665 | **Pine Grove** | 4,303 |
| 95666 | **Pioneer** | 5,164 |
| 95675 | **River Pines** | 566 |
| *Total Population in Communities of Concern* | | *17,134* |
| *Total Population in Hospital Service Area* | | *59,877* |
| *Percentage of Service Area Population in Community of Concern* | | *28.6%* |

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

Figure 5 displays the ZIP Codes highlighted in pink that are Communities of Concern for the SAH service area.

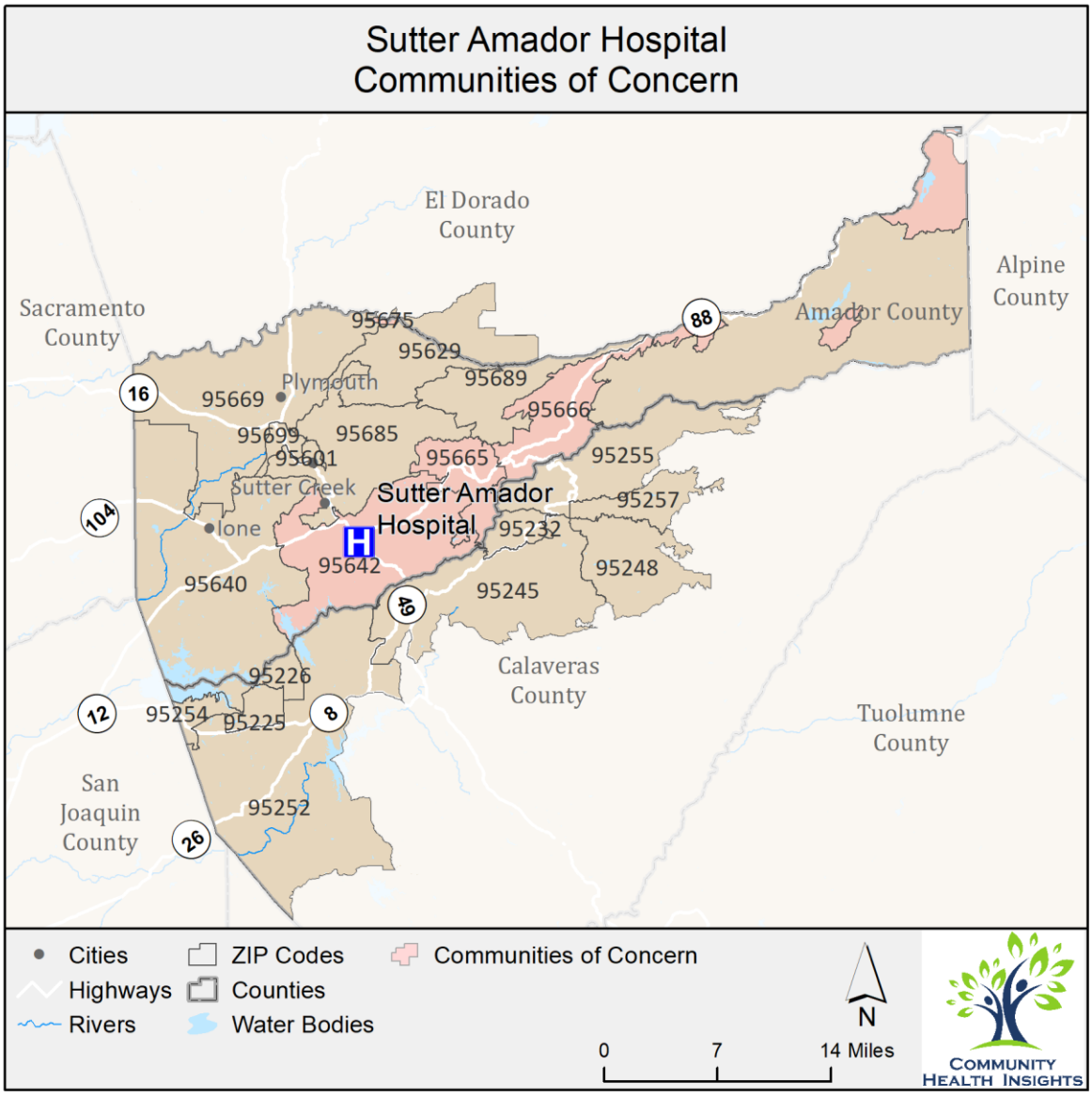
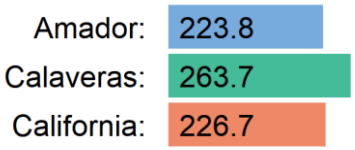
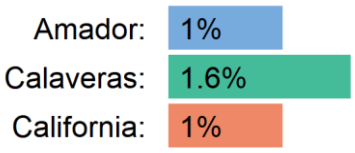
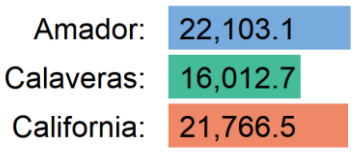
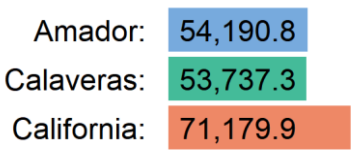



*Figure 5: SAH Communities of Concern.*

## The Impact of COVID-19 on Health Needs

COVID-19 related health indicators regard the HSA are noted in Table 6.

*Table 6: COVID-19-related rates for the SAH service area.*

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| COVID-19 Mortality | Number of deaths due to COVID-19 per 100,000 population. | 223.8 | 263.7 | 226.7 |   |
| COVID-19 Case Fatality | Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases. | 1.0% | 1.6% | 1.0% |   |
| COVID-19 Cumulative Incidence | Number of laboratory-confirmed COVID-19 cases per 100,000 population. | 22,103.1 | 16,012.7 | 21,766.5 |   |
| COVID-19 Cumulative Full Vaccination Rate | Number of completed COVID-19 vaccinations per 100,000 population. | 54,190.8 | 53,737.3 | 71,179.9 |   |

COVID-19 data collected on April 21 2022

COVID-19 data for Amador County show slightly lower mortality rates and lower full vaccination rates compared to the state. Also, the COVID-19 cumulative incidence rate was higher in Amador County in compared to the state rate. COVID-19 data for Calaveras County showed higher morality rates, a higher case fatality rate, a lower cumulative incidence rate but a lower cumulative vaccination rate than the state.

Key informants and focus group participants were asked how the COVID-19 pandemic had impacted the health needs they described during interviews. Community survey provider survey respondents were also asked to identify ways in which COVID-19 impacted health needs in the communities they served. A summary of their responses is shown in Table 7.

*Table 7: The impacts of COVID-19 on health need as identified in primary data sources.*

| Key Informant and Focus Group Responses | Community Service Provider Survey Responses |
|---|---|
| • Routine medical care and preventative services were put off.<br>• Many people stopped exercising and did not eat healthy.<br>• Mental health issues increased such as anxiety and depression.<br>• Isolation increased, especially in youth and seniors.<br>• The pandemic created a division in the community around mask mandates and vaccines.<br>• People could not get the resources they needed.<br>• Businesses closed and some were unable to reopen.<br>• Needed medical and dental appointments were cancelled or delayed. .<br>• Families struggled with online learning due to lack of adequate broadband/internet, and not having the technology needed for online learning.<br>• Social development in youth was delayed when schools shut down.<br>• Physical and mental abuse of youth and the elderly went unchecked.<br>• People were confused by the ever-changing CDC communications.<br>• Immunization for children were delayed.<br>• There was a lack of volunteers to help at the local food bank.<br>• COVID-19 shined a light on health care access issues.<br>• Telehealth expanded, but many did not have access to the technology to utilize the service.<br>• More people were signed up on Medi-Cal creating a burden on the county trying to meet their needs.<br>• Vaccine mandates and shutdowns created tension between the school district and parents.<br>• Increased need for behavioral health services, especially for youth that wanted and needed counseling.<br>• People were hesitant to get the vaccine and were not willing to trust medical advice. | • Isolation is harming the mental health of community members.<br>• Residents encounter economic hardships from lost or reduced employment.<br>• Residents delay or forgo healthcare to limit their exposure to the virus.<br>• Residents in the community are being evicted from their homes.<br>• Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services). |

## Resources Potentially Available to Meet the Significant Health Needs

In all, 128 resources were identified in the SAH service area that were potentially available to meet the identified SHNs. These resources were provided by a total of 48 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Sutter Amador Hospital CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers for each significant health need as shown in Table 8. For more specific examination of resources by geographic location, as well as the detailed method for identifying these, see the technical section of this report.

*Table 8: Resources potentially available to meet significant health needs in priority order.*

| Significant Health Needs (in Priority Order) | Number of Resources |
|---|---|
| Access to Quality Primary Care Health Services | 5 |
| Access to Mental/Behavioral Health and Substance Use Services | 18 |
| Access to Basic Needs Such as Housing, Jobs, and Food | 29 |
| Access to Specialty and Extended Care | 5 |
| Access to Functional Needs | 8 |
| Increased Community Connections | 30 |
| Active Living and Healthy Eating | 8 |
| Injury and Disease Prevention and Management | 16 |
| Safe and Violence-Free Environment | 9 |
| **Total Resources** | **128** |

## Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the SHNs identified in the hospital facility's prior CHNA(s) (p. 78969)."[12] SAH invested efforts to address the SHNs identified in the prior CHNA. Appendix A includes details of those efforts.

## Conclusion

CHNAs play a key role in helping nonprofit hospitals and other community organizations determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in the CHNA report can help provide nonprofit hospitals and community service providers with content to work in collaboration to engage in meaningful community work. Please send any feedback about this CHNA report to SHCB@sutterhealth.org with "CHNA Comments" in the subject line. Feedback received will be incorporate into the next CHNA.

[12] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

# 2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Sutter Amador Hospital (SAH) Hospital Service Area (HSA).

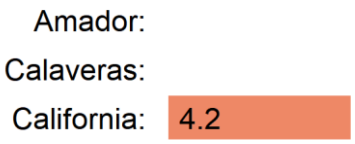
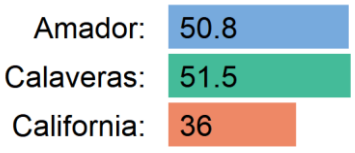
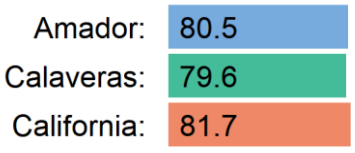
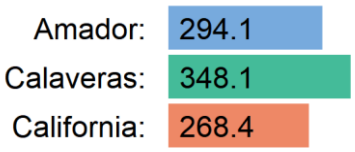
## Results of Data Analysis

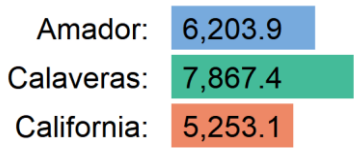
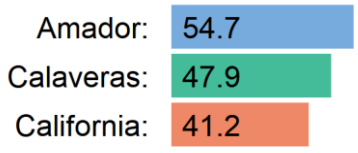
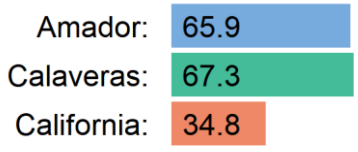
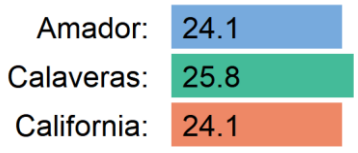
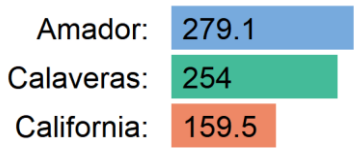
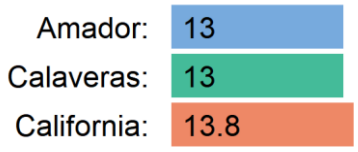
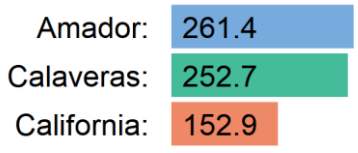
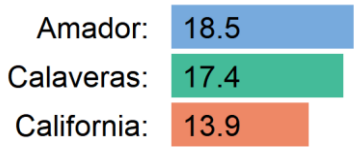
### Compiled Secondary Data

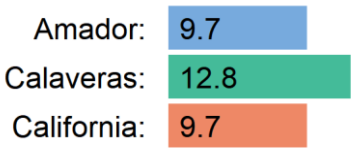
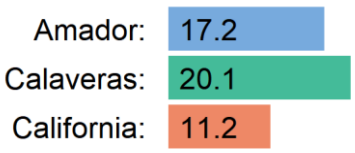
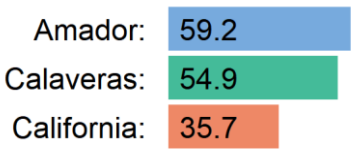
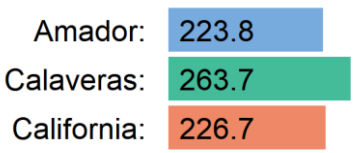
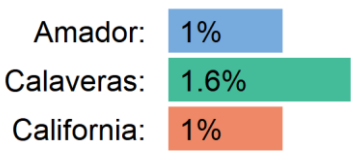
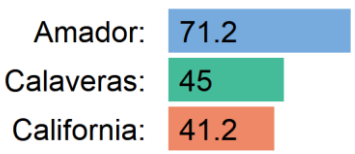
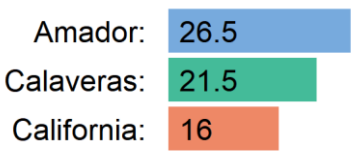
The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. Indicator values for Amador County were compared to the California state benchmark and are highlighted below when performance was worse in the county than in the state. Rates for Calaveras County are also included in the tables and figures below. The associated figures show rates for the counties compared to the California state rates.

### Length of Life

*Table 9: County length of life indicators compared to state benchmarks.*

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| **Early Life** | | | | | |
| Infant Mortality | Number of all infant deaths (within 1 year), per 1,000 live births. | | | 4.2 |   |
| Child Mortality | Number of deaths among children under age 18 per 100,000 population. | 50.8 | 51.5 | 36.0 |   |
| Life Expectancy | Average number of years a person can expect to live. | 80.5 | 79.6 | 81.7 |   |
| **Overall** | | | | | |
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 294.1 | 348.1 | 268.4 |   |

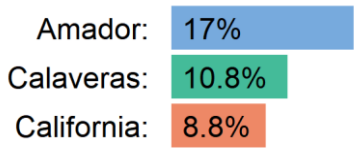
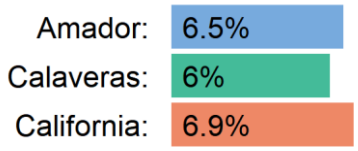
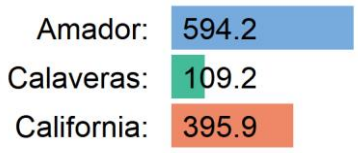
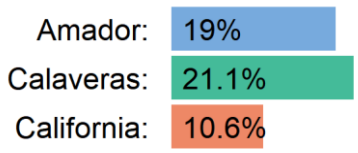
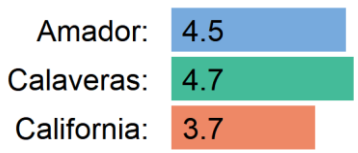
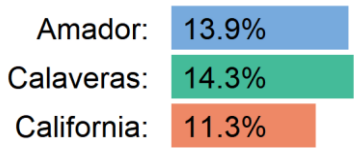
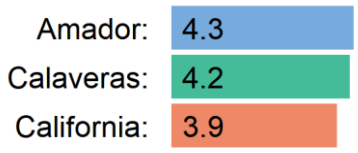
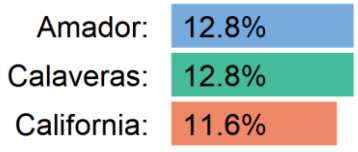
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | 6,203.9 | 7,867.4 | 5,253.1 |   |
| Stroke Mortality | Number of deaths due to stroke per 100,000 population. | 54.7 | 47.9 | 41.2 |   |
| Chronic Lower Respiratory Disease Mortality | Number of deaths due to chronic lower respiratory disease per 100,000 population. | 65.9 | 67.3 | 34.8 |   |
| Diabetes Mortality | Number of deaths due to diabetes per 100,000 population. | 24.1 | 25.8 | 24.1 |   |
| Heart Disease Mortality | Number of deaths due to heart disease per 100,000 population. | 279.1 | 254.0 | 159.5 |   |
| Hypertension Mortality | Number of deaths due to hypertension per 100,000 population. | 13.0 | 13.0 | 13.8 |   |
| **Cancer, Liver, and Kidney Disease** | | | | | |
| Cancer Mortality | Number of deaths due to cancer per 100,000 population. | 261.4 | 252.7 | 152.9 |   |
| Liver Disease Mortality | Number of deaths due to liver disease per 100,000 population. | 18.5 | 17.4 | 13.9 |   |

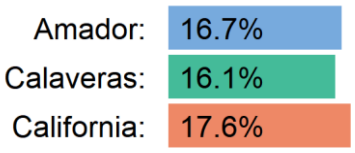
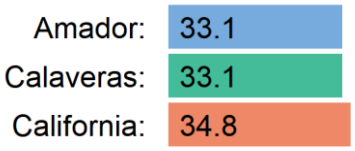
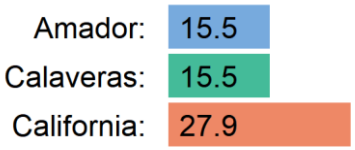
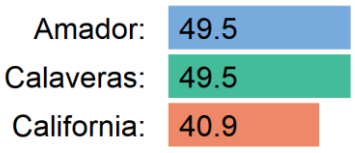
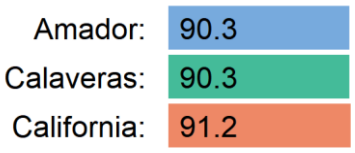
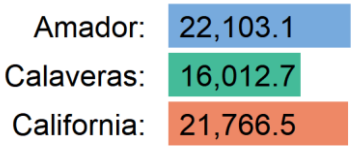
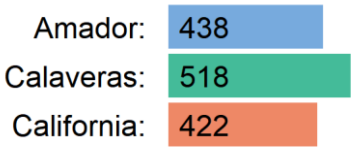
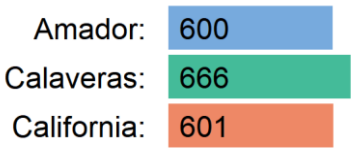
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Kidney Disease Mortality | Number of deaths due to kidney disease per 100,000 population. | 9.7 | 12.8 | 9.7 |  |
| **Intentional and Unintentional Injuries** | | | | | |
| Suicide Mortality | Number of deaths due to suicide per 100,000 population. | 17.2 | 20.1 | 11.2 |  |
| Unintentional Injuries Mortality | Number of deaths due to unintentional injuries per 100,000 population. | 59.2 | 54.9 | 35.7 |  |
| **COVID-19** | | | | | |
| COVID-19 Mortality | Number of deaths due to COVID-19 per 100,000 population. | 223.8 | 263.7 | 226.7 |  |
| COVID-19 Case Fatality | Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases. | 1.0% | 1.6% | 1.0% |  |
| **Other** | | | | | |
| Alzheimer's Disease Mortality | Number of deaths due to Alzheimer's disease per 100,000 population. | 71.2 | 45.0 | 41.2 |  |
| Influenza and Pneumonia Mortality | Number of deaths due to influenza and pneumonia per 100,000 population. | 26.5 | 21.5 | 16.0 |  |

## Quality of Life

*Table 10: County quality of life indicators compared to state benchmarks.*

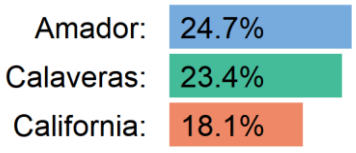
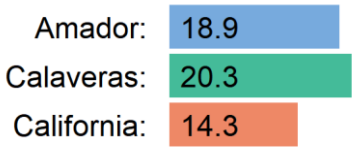
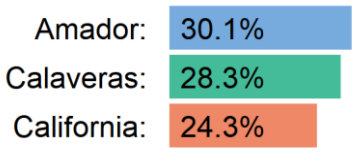
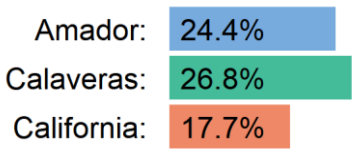
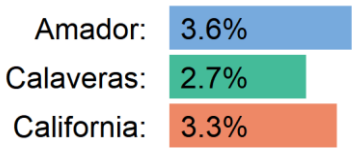
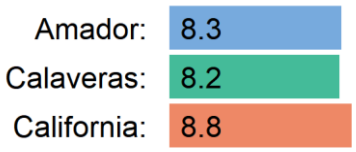
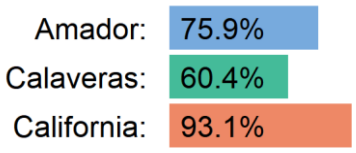
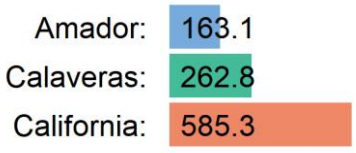
| Indicators | Description | Amador | Calaveras | California |
|---|---|---|---|---|
| **Chronic Disease** | | | | |

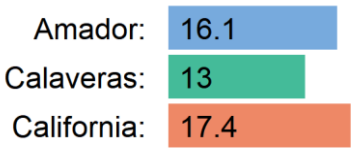
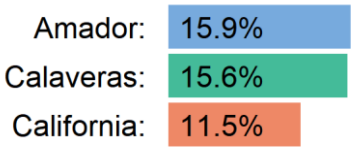
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Diabetes Prevalence | Percentage of adults ages 20 and above with diagnosed diabetes. | 17.0% | 10.8% | 8.8% |   |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | 6.5% | 6.0% | 6.9% |   |
| HIV Prevalence | Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population. | 594.2 | 109.2 | 395.9 |   |
| Disability | Percentage of the total civilian noninstitutionalized population with a disability | 19.0% | 21.1% | 10.6% |   |
| **Mental Health** | | | | | |
| Poor Mental Health Days | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). | 4.5 | 4.7 | 3.7 |   |
| Frequent Mental Distress | Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). | 13.9% | 14.3% | 11.3% |   |
| Poor Physical Health Days | Average number of physically unhealthy days reported in past 30 days (age-adjusted). | 4.3 | 4.2 | 3.9 |   |
| Frequent Physical Distress | Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted). | 12.8% | 12.8% | 11.6% |   |

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Poor or Fair Health | Percentage of adults reporting fair or poor health (age-adjusted). | 16.7% | 16.1% | 17.6% |   |
| **Cancer** | | | | | |
| Colorectal Cancer Prevalence | Colon and rectum cancers per 100,000 population (age-adjusted). | 33.1 | 33.1 | 34.8 |   |
| Breast Cancer Prevalence | Female in situ breast cancers per 100,000 female population (age-adjusted). | 15.5 | 15.5 | 27.9 |   |
| Lung Cancer Prevalence | Lung and bronchus cancers per 100,000 population (age-adjusted). | 49.5 | 49.5 | 40.9 |   |
| Prostate Cancer Prevalence | Prostate cancers per 100,000 male population (age-adjusted). | 90.3 | 90.3 | 91.2 |   |
| **COVID-19** | | | | | |
| COVID-19 Cumulative Incidence | Number of laboratory-confirmed COVID-19 cases per 100,000 population. | 22,103.1 | 16,012.7 | 21,766.5 |   |
| **Other** | | | | | |
| Asthma ED Rates | Emergency department visits due to asthma per 10,000 (age-adjusted). | 438.0 | 518.0 | 422.0 |   |
| Asthma ED Rates for Children | Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted). | 600.0 | 666.0 | 601.0 |   |

## Health Behavior

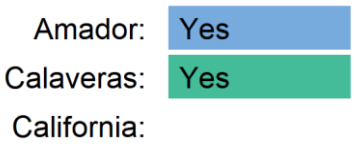
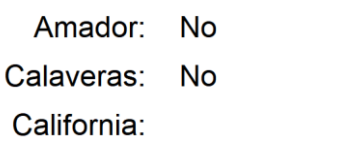
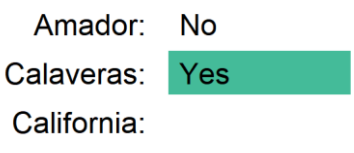
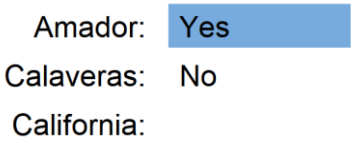
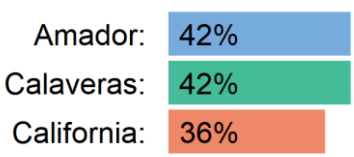
*Table 11: County health behavior indicators compared to state benchmarks.*

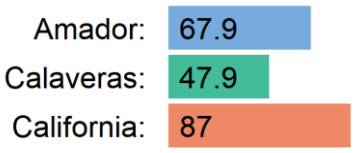
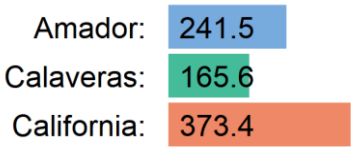
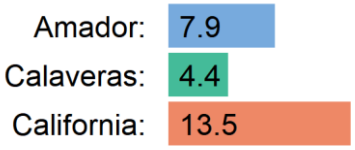
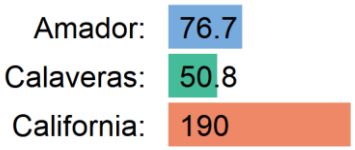
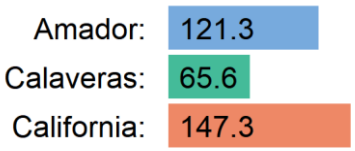
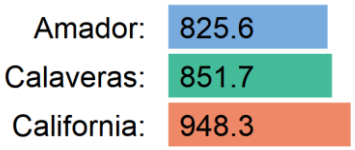
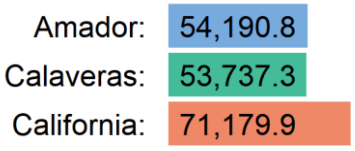
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Excessive Drinking | Percentage of adults reporting binge or heavy drinking (age-adjusted). | 24.7% | 23.4% | 18.1% |   |
| Drug Induced Death | Drug induced deaths per 100,000 (age-adjusted). | 18.9 | 20.3 | 14.3 |   |
| Adult Obesity | Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. | 30.1% | 28.3% | 24.3% |   |
| Physical Inactivity | Percentage of adults ages 20 and over reporting no leisure-time physical activity. | 24.4% | 26.8% | 17.7% |   |
| Limited Access to Healthy Foods | Percentage of population who are low-income and do not live close to a grocery store. | 3.6% | 2.7% | 3.3% |   |
| Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). | 8.3 | 8.2 | 8.8 |   |
| Access to Exercise Opportunities | Percentage of population with adequate access to locations for physical activity. | 75.9% | 60.4% | 93.1% |   |
| Chlamydia Incidence | Number of newly diagnosed chlamydia cases per 100,000 population. | 163.1 | 262.8 | 585.3 |   |

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Teen Birth Rate | Number of births per 1,000 female population ages 15-19. | 16.1 | 13.0 | 17.4 |  |
| Adult Smoking | Percentage of adults who are current smokers (age-adjusted). | 15.9% | 15.6% | 11.5% |  |

## Clinical Care

*Table 12: County clinical care indicators compared to state benchmarks.*

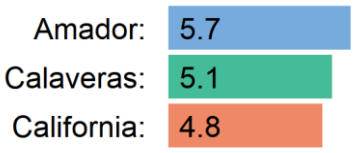
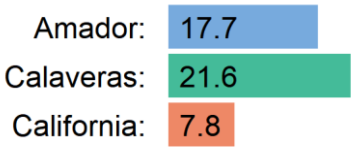
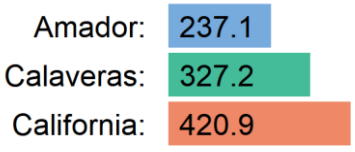
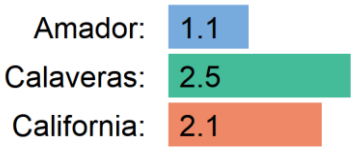
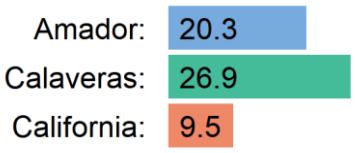
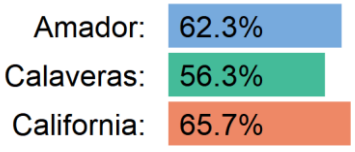
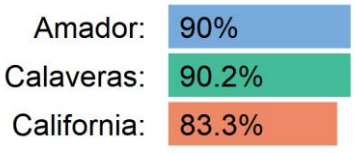
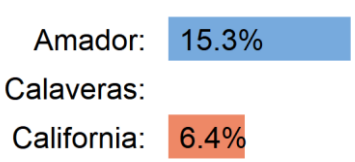
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Primary Care Shortage Area | Presence of a primary care health professional shortage area within the county. | Yes | Yes | |  |
| Dental Care Shortage Area | Presence of a dental care health professional shortage area within the county. | No | No | |  |
| Mental Health Care Shortage Area | Presence of a mental health professional shortage area within the county. | No | Yes | |  |
| Medically Underserved Area | Presence of a medically underserved area within the county. | Yes | No | |  |
| Mammography Screening | Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. | 42.0% | 42.0% | 36.0% |  |

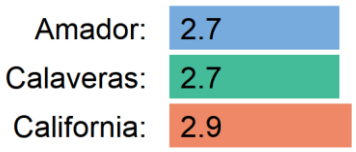
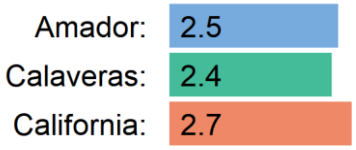
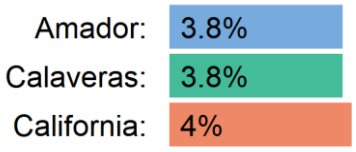
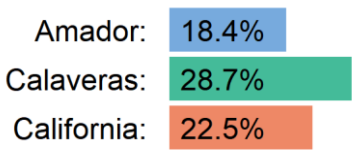
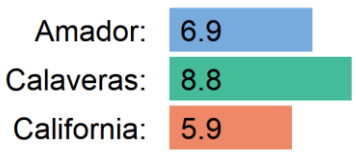
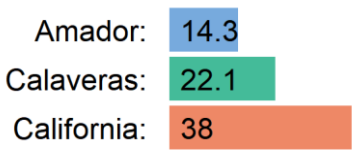
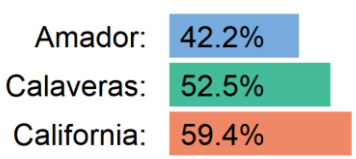
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Dentists | Dentists per 100,000 population. | 67.9 | 47.9 | 87.0 |   |
| Mental Health Providers | Mental health providers per 100,000 population. | 241.5 | 165.6 | 373.4 |   |
| Psychiatry Providers | Psychiatry providers per 100,000 population. | 7.9 | 4.4 | 13.5 |   |
| Specialty Care Providers | Specialty care providers (non-primary care physicians) per 100,000 population. | 76.7 | 50.8 | 190.0 |   |
| Primary Care Providers | Primary care physicians per 100,000 population + other primary care providers per 100,000 population. | 121.3 | 65.6 | 147.3 |   |
| Preventable Hospitalization | Preventable hospitalizations per 100,000 (age-sex-poverty adjusted) | 825.6 | 851.7 | 948.3 |   |
| **COVID-19** | | | | | |
| COVID-19 Cumulative Full Vaccination Rate | Number of completed COVID-19 vaccinations per 100,000 population. | 54,190.8 | 53,737.3 | 71,179.9 |   |

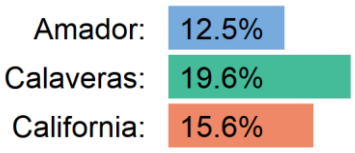
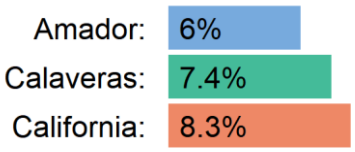
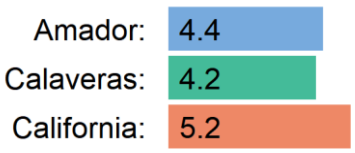
## Socio-Economic and Demographic Factors

*Table 13: County socio-economic and demographic factors indicators compared to state benchmarks.*

| Indicators | Description | Amador | Calaveras | California |
|---|---|---|---|---|
| **Community Safety** | | | | |

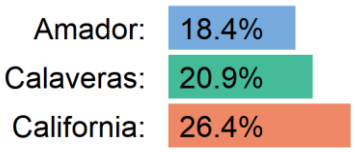
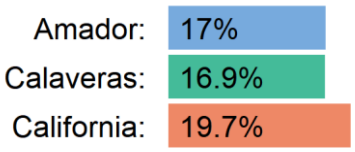
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Homicide Rate | Number of deaths due to homicide per 100,000 population. | 5.7 | 5.1 | 4.8 |   |
| Firearm Fatalities Rate | Number of deaths due to firearms per 100,000 population. | 17.7 | 21.6 | 7.8 |   |
| Violent Crime Rate | Number of reported violent crime offenses per 100,000 population. | 237.1 | 327.2 | 420.9 |   |
| Juvenile Arrest Rate | Felony juvenile arrests per 1,000 juveniles | 1.1 | 2.5 | 2.1 |   |
| Motor Vehicle Crash Death | Number of motor vehicle crash deaths per 100,000 population. | 20.3 | 26.9 | 9.5 |   |
| **Education** | | | | | |
| Some College | Percentage of adults ages 25-44 with some post-secondary education. | 62.3% | 56.3% | 65.7% |   |
| High School Completion | Percentage of adults ages 25 and over with a high school diploma or equivalent. | 90.0% | 90.2% | 83.3% |   |
| Disconnected Youth | Percentage of teens and young adults ages 16-19 who are neither working nor in school. | 15.3% | | 6.4% |   |

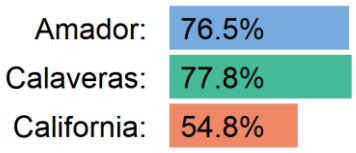
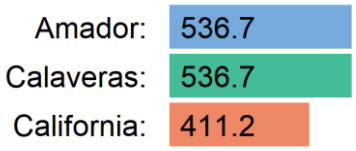
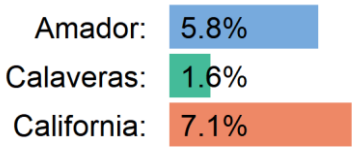
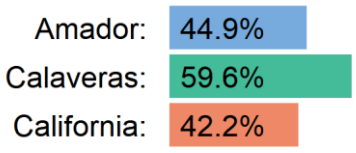
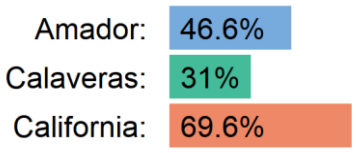
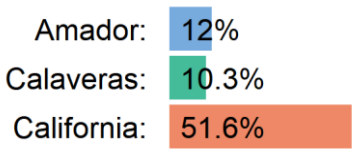
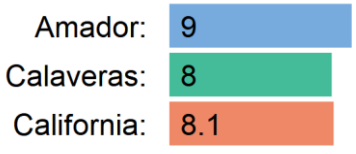
| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | 2.7 | 2.7 | 2.9 |   |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | 2.5 | 2.4 | 2.7 |   |
| **Employment** | | | | | |
| Unemployment | Percentage of population ages 16 and older unemployed but seeking work. | 3.8% | 3.8% | 4.0% |   |
| **Family and Social Support** | | | | | |
| Children in Single-Parent Households | Percentage of children that live in a household headed by single parent. | 18.4% | 28.7% | 22.5% |   |
| Social Associations | Number of membership associations per 10,000 population. | 6.9 | 8.8 | 5.9 |   |
| Residential Segregation (Non-White/White) | Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents. | 14.3 | 22.1 | 38.0 |   |
| **Income** | | | | | |
| Children Eligible for Free Lunch | Percentage of children enrolled in public schools that are eligible for free or reduced price lunch. | 42.2% | 52.5% | 59.4% |   |

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Children in Poverty | Percentage of people under age 18 in poverty. | 12.5% | 19.6% | 15.6% |  |
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | $62,640.0 | $68,248.0 | $80,423.0 |  |
| Uninsured Population under 64 | Percentage of population under age 65 without health insurance. | 6.0% | 7.4% | 8.3% |  |
| Income Inequality | Ratio of household income at the 80th percentile to income at the 20th percentile. | 4.4 | 4.2 | 5.2 |  |

## Physical Environment

*Table 14: County physical environment indicators compared to state benchmarks.*

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| **Housing** | | | | | |
| Severe Housing Problems | Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 18.4% | 20.9% | 26.4% |  |
| Severe Housing Cost Burden | Percentage of households that spend 50% or more of their household income on housing. | 17.0% | 16.9% | 19.7% |  |

| Indicators | Description | Amador | Calaveras | California | |
|---|---|---|---|---|---|
| Homeownership | Percentage of occupied housing units that are owned. | 76.5% | 77.8% | 54.8% |   |
| Homelessness Rate | Number of homeless individuals per 100,000 population. | 536.7 | 536.7 | 411.2 |   |
| **Transit** | | | | | |
| Households with no Vehicle Available | Percentage of occupied housing units that have no vehicles available. | 5.8% | 1.6% | 7.1% |   |
| Long Commute - Driving Alone | Among workers who commute in their car alone, the percentage that commute more than 30 minutes. | 44.9% | 59.6% | 42.2% |   |
| Access to Public Transit | Percentage of population living near a fixed public transportation stop | 46.6% | 31.0% | 69.6% |   |
| **Air and Water Quality** | | | | | |
| Pollution Burden Percent | Percentage of population living in a census tract with a CalEnviroscreen 3.0 pollution burden score percentile of 50 or greater | 12.0% | 10.3% | 51.6% |   |
| Air Pollution - Particulate Matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). | 9.0 | 8.0 | 8.1 |   |

| Indicators | Description | Amador | Calaveras | California | | |
|---|---|---|---|---|---|---|
| Drinking Water Violations | Presence of health-related drinking water violations in the county. | No | Yes | | Amador:<br>Calaveras:<br>California: | No<br>Yes |

## Community Service Provider Survey Results

*Table 15: Service provider survey results for Amador, Calaveras Counties.*

| **Service Provider Survey Snapshot \| Amador County (N=9)** | |
|---|---|
| **Health Needs** | **% Reporting** |
| **Most Frequently Reported** | |
| Access to Quality Primary Care Health Services | 88.9% |
| Access to Basic Needs Such as Housing, Jobs, and Food | 77.8% |
| Access to Mental/Behavioral Health and Substance-Abuse Services | 77.8% |
| Access to Specialty and Extended Care | 77.8% |
| **Top 3/ Priority *(Most Frequently Reported Characteristics)*** | |
| Access to Quality Primary Care Health Services | 77.8% |
| *It is difficult to recruit and retain primary care providers in the region.* | |
| *There aren't enough primary care service providers in the area.* | |
| *Too few providers in the area accept Medi-Cal.* | |
| *Patients have difficulty obtaining appointments outside of regular business hours.* | |
| *Wait-times for appointments are excessively long.* | |
| Access to Mental/Behavioral Health and Substance Abuse Services | 66.7% |
| *Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.* | |
| *Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).* | |
| *The area lacks the infrastructure to support acute mental health crises.* | |
| *There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers).* | |
| *There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).* | |
| Access to Basic Needs Such as Housing, Jobs, and Food | 44.5% |
| *It is difficult to find affordable childcare.* | |
| *Lack of affordable housing is a significant issue in the area.* | |
| *The area needs additional low-income housing options.* | |

## CHNA Methods and Processes

Two related models were foundational in this CHNA. The first is a conceptual model that expresses the theoretical understanding of community health used in the analysis. This understanding is important because it provides the framework underpinning the collection of primary and secondary data. It is the

tool used to ensure that the results are based on a rigorous understanding of those factors that influence the health of a community. The second model is a process model that describes the various stages of the analysis. It is the tool that ensures that the resulting analysis is based on a tight integration of community voice and secondary data and that the analysis meets federal regulations for conducting hospital CHNAs.

### *Conceptual Model*

The conceptual model used in this needs assessment is shown in Figure 6. This model organizes populations' individual health-related characteristics in terms of how they relate to up- or downstream health and health-disparities factors. In this model, health outcomes (quality and length of life) are understood to result from the influence of health factors describing interrelated individual, environmental, and community characteristics, which in turn are influenced by underlying policies and programs.

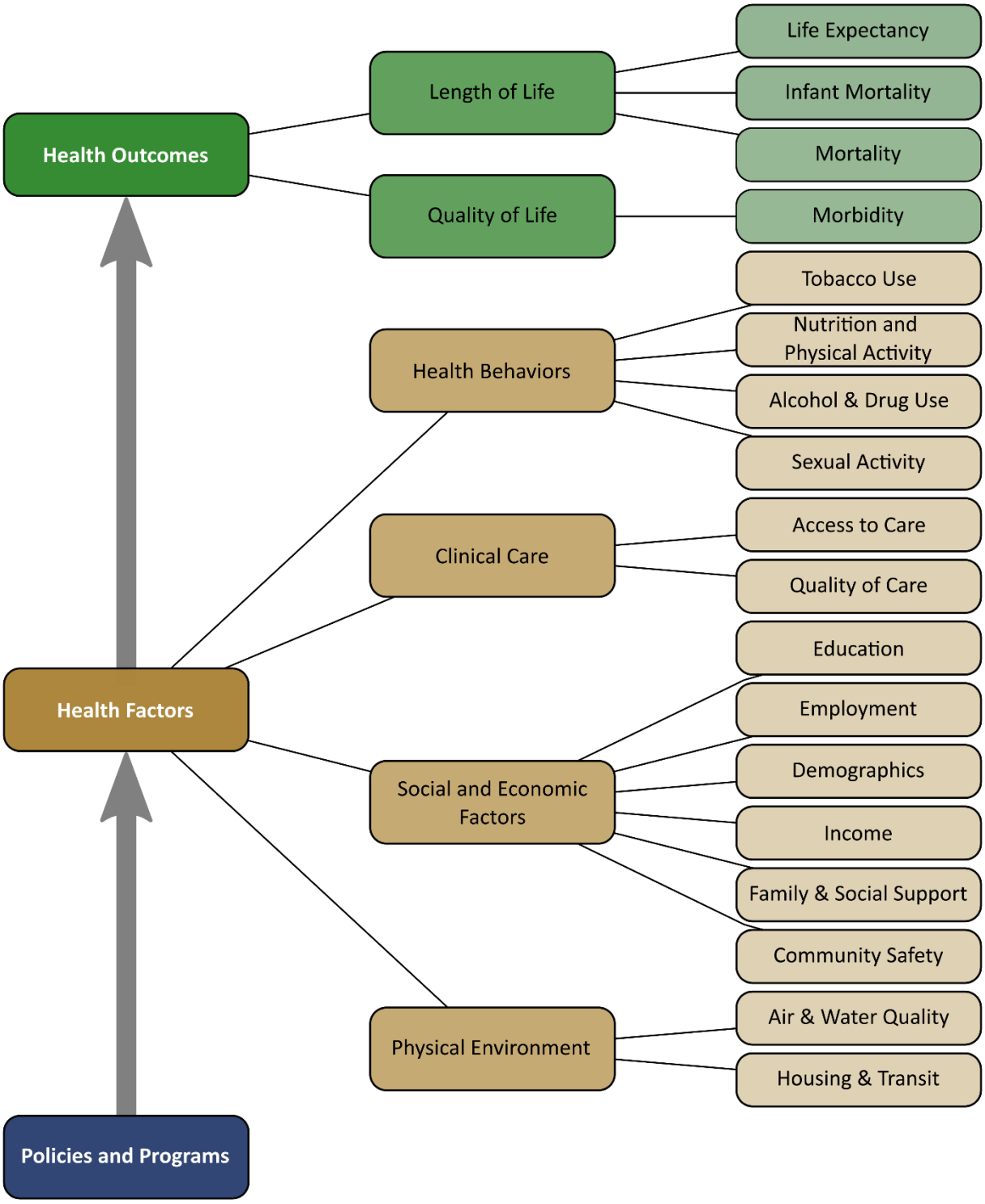



*Figure 6: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.*

This model was used to guide the selection of secondary indicators in this analysis as well as to express in general how these upstream health factors lead to the downstream health outcomes. It also suggests

that poor health outcomes within the service area can be improved through policies and programs that address the health factors contributing to them. This conceptual model is a slightly modified version of the County Health Rankings Model used by the Robert Wood Johnson Foundation. It was primarily altered by adding a "Demographics" category to the "Social and Economic Factors" in recognition of the influence of demographic characteristics on health outcomes.

To generate the list of secondary indicators used in the assessment, each conceptual model category was reviewed to identify potential indicators that could be used to fully represent the category. The results of this discussion were then used to guide secondary data collection.

### *Process Model*

Figure 7 outlines the data collection and analysis stages of this process. The project began by confirming the HSA for Sutter Amador Hospital for which the CHNA would be conducted. Primary data collection included key informant interviews and focus-groups with community health experts and residents as well as a community survey provider survey. Initial key informant interviews were used to identify Communities of Concern which are areas or population subgroups within the county experiencing health disparities.

Overall primary and secondary data were integrated to identify SHNs for the HSA. SHNs were then prioritized based on analysis of the primary data. Finally, information was collected regarding the resources available within the community to meet the identified health needs. An evaluation of the impact of the hospital's prior efforts was obtained from hospital representatives and any written comments on the previous CHNA were gathered and included in the report.

Greater detail on the collection and processing of the secondary and primary data is given in the next two sections. This is followed by a more detailed description of the methodology utilized during the main analytical stages of the process.

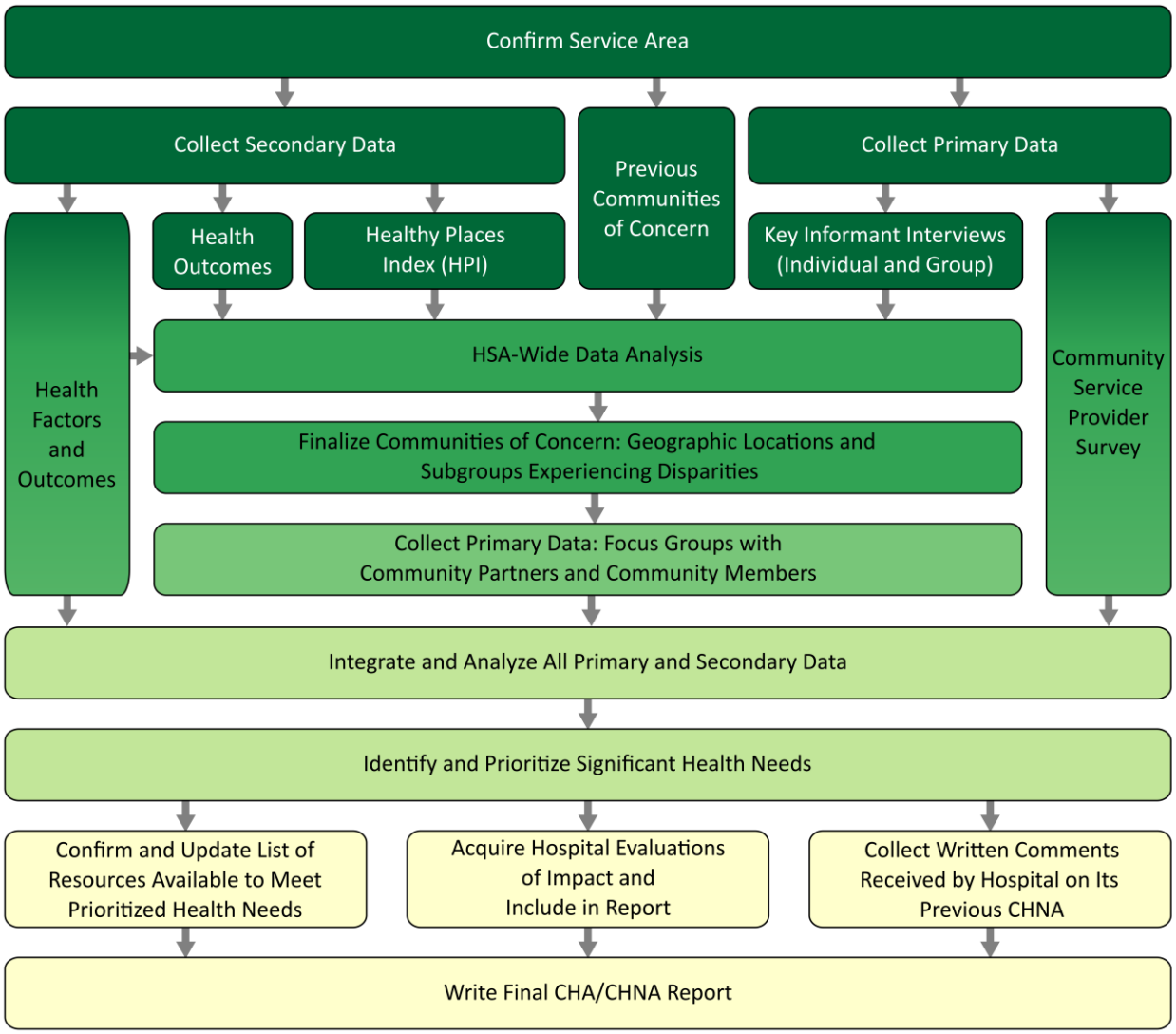



*Figure 7: CHNA process model for SAH.*

## Primary Data Collection and Processing

### *Primary Data Collection*

Input from the community served by Sutter Amador Hospital was collected through two main mechanisms. First, key informant interviews were conducted with community health experts and area service providers (i.e., members of social service nonprofit organizations and related healthcare organizations). These interviews occurred in both one-on-one and in group interview settings. Second, focus groups were conducted with community residents that were identified as populations experiencing disparities.

All participants were given an informed consent form prior to their participation, which provided information about the project, asked for permission to record the interview, and listed the potential benefits and risks for involvement in the interview. All interview data were collected through note taking and, in some instances, recording.

## *Key Informant Results*

Primary data collection with key informants included two phases. First, phase one began by interviewing area-wide service providers with knowledge of the service area, including input from the designated Public Health Department. Data from these area-wide informants, coupled with socio-demographic data, was used to identify additional key informants for the assessment that were included in phase two.

As a part of the interview process, all key informants were asked to identify vulnerable populations. The interviewer asked each participant to verbally explain what vulnerable populations existed in the county. As needed for a visual aid, key informants were provided a map of the HSA to directly point to the geographic locations of these vulnerable communities. Additional key informant interviews were focused on the geographic locations and/or subgroups identified in the earlier phase.

Table 16 contains a listing of community health experts, or key informants, which contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

*Table 16: Key informant list.*

| Organization | Date | Number of Participants | Area of Expertise | Populations Served |
|---|---|---|---|---|
| First 5 Amador | 02/17/2022 | 1 | Childhood development | Youth 0 - 5 years and their families |
| Sutter Plymouth Health Center | 03/03/2022 | 2 | Healthcare services | |
| Amador County Health and Human Services | 03/03/2022 | 3 | Public Health | Amador County |
| Sutter Amador Hospital Staff | 03/04/2022 | 3 | Acute care hospital: Healthcare services | Amador County |
| Sutter Medical Group | 03/04/2022 | 1 | Healthcare provider | Adults in Amador County |
| Wellspace Health | 03/08/2022 | 4 | FQHC: Healthcare services | Low income; Medi-Cal; underserved |
| Sutter Medical Foundation, Amador | 03/09/2022 | 3 | Healthcare providers | Amador County |
| National Alliance on Mental Illness (NAMI) | 03/10/2022 | 1 | Mental and behavioral health | Amador County |
| Amador Tuolumne Community Action Agency | 03/21/2022 | 1 | Community support services | Low income; homeless; seniors; Hispanic; foster youth |
| Interfaith Food Bank | 03/23/2022 | 1 | Food insecurity | Low income, underserved |

## *Key Informant Interview Guide*

The following questions served as the interview guides for key informant interviews.

**2022 CHNA Group/Key Informant Interview Protocol**

1. **BACKGROUND**
    a) **Please tell me about your current role and the organization you work for?**
        i. Probe for:
            1. Public health (division or unit)
            2. Hospital health system
            3. Local non-profit
            4. Community member
    b. **How would you define the community (ies) you or your organization serves?**
        i. Probe for:
            1. Specific geographic areas?
            2. Specific populations served?
            3. *Who? Where? Racial/ethnic make-up, physical environment (urban/ rural, large/small)*
2. **CHARACTERISTICS OF A HEALTHY COMMUNITY**
    a. **In your view, what does a healthy community look like?**
        i. Probe for:
            1. Social factors
            2. Economic factors
            3. Clinical care
            4. Physical/built environment (food environment, green spaces)
            5. Neighborhood safety
3. **HEALTH ISSUES**
    a. **What would you say are the biggest health needs in the community?**
        i. Probe for:
            1. How has the presence of COVID-19 impacted these health needs?
    b. **INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live?**
        i. Probe for:
            1. What specific geographic locations struggle with health issues the most?
            2. What specific groups of community members experience health issues the most?
4. **CHALLENGES/BARRIERS**
    a. **Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?**
        i. **Do these inequities exist among certain population groups?**
        ii. Probe for:
            1. Health Behaviors (maladaptive, coping)
            2. Social factors (social connections, family connectedness, relationship with law enforcement)
            3. Economic factors (income, access to jobs, affordable housing, affordable food)
            4. Clinical Care factors (access to primary care, secondary care, quality of care)
            5. Physical (Built) environment (safe and healthy housing, walkable communities, safe parks)
5. **SOLUTIONS**
    a. **What solutions are needed to address the health needs and or challenges mentioned?**
        i. Probe for:

1. Policies
2. Care coordination
3. Access to care
4. Environmental change

6. **PRIORITY**
    a. **Which would you say are currently the most important or urgent health issues or challenges to address (at least 3 to 5) in order to improve the health of the community?**
7. **RESOURCES**
    a. **What resources exist in the community to help people live healthy lives?**
        i. Probe for:
            1. Barriers to accessing these resources.
            2. Added resources that have been created since 2019
            3. New partnerships/projects/funding
8. **PARTICIPANT DRIVEN SAMPLING:**
    a. **What other people, groups or organizations would you recommend we speak to about the health of the community?**
        i. Name 3 types of service providers that you would suggest we include in this work?
        ii. Name 3 types of community members that you would recommend we speak to in this work?
9. **OPEN: Is there anything else you would like to share with our team about the health of the community?**

### *Focus Group Results*

Focus group interviews were conducted with community members or service providers living or working in geographic areas of the service area identified as locations or populations experiencing a disparate amount of poor socioeconomic conditions and poor health outcomes. Recruitment consisted of referrals from designated service providers representing vulnerable populations, as well as direct outreach to special population groups.

Table 17 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

*Table 17: Focus group list.*

| Hosting Organization | Date | Number of Participants | Populations Represented |
|---|---|---|---|
| Amador Senior Center | 04/05/2022 | 7 | Seniors |
| Upcountry Community Center | 04/05/2022 | 11 | Low income families; Spanish speaking; seniors |

### *Focus Group Interview Guide*

The following questions served as the interview guides for focus group interviews.

**2022 CHNA Focus Group Interview Protocol**

1. Let's start by introducing ourselves. Please tell us your name, the town you live in, and one thing that you are proud of about your community.
2. We would like to hear about the community where you live. Tell us in a few words what you think of as "your community." What it is like to live in your community?
3. What do you think that a "healthy environment" is?
4. When thinking about your community based on the healthy environment you just described, what are the biggest health needs in your community?
5. Are needs more prevalent in a certain geographic area, or within a certain group of the community?
6. How has the presence of COVID-19 impacted these health needs?
7. What are the challenges or barriers to being healthy in your community?
8. What are some solutions that can help solve the barriers and challenges you talked about?
9. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address to improve the health of the community?
10. Are these needs that have recently come up or have they been around for a long time?
11. What are resources that exist in the community that help your community live healthy lives and address the health issues and inequity we have discussed?
12. Is there anything else you would like to share with our team about the health of the community?

### *Primary Data Processing*

Key informant and focus group data were analyzed using qualitative analytic software. Content analysis included thematic coding to potential health need categories, the identification of special populations experiencing health issues, and the identification of resources. In some instances, data were coded in accordance with the interview question guide. Results were then aggregated to inform the determination of prioritized SHNs.

## Community Service Provider Survey

A web-based survey was then administered to community service providers (CSP) who delivered health and social services to community residents of the HSA. A list of CSPs affiliated with the nonprofit hospitals included in this report are used as an initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey aims and inviting them to participate. Participants we also encouraged to forward the recruitment message to other CSPs in their networks. The survey was designed using Qualtrics, an online survey platform, and was available for approximately two weeks. 9 respondents completed the survey. Survey respondents were also given the opportunity to be acknowledged for their participation in the report and are listed as follows:

Jody Boetzer, Denise Cloward, Michael Cureton, Beth Stanton, and Mel Welsh

After providing socio-demographic information including the county they served and their affiliated organization(s), survey respondents were shown a list of 12 potential health needs and asked to identify which were unmet health needs in their community. In order to reduce any confusion or ambiguity that could introduce bias, participants could scroll over each health need for a definition. Respondents were then asked to select which of the needs they identified as unmet in their community were the priority to address (up to three health needs). Upon selection of these priority unmet health needs, respondents were asked about the characteristics of each as it is expressed in their community. Depending upon the

specific health need, respondents were shown a list of between 7-12 characteristics and could select all that apply. Respondents were also offered the opportunity to provide additional information about the health need in their community if it was not provided as a response option. Finally, we included a set of questions about how the COVID-19 pandemic impacted the health needs of the community.

When the survey period was over, incomplete, and duplicate responses were removed from the dataset and the survey responses were double-checked for accuracy. Descriptive statistics and frequencies were used to summarize the health needs. This information was used along with other data sources to both identify and rank SHNs in the community, and to describe how the health needs are expressed.

## Secondary Data Collection and Processing

We use "secondary data" to refer to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to 1) inform the identification of Communities of Concern, 2) support the identification of health needs within the SAH HSA. This section details the data sources and processing steps used to obtain the secondary data used in each of these steps and prepare them for analysis.

### *Community of Concern Identification Datasets*

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),[13] derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),[14] health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2015-2019 due to each of the causes listed in Table 18.

*Table 18: Mortality indicators used in Community of Concern Identification.*

| Cause of Death | ICD 10 Codes |
|---|---|
| Alzheimer's disease | G30 |
| Malignant neoplasms (cancers) | C00-C97 |
| Chronic lower respiratory disease (CLRD) | J40-J47 |
| Diabetes mellitus | E10-E14 |
| Diseases of heart | I00-I09, I11, I13, I20-I51 |
| Essential hypertension and hypertensive renal disease | I10, I12, I15 |
| Accidents (unintentional injuries) | V01-X59, Y85-Y86 |
| Chronic liver disease and cirrhosis | K70, K73-K74 |
| Nephritis, nephrotic syndrome, and nephrosis | N00-N07, N17-N19, N25-N27 |
| Pneumonia and influenza | J09-J18 |
| Cerebrovascular disease (stroke) | I60-I69 |
| Intentional self-harm (suicide) | *U03, X60-X84, Y87.0 |

[13] Public Health Alliance of Southern California. 2021. HPI_MasterFile_2021-04-22.zip. Data file. Retrieved 1 May 2021 from https://healthyplacesindex.org/wp-content/uploads/2021/04/HPI_MasterFile_2021-04-22.zip.
[14] State of California, Department of Public Health. 2021. California Comprehensive Master Death File (Static), 2015-2019.

While the HPI dataset was used as-is, additional processing was required to prepare the mortality data for analysis. This included two main steps. First, ZIP Codes associated with PO Boxes needed to be merged with the larger ZIP Codes in which they were located. Once this was completed, smoothed mortality rates were calculated for each resulting ZIP Code.

### *ZIP Code Consolidation*

The mortality indicators used here included deaths reported for the ZIP Code at the decedent's place of residence. ZIP Codes are defined by the U.S. Postal Service as a specific location (such as a PO Box), or a set of roads along which addresses are located. The roads that comprise such a ZIP Code may not form contiguous areas and do not match the areas used by the U.S. Census Bureau (the main source of population and demographic data in the United States) to report population. Instead of measuring the population along a collection of roads, the census reports population figures for distinct, contiguous areas. To support the analysis of ZIP Code data, the U.S. Census Bureau created ZIP Code Tabulation Areas (ZCTAs). ZCTAs are created by identifying the dominant ZIP Code for addresses in a given Census block (the smallest unit of census data available), and then grouping blocks with the same dominant ZIP Code into a corresponding ZCTA. The creation of ZCTAs allows us to identify population figures that make it possible to calculate mortality rates for each ZCTA. However, the difference in the definition between mailing ZIP Codes and ZCTAs has two important implications for analyses of ZIP Code level data.

First, ZCTAs are approximate representations of ZIP Codes rather than exact matches. While this is not ideal, it is nevertheless the nature of the data being analyzed. Second, not all ZIP Codes have corresponding ZCTAs. Some PO Box ZIP Codes or other unique ZIP Codes (such as a ZIP Code assigned to a single facility) may not have enough addressees residing in a given census block to ever result in the creation of a corresponding ZCTA. But residents whose mailing addresses are associated with these ZIP Codes will still show up in reported health-outcome data. This means that rates cannot be calculated for these ZIP Codes individually because there are no matching ZCTA population figures.

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California[15] were compared to ZCTA boundaries.[16] These unique ZIP Codes were then assigned to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

### *Rate Calculation and Smoothing*

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical bayes smoothed rates (EBRs) were created for all indicators possible.[17] Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small-number problem. Empirical bayes smoothing seeks to

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[15] Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from http://www.Zip-Codes.com.
[16] US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from https://www.census.gov/cgi-bin/geo/shapefiles/index.php.
[17] Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

Because the EBR were created for all ZCTAs in the state, ZCTAs with small populations that may have unstable high rates had their rates "shrunk" to more closely match the overall indicator rate for ZCTAs in the entire state. This adjustment can be substantial for ZCTAs with exceedingly small populations. The difference between raw rates and EBRs in ZCTAs with exceptionally large populations, on the other hand, is negligible. In this way, the stable rates in large-population ZIP Codes are preserved, and the unstable rates in smaller-population ZIP Codes are shrunk to more closely match the state norm. While this may not entirely resolve the small-number problem in all cases, it does make the comparison of the resulting rates more appropriate. Because the rate for each ZCTA is adjusted by the EBR process, this also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

EBRs were calculated for each mortality indicator using the total population figure reported for ZCTAs in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

### *Significant Health Need Identification Dataset*

The second main set of data used in the CHNA includes the health factor and health outcome indicators used to identify SHNs. The selection of these indicators was guided by the previously identified conceptual model. Table 19 lists these indicators, their sources, the years they were measured, and the health-related characteristics from the conceptual model they are primarily used to represent.

*Table 19: Health factor and health outcome indicators used in health need identification.*

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|---|---|---|---|---|---|
| Health Outcomes | Length of Life | Infant Mortality | Infant Mortality | County Health Rankings | 2013 - 2019 |
| | | Life Expectancy | Child Mortality | County Health Rankings | 2016 - 2019 |
| | | | Life Expectancy | County Health Rankings | 2017 - 2019 |
| | | | Premature Age-Adjusted Mortality | County Health Rankings | 2017 - 2019 |
| | | | Premature Death | County Health Rankings | 2017 - 2019 |
| | | Mortality | Stroke Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Chronic Lower Respiratory Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|---|---|---|---|---|---|
| | | | Diabetes Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Heart Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Hypertension Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Cancer Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Liver Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Kidney Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Suicide Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Unintentional Injuries Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | COVID-19 Mortality | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-04-21 |
| | | | COVID-19 Case Fatality | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-04-21 |
| | | | Alzheimer's Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Influenza and Pneumonia Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | Quality of Life | Morbidity | Diabetes Prevalence | County Health Rankings | 2017 |
| | | | Low Birthweight | County Health Rankings | 2013 - 2019 |
| | | | HIV Prevalence | County Health Rankings | 2018 |
| | | | Disability | 2019 American Community Survey 5 year estimate variable S1810_C03_001E | 2015 - 2019 |
| | | | Poor Mental Health Days | County Health Rankings | 2018 |
| | | | Frequent Mental Distress | County Health Rankings | 2018 |
| | | | Poor Physical Health Days | County Health Rankings | 2018 |
| | | | Frequent Physical Distress | County Health Rankings | 2018 |
| | | | Poor or Fair Health | County Health Rankings | 2018 |

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|---|---|---|---|---|---|
| | | | Colorectal Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | Breast Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | Lung Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | Prostate Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | COVID-19 Cumulative Incidence | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-04-21 |
| | | | Asthma ED Rates | Tracking California | 2018 |
| | | | Asthma ED Rates for Children | Tracking California | 2018 |
| Health Factors | Health Behavior | Alcohol and Drug Use | Excessive Drinking | County Health Rankings | 2018 |
| | | | Drug Induced Death | CDPH 2021 County Health Status Profiles | 2017 - 2019 |
| | | Nutrition and Physical Activity | Adult Obesity | County Health Rankings | 2017 |
| | | | Physical Inactivity | County Health Rankings | 2017 |
| | | | Limited Access to Healthy Foods | County Health Rankings | 2015 |
| | | | Food Environment Index | County Health Rankings | 2015 & 2018 |
| | | | Access to Exercise Opportunities | County Health Rankings | 2010 & 2019 |
| | | Sexual Activity | Chlamydia Incidence | County Health Rankings | 2018 |
| | | | Teen Birth Rate | County Health Rankings | 2013 - 2019 |
| | | Tobacco Use | Adult Smoking | County Health Rankings | 2018 |
| | Clinical Care | Access to Care | Primary Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Dental Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Mental Health Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Medically Underserved Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Mammography Screening | County Health Rankings | 2018 |
| | | | Dentists | County Health Rankings | 2019 |
| | | | Mental Health Providers | County Health Rankings | 2020 |

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|---|---|---|---|---|---|
| | | | Psychiatry Providers | County Health Rankings | 2020 |
| | | | Specialty Care Providers | County Health Rankings | 2020 |
| | | | Primary Care Providers | County Health Rankings | 2018; 2020 |
| | | Quality Care | Preventable Hospitalization | California Office of Statewide Health Planning and Development Prevention Quality Indicators for California | 2019 |
| | | | COVID-19 Cumulative Full Vaccination Rate | CDPH COVID-19 Vaccine Progress Dashboard Data | Collected on 2022-04-21 |
| | Socio-Economic and Demographic Factors | Community Safety | Homicide Rate | County Health Rankings | 2013 - 2019 |
| | | | Firearm Fatalities Rate | County Health Rankings | 2015 - 2019 |
| | | | Violent Crime Rate | County Health Rankings | 2014 & 2016 |
| | | | Juvenile Arrest Rate | Criminal Justice Data: Arrests, OpenJustice, California Department of Justice | 2015 - 2019 |
| | | | Motor Vehicle Crash Death | County Health Rankings | 2013 - 2019 |
| | | Education | Some College | County Health Rankings | 2015 - 2019 |
| | | | High School Completion | County Health Rankings | 2015 - 2019 |
| | | | Disconnected Youth | County Health Rankings | 2015 - 2019 |
| | | | Third Grade Reading Level | County Health Rankings | 2018 |
| | | | Third Grade Math Level | County Health Rankings | 2018 |
| | | Employment | Unemployment | County Health Rankings | 2019 |
| | | Family and Social Support | Children in Single-Parent Households | County Health Rankings | 2015 - 2019 |
| | | | Social Associations | County Health Rankings | 2018 |
| | | | Residential Segregation (Non-White/White) | County Health Rankings | 2015 - 2019 |

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|---|---|---|---|---|---|
| | | Income | Children Eligible for Free Lunch | County Health Rankings | 2018 - 2019 |
| | | | Children in Poverty | County Health Rankings | 2019 |
| | | | Median Household Income | County Health Rankings | 2019 |
| | | | Uninsured Population under 64 | County Health Rankings | 2018 |
| | | | Income Inequality | County Health Rankings | 2015 - 2019 |
| | Physical Environment | Housing and Transit | Severe Housing Problems | County Health Rankings | 2013 - 2017 |
| | | | Severe Housing Cost Burden | County Health Rankings | 2015 - 2019 |
| | | | Homeownership | County Health Rankings | 2015 - 2019 |
| | | | Homelessness Rate | US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report | 2020 |
| | | | Households with no Vehicle Available | 2019 American Community Survey 5-year estimate variable DP04_0058PE | 2015 - 2019 |
| | | | Long Commute - Driving Alone | County Health Rankings | 2015 - 2019 |
| | | | Access to Public Transit | OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau | 2021; 2020 |
| | | Air and Water Quality | Pollution Burden Percent | California Office of Environmental Health Hazard Assessment | 2018 |
| | | | Air Pollution - Particulate Matter | County Health Rankings | 2016 |
| | | | Drinking Water Violations | County Health Rankings | 2019 |

The following sections give further details about the sources of these data and any processing applied to prepare them for use in the analysis.

### *County Health Rankings Data*

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings[18] dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 20.

*Table 20: Sources and time periods for indicators obtained from County Health Rankings.*

| CHR Indicator | Time Period | Data Source |
|---|---|---|
| Infant Mortality | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Child Mortality | 2016 - 2019 | National Center for Health Statistics - Mortality Files |
| Life Expectancy | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Premature Age-Adjusted Mortality | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Premature Death | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Diabetes Prevalence | 2017 | United States Diabetes Surveillance System |
| Low Birthweight | 2013 - 2019 | National Center for Health Statistics - Natality files |
| HIV Prevalence | 2018 | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention |
| Poor Mental Health Days | 2018 | Behavioral Risk Factor Surveillance System |
| Frequent Mental Distress | 2018 | Behavioral Risk Factor Surveillance System |
| Poor Physical Health Days | 2018 | Behavioral Risk Factor Surveillance System |
| Frequent Physical Distress | 2018 | Behavioral Risk Factor Surveillance System |
| Poor or Fair Health | 2018 | Behavioral Risk Factor Surveillance System |
| Excessive Drinking | 2018 | Behavioral Risk Factor Surveillance System |
| Adult Obesity | 2017 | United States Diabetes Surveillance System |
| Physical Inactivity | 2017 | United States Diabetes Surveillance System |
| Limited Access to Healthy Foods | 2015 | USDA Food Environment Atlas |
| Food Environment Index | 2015 & 2018 | USDA Food Environment Atlas, Map the Meal Gap from Feeding America |
| Access to Exercise Opportunities | 2010 & 2019 | Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files |

[18] University of Wisconsin Population Health Institute. 2021. County Health Rankings State Report 2021. Retrieved 6 May 2021 from https://www.countyhealthrankings.org/app/oregon/2021/downloads and https://www.countyhealthrankings.org/app/california/2021/downloads.

| | | |
|---|---|---|
| Chlamydia Incidence | 2018 | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention |
| Teen Birth Rate | 2013 - 2019 | National Center for Health Statistics - Natality files |
| Adult Smoking | 2018 | Behavioral Risk Factor Surveillance System |
| Mammography Screening | 2018 | Mapping Medicare Disparities Tool |
| Dentists | 2019 | Area Health Resource File/National Provider Identification file |
| Mental Health Providers | 2020 | CMS, National Provider Identification |
| Psychiatry Providers | 2020 | Area Health Resource File |
| Specialty Care Providers | 2020 | Area Health Resource File |
| Primary Care Providers | 2018; 2020 | Area Health Resource File/American Medical Association; CMS, National Provider Identification |
| Homicide Rate | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Firearm Fatalities Rate | 2015 - 2019 | National Center for Health Statistics - Mortality Files |
| Violent Crime Rate | 2014 & 2016 | Uniform Crime Reporting - FBI |
| Motor Vehicle Crash Death | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Some College | 2015 - 2019 | American Community Survey, 5-year estimates |
| High School Completion | 2015 - 2019 | American Community Survey, 5-year estimates |
| Disconnected Youth | 2015 - 2019 | American Community Survey, 5-year estimates |
| Third Grade Reading Level | 2018 | Stanford Education Data Archive |
| Third Grade Math Level | 2018 | Stanford Education Data Archive |
| Unemployment | 2019 | Bureau of Labor Statistics |
| Children in Single-Parent Households | 2015 - 2019 | American Community Survey, 5-year estimates |
| Social Associations | 2018 | County Business Patterns |
| Residential Segregation (Non-White/White) | 2015 - 2019 | American Community Survey, 5-year estimates |
| Children Eligible for Free Lunch | 2018 - 2019 | National Center for Education Statistics |
| Children in Poverty | 2019 | Small Area Income and Poverty Estimates |
| Median Household Income | 2019 | Small Area Income and Poverty Estimates |
| Uninsured Population under 64 | 2018 | Small Area Health Insurance Estimates |
| Income Inequality | 2015 - 2019 | American Community Survey, 5-year estimates |
| Severe Housing Problems | 2013 - 2017 | Comprehensive Housing Affordability Strategy (CHAS) data |
| Severe Housing Cost Burden | 2015 - 2019 | American Community Survey, 5-year estimates |

| | | |
|---|---|---|
| Homeownership | 2015 - 2019 | American Community Survey, 5-year estimates |
| Long Commute - Driving Alone | 2015 - 2019 | American Community Survey, 5-year estimates |
| Air Pollution - Particulate Matter | 2016 | Environmental Public Health Tracking Network |
| Drinking Water Violations | 2019 | Safe Drinking Water Information System |

The provider rates for the primary care physicians and other primary care providers indicators obtained from CHR were summed to create the final primary care provider indicator used in this analysis.

### *California Department of Public Health*

### *By-Cause Mortality Data*

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa[19] online data query system for the years 2015-2019. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

CDPH masks the actual number of deaths that occur in a county for a given year and cause if there are between 1 and 10 total deaths recorded. Because of this, the following process was used to estimate the total number of deaths for counties whose actual values were masked. First, mortality rates for each cause and year were calculated for the state. The differences between the by-cause mortality for the state and the total by-cause mortality reported across all counties in the state for each cause and year were also calculated.

Next, we applied the state by-cause mortality rate for each cause and year to estimate mortality at the county level if the reported value was masked. This was done by multiplying the cause/year appropriate state-level mortality rate by the 2017 populations of counties with masked values. Resulting estimates that were less than 1 or greater than 10 were set to 1 and 10 respectively to match the known CDPH masking criteria.

The total number of deaths estimated for counties that had masked values for each year/cause was then compared to the difference between the reported total county and state deaths for the corresponding year/cause. If the number of estimated county deaths exceeded this difference, county estimates were further adjusted. This was done by iteratively ranking county estimates for a given year/cause, then from highest to lowest, reducing the estimates by 1 until they reached a minimum of 1 death. This continued until the estimated deaths for counties with masked values equaled the difference between the state and total reported county values.

[19] State of California, Department of Public Health. 2021. California Vital Data (Cal-ViDa), Death Query. Retrieved 1 Jun 2021 from https://cal-vida.cdph.ca.gov/.

### *COVID-19 Data*

Data on the cumulative number of cases and deaths[20] and completed vaccinations[21] for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

### *Drug-Induced Deaths Data*

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles[22] and report age-adjusted deaths per 100,000.

### *U.S. Heath Resources and Services Administration*

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration[23] (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

### *Health Professional Shortage Areas*

The health professional shortage area and medically underserved area data were not provided at the county level. Rather, they show all areas in the state that were designated as shortage areas. These areas could include a portion of a county or an entire county, or they could span multiple counties. To develop measures at the county level to match the other health-factor and health-outcome indicators used in health need identification, these shortage areas were compared to the boundaries of each county in the state. Counties that were partially or entirely covered by a shortage area were noted.

### *Psychiatry and Specialty Care Providers*

The HRSA's Area Health Resource Files provide information on physicians and allied healthcare providers for U.S. counties. This information was used to determine the rate of specialty care providers and the

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[20] State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved April 21, 2022, from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

[21] State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved April 21 2022 from https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv.

[22] State of California, Department of Public Health, Vital Records Data and Statistics. 2021. County Health Status Profiles 2021: CHSP 2021 Tables 1-29. Spreadsheet. Retrieved 21 Jul 2021 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP_2021_Tables_1-29_04.16.2021.xlsx.

[23] US Health Resources & Services Administration. 2021. Area Health Resources Files and Shortage Areas. Retrieved on 3 Feb 2021 from https://data.hrsa.gov/data/download.

rate of psychiatrists for each county and for the state. For the purposes of this analysis, a specialty care provider was defined as a physician who was not defined by the HRSA as a primary care provider. This was found by subtracting the total number of primary care physicians (both MDs and DOs, primary care, patient care, and non-federal, excluding hospital residents and those 75 years of age or older) from the total number of physicians (both MDs and DOs, patient care, non-federal) in 2018. This number was then divided by the 2018 total population given in the 2018 American Community Survey 5-year Estimates table B03002, and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

The total of specialty care physicians in each county was summed to find the total specialty care physicians in the state, and state rates were calculated following the same approach as used for county rates. This same process was also used to calculate the number of psychiatrists per 100,000 for each county and the state using the number of total patient care, non-federal psychiatrists from the Area Health Resource Files. It should be noted that psychiatrists are included in the list of specialty care physicians, so that indicator represents a subset of specialty care providers rather than a separate group.

### *California Cancer Registry*

Data obtained from the California Cancer Registry[24] includes age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2013 to 2017, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

### *Tracking California*

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California.[25] These data reported age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

### *US Census Bureau*

Data from the US Census Bureau was used for two additional indicators: the percentage of households with no vehicles available (table DPO4, variable 0058PE), and the percentage of the civilian non-institutionalized population with some disability (table S1810, variable C03_001E). Values for both of these variables were obtained from the 2019 American Community Survey 5-year Estimates dataset.

[24] California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from https://www.cancer-rates.info/ca/.
[25] Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.

### *California Office of Environmental Health Hazard Assessment*

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroscreen 3.0[26] dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroscreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

### *California Department of Health Care Access and Information*

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators.[27] These data are reported as risk-adjusted rates per 100,000.

### *California Department of Justice*

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.[28] This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015 - 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I, respectively.

### *US Department of Housing and Urban Development*

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report[29] were used to calculate homelessness rates for the counties and state. This data reported point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

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[26] California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from https://oehha.ca.gov/calenviroscreen/maps-data.
[27] Office of Statewide Health Planning and Development. 2021. Prevention Quality Indicators (PQI) for California. Data files for Statewide and County. Retrieved 12 Mar 2021 from https://oshpd.ca.gov/data-and-reports/healthcare-quality/ahrq-quality-indicators/.
[28] California Department of Justice, OpenJustice. 2021. Criminal Justice Data: Arrests. Retrieved 17 Jun 2021 from https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2020-07/OnlineArrestData1980-2019.csv.
[29] US Department of Housing and Urban Development. 2021. 2020 Annual Homeless Assessment Report: 2007 - 2020 Point-in-Time Estimates by CoC. Retrieved 14 Jul 2021 from https://www.huduser.gov/portal/sites/default/files/xls/2007-2020-PIT-Estimates-by-CoC.xlsx.

To calculate county rates, CoC were first related to county boundaries. Rates for CoC that covered single counties were calculated by dividing the CoC PIT estimate by the county population. If a given county was covered by multiple CoC, their PIT were totaled and then divided by the total county population to calculate the rate. When a single CoC covered multiple counties, the CoC PIT was divided by the total of all included county populations, and the resulting rate was applied to each individual county.

Population data came from the total population value reported in Table B03002 from the 2019 American Community Survey 5-year Estimates dataset. Derived rates were multiplied by 100,000 to report rates per 100,000.

### *Proximity to Transit Stops*

The proximity to transit stops variable reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Due to delays in data releases stemming from the COVID-19 pandemic, the most recent Census block population data available at the time of the analysis was from the 2010 Decennial Census,[30] so this was the data used to represent the distribution of population for this indicator.

Transit stop data were identified first by using tools in the TidyTransit[31] library for the R statistical programming language.[32] This was used to identify transit providers with stops located within 100 miles of the state boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData,[33] Transitland,[34] Transitwiki.org,[35] and Santa Ynez Valley Transit.[36] Each of these websites list public transit data that have been made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf[37] library in R was then used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all

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[30] US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/.

[31] Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley, and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. Retrieved 10 Sep 2021 from https://CRAN.R-project.org/package=tidytransit.

[32] R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/.

[33] OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from https://openmobilitydata.org/l/67-california-usa.

[34] Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from https://www.transit.land/operators.

[35] Transitwiki.org. 2021. List of publicly-accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.

[36] Santa Ynez Valley Transit. GTFS Files. Retrieved 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.

[37] Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, https://doi.org/10.32614/RJ-2018-009.

tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

## Detailed Analytical Methodology

The collected and processed primary and secondary data were integrated in three main analytical stages. First, secondary health outcome and health factor data were combined with area-wide key informant interviews help identify Communities of Concern. These Communities of Concern could potentially include geographic regions as well as specific sub-populations bearing disproportionate health burdens. This information was used to focus the remaining interview and focus-group collection efforts on those areas and subpopulations. Next, the resulting data, along with the results from the service provider survey, were combined with secondary health need identification data to identify SHNs within the service area. Finally, primary data were used to prioritize those identified SHNs. The specific details for these analytical steps are given in the following three sections.

### Community of Concern Identification

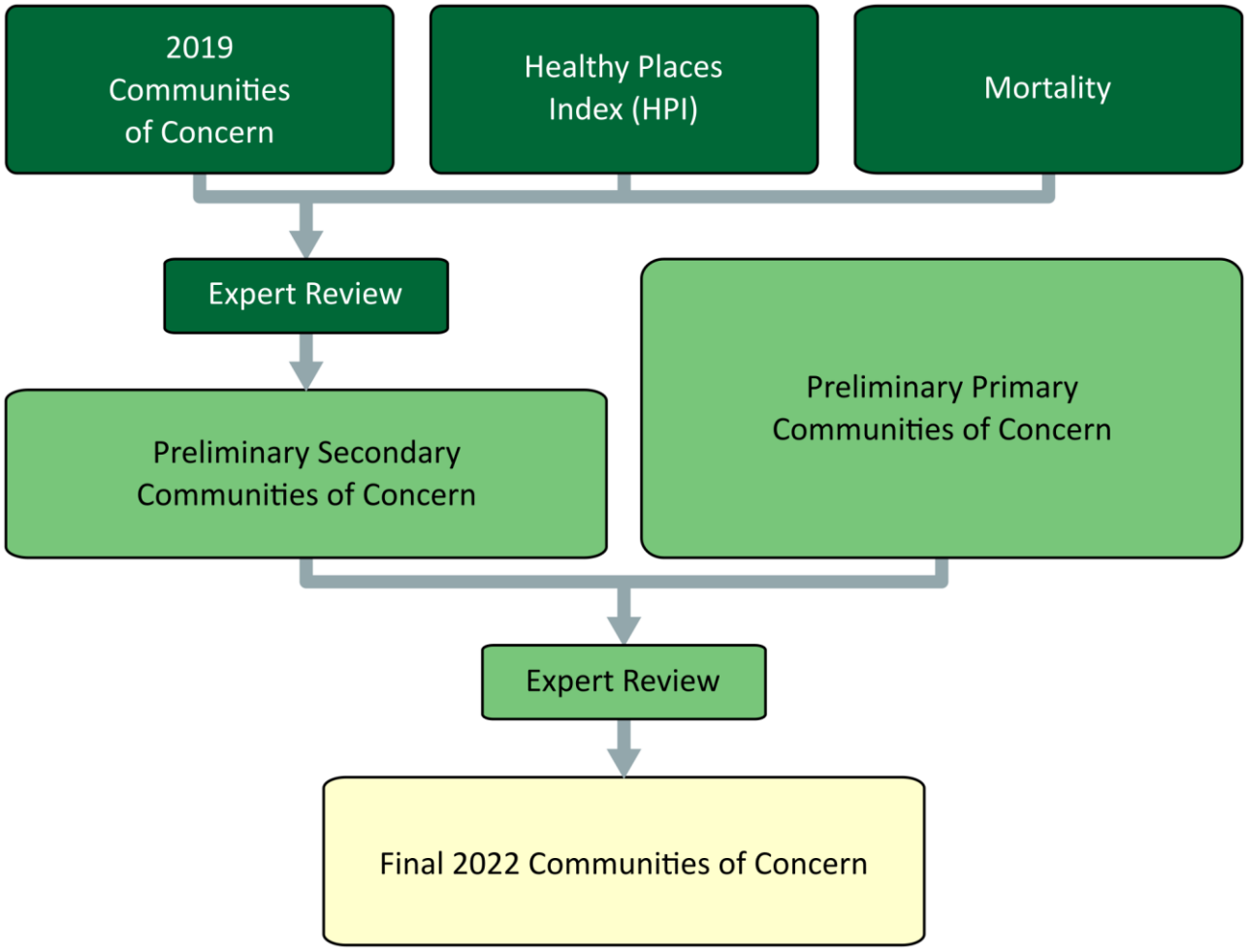


*Figure 8: Community of Concern identification process.*

As illustrated in Figure 8, 2022 Communities of Concern were identified through a process that drew upon both primary and secondary data. Three main secondary data sources were used in this analysis: Communities of Concern identified in the 2019 CHNA; the census tract-level California Healthy Places Index (HPI); and the CDPH ZCTA-level mortality data.

An evaluation procedure was developed for each of these datasets and applied to each ZCTA within the HSA. The following secondary data selection criteria were used to identify preliminary Communities of Concern.

### *2019 Community of Concern*

A ZCTA was included if it was included in the 2019 CHNA Community of Concern list for the HSA. This was done to allow greater continuity between CHNA rounds and reflects the work of the hospital systems oriented to serve these disadvantaged communities.

### *Healthy Places Index (HPI)*

A ZCTA was included if it intersected a census tract whose HPI value fell within the lowest 20% of those in the HSA. These census tracts represent areas with consistently high concentrations of demographic subgroups identified in the research literature as being more likely to experience health-related disadvantages.

### *CDPH Mortality Data*

The review of ZCTAs based on mortality data utilized the ZCTA-level CDPH health outcome indicators described previously. These indicators were heart disease, cancer, stroke, CLD, Alzheimer's disease, unintentional injuries, diabetes, influenza and pneumonia, chronic liver disease, hypertension, suicide, and kidney disease mortality rates per 100,000 people. The number of times each ZCTA's rates for these indicators fell within the top 20% in the HSA was counted. Those ZCTAs whose counted values exceeded the 80th percentile for all of the ZCTAs in the HSA met the Community of Concern mortality selection criteria.

### *Integration of Secondary Criteria*

Any ZCTA that met any of the three selection criteria (2019 Community of Concern, HPI, and Mortality) was reviewed for inclusion as a 2022 Community of Concern, with greater weight given to those ZCTAs meeting two or more of the selection criteria. An additional round of expert review was applied to determine if any other ZCTAs not thus far indicated should be included based on some other unanticipated secondary data consideration. This list then became the final Preliminary Secondary Communities of Concern.

### *Preliminary Primary Communities of Concern*

Preliminary primary Communities of Concern were identified by reviewing the geographic locations or population subgroups that were consistently identified by the area-wide primary data sources.

### *Integration of Preliminary Primary and Secondary Communities of Concern*

Any ZCTA that was identified in either the Preliminary Primary or Secondary Community of Concern list was considered for inclusion as a 2022 Community of Concern. An additional round of expert review was then applied to determine if, based on any primary or secondary data consideration, any final adjustments should be made to this list. The resulting set of ZCTAs was then used as the final 2022 Communities of Concern.

## Significant Health Need Identification

The general methods through which SHNs were identified are shown in Figure 9 and described here in greater detail. The first step in this process was to identify a set of potential health needs (PHNs) from which SHNs could be selected. This was done by reviewing the health needs identified during prior CHNAs among various hospitals throughout Central and Northern California and then supplementing this list based on a preliminary analysis of the primary qualitative data collected for the current CHNA. This resulted the list of PHNs shown in Table 21.

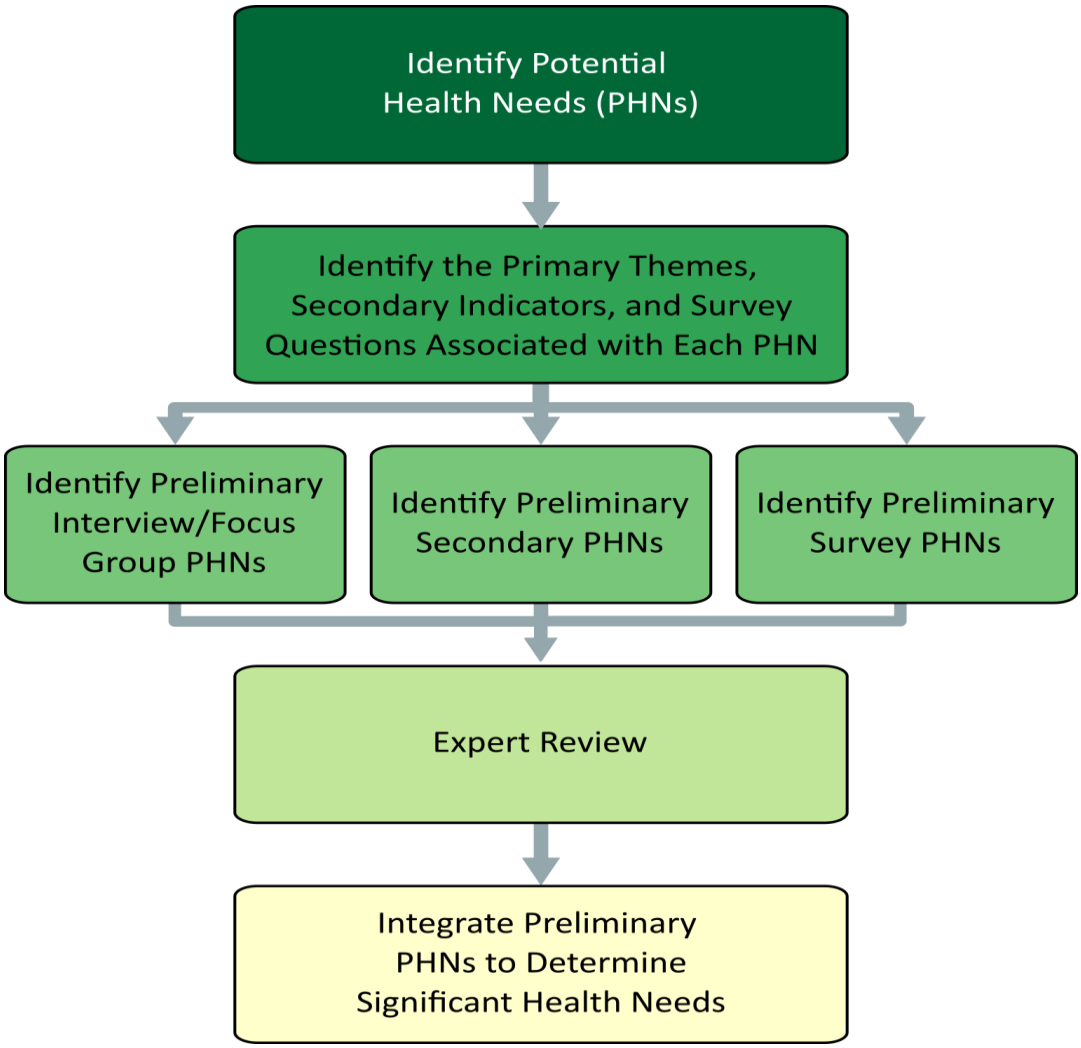


*Figure 9: Significant health need identification process.*

*Table 21: 2022 Potential Health Needs.*

| Potential Health Needs (PHNs) | |
|---|---|
| PHN1 | Access to Mental/Behavioral Health and Substance Use Services |
| PHN2 | Access to Quality Primary Care Health Services |
| PHN3 | Active Living and Healthy Eating |
| PHN4 | Safe and Violence-Free Environment |
| PHN5 | Access to Dental Care and Preventive Services |
| PHN6 | Healthy Physical Environment |
| PHN7 | Access to Basic Needs Such as Housing, Jobs, and Food |
| PHN8 | Access to Functional Needs |
| PHN9 | Access to Specialty and Extended Care |
| PHN10 | Injury and Disease Prevention and Management |
| PHN11 | Increased Community Connections |
| PHN12 | System Navigation |

The next step in the process was to identify primary themes and secondary indicators associated with each of these health needs as shown in Tables 22 through 33. Primary theme associations were used to guide coding of the primary data sources to specific PHNs.

**Access to Mental/Behavioral Health and Substance Use Services**

*Table 22: Primary themes and secondary indicators associated with PHN1.*

| Primary Themes | Secondary Indicators |
|---|---|
| There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). | Life Expectancy |
| The cost for mental/behavioral health treatment is too high. | Premature Age-Adjusted Mortality |
| Treatment options in the area for those with Medi-Cal are limited. | Premature Death |
| Awareness of mental health issues among community members is low. | Liver Disease Mortality |
| Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools). | Suicide Mortality |
| The stigma around seeking mental health treatment keeps people out of care. | Poor Mental Health Days |
| Additional services for those who are homeless and dealing with mental/behavioral health issues are needed. | Frequent Mental Distress |
| The area lacks the infrastructure to support acute mental health crises. | Poor Physical Health Days |
| Mental/behavioral health services are available in the area, but people do not know about them. | Frequent Physical Distress |
| It's difficult for people to navigate for mental/behavioral healthcare. | Poor or Fair Health |
| Substance use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). | Excessive Drinking |
| There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers). | Drug Induced Death |
| Substance use treatment options for those with Medi-Cal are limited. | Adult Smoking |
| There aren't enough services here for those who are homeless and dealing with substance use issues. | Primary Care Shortage Area |
| | Mental Health Care Shortage Area |
| | Medically Underserved Area |
| | Mental Health Providers |
| | Psychiatry Providers |
| | Firearm Fatalities Rate |
| | Juvenile Arrest Rate |
| | Disconnected Youth |

| Primary Themes | Secondary Indicators |
|---|---|
| The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community.<br>Substance use is an issue among youth in particular.<br>There are substance use treatment services available here, but people do not know about them. | Social Associations<br>Residential Segregation (Non-White/White)<br>Income Inequality<br>Severe Housing Cost Burden<br>Homelessness Rate |

**Access to Quality Primary Care Health Services**

*Table 23: Primary themes and secondary indicators associated with PHN2.*

| Primary Themes | Secondary Indicators |
|---|---|
| Insurance is unaffordable.<br>Wait-times for appointments are excessively long.<br>Out-of-pocket costs are too high.<br>There aren't enough primary care service providers in the area.<br>Patients have difficulty obtaining appointments outside of regular business hours.<br>Too few providers in the area accept Medi-Cal.<br>It is difficult to recruit and retain primary care providers in the region.<br>Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).<br>The quality of care is low (e.g., appointments are rushed, providers lack cultural competence).<br>Patients seeking primary care overwhelm local emergency departments.<br>Primary care services are available but are difficult for many people to navigate. | Infant Mortality<br>Child Mortality<br>Life Expectancy<br>Premature Age-Adjusted Mortality<br>Premature Death<br>Stroke Mortality<br>Chronic Lower Respiratory Disease Mortality<br>Diabetes Mortality<br>Heart Disease Mortality<br>Hypertension Mortality<br>Cancer Mortality<br>Liver Disease Mortality<br>Kidney Disease Mortality<br>COVID-19 Mortality<br>COVID-19 Case Fatality<br>Alzheimer's Disease Mortality<br>Influenza and Pneumonia Mortality<br>Diabetes Prevalence<br>Low Birthweight<br>Poor Mental Health Days<br>Frequent Mental Distress<br>Poor Physical Health Days<br>Frequent Physical Distress<br>Poor or Fair Health<br>Colorectal Cancer Prevalence<br>Breast Cancer Prevalence<br>Lung Cancer Prevalence<br>Prostate Cancer Prevalence<br>Asthma ED Rates<br>Asthma ED Rates for Children<br>Primary Care Shortage Area |

| Primary Themes | Secondary Indicators |
|---|---|
| | Medically Underserved Area |
| | Mammography Screening |
| | Primary Care Providers |
| | Preventable Hospitalization |
| | COVID-19 Cumulative Full Vaccination Rate |
| | Residential Segregation (Non-White/White) |
| | Uninsured Population under 64 |
| | Income Inequality |
| | Homelessness Rate |

**Active Living and Healthy Eating**

*Table 24: Primary themes and secondary indicators associated with PHN3.*

| Primary Themes | Secondary Indicators |
|---|---|
| There are food deserts in the area where fresh, unprocessed foods are not available. | Life Expectancy |
| Fresh, unprocessed foods are unaffordable. | Premature Age-Adjusted Mortality |
| Food insecurity is an issue here. | Premature Death |
| Students need healthier food options in schools. | Stroke Mortality |
| The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, or parks are inaccessible). | Diabetes Mortality |
| | Heart Disease Mortality |
| | Hypertension Mortality |
| The community needs nutrition education programs. | Cancer Mortality |
| Homelessness in parks or other public spaces deters their use. | Kidney Disease Mortality |
| Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming. | Diabetes Prevalence |
| | Poor Mental Health Days |
| There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues) | Frequent Mental Distress |
| | Poor Physical Health Days |
| The food available in local homeless shelters and food banks is not nutritious. | Frequent Physical Distress |
| | Poor or Fair Health |
| Grocery store option in the area are limited. | Colorectal Cancer Prevalence |
| | Breast Cancer Prevalence |
| | Prostate Cancer Prevalence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Adult Obesity |
| | Physical Inactivity |
| | Limited Access to Healthy Foods |
| | Food Environment Index |

| Primary Themes | Secondary Indicators |
|---|---|
| | Access to Exercise Opportunities<br>Residential Segregation (Non-White/White)<br>Income Inequality<br>Severe Housing Cost Burden<br>Homelessness Rate<br>Long Commute - Driving Alone<br>Access to Public Transit |

**Safe and Violence-Free Environment**

*Table 25: Primary themes and secondary indicators associated with PHN4.*

| Primary Themes | Secondary Indicators |
|---|---|
| People feel unsafe because of crime.<br>There are not enough resources to address domestic violence and sexual assault.<br>Isolated or poorly-lit streets make pedestrian travel unsafe.<br>Public parks seem unsafe because of illegal activity taking place.<br>Youth need more safe places to go after school.<br>Specific groups in this community are targeted because of characteristics like race/ethnicity or age.<br>There isn't adequate police protection police protection.<br>Gang activity is an issue in the area.<br>Human trafficking is an issue in the area.<br>The current political environment makes some concerned for their safety. | Life Expectancy<br>Premature Death<br>Hypertension Mortality<br>Poor Mental Health Days<br>Frequent Mental Distress<br>Frequent Physical Distress<br>Poor or Fair Health<br>Physical Inactivity<br>Access to Exercise Opportunities<br>Homicide Rate<br>Firearm Fatalities Rate<br>Violent Crime Rate<br>Juvenile Arrest Rate<br>Motor Vehicle Crash Death<br>Disconnected Youth<br>Social Associations<br>Income Inequality<br>Severe Housing Problems<br>Severe Housing Cost Burden<br>Homelessness Rate |

**Access to Dental Care and Preventive Services**

*Table 26: Primary themes and secondary indicators associated with PHN5.*

| Primary Themes | Secondary Indicators |
|---|---|
| There aren't enough providers in the area who accept Denti-Cal. | Frequent Mental Distress |
| The lack of access to dental care here leads to overuse of emergency departments. | Poor Physical Health Days |
| Quality dental services for kids are lacking. | Frequent Physical Distress |
| It's hard to get an appointment for dental care. | Poor or Fair Health |
| People in the area have to travel to receive dental care. | Dental Care Shortage Area |
| Dental care here is unaffordable, even if you have insurance. | Dentists |
| | Residential Segregation (Non-White/White) |
| | Income Inequality |
| | Homelessness Rate |

**Healthy Physical Environment**

*Table 27: Primary themes and secondary indicators associated with PHN6.*

| Primary Themes | Secondary Indicators |
|---|---|
| The air quality contributes to high rates of asthma. | Infant Mortality |
| Poor water quality is a concern in the area. | Life Expectancy |
| Agricultural activity harms the air quality. | Premature Age-Adjusted Mortality |
| Low-income housing is substandard. | Premature Death |
| Residents' use of tobacco and e-cigarettes harms the air quality. | Chronic Lower Respiratory Disease Mortality |
| Industrial activity in the area harms the air quality. | Hypertension Mortality |
| Heavy traffic in the area harms the air quality. | Cancer Mortality |
| Wildfires in the region harm the air quality. | Frequent Mental Distress |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | Colorectal Cancer Prevalence |
| | Breast Cancer Prevalence |
| | Lung Cancer Prevalence |
| | Prostate Cancer Prevalence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Adult Smoking |
| | Income Inequality |
| | Severe Housing Cost Burden |
| | Homelessness Rate |
| | Long Commute - Driving Alone |
| | Pollution Burden Percent |
| | Air Pollution - Particulate Matter |
| | Drinking Water Violations |

**Access to Basic Needs Such as Housing, Jobs, and Food**

*Table 28: Primary themes and secondary indicators associated with PHN7.*

| Primary Themes | Secondary Indicators |
|---|---|
| Lack of affordable housing is a significant issue in the area.<br>The area needs additional low-income housing options.<br>Poverty in the county is high.<br>Many people in the area do not make a living wage.<br>Employment opportunities in the area are limited.<br>Services for homeless residents in the area are insufficient.<br>Services are inaccessible for Spanish-speaking and immigrant residents.<br>Many residents struggle with food insecurity.<br>It is difficult to find affordable childcare.<br>Educational attainment in the area is low. | Infant Mortality<br>Child Mortality<br>Life Expectancy<br>Premature Age-Adjusted Mortality<br>Premature Death<br>Hypertension Mortality<br>COVID-19 Mortality<br>COVID-19 Case Fatality<br>Diabetes Prevalence<br>Low Birthweight<br>Poor Mental Health Days<br>Frequent Mental Distress<br>Poor Physical Health Days<br>Frequent Physical Distress<br>Poor or Fair Health<br>COVID-19 Cumulative Incidence<br>Asthma ED Rates<br>Asthma ED Rates for Children<br>Drug Induced Death<br>Adult Obesity<br>Limited Access to Healthy Foods<br>Food Environment Index<br>Medically Underserved Area<br>COVID-19 Cumulative Full Vaccination Rate<br>Some College<br>High School Completion<br>Disconnected Youth<br>Third Grade Reading Level<br>Third Grade Math Level<br>Unemployment<br>Children in Single-Parent Households<br>Social Associations<br>Residential Segregation (Non-White/White)<br>Children Eligible for Free Lunch<br>Children in Poverty<br>Median Household Income<br>Uninsured Population under 64<br>Income Inequality<br>Severe Housing Problems<br>Severe Housing Cost Burden |

| Primary Themes | Secondary Indicators |
|---|---|
| | Homeownership |
| | Homelessness Rate |
| | Households with no Vehicle Available |
| | Long Commute - Driving Alone |

**Access to Functional Needs**

*Table 29: Primary themes and secondary indicators associated with PHN8.*

| Primary Themes | Secondary Indicators |
|---|---|
| Many residents do not have reliable personal transportation. | Disability |
| Medical transport in the area is limited. | Frequent Mental Distress |
| Roads and sidewalks in the area are not well-maintained. | Frequent Physical Distress |
| The distance between service providers is inconvenient for those using public transportation. | Poor or Fair Health |
| | Adult Obesity |
| Using public transportation to reach providers can take an exceptionally long time. | COVID-19 Cumulative Full Vaccination Rate |
| The cost of public transportation is too high. | Income Inequality |
| Public transportation service routes are limited. | Homelessness Rate |
| Public transportation schedules are limited. | Households with no Vehicle Available |
| The geography of the area makes it difficult for those without reliable transportation to get around. | Long Commute - Driving Alone |
| Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children). | Access to Public Transit |
| There aren't enough taxi and ride-share options (e.g., Uber, Lyft). | |

**Access to Specialty and Extended Care**

*Table 30: Primary themes and secondary indicators associated with PHN9.*

| Primary Themes | Secondary Indicators |
|---|---|
| Wait-times for specialist appointments are excessively long. | Infant Mortality |
| It is difficult to recruit and retain specialists in the area. | Life Expectancy |
| Not all specialty care is covered by insurance. | Premature Age-Adjusted Mortality |
| Out-of-pocket costs for specialty and extended care are too high. | |
| People have to travel to reach specialists. | Premature Death |
| Too few specialty and extended care providers accept Medi-Cal. | Stroke Mortality |
| The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care) | Chronic Lower Respiratory Disease Mortality |
| There isn't enough OB/GYN care available. | Diabetes Mortality |
| Additional hospice and palliative care options are needed. | Heart Disease Mortality |
| The area lacks a kind of specialist or extended care option not listed here. | Hypertension Mortality |
| | Cancer Mortality |
| | Liver Disease Mortality |

| Primary Themes | Secondary Indicators |
|---|---|
| | Kidney Disease Mortality<br>COVID-19 Mortality<br>COVID-19 Case Fatality<br>Alzheimer's Disease Mortality<br>Diabetes Prevalence<br>Poor Mental Health Days<br>Frequent Mental Distress<br>Poor Physical Health Days<br>Frequent Physical Distress<br>Poor or Fair Health<br>Lung Cancer Prevalence<br>Asthma ED Rates<br>Asthma ED Rates for Children<br>Drug Induced Death<br>Psychiatry Providers<br>Specialty Care Providers<br>Preventable Hospitalization<br>Residential Segregation (Non-White/White)<br>Income Inequality<br>Homelessness Rate |

**Injury and Disease Prevention and Management**

*Table 31: Primary themes and secondary indicators associated with PHN10.*

| Primary Themes | Secondary Indicators |
|---|---|
| There isn't really a focus on prevention around here.<br>Preventive health services for women are needed (e.g., breast and cervical cancer screening).<br>There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease).<br>Vaccination rates are lower than they need to be.<br>Health education in the schools needs to be improved.<br>Additional HIV and STI prevention efforts are needed.<br>The community needs nutrition education opportunities.<br>Schools should offer better sexual health education.<br>Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants).<br>Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). | Infant Mortality<br>Child Mortality<br>Stroke Mortality<br>Chronic Lower Respiratory Disease Mortality<br>Diabetes Mortality<br>Heart Disease Mortality<br>Hypertension Mortality<br>Liver Disease Mortality<br>Kidney Disease Mortality<br>Suicide Mortality<br>Unintentional Injuries Mortality<br>COVID-19 Mortality<br>COVID-19 Case Fatality<br>Alzheimer's Disease Mortality<br>Diabetes Prevalence |

| Primary Themes | Secondary Indicators |
|---|---|
| | Low Birthweight |
| | HIV Prevalence |
| | Poor Mental Health Days |
| | Frequent Mental Distress |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | COVID-19 Cumulative Incidence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Excessive Drinking |
| | Drug Induced Death |
| | Adult Obesity |
| | Physical Inactivity |
| | Chlamydia Incidence |
| | Teen Birth Rate |
| | Adult Smoking |
| | COVID-19 Cumulative Full Vaccination Rate |
| | Firearm Fatalities Rate |
| | Juvenile Arrest Rate |
| | Motor Vehicle Crash Death |
| | Disconnected Youth |
| | Third Grade Reading Level |
| | Third Grade Math Level |
| | Income Inequality |
| | Homelessness Rate |

**Increased Community Connections**

*Table 32: Primary themes and secondary indicators associated with PHN11.*

| Primary Themes | Secondary Indicators |
|---|---|
| Health and social-service providers operate in silos; we need cross-sector connection. | Infant Mortality |
| Building community connections doesn't seem like a focus in the area. | Child Mortality |
| Relations between law enforcement and the community need to be improved. | Life Expectancy |
| The community needs to invest more in the local public schools. | Premature Age-Adjusted Mortality |
| There isn't enough funding for social services in the county. | Premature Death |
| People in the community face discrimination from local service providers. | Stroke Mortality |
| | Diabetes Mortality |
| | Heart Disease Mortality |
| | Hypertension Mortality |
| | Suicide Mortality |

| Primary Themes | Secondary Indicators |
|---|---|
| City and county leaders need to work together. | Unintentional Injuries Mortality<br>Diabetes Prevalence<br>Low Birthweight<br>Poor Mental Health Days<br>Frequent Mental Distress<br>Poor Physical Health Days<br>Frequent Physical Distress<br>Poor or Fair Health<br>Excessive Drinking<br>Drug Induced Death<br>Physical Inactivity<br>Access to Exercise Opportunities<br>Teen Birth Rate<br>Primary Care Shortage Area<br>Mental Health Care Shortage Area<br>Medically Underserved Area<br>Mental Health Providers<br>Psychiatry Providers<br>Specialty Care Providers<br>Primary Care Providers<br>Preventable Hospitalization<br>COVID-19 Cumulative Full Vaccination Rate<br>Homicide Rate<br>Firearm Fatalities Rate<br>Violent Crime Rate<br>Juvenile Arrest Rate<br>Some College<br>High School Completion<br>Disconnected Youth<br>Unemployment<br>Children in Single-Parent Households<br>Social Associations<br>Residential Segregation (Non-White/White)<br>Income Inequality<br>Homelessness Rate<br>Households with no Vehicle Available<br>Long Commute - Driving Alone<br>Access to Public Transit |

**System Navigation**

*Table 33: Primary themes and secondary indicators associated with PHN12.*

| Primary Themes | Secondary Indicators |
|---|---|
| People may not be aware of the services they are eligible for. | |
| It is difficult for people to navigate multiple, different health care systems. | |
| The area needs more navigators to help to get people connected to services. | |
| People have trouble understanding their insurance benefits. | |
| Automated phone systems can be difficult for those who are unfamiliar with the healthcare system | |
| Dealing with medical and insurance paperwork can be overwhelming. | |
| Medical terminology is confusing. | |
| Some people just don't know where to start in order to access care or benefits. | |

Next, values for the secondary health-factor and health-outcome indicators identified were compared to state benchmarks to determine if a secondary indicator performed poorly within the county. Some indicators were considered problematic if they exceeded the benchmark, others were considered problematic if they were below the benchmark, and the presence of certain other indicators within the county, such as health professional shortage areas, indicated issues. Table 34 lists each secondary indicator and describes the comparison made to the benchmark to determine if it was problematic.

*Table 34: Benchmark comparisons to show indicator performance.*

| Indicator | Benchmark Comparison Indicating Poor Performance |
|---|---|
| Infant Mortality | Higher |
| Child Mortality | Higher |
| Life Expectancy | Lower |
| Premature Age-Adjusted Mortality | Higher |
| Premature Death | Higher |
| Stroke Mortality | Higher |
| Chronic Lower Respiratory Disease Mortality | Higher |
| Diabetes Mortality | Higher |
| Heart Disease Mortality | Higher |
| Hypertension Mortality | Higher |
| Cancer Mortality | Higher |
| Liver Disease Mortality | Higher |
| Kidney Disease Mortality | Higher |
| Suicide Mortality | Higher |
| Unintentional Injuries Mortality | Higher |
| COVID-19 Mortality | Higher |
| COVID-19 Case Fatality | Higher |
| Alzheimer's Disease Mortality | Higher |
| Influenza and Pneumonia Mortality | Higher |
| Diabetes Prevalence | Higher |

| Indicator | Benchmark Comparison Indicating Poor Performance |
|---|---|
| Low Birthweight | Higher |
| HIV Prevalence | Higher |
| Disability | Higher |
| Poor Mental Health Days | Higher |
| Frequent Mental Distress | Higher |
| Poor Physical Health Days | Higher |
| Frequent Physical Distress | Higher |
| Poor or Fair Health | Higher |
| Colorectal Cancer Prevalence | Higher |
| Breast Cancer Prevalence | Higher |
| Lung Cancer Prevalence | Higher |
| Prostate Cancer Prevalence | Higher |
| COVID-19 Cumulative Incidence | Higher |
| Asthma ED Rates | Higher |
| Asthma ED Rates for Children | Higher |
| Excessive Drinking | Higher |
| Drug Induced Death | Higher |
| Adult Obesity | Higher |
| Physical Inactivity | Higher |
| Limited Access to Healthy Foods | Higher |
| Food Environment Index | Lower |
| Access to Exercise Opportunities | Lower |
| Chlamydia Incidence | Higher |
| Teen Birth Rate | Higher |
| Adult Smoking | Higher |
| Primary Care Shortage Area | Present |
| Dental Care Shortage Area | Present |
| Mental Health Care Shortage Area | Present |
| Medically Underserved Area | Present |
| Mammography Screening | Lower |
| Dentists | Lower |
| Mental Health Providers | Lower |
| Psychiatry Providers | Lower |
| Specialty Care Providers | Lower |
| Primary Care Providers | Lower |
| Preventable Hospitalization | Higher |
| COVID-19 Cumulative Full Vaccination Rate | Lower |
| Homicide Rate | Higher |
| Firearm Fatalities Rate | Higher |
| Violent Crime Rate | Higher |
| Juvenile Arrest Rate | Higher |
| Motor Vehicle Crash Death | Higher |
| Some College | Lower |
| High School Completion | Lower |
| Disconnected Youth | Higher |
| Third Grade Reading Level | Lower |
| Third Grade Math Level | Lower |

| Indicator | Benchmark Comparison Indicating Poor Performance |
|---|---|
| Unemployment | Higher |
| Children in Single-Parent Households | Higher |
| Social Associations | Lower |
| Residential Segregation (Non-White/White) | Higher |
| Children Eligible for Free Lunch | Higher |
| Children in Poverty | Higher |
| Median Household Income | Lower |
| Uninsured Population under 64 | Higher |
| Income Inequality | Higher |
| Severe Housing Problems | Higher |
| Severe Housing Cost Burden | Higher |
| Homeownership | Lower |
| Homelessness Rate | Higher |
| Households with no Vehicle Available | Higher |
| Long Commute - Driving Alone | Higher |
| Access to Public Transit | Lower |
| Pollution Burden Percent | Higher |
| Air Pollution - Particulate Matter | Higher |
| Drinking Water Violations | Present |

Once these poorly performing quantitative indicators were identified, they were used to determine preliminary secondary SHNs. This was done by calculating the percentage of all secondary indicators associated with a given PHN that were identified as performing poorly within the HSA. While all PHNs represented actual health needs within the HSA to a greater or lesser extent, a PHN was considered a preliminary secondary health need if the percentage of poorly performing indicators exceeded one of a number of established thresholds: any poorly performing associated secondary indicators; or at least 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80% of the associated indicators were found to perform poorly. A similar set of standards was used to identify the preliminary interview and focus-group health needs: any of the survey respondents mentioned a theme associated with a PHN, or if at least 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80% of the respondents mentioned an associated theme. Finally, similar thresholds (any mention, 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80%) were also applied to the percent of survey respondents selecting a particular health need as one of the top health needs in the HSA.

These sets of criteria (any mention, 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80%) were used because we could not anticipate which specific standard would be most meaningful within the context of the HSA. Having multiple objective decision criteria allows the process to be more easily described but still allows for enough flexibility to respond to evolving conditions in the HSA. To this end, a final round of expert reviews was used to compare the set selection criteria to find the level at which the criteria converged towards a final set of SHNs.

For this report, a PHN was selected as a preliminary quantitative significant health need if 50% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by 40% or more of the primary sources as performing poorly; and as a preliminary community survey provider survey significant health need if it was identified by at least 40% of survey respondents. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in 2 of 3 of these categories.

## Health Need Prioritization

The last step in the analysis was to prioritize the identified SHNs. To reflect the voice of the community, significant health need prioritization was based solely on primary data. Key informants and focus-group participants were asked to identify the three most SHNs in their communities. These responses were associated with one or more of the potential health needs. This, along with the responses across the rest of the interviews and focus groups, was used to derive two measures for each significant health need.

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need. Finally, the number of times each health need was selected as one of the top health needs by survey respondents was also included.

These three measures were then rescaled so that the SHN with the maximum value for each measure equaled one, the minimum equaled zero, and all other SHNs had values appropriately proportional to the maximum and minimum values. The rescaled values were then summed to create a combined SHN prioritization index. SHNs were ranked in descending order based on this index value so that the SHN with the highest value was identified as the highest-priority health need, the SHN with the second highest value was identified as the second-highest-priority health need, and so on.

## Detailed List of Resources to Address Health Needs

*Table 35: Resources available to meet health needs.*

| Organization Information | | | Significant Health Needs | | | | | | | | | Other Health Needs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Primary ZIP Code | Website | Access to Quality Primary Care Health Services | Access to Mental/Behavioral Health and Substance | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Specialty and Extended Care | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Injury and Disease Prevention and Management | Safe and Violence-Free Environment | Access to Dental Care and Preventive Services | Healthy Physical Environment | System Navigation |
| Amador Calaveras Counseling Services | 95685 | amador.networkofcare.org/mh/services/advanced-search.aspx?k=counseling | | x | | | | x | | | | | | |
| Amador Child Abuse Prevention Council | 95642 | www.amadorcapc.org | | x | | | | | | | x | | | |
| Amador Child Care Council | 95642 | amadorchildcarecouncil.amadorcoe.org | | | x | | | | | x | | | | |
| Amador College Connect | 95642 | amadorcollegeconnect.com | | | x | | | x | | | | | | |
| Amador Community Health Center - WellSpace Health | 95842 | www.wellspacehealth.org/location/amador-community-health-center-immediate-care | x | x | | | | | | | | x | | x |
| Amador County Behavioral and Mental Health | County-wide | www.amadorgov.org/services/behavioral-health/mental-health | | x | | | | | | | | | | x |
| Amador County Commission on Aging-Amador Senior Center | 95642 | www.amadorseniorcenter.org | | x | x | | x | x | x | | x | | | |
| Amador County- Dental Health Partnership | County-wide | www.amadorgov.org/services/public-health/oral-health | | | | | | | | | | x | | |
| Amador County-Domestic Violence Council | County-wide | www.amadorgov.org/departments/probation/domestic-violence | | | | | | | | | x | | | |
| Amador County Network of Care | County-wide | amador.networkofcare.org/mh/index.aspx | x | x | x | x | x | | x | x | x | x | x | |
| Amador County Public Health | County-wide | www.amadorgov.org/services/public-health | x | | | | | | | x | | | x | x |
| Amador County Recreation Agency | 95685 | www.goacra.org | | | | | | | | | x | | x | |

| Organization Information | | | Significant Health Needs | | | | | | | | | Other Health Needs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Primary ZIP Code | Website | Access to Quality Primary Care Health Services | Access to Mental/Behavioral Health and Substance | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Specialty and Extended Care | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Injury and Disease Prevention and Management | Safe and Violence-Free Environment | Access to Dental Care and Preventive Services | Healthy Physical Environment | System Navigation |
| Amador County Unified School District | County-wide | amadorcoe.org | | x | x | | | | | | | | | x |
| Amador Pregnancy Help Center -Prenatal | 95642 | amadorpregnancyhelpcenter.com | | x | | x | | | | | x | | | |
| Amador RIDES | 95642 | amadortransit.com/amador-rides | | | | | x | x | | | | | | |
| Amador Senior Center | 95642 | www.amadorseniorcenter.org | | x | x | | x | x | x | | x | | | |
| Amador STARS | 95642 | www.amadorstars.org | | | | x | x | x | | | | | | |
| Amador Transit/Dial-A-Ride | 95642 | amadortransit.com/dial-a-ride | | | | | x | x | | | | | | |
| Amador-Tuolumne Community Action Agency (A-TCAA) | 95642 | www.atcaa.org | | | x | | | x | | x | | | | |
| A-TCAA Early Head Start/Head Start/State Preschool | 95642, 95640 | www.atcaa.org/early-childhood-svs | | | x | | | x | | x | | | | |
| Church of the Nazarene | 95685 | www.scnaz.org | | x | x | | | x | | | | | | |
| City of Jackson, Mayor's Office | 95642 | www.ci.jackson.ca.us | | | x | | | | x | | x | | x | |
| Common Ground Senior Meals | 95642 | commongroundseniorservices.org | | | | | | x | x | | | | | |
| First 5 Amador | 95642 | www.first5amador.com/health-wellness | | | x | | | x | | x | | x | | |
| Hospice of Amador and Calaveras Counties -- Grief Busters | 95642 | hospiceofamador.org/grief-support | | x | x | | | | | | | | | |
| Interfaith Food Bank OF Amador County | 95642 | feedamador.org | | | x | | | x | x | x | | | | |
| Ione Community Methodist Church | 95640 | ione-community-united-methodist.business.site | | x | x | | | x | | | | | | |
| MACT Clinic | 95642 | www.macthealth.org | x | x | | | | x | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | Other Health Needs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Primary ZIP Code | Website | Access to Quality Primary Care Health Services | Access to Mental/Behavioral Health and Substance | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Specialty and Extended Care | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Injury and Disease Prevention and Management | Safe and Violence-Free Environment | Access to Dental Care and Preventive Services | Healthy Physical Environment | System Navigation |
| MACT Dental Clinic | 95642 | www.macthealth.org/locations | | | | | | x | | | | x | | |
| Mother Lode Job Training | 95685 | www.mljt.org | | | x | | | | | | | | | |
| NAMI Amador | 95642 | namiamador.org | | x | | | | x | | | | | | x |
| Nexus Youth and Family Services -- Camanche Lake Community Center | 95640 | www.nexusyfs.org | | | x | | | x | | | | | | |
| Nexus Youth and Family Services -- Ione Family Resource Center | 95640 | www.nexusyfs.org | | | x | | | x | | x | | | | |
| Nexus Youth and Family Services -- Upcountry Community Center | 95665 | www.nexusyfs.org | | | x | | | x | | x | | | | |
| Operation Care | 95642 | operationcare.org | | | x | | | | | x | x | | | |
| Sierra Hope | 95222 | www.sierrahope.org | | | | | | x | | x | | | | |
| Sierra Wind Wellness and Recovery Center | 95642 | www.calvoices.org/programs-and-services | | x | x | | | x | x | x | | | | x |
| Society of St. Vincent de Paul | 95689 | www.amadorcatholic.com/society-of-st-vincent-de-paul | | | x | | | x | | | | | | |
| Sutter Creek Smiles | 95685 | suttercreeksmiles.org | | | | | | x | | | | x | | |
| Sutter Health- Sutter Amador Hospital | 95642 | www.sutterhealth.org/amador | x | x | x | | | x | | x | | | | |
| Sutter Health- Sutter Amador Hospital Foundation | County-wide | www.sutterhealth.org/amador/giving | | | x | x | | x | | x | | | | |
| The Arc of Amador and Calaveras Counties | 95642 | arcofamador.org | | | x | x | x | x | | | | | | |
| The Resource Connection | 95685 | trcac.org | | | x | | x | x | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | Other Health Needs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Primary ZIP Code | Website | Access to Quality Primary Care Health Services | Access to Mental/Behavioral Health and Substance | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Specialty and Extended Care | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Injury and Disease Prevention and Management | Safe and Violence-Free Environment | Access to Dental Care and Preventive Services | Healthy Physical Environment | System Navigation |
| Tobacco Reduction of Amador | County-wide | www.amadorgov.org/services/public-health/tobacco-reduction | | x | | | | | | | | | | |
| Tribal TANF | 95642 | cttp.net/amador | | | x | | | x | | | | | | |
| UC Cooperative Extension - Central Sierra | 95616 | cecentralsierra.ucanr.edu | | | x | | | | | | | | | |
| Victory Village | 95642 | www.vvvets.org | | x | x | | | | | x | | | | x |
| Women Infants and Children Program | 95685 | trcac.org/wic | | | x | | | x | x | x | | | | |

## Limits and Information Gaps

Study limitations for this CHNA included obtaining secondary quantitative data specific to population subgroups and assuring community representation through primary data collection. Most quantitative data used in this assessment were not available by race/ethnicity. The timeliness of the data also presented a challenge, as some of the data were collected in different years; however, this is clearly noted in the report to allow for proper comparison.

For primary data, gaining access to participants that best represent the populations needed for this assessment was a challenge for the key informant interviews, focus groups and CSP survey. The COVID-19 pandemic made this more difficult as community members were more difficult to recruit for focus groups. Though an effort was made to verify all resources (assets) through a web search, some resources that exist in the service area may not be listed.

Finally, though this CHNA was conducted with an equity focus, data that point to differences among population subgroups that are more “upstream” focused are not as available as those data that detail the resulting health disparities. Having a clearer picture of early-in-life opportunity differences experienced among various populations that result in later-in-life disparities can help direct community health improvement efforts for maximum impact.

# Appendix A: Evaluation of the Impact of Actions Taken Since 2019 CHNA for Sutter Amador Hospital

### Access to Mental/Behavioral/Substance Abuse Services

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| Name of program/activity/initiative | Suicide Prevention Follow-up Program |
| Description | The Suicide Prevention Follow-up Program was designed to help take the important first steps toward recovery after a suicidal crisis. Participation can help keep patients safe from suicide post-discharge. Support from the program provides hope and a safe, confidential space to talk about what patients have been experiencing, cope with the challenges and feelings that may arise after visiting the Emergency Department (ED). In addition, continuity in care is provided through emotional support, treatment referrals, coping skills, an action plan for times of crisis, and materials for suicide attempt survivors and those who have felt suicidal. |
| Goals | By linking patients who have attempted suicide or presented with suicidal ideations in our ED, we have the ability to provide patients with the support and additional resources needed for suicide attempt survivors and those who have felt suicidal. |
| Outcomes | This program ended at the beginning of 2019 and no results are available. |
| Name of program/activity/initiative | Go! Youth Program |
| Description | The Go! Youth program is building a foundation for healthy relationships and lifestyle choices by providing education on topics such as healthy relationships, personal hygiene, drug abuse, self-esteem, life skills, and mental health. The population served are primarily youth from lower income families. Their families are able to access the local foodbank twice a month and the food bags provided for group twice a month will not cover all of their needs but will help to fill a gap. The program helps to supplement the food needs by providing fresh fruits and vegetables. |
| Goals | The goal of the program is to provide a foundation for healthy relationships and choices through education. |
| Outcomes | In 2020, the program began and there were 1,233 services provided to 104 families.<br>In 2021, there were 1,306 services provided to 408 families. |
| Name of program/activity/initiative | Employ & Empower |
| Description | Case management services are provided to survivors of human trafficking or individuals at risk of exploitation between the ages of 16 and 50. Social workers will assist with goal setting, mental health services, childcare, obtain legal documentation, career development, job skills and education. Each client is assessed to allow for accurate case plan goals. Clients are connected to mental health resources and |

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| | support at no cost. Financial assistance is provided to clients to help secure daycare until they remain consistently employed. Career development includes helping clients access documents necessary for employment, transportation education, purchasing professional clothing, promoting financial literacy skills, career goal setting, job readiness skills, job training, job placement and retention services. |
| Goals | Provide case management and wrap around services to help provide career development for survivors human trafficking or at-risk of exploitation. |
| Outcomes | In 2021, the program began and provided 723 services to 42 individuals. |
| Name of program/activity/initiative | Youth Mentorship |
| Description | Youth are mentored at the local junior high and high school in Jackson, servicing over 200 students. Many of the students are considered at-risk youth and children of essential workers that are forced to leave their children to complete distanced learning alone. As a result, the students are failing courses and feeling a ripple effect in their mental health.<br><br>Each year, Nexus Youth hosts a camping trip as a reward to students who maintain a 2.0 GPA and this camping trip often serves as an incentive for students who require academic support at home. The participants will build new relationships and strengthen existing relationships with their peers and staff. While on the camping trip, the youth learn valuable communication skills, conflict management, and social skills that will help them throughout their life without the distraction of cell phones or cell service. The program offers the youth an opportunity to grow in a safe place surrounded by staff that desire to see each child reach their potential. |
| Goals | The goal of the program is to promote healthy physical, social, and emotional well-being to all the participants. |
| Outcomes | In 2021, the program began and provided 54 services to 42 individuals. |

**Access to Quality Primary Care Health Services**

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| Name of program/activity/initiative | Primary Care Program – HPV Vaccinations |
| Description | The Primary Care program provides services and education of HPV vaccinations to prevent cervical cancer. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as access to quality primary care health services; and injury and disease prevention management. |
| Goals | Funding will allow for the implementation of 5 HPV vaccination strategies. HPV vaccinations will target 11-12-year-old boys and girls, the American Cancer Society and CDC recommended age. |
| Outcomes | In 2020, there were 2 Virtual Community and Provider HPV Webinars. Please note, this program discontinued at the end of 2020 and many |

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| | programs didn't perform as initially anticipated due to COVID – particularly those around screening/vaccinations since much of that was halted for health systems at one point in time. |
| Name of program/activity/initiative | Community COVID Clinic |
| Description | A locally Federally Qualified Health Center open a COVID Clinic to provide COVID-19 screenings and tests to all community members. |
| Goals | The goal is to conduct COVID-19 screenings and tests to all community members. |
| Outcomes | In 2020, the program services began and concluded at the end of the year. The program served the broader community including uninsured, underinsured, and commercial patients. |
| Name of program/activity/initiative | Patient Outreach |
| Description | The patient outreach program conducted patient outreach activities in the Amador community to better inform low-income and uninsured people what programs and services are available in their community. |
| Goals | The goal of the program is to inform low-income and uninsured patients of program and services available. |
| Outcomes | In 2020, the program services began and concluded at the end of the year. The program reached 7,952 patients and provided 6,677 services. |

**Access to Basic Needs Such as Housing, Jobs, and Food**

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| Name of program/activity/initiative | Modified Project Roomkey |
| Description | The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS programs. Referrals will be received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital. |
| Goals | The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients. |
| Outcomes | In 2021, the program began in response to COVID and served 80 adults & youth with 3,073 services. |
| Name of program/activity/initiative | COVID-19 Food Security Response |

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| Description | In response to COVID-19, food banks were experiencing a sharp increase in need. The funding will increase food capacity to meet increased demand, specifically used for additional boxes and food. |
| Goals | The goal of the program is to meet the increased demand of food due to the impact of COVID-19. |
| Outcomes | In 2020, the program began in response to COVID and served 29,460 individuals with 29,374 services.<br>In 2021, the program served 8,973 individuals with 25,500 services. |
| Name of program/activity/initiative | Senior Protein Program |
| Description | The Senior Meal Bag Program provides fresh and nutritious foods to senior citizens of Amador County. Funding will help add a protein component to the meal bags, such as poultry and beef. In addition, funding will allow the program's expansion to new distribution sites in River pines, Plymouth, and Ione. |
| Goals | The goal of the program is to provide seniors with more protein rich foods and reach rural locations of the community. |
| Outcomes | In 2020, the program began and served 18,473 individuals.<br>In 2021, the program served 8,973 individuals. |
| Name of program/activity/initiative | Go! Youth Program |
| Description | The Go! Youth program is building a foundation for healthy relationships and lifestyle choices by providing education on topics such as healthy relationships, personal hygiene, drug abuse, self-esteem, life skills, and mental health. The population served are primarily youth from lower income families. Their families are able to access the local foodbank twice a month and the food bags provided for group twice a month will not cover all of their needs but will help to fill a gap. The program helps to supplement the food needs by providing fresh fruits and vegetables. |
| Goals | The goal of the program is to provide a foundation for healthy relationships and choices through education. |
| Outcomes | In 2020, the program began and there were 1,233 services provided to 104 families.<br>In 2021, there were 1,306 services provided to 408 families. |
| Name of program/activity/initiative | Employ & Empower |
| Description | Case management services are provided to survivors of human trafficking or individuals at risk of exploitation between the ages of 16 and 50. Social workers will assist with goal setting, mental health services, childcare, obtain legal documentation, career development, job skills and education. Each client is assessed to allow for accurate case plan goals. Clients are connected to mental health resources and support at no cost. Financial assistance is provided to clients to help secure daycare until they remain consistently employed. Career development includes helping clients access documents necessary for employment, transportation education, purchasing professional |

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| | clothing, promoting financial literacy skills, career goal setting, job readiness skills, job training, job placement and retention services. |
| Goals | Provide case management and wrap around services to help provide career development for survivors human trafficking or at-risk of exploitation. |
| Outcomes | In 2021, the program began and provided 723 services to 42 individuals. |
| Name of program/activity/initiative | Expanding Food Distribution to Vulnerable Populations |
| Description | The expansion of food distribution to vulnerable populations, includes the Seniors Meal Box program, Amador County School District's School Box program and targeting the most remote areas of Amador with a particular focus on River Pines and upper Buckhorn. |
| Goals | The goal of the program is to improve the quality, nutritional value and increase the quantity of the school box program currently provided to Amador County School District and seniors. |
| Outcomes | In 2021, the program began and served 3,230 individuals with 3,220 services. |

**Injury and Disease Prevention Management**

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|---|---|
| Name of program/activity/initiative | Primary Care Program – HPV Vaccinations |
| Description | The Primary Care program provides services and education of HPV vaccinations to prevent cervical cancer. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as access to quality primary care health services; and injury and disease prevention management. |
| Goals | Funding will allow for the implementation of 5 HPV vaccination strategies. HPV vaccinations will target 11-12-year-old boys and girls, the American Cancer Society and CDC recommended age. |
| Outcomes | In 2020, there were 2 Virtual Community and Provider HPV Webinars. Please note, this program discontinued at the end of 2020 and many programs didn't perform as initially anticipated due to COVID – particularly those around screening/vaccinations since much of that was halted for health systems at one point in time. |

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| Name of program/activity/initiative | Primary Care Program – Colorectal Screenings |
| Description | The Primary Care Program will provide services and education of colorectal screenings. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as injury and disease prevention management; and access to specialty and extended care. |
| Goals | Funding will allow for the engagement in colorectal cancer prevention strategies on 10 evidence-based interventions for colorectal cancer |

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| | screenings. In addition, the program will host a colorectal cancer learning collaborative to share best practices and evidence-based interventions with health centers and stakeholders. |
| Outcomes | This program did not launch as anticipated due to COVID closures – particularly those around screening/vaccinations since much of that was halted for health systems at one point in time. |

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| Name of program/activity/initiative | Amador Lifeline |
| Description | Amador Lifeline is a paid subscription program that allows for seniors and individuals with disabilities, chronic illnesses, and those in rehabilitative care in Amador County to remain living independently in their own homes with some sense of security and peace of mind. We are helping to supplement funding, which ensures that low-income Amador County residents can afford the paid subscription program by utilizing a sliding scale schedule. |
| Goals | The goal of this program is to link isolated, disabled and/or senior residents of Amador County with assistance and resources with the simple touch of a button. Given Amador's rural environment, this program is incredibly important to seniors. |
| Outcomes | In 2020, the program served 43 individuals with 48 services.<br>In 2021, the program served 49 individuals with 24 services. |
| Name of program/activity/initiative | Modified Project Roomkey |
| Description | The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS programs. Referrals will be received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital. |
| Goals | The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients. |
| Outcomes | In 2021, the program began in response to COVID and served 80 adults & youth with 3,073 services. |
| Name of program/activity/initiative | Senior Protein Program |
| Description | The Senior Meal Bag Program provides fresh and nutritious foods to senior citizens of Amador County. Funding will help add a protein component to the meal bags, such as poultry and beef. In addition, |

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| | funding will allow the program's expansion to new distribution sites in River pines, Plymouth, and Ione. |
| Goals | The goal of the program is to provide seniors with more protein rich foods and reach rural locations of the community. |
| Outcomes | In 2020, the program began and served 18,473 individuals.<br>In 2021, the program served 8,973 individuals. |
| Name of program/activity/initiative | Community COVID Clinic |
| Description | A locally Federally Qualified Health Center open a COVID Clinic to provide COVID-19 screenings and tests to all community members. |
| Goals | The goal is to conduct COVID-19 screenings and tests to all community members. |
| Outcomes | In 2020, the program services began and concluded at the end of the year. The program served the broader community including uninsured, underinsured, and commercial patients. |

**Access and Functional Needs**

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| Name of program/activity/initiative | Amador Rides |
| Description | Amador Rides utilizes volunteer drives to provide transportation to and from medical appointments for Amador County's underserved who are unable to access necessary medical care, due to transportation constraints, especially in the rural areas of Amador County. Scheduling and keeping non-emergency medical appointments is essential to maintaining quality of life, preventing injury, and treating illness. |
| Goals | The goal of Amador Rides is to provide rides to and from medical appointments for seniors and disabled residents of Amador County. |
| Outcomes | In 2019, the program served 372 individuals with 1,160 rides.<br>In 2020, the program served 247 individuals with 380 rides.<br>In 2021, the program did not seek funding due to lack of volunteer drivers as a result of COVID-19. The program is anticipated to resume services in 2022. |
| Name of program/activity/initiative | Modified Project Roomkey |
| Description | The modified version of Project Room Key program offers transportation, a minimum of two weeks of quarantined lodging, and wraparound services for eligible clients. Eligible clients are individuals without any form of shelter, contract traced and not able to return their only housing situation, or COVID positive. In addition, clients that are extremely vulnerable will be accepted into the program, which is defined as those who are 65 years or older with multiple comorbidities that puts the clients at higher risk. The funding from Sutter Health will help fill the gap of CARES dollars that will soon deplete and result in the lack of a safe place for individuals without shelter to self-isolate. While in the care of the program, patients will be case managed and connected to community resources, such as housing and eligible HHS |

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| | programs. Referrals will be received from the Amador Public Health Department, local law enforcement and Sutter Amador Hospital. |
| Goals | The goal of the program is to transport, temporarily house and provide wrap around services to eligible clients. |
| Outcomes | In 2021, the program began in response to COVID and served 80 adults & youth with 3,073 services. |
| Name of program/activity/initiative | Transportation Program for Cancer Patients |
| Description | Support, Transportation, and Resource Services are provided to patients in cancer treatment or follow up from cancer treatment. We offer support groups, a resource community library, a free wig program (provided by a licensed cosmetologist). |
| Goals | The goal of the program is to provide support and transportation services to patients who live in Amador County. |
| Outcomes | In 2020, the program served 244 individuals with 1,494 rides.<br>In 2021, the program served 214 individuals with 1,373 rides. |

**Access to Dental Care and Preventative Services**

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|---|---|
| Name of program/activity/initiative | Expansion of Pediatric Dental Program |
| Description | The expansion of the Pediatric Dental Program provided to children and adolescents with allow for the best possible opportunity for good oral health that will last a lifetime. Untreated tooth decay can cause pain and infection that can lead to problems with eating, speaking and overall health. Through this program, patients are referred to specialists as needed. Dental services, include: comprehensive examinations, recall examinations, emergency visits/examinations and diagnosis, regular and deep cleanings, full-mouth & individual x-rays, fluoride treatments, dental sealants, oral hygiene instruction, temporary fillings, dental fillings and restorations, crowns for primary and permanent teeth, space maintainers, and routine extractions. |
| Goals | The goals of the program are to increase access to pediatric dental services. |
| Outcomes | In 2019, the program had plans to proceed with opening pediatric dental services but was unable to as a result of COVID closures. |
| Name of program/activity/initiative | Oral Health Program |
| Description | Dental hygiene kits will be distributed to low-income and underserved populations at toddler playgroups, school readiness programs, the food bank and school lunch programs. In addition, distribute oral health-related children's books for Adventist Health and MACT Indian Health Clinic to distribute to families once child receives a fluoride varnish treatment at well baby check visit. |
| Goals | The goals of the program are to improve to pediatric dental education. |

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| Outcomes | In 2021, the program began and concluded at the end of the year. The program served 1,020 individuals. |

**Access to Specialty and Extended Care**

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| Name of program/activity/initiative | Primary Care Program – Colorectal Screenings |
| Description | The Primary Care Program will provide services and education of colorectal screenings. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as injury and disease prevention management; and access to specialty and extended care. |
| Goals | Funding will allow for the engagement in colorectal cancer prevention strategies on 10 evidence-based interventions for colorectal cancer screenings. In addition, the program will host a colorectal cancer learning collaborative to share best practices and evidence-based interventions with health centers and stakeholders. |
| Outcomes | This program did not launch as anticipated due to COVID closures – particularly those around screening/vaccinations since much of that was halted for health systems at one point in time. |

### Needs Sutter Amador Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Amador Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy plan does not include specific plans to address the following significant health needs that were identified in the 2019 Community Health Needs Assessment for the following reasons:

N/A

### Approval by Governing Board

The implementation strategy was approved by the Sutter Health Valley Area Board on November 21, 2019