2022
Community Health Needs Assessment

Sutter Health
Sutter Lakeside Hospital

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public service to help improve their community members' lives. One area of public service where these entities share responsibility is ensuring all community members have the opportunity to live a healthy life.

The Community Health Needs Assessment (CHNA) is one way public service agencies support the health of their communities. These assessments are required of non-profit hospitals and public health departments every three and five years, respectively, to understand the health needs of the communities they serve. The purpose of this assessment is to engage the communities in identifying community health needs, and to align resources across the community benefit functions of a non-profit hospital, strategies of public health, and services of community-based organizations to drive towards improved health for all.

For 2022, the collaborative between Hope Rising, Adventist Health Clear Lake, Lake County Public Health and Sutter Lakeside Hospital took this requirement one step further with the vision of designing a story-centric and people-centric CHNA. We envisioned a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. This process involved input from community focus groups and key informant interviews representing the broad interests of the community served by hospitals and collaborative organizations. In addition, input was gathered from local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income and minority populations. We intentionally prioritized understanding the social and health needs of uninsured or underinsured, low-income and minority persons in the community (see description of Focus Group participants, Section III.B).

To conduct this assessment, we used secondary and primary data from focus groups and key informant interviews conducted between October 2021 – January 2022. A local Steering Committee (see Section I.E) reviewed data and prioritized community health needs over the course of three meetings (data collection planning, data review and needs prioritization) taking place between October 2021 – March 2022. This group determined the following final community health priority areas:

Access to Care

Health Risk Behaviors

Mental Health

In this report, you will first find a Community Summary that introduces the community served by our hospital and lists the prioritized community health needs. The Community Summary is a brief overview of the main points from the CHNA followed by an in-depth and detailed report including:

Our Partners: CHNA Steering Committee (see Section I.E)

Description of Hospital and Community Served (see Section II)

Significant Identified Health Needs and Priority Areas Selected (see Section III)

Data Collection and Analysis (see Section IV)

Prioritization Process (see Section IV)

Next Steps (see Section IV.C)

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. The entire report is published online and available in print form by contacting **SHCB@sutterhealth.org**.

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What if . . .

Everyone from newborns to older adult patients easily received the unique care they needed?

Education and understanding led to better opportunities for a healthier life?

Everyone had someone to talk to about their mental well-being?

Community Vision Summary

Taking a step toward a healthier, better life

This is the vision of the future as seen through the Community Health Needs Assessment, or CHNA. The goal of the CHNA is to leverage community stakeholders and data to identify and maximize resources and to focus on meeting the most significant health needs of our community over the next three years.

Members of the CHNA Steering Committee – comprised of healthcare, civic, public, and business leaders – led this process of identifying and addressing health needs for a healthier community. These members took a deep look at where people live, learn, work and play to discover areas of opportunity that, through collaboration, could be strengthened and lead to a healthier you, stronger families and safer communities.

This CHNA involved interviews with career development experts, civic leaders, farmworkers, food security providers, higher education professionals, homeless service providers, law enforcement, medical providers, public health and older adults. We also conducted a community survey and gathered public data. Through this process, we learned about our community members' current state of health and listened to their greatest concerns for their friends and family.

There were 13 significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, community safety, community vitality (civic), community vitality (economic), environment and infrastructure, financial stability (employment), financial stability (cost of living), food security, health conditions, health risk behaviors, housing (cost), housing (unhoused) and mental health. The Steering Committee then selected high priority needs based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period, which were: access to care, health risk behaviors and mental health.

The following pages share opportunities where you, your family and your community can drive change for improved well-being.

Join us to activate our diverse community, improve lives, and make a "what if" dream into a powerful "what is" reality.

What if . . .

Everyone from newborns to older adult patients received the unique care they needed, thanks to good **Access to Care**

Education and understanding led to better opportunities for a healthier life, reducing **Health Risk Behaviors**

Everyone had someone to talk to about their mental wellbeing, with accessible programs addressing **Mental Health**

Getting to know our Lake County service area*

Near America's oldest lake and the recreational and outdoor activities it supports, our hospital serves a scenic, rural community with a total population of 69,918. Surrounded by mountainous terrain, Lake County is divided into two main cities, with Clearlake on the south shore and Lakeport on the north shore.

The community is vibrant with art galleries, festivals, local events and small businesses. Of the total population, 21.09% are Hispanic.

The median household income for the community we serve is $50,811, and 68.05% of income is spent on housing and transportation. In this community, 23.94% of children live in poverty, compared to 16.80% in California and 17.48% in the country. Additionally, 7.83% of students are unhoused, compared to 4.25% in the state and 2.77% in the country.

Let's begin with an overview of the last three years, including a closer look at community member comments, priorities and numbers that guided the decision-making process towards a path to better health, wholeness and hope for our community.

*service area is a collaborative extension of the hospital's primary service area, with additional zip codes selected by the Steering Committee (See section II.C).

This service area represents Sutter Health Lakeside and Adventist Health Clearlake's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the County of Lake CHNA service area.

What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

CHNA 2019 successes and lessons learned

Before we begin to look ahead, let's look back at a few highlights to see what has been learned and accomplished over the last three years, where we focused on access to health services, alcoholism, drug use, housing stability & homelessness, mental health, poverty, and unemployment as our 2019 CHNA prioritized health needs.

People carry burdens of homelessness, fear, and pain. But Sutter Lakeside team members launched efforts to address housing and reduce homelessness through warming shelters and open doors like Hope Rising. Through the SAFE RX Lake County Program, 4,648 were served, helping people cope with pain. Over 300 people participated in 22 classes in the Smart Start Program, teaching parents about safe sleep practices that reduce the rate of SIDS. And 312 people were vaccinated against influenza. Our community partnerships and collaborations have inspired hope.

Access to Care

COMMUNITY VOICES

- Community members raised concerns around receiving adequate and timely treatment.
- People shared that traveling long distances to appointments takes up an entire day, resulting in losing time from work, which affects wages and family time.
- There's a concern around the lack of treatment opportunities in the county, including limited at-home support and long-term residential treatment programs.
- People are frustrated with health professionals who are here to intern and practice, then leave as soon as they have the opportunity.
- Residents noted they really need an urgent care center since everyone goes to the ER, which results in a huge wait and medical bill.

Health care should be accessible to people of all ages, from all walks of life. Currently, that vision remains out of reach.

The data sets speak volumes:

- There are just 67 primary care providers per 100,000 population in our Lake County service area, compared to 104 primary care providers per 100,000 population in the United States.
- 78% of residents in this community live in an area affected by a Health Professional Shortage Area —which is more than three times higher than the rate for all of California.
- Community members reported limited healthcare access leads patients to turn to emergency rooms for basic services.

Residents recently voiced concerns about not receiving adequate care, requesting an accessible urgent care center. They shared concerns around the lack of treatment opportunities in the county, including residential treatment programs. There is frustration due to health care providers training locally and then moving on.

The challenges are many. But quality, affordable care is at the core of healthy lives and communities.

Community Health Needs Survey:

North Coast* 25% of those surveyed selected Access to Care as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Find Access to Care resources in your community to live better, longer.

E Center – Building Healthy Communities
530-634-1200, ecenter.org

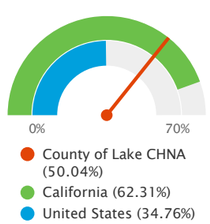
Community Development Services
707-279-1540, communitydevelopmentservices.info

Blue Zones Project - Lake County: Improve your health, live longer, and learn about Blue Zones Project, lc.bluezonesproject.com

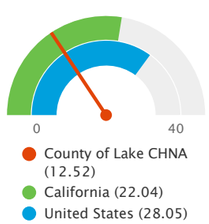
Get Connected Get Help with 211, Powered by people in your community, available 24/7, 211lake.org

SECONDARY DATA INFOGRAPHIC STATS:

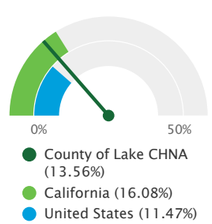
Percentage of Population within Half Mile of Public Transit



Intensive Care Unit Hospital Beds, Rate per 100,000 Population



Population Age 25+ with No High School Diploma, Percent



Availability - Primary Care - Primary Care Providers

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
County of Lake CHNA	69,917	22	47	**67.11**
Lake County, CA	68,163	22	46	67.49
Mendocino County, CA	91,601	16	95	103.71
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44

Health Risk Behaviors

COMMUNITY VOICES

- The community is seen as the poorest and unhealthiest county in California by some residents.
- There is a worry that kids are picking easy and unhealthy items to eat like chips, soda, donuts, and energy drinks.
- Excessive screen time is seen as a problem for many kids.
- Several residents said that marijuana and over-the-counter medicines are a problem. Parents expressed needing education about different drugs to know what to look for, sharing concerns that even things like Tylenol can be misused.
- There is a belief that there are high rates of suicide, alcohol use and drug use in this community.
- Kids not eating healthily in school and families not eating together are seen as problems.

Today, Medicare beneficiaries in our Lake County service area experience substance use disorder at a much higher rate than the rest of the state. Kids of all ages can easily access unhealthy foods such as soda, donuts and chips, and smoking rates are well over the state average. Additionally, statistics show that nearly 15% of infants born in this community have low birth weights, setting the stage for future – and very real – health concerns.

Communities hold the potential for creating opportunities for all. Over time, collective, community-driven changes will give way to healthier environments, activities, attitudes and life-changing engagements.

Find Health Risk Behaviors resources in your community to live better, longer.

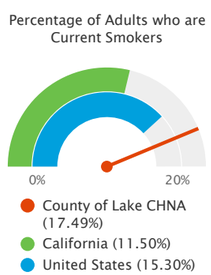
Healthy Start, Lake County Office of Education
707-262-4153, lakecoe.org

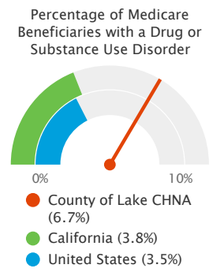
Lake County Behavioral Health (SUD Services)
707-263-5220, lakecountyca.gov

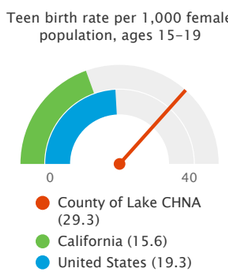
Blue Zones Project - Lake County: Improve your health, live longer, and learn about Blue Zones Project, lc.bluezonesproject.com

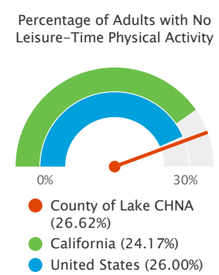
Get Connected Get Help with 211, Powered by people in your community, available 24/7, 211lake.org

SECONDARY DATA INFOGRAPHIC STATS:









Mental Health

COMMUNITY VOICES

- There is a perceived increase in domestic violence in the area.
- There is a worry that community members are self-medicating to address mental health problems.
- COVID-19 has led to intense isolation, contributing to some people experiencing depression and anxiety, community members say. The problem is compounded by a lack of awareness of where people can seek mental health services.
- Some shared thoughts that the difficulty in accessing mental health services has increased the severity of this problem.
- There is a stigma attached to receiving mental health services, compounding the problem for some.
- Substance abuse, especially when coupled with mental health problems, is seen as leading to long-term health problems for many in this area.

Mental health is undeniably complex, with a wide variety of reactions and responses – from engaging in treatment to fear to avoidance. Families cannot understand what is happening to their loved one, they don't know how to help, and too often, accessing needed services is difficult.

The concerns and challenges that come with poor mental health can lead to an increase in domestic violence, anxiety, depression, hopelessness and substance use. According to a recent survey, 44 % of people surveyed selected mental health as a top concern. Another troubling fact is the rate of deaths by suicide is much higher in our Lake County community (26.3 per 100,000 population) than in California (10.5 per 100,000 population) and in the United States (13.8 per 100,000 population). These few realities alone can make one wonder how to bring health and well-being back to this beautiful place.

Community Health Needs Survey:

North Coast* 44% of those surveyed selected Mental Health as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Find Mental Health resources in your community to live better, longer.

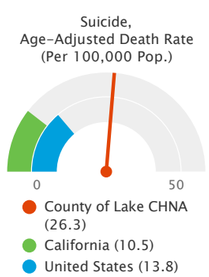
Lake County Behavioral Health
707-263-5220, lakecountyca.gov

Clearlake Senior Center
707-994-3051, hsscclearlake.org

Blue Zones Project - Lake County: Improve your health, live longer, and learn about Blue Zones Project, lc.bluezonesproject.com/home

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 211lake.org

SECONDARY DATA INFOGRAPHIC STATS:



Risk Factors - Access to Care - Access to Mental Health Providers

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
County of Lake CHNA	69,917	2	92	**131.27**
Lake County, CA	68,163	2	88	129.10
Mendocino County, CA	91,601	14	192	209.60
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

Risk Factors - Stress & Trauma - Violent Crime Rate

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
County of Lake CHNA	354	**538.2**
Lake County, CA	343	535.5
Mendocino County, CA	559	640.5
California	164,253	420.9
United States	1,240,534	386.5

Risk Factors - Stress & Trauma - Unemployment

Report Area	Labor Force	Number Unemployed	Unemployment Rate
County of Lake CHNA	27,311	2,827	**10.35%**
Lake County, CA	26,743	2,819	10.54%
Mendocino County, CA	40,905	3,536	8.64%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

What if . . .

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Many of us have given away the condition of our health to doctors, hospitals and health programs. But in reality, it's not any one plan or pill that will change your well-being. It's you. It's us, together with our community, working to create equitable opportunities so we can all actively move more, eat well, and be connected to community life, friends and family.

It took many committed community members to help create the 2022 CHNA. Steering Committee members shared their ideas and concerns and worked – and continue to work – to create a new vision.

Proudly, we share that this CHNA is part of a county-wide collaboration—but these community organizations can't do it alone. It takes collaboration, partnership, consistency and teamwork.

People of all walks of life offered ideas for the 2022 CHNA, helping to lead the way by focusing on needs otherwise too often overlooked. The final efforts are proving to be useful and enlightening – potentially leading to new directions and new opportunities.

To all who helped, we say **THANK YOU**. To those who now see the needs and opportunities, we welcome you. Change changes. Let's work together to inspire health, wholeness and hope in our community.

We thank the Lake County CHNA Steering Committee, which collaborated and partnered to create the 2022 CHNA. Through a series of three collaborative meetings, engagement of community members, and reviewing data, each committee member brought their unique perspective and view as seen through their job and the work they performed during the development of the CHNA.

Gemalli Austin; Tribal Health

Patty Bruder; North Coast Opportunities, Executive Director

Cirilo Cortez, Ph.D.; Woodland Community College, Executive Director

Lisa Davey-Bates; Lake County Transit, Executive Director

Brock Falkenberg; Lake County Office of Education, Superintendent of Schools

Alan Flora; City of Clearlake, City Manager

Andrea Garfia; Sutter Health, North Bay Coordinator, Community Health

Faith Hornby; Adventist Health Clear Lake, Manager of Philanthropy

Carol Huchingson; Lake County Administrative Officer

Kevin Ingram; City of Lakeport, City Manager

Denise Johnson; Lakeport/Kelseyville, Lake Family Resource Center Manager

Shannon Kimbell-Auth; Adventist Health Clear Lake, Community Well-Being Manager

Scott Knight; Sutter Lakeside Hospital, Chief Administrative Officer

Crystal Markytan; Lake County Department of Social Services, Director

Brian Martin; Lake County Sheriff's Office; Sheriff

Rick Mayo; NAACP Lake County, President

Erik McLaughlin, MD; Lake County Public Health, Public Health Officer

Todd Metcalf; Lake County Behavioral Health, Behavioral Health Services Director

Lisa Morrow; Lake Family Resource Center, Executive Director

Russ Perdock; Adventist Health Clear Lake; Director

Laura McAndrews Sammel; Lake County Chamber of Commerce, Director

Saul Sanabria; Lake County Veterans Services, Veteran Services Officer

Anna Santana; Health Start, Director

Willie Sapeta; Lake County Fire Protection District, Fire Chief

Marc Shapiro, MD; Adventist Health Clear Lake, Medical Director

Jose "Moke" Simon; Lake County, Board of Supervisors District 1 Supervisor / Middletown Rancheria of Pomo Indians of California, Tribal Chairman

Marilyn Wakefield; Adventist Health Clear Lake, Director, Clinical Integration

Rachel Walsh; Sutter Lakeside Hospital, Patient Access Manager

Andrew White; Clearlake Police Department, Chief of Police

II. About Us

A. Sutter Lakeside Hospital

Sutter Lakeside Hospital is proud to serve residents of Lake County with a 25-bed critical access hospital. Over the past five years, residents have proven their resilience in the face of devastating fires, power shutoffs, economic hardship, and the COVID-19 pandemic. The Lake County community has worked cohesively to strengthen resources available to families and build economic stature.

B. Sutter Health

Sutter Health is the not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

Learn more about how we're transforming healthcare at sutterhealth.org and vitals.sutterhealth.org. Sutter Health's total investment in community benefit in 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").
2. Insured are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical expenses amounting to more than 10% of their family income over the last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income).
3. Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

D. Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Sutter Health Lakeside and Adventist Health Clear Lake's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

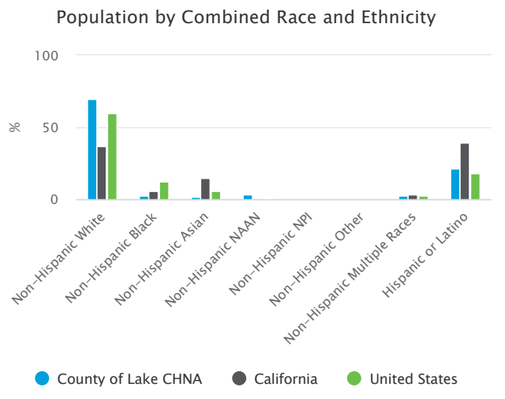
The County of Lake CHNA market has a total population of 69,918 (based on the 2020 Decennial Census). The largest city in the service area is Clear Lake, with a population of 15,250. The service area is comprised of the following zip codes: 95451, 95443, 95435, 95464, 95493, 95426, 95423, 95485, 95457, 95461, 95469, 95458, 95453, 95422, 95467.

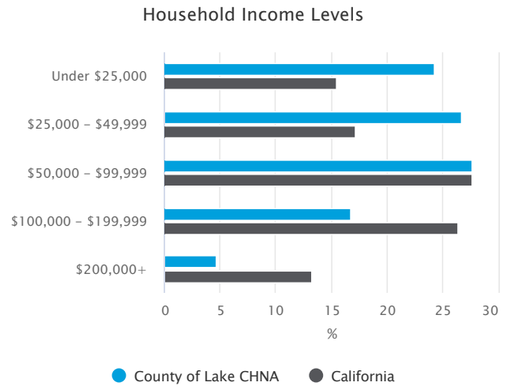
Total Population

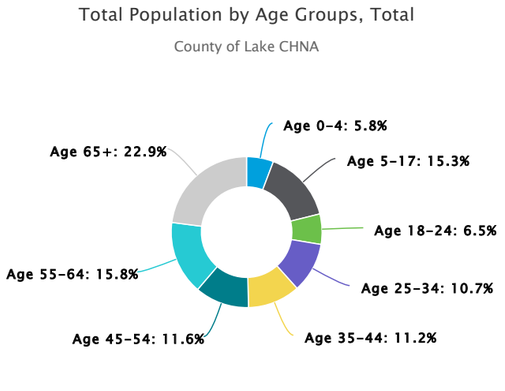
69,918

67.59%
of the population owns their home

32.41%
of the population rents their home







III. Significant Identified Health Needs, Primary, Secondary Data & Written Comments

A. Significant Identified Health Needs

Steering Committee members, alongside their staff, boards and constituencies reviewed and discussed a presentation of significant identified health needs, which was a list of the top five needs across each data source (see section V for methodology). They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. From the list of significant identified health needs in the table, the following three health needs were prioritized as a high priority need, based on the criteria considered (see Section IV. A for full prioritization methodology): Access to Care, Health Risk Behaviors and Mental Health.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Access to Care	See Sections III.C - E
Health Risk Behaviors	See Sections III.C - E
Mental Health	See Sections III.C - E
Lower Priority Needs ***please note web address leads to multiple 211 resources within each priority need***	
Financial Stability: Employment 211lakecounty.org/index.php/employment	Median incomes are much lower than the rest of California, and a high percentage of residents in the Lake County CHNA service area live in poverty (21.05% compared to 13.42% across the US). Focus group members also saw the high cost of living and limited employment options as drivers of financial instability.
Financial Stability: Cost of Living 211lakecounty.org/index.php/finance	Median incomes are much lower than the rest of California, and community residents identified problems in paying for food, healthcare, transportation, and housing. 79% of surveyed residents identified the cost of living as a health need.
Health Conditions 211lakecounty.org/index.php/health	This region has higher heart disease and diabetes prevalence and cancer mortality rates than the rest of the state. No urgent care is currently available, and residents noted that long travel times to see specialists make it hard to get the medical care they need.
Food Security 211lakecounty.org/index.php/food	In the Lake County service area, 74% of school-age children qualify for free and reduced-price school meals, and the rate of people in poverty is very high (21.05%). Residents expressed concerns about the limited availability of reasonably priced, healthy foods.
Community Safety 211lakecounty.org/index.php/legal	The violent crime rate in the Lake County CHNA service area surpasses state and federal rates to a noteworthy degree, 536 crimes/100,000 population in the region compared to 418/100,000 in California and 386/100,000 in the US.
Environment and Infrastructure 211lakecounty.org/index.php/government	Key Informants noted a lack of access to safe parks and public spaces, an infrastructure designed primarily for cars, limited sidewalks, and poor-quality roads as major built environment issues.
Community Vitality: Civic 211lakecounty.org/index.php/utilities 211lakecounty.org/index.php/education	The difficulties attracting new businesses to the area, insufficient high-speed internet access, the relatively low level of education across the population, and lack of overall community development were called out as problems by Key Informants.
Housing: Unhoused 211lakecounty.org/index.php/housing 211lakecounty.org/index.php/crisis	Multiple drivers towards homelessness were noted by focus group participants, including limited employment opportunities and the very high cost of living. A lack of community connection and a history of personal trauma were also seen as contributing factors. It was noted that there are not enough housing units, and the cost is prohibitive for many. Homelessness was viewed as a health need by 53% of the surveyed residents in the area.
Housing: Costs 211lakecounty.org/index.php/housing	48% of residents indicated that lack of affordable housing was a health problem in their community. Focus group and key informant interviewees noted the high cost of housing, limited housing stock, and an influx of house buyers from urban areas as some of the causes.
Community Vitality: Economic 211lakecounty.org/index.php/employment	Difficulty recruiting professionals due to low salaries and limited housing options was noted by Key Informants. Overall, the difficulty of promoting economic development in local towns was also seen as a problem.

B. Primary, Secondary, and Survey Data Overview

This Community Health Needs Assessment was developed using four separate sources of primary and secondary data. This mixed methods approach is considered a preferred practice for needs assessments because it allows for the greatest understanding of community needs from the broadest range of perspectives. Primary data refers to data collected and analyzed specifically for this project, while secondary data refers to data compiled and analyzed by external groups and utilized here.

Qualitative primary data collection involved focus group interviews with local service providers and service recipients and individual key informant interviews with local leaders. These were conducted in-person and virtually. Direct quotes were taken from a transcription of key informant interviews and are intended to be 100% accurate but could not be verified in all situations. This information was collected by the Adventist Health Community Well-Being team and evaluation consultants from the Center for Behavioral Health Integration. Secondary data was amassed and analyzed across 45 different data sets by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES). Finally, survey data sets of registered voters in the community were collected and analyzed by UC Berkeley Institute of Governmental Studies (IGS). A detailed explanation of data collection methodology can be found in Sections IV and V.

In total, seven focus groups were conducted with 41 participants, and 19 key informant interviews were held. Survey data was gathered from the North Coast region (region name defined by survey administrator, UC Berkeley IGS). See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

The CHNA Steering Committee (membership found in Section I. E) identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations – the voices of those with chronic disease, low incomes and the underserved – were heard. Analytical methods for focus groups and key informant interviews found in Section IV. B.

FOCUS GROUPS

- Seven (7) focus groups
- Forty-one (41) people participated

Focus group comments were gathered during in-person, virtual and hybrid focus groups, typically running 90-minutes.

KEY INFORMANTS

- Nineteen (19) individual interviews

During 60-minute interview key informants shared their greatest concerns around health needs, health equity and social determinants of health for those they serve.

PARTICIPATING ORGANIZATIONS

Adventist Health Clearlake, City of Clearlake, City of Lakeport, County of Lake, Employment Development Department, Hope Rising, Lake County Aging Services, Lake County Behavioral Health, Lake County Chamber of Commerce, Lake County Health & Human Services, Lake County Sheriff's Department, Lake County Department of Public Health, Lake County Office of Education, Lake County Transit Authority, Lake County Tribal Health, Lake Family Resource Center, Sutter-Lakeside Hospital and Woodland Community College

REPRESENTED RACE/ETHNICITIES

American Indian, Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Agricultural workers (Spanish-speaking), civic government & leadership, community-based healthcare workers focusing on behavioral health, education, health & human services, higher education, providers, families, food insecure, law enforcement, low-income, medically underserved, men, older adults, public health, students, tribal health services, unhoused and women populations.

The three high-priority health needs are described in further detail on the following pages.

SURVEY RESULTS

REGION & STATEWIDE SUMMARY

North Coast: Survey Results of Top Needs
See Section V. B. for more information.

-4% Statewide margin of error

Needs	County of Lake	Statewide
Financial Stability- Cost of Living	79%	83%
Housing- Unhoused	53%	63%
Housing- Cost	48%	55%
Mental Health	44%	48%
Financial Stability- Employment	30%	47%
COVID-19	29%	31%
Access to Care- Senior Care	29%	24%
Access to Care- Primary Care	25%	22%
Food Insecurity	21%	23%
Environment & Infrastructure- Transportation	19%	15%
Education	18%	15%

C. Access to Care

Availability of healthcare services is limited in Lake County, creating barriers to accessing care. In our Lake County service area, there are fewer primary care providers (67 per 100,000 people) compared to California (100 per 100,000) and the U.S. (104 per 100,000). Over 78% of residents live in a federally designated Health Professional Shortage Area. That's almost four times higher than the national and state average. The Lake County CHNA service area also has a shortage of Intensive Care Unit beds, with just 12.5 ICU beds per 100,000 residents, roughly ten beds fewer than the state average and 16 beds fewer than the national average. These numbers represent a concern as our population grows.

About 50% of the residents in the Lake County CHNA service area live within a half-mile of public transportation. This is higher than the national average (34.8%) but much lower than the state average (62.3%). Considering the combination of limited availability of healthcare services and challenges with transportation, residents have great trouble lining up health care and also difficulty getting to appointments without a reliable personal vehicle.

Health literacy and educational attainment are possible barriers to healthcare access and positive health outcomes. About 13.6% of the adult population in the Lake County CHNA service area has no high school diploma, compared to about 16% in California and about 12 % in the United States. This rate is much higher for Blacks or African Americans (21.3%); Native Americans or Alaska Natives (32.9%); Asians (22.3%); Native Hawaiian or Pacific Islander (38.5%); multiple races (22.4%); and those identifying as some other race (33.5%); and is only lower for those identifying as white (9.9%). Furthermore, about 24% of Hispanics ages five and older have limited English proficiency, limiting their opportunity to access resources to learn about health matters, schedule appointments or get test results.

The problems outlined here are all amplified for racial, ethnic, and cultural minorities, which could lead to a lower quality of life and reduced health and wellness outcomes for those populations.

PRIMARY COMMENTS

FOCUS GROUPS COMMENTS (PARAPHRASED FROM PRIMARY DATA INTERVIEW NOTES)

- Community members raised concerns around receiving adequate and timely treatment.
- Traveling long distances to appointments takes up an entire day to drive there and back, resulting in losing time from work, which affects wages and family time.
- There's a concern around the lack of treatment opportunities in the county, including limited at-home support and long-term residential treatment programs.
- People are frustrated with health professionals who are here to intern and practice and then leave as soon as they have the opportunity.
- Residents noted they really need an urgent care center since everyone goes to the ER, which results in a huge wait and medical bill.
- There are multiple types of transportation barriers that affect people's ability to see a doctor.
- Cultural and language barriers make it harder for many to seek care or to get the care they need.
- The loss of healthcare providers in the community has taken a major toll over time.

KEY INFORMANT COMMENTS

- There's a concern around the lack of treatment opportunities in the county, including limited at-home support and long-term residential treatment programs.
- The rural nature of the community is seen as a reason why it is hard to hire and retain doctors, both primary and specialty care.
- The limited number of doctors means people have to travel long distances for care.
- The lack of urgent care facilities was called out repeatedly as a major healthcare access problem.
- Transportation is an issue, getting people in to see the doctor and getting people home from the hospital.

Scan QR Code for more information on the full Care Report

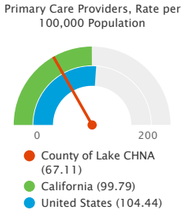
Secondary Data Summary

Access to Care

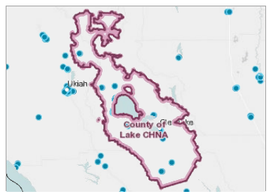
Availability - Primary Care - Primary Care Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The number of facilities that specialize in primary health care are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
County of Lake CHNA	69,917	22	47	**67.11**
Lake County, CA	68,163	22	46	67.49
Mendocino County, CA	91,601	16	95	103.71
California	39,538,223	12,051	39,455	99.79
United States	334,735,155	117,465	349,603	104.44



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). July 2022. Source geography: Address



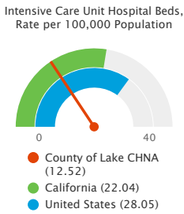
Primary Care Physicians, All, CMS NPPES July 2022

Primary Care Physicians, All, CMS NPPES July 2022
County of Lake CHNA

Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports information about the availability of hospital beds across the United States. The data behind this layer comes from Definitive Healthcare; the group is providing their proprietary hospital bed count data "in order to enable observation of the care capacity of hospitals across the country as cases of COVID-19 proliferate". In the report area, the amount of Intensive Care Unit hospital beds is 8 in total or 12.52 per 100,000 population.

Report Area	Total Population (2018)	Licensed Beds	Staffed Beds		Licensed Beds, Rate per 100,000 Pop.	Staffed Beds per 100,000 Pop.	ICU Beds, Rate per 100,000 Pop.
County of Lake CHNA	66,060	64	51		97.99	78.60	**12.52**
Lake County, CA	64,382	62	50		96.30	77.66	12.43
Mendocino County, CA	87,606	142	100		162.09	114.15	15.98
California	79,114,090	162,424	161,604		205.30	204.27	22.04
United States	654,334,868	1,872,694	1,602,386		286.20	244.89	28.05



Note: This indicator is compared to the state average.
Data Source: Definitive Healthcare. Accessed via Hospital Beds Dashboard on Esri's COVID-19 GIS Hub. 2020. Source geography: County

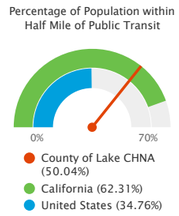
ICU Beds, Rate per 100,000 by County, Definitive Healthcare 2020

No ICU Beds
0.1 - 10.0
10.1 - 20.0
20.1 - 40.0
Over 40.0
County of Lake CHNA

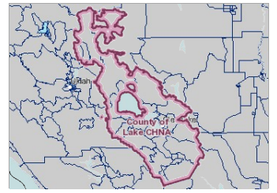
Barriers - Transportation - Distance to Public Transit

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
County of Lake CHNA	66,016	33,032	**50.04%**
Lake County, CA	64,148	33,039	51.5%
Mendocino County, CA	87,422	37,191	42.54%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%



Note: This indicator is compared to the state average.
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2019. Source geography: Tract



Population Living Near a Transit Stop, Percent within 0.50 Miles by Block Group, EPA SLD 2019

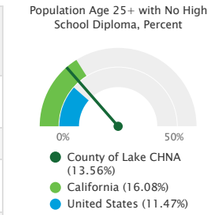
Over 80.0%
60.1 - 80.0%
20.1 - 60.0%
Under 20.1%
No Population Within 0.50 Miles
County of Lake CHNA

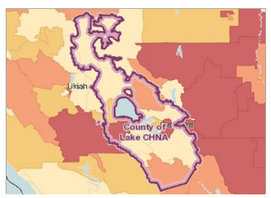
Barriers - Health Literacy - Educational Attainment

Within the report area there are 6,450 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 13.56% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent
County of Lake CHNA	47,564	6,450	13.56%
Lake County, CA	46,482	6,403	13.78%
Mendocino County, CA	62,022	8,269	13.33%
California	26,665,143	4,286,538	16.08%
United States	222,836,834	25,562,680	11.47%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract



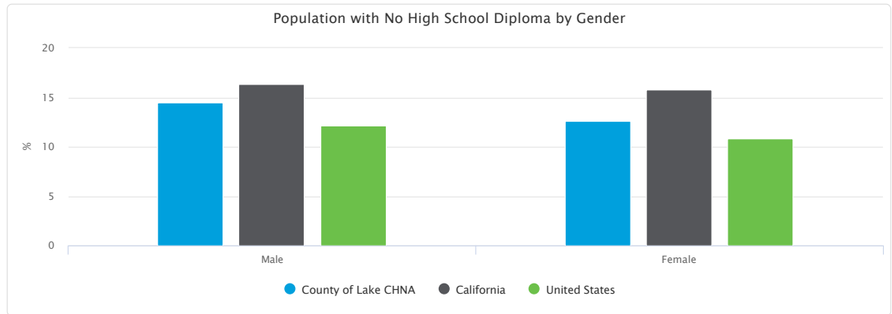


Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2016-20

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- County of Lake CHNA

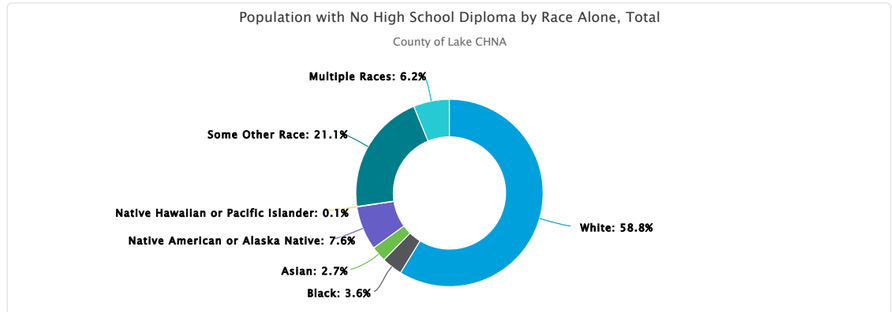
Population with No High School Diploma by Gender

Report Area	Male	Female	Male, Percent	Female, Percent
County of Lake CHNA	3,397	3,053	14.49%	12.66%
Lake County, CA	3,373	3,030	14.74%	12.84%
Mendocino County, CA	4,433	3,836	14.61%	12.11%
California	2,135,833	2,150,705	16.34%	15.82%
United States	13,141,042	12,421,638	12.19%	10.80%



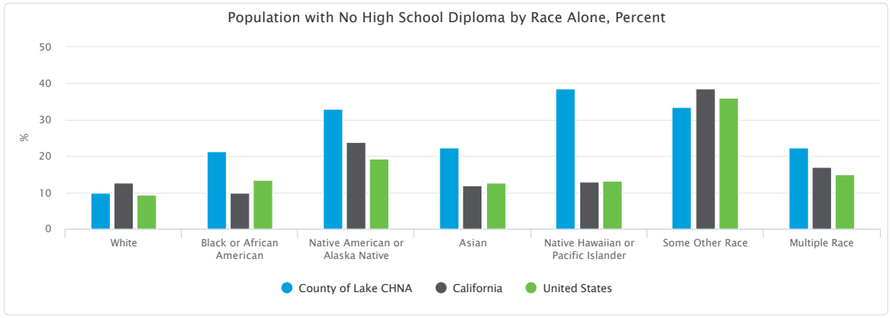
Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	Native American or Alaska Native		Some Other Race	Multiple Races
County of Lake CHNA	3,791	231	172	490		1,360	401
Lake County, CA	3,744	231	172	490		1,360	401
Mendocino County, CA	5,624	31	100	569		1,385	558
California	1,977,822	151,677	510,287	49,513		1,312,799	271,022
United States	15,123,109	3,547,596	1,655,662	327,426		3,624,534	1,233,270



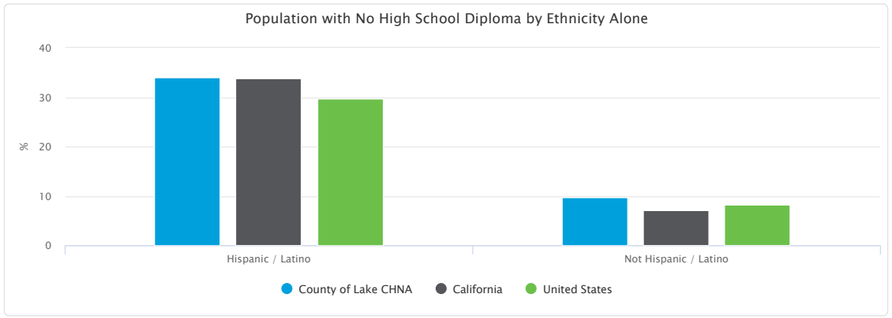
Population with No High School Diploma by Race Alone, Percent

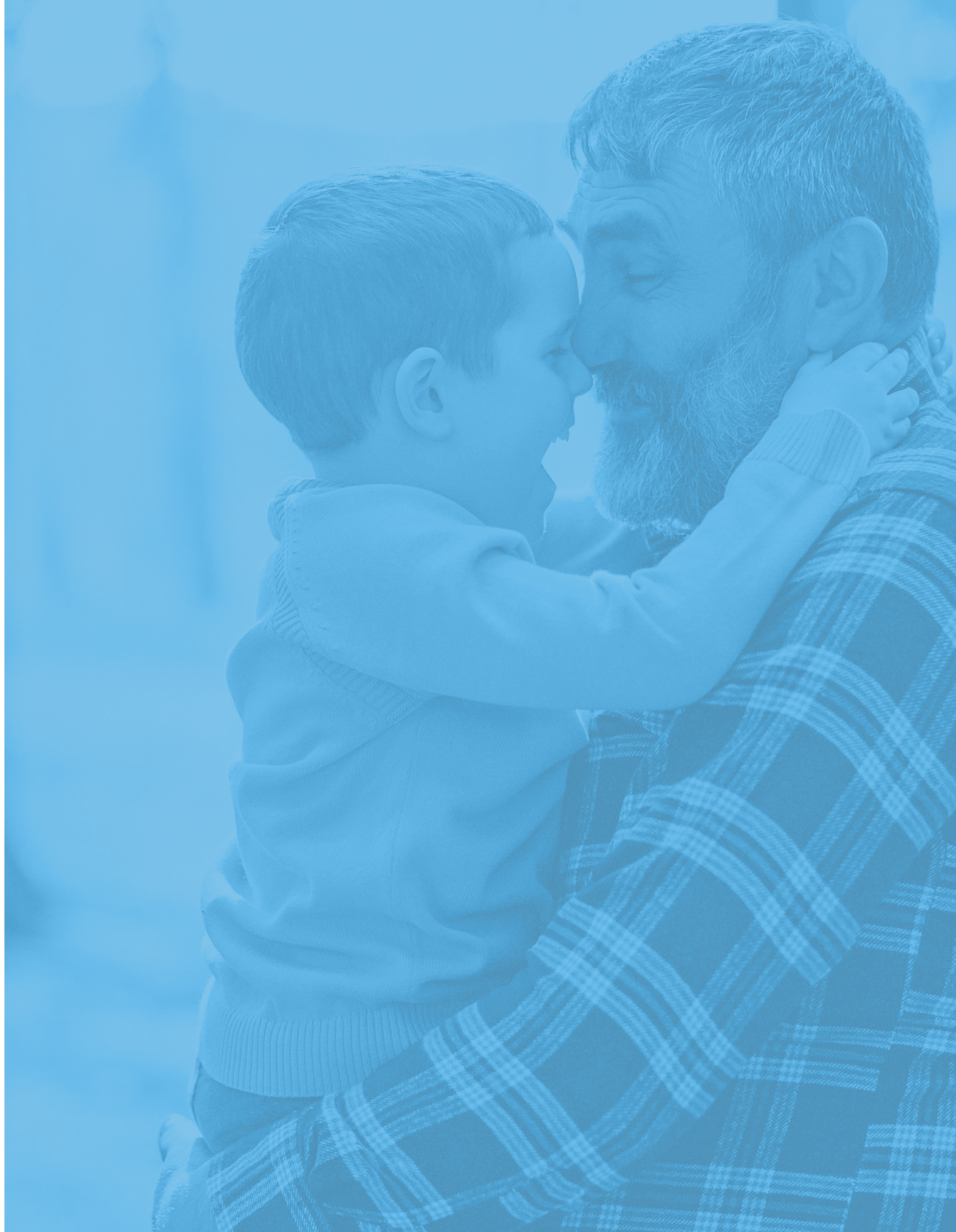
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
County of Lake CHNA	9.88%	21.27%	32.89%	22.28%	38.46%	33.50%	22.43%
Lake County, CA	10.00%	21.33%	33.31%	23.18%	38.46%	33.88%	23.25%
Mendocino County, CA	10.77%	12.02%	24.12%	7.64%	1.56%	47.27%	19.84%
California	12.72%	9.82%	23.96%	11.96%	13.03%	38.68%	16.99%
United States	9.28%	13.33%	19.41%	12.71%	13.15%	36.14%	15.01%



Population with No High School Diploma by Ethnicity Alone

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
County of Lake CHNA	2,544	3,906	34.07%	9.74%
Lake County, CA	2,544	3,859	34.52%	9.87%
Mendocino County, CA	4,250	4,019	36.36%	7.98%
California	3,025,438	1,261,100	33.80%	7.12%
United States	10,134,213	15,428,467	29.74%	8.17%





D. Health Risk Behaviors

Behaviors that increase the likelihood of illness and poor overall health in the short and long-term for residents in our Lake County service area are a key place to focus prevention efforts. There are several areas of note in this regard.

A large swath of adults in this service area are smokers, with 17.5% of the population identifying as having smoked at least 100 cigarettes in their lifetime and currently smoking every day or some days. This is compared to the California rate of 11.5 % and the U.S. rate of 15.3%.

Health risk behaviors among the older adults are worth further consideration. Roughly 3.3% of service area Medicare beneficiaries have alcohol-use disorders, compared to the state average rate (2.2%) and the national average rate (2.1%). About 6.7% of service area Medicare beneficiaries have a drug- or substance-use disorder. This is much higher than the state average (3.8%) and the national average (3.5%).

Reproductive health risk behaviors are seen in an escalated rate of teen pregnancy in our Lake County service area (29.3), compared to both California (15.6) and the U.S. (19.3). Additionally, 14.6% of total live births were infants weighing less than 5.5 pounds, compared to 6.9% of births in California and 8.2% in the U.S.

Physical inactivity also has short- and long-term health implications. About 27% of local residents did not participate in any physical activity or exercise, including running, calisthenics, golf, gardening, or walking for exercise — roughly three percentage points higher than the state average and one percentage point higher than the national average. Meanwhile, 9.7% of local kids ages six to17 meet the criteria for physical inactivity.

In terms of prevention and early identification of potential issues, a little more than one-in-four local women ages 65 and older are up to date on clinical preventative services, such as flu shots, mammograms or colonoscopies. This is a lower rate than the state average (32.7%) and the U.S. (28.4%). Men 65 and older in the service area are also behind on preventative services, with only 26.2% being current on core preventative services as compared to 29.2% in California and 32.4% in the U.S.

Roughly 71.1% of the service area's adult population is fully vaccinated for COVID-19. While significantly lower than California rates (80.7%), it is similar to the U.S. rate (73.6%).

Scan QR Code for more information on the full Report

PRIMARY COMMENTS

FOCUS GROUPS

- The community is seen as the poorest and unhealthiest county in California by some residents.
- There is a worry that kids are picking easy and unhealthy items to eat like chips, soda, donuts, and energy drinks.
- Excessive screen time is seen as a problem for many kids.
- There is a belief there is a high rate of suicides, alcohol use and drug us in this community.
- Interviewees noted that use of alcohol and drugs start at a young age. There is a lack of communication with parents to help educate their kids, and that's become a problem.
- There are many single-parent households experiencing high stress levels, and some believe this causes people to cope with alcohol and drugs.
- People noted that many people are not comfortable cooking healthy food and that community-based education can help with this.

KEY INFORMANT COMMENTS

- Several residents said that marijuana and over-the-counter medicines are a problem. Parents expressed needing education about different drugs to know what to look for, sharing concerns that even things like Tylenol can be misused.
- Kids not eating healthily in school and families not eating together are seen as a problem.
- Behavioral health programs struggle to find providers due to lack of funding; people are having to be seen virtually.
- There's a large population in Lake County that misuses substances, and they have major substance use disorders, per numerous interviewees.
- Mental health is neglected due to the stigma around drug use and alcoholism in the eyes of some.
- Employee-led opportunities to exercise, eat healthy meals, and attend to hygiene needs are seen as an important consideration.
- Lack of affordable healthcare is also seen as a barrier to engaging in healthy behaviors.

Secondary Data Summary

Health Risk Behaviors

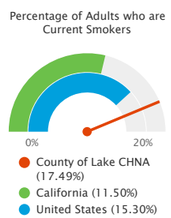
Tobacco - Current Smoking

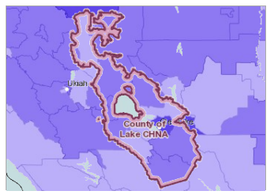
This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Within the report area there are 17.49% adults who have smoked or currently smoke of the total population.

Report Area	Total Population (2019)	Adult Current Smokers (Crude)	Adult Current Smokers (Age-Adjusted)
County of Lake CHNA	66,366	**17.49%**	No data
Lake County, CA	64,386	15.80%	16.50%
Mendocino County, CA	86,749	14.30%	14.80%
California	39,512,223	11.50%	11.54%
United States	328,239,523	15.30%	15.70%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract





Current Smokers, Adult, Percentage of Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

- Over 25.0%
- 20.1% - 25.0%
- 15.1% - 20.0%
- Under 15.1%
- No Data or Data Suppressed
- County of Lake CHNA

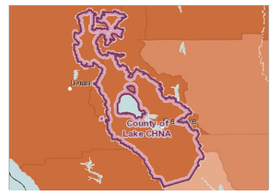
Illicit Drugs - Substance Use Disorder

This indicator reports the percentage of the Medicare fee-for-service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program.

Within the report area, there are a total of 1,036 beneficiaries with substance use disorder. This represents a 6.7% of the Medicare fee-for-service beneficiaries.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
County of Lake CHNA	15,519	1,036	**6.7%**
Lake County, CA	15,147	1,011	6.7%
Mendocino County, CA	19,410	1,316	6.8%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, CMS - Chronic Conditions Warehouse. 2018. Source geography: County



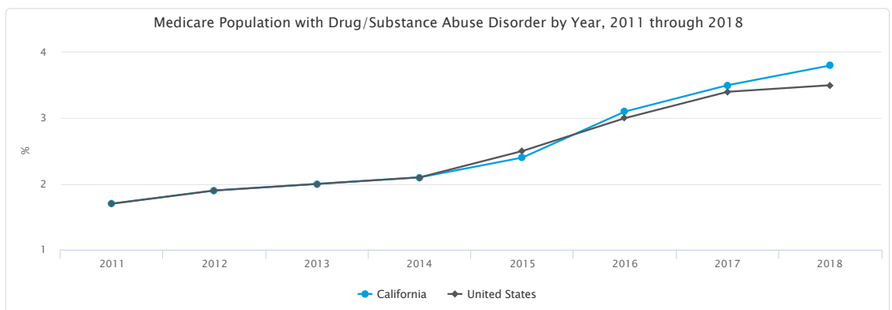
Beneficiaries with Drug/Substance Use Disorder, Percent by County, CMS 2018

- Over 5.0%
- 3.1 - 5.0%
- 2.1 - 3.0%
- Under 2.1%
- No Data or Data Suppressed
- County of Lake CHNA

Medicare Population with Drug/Substance Abuse Disorder by Year, 2011 through 2018

This indicator reports the percentage of the Medicare fee-for-service population with drug or substance use disorders over time.

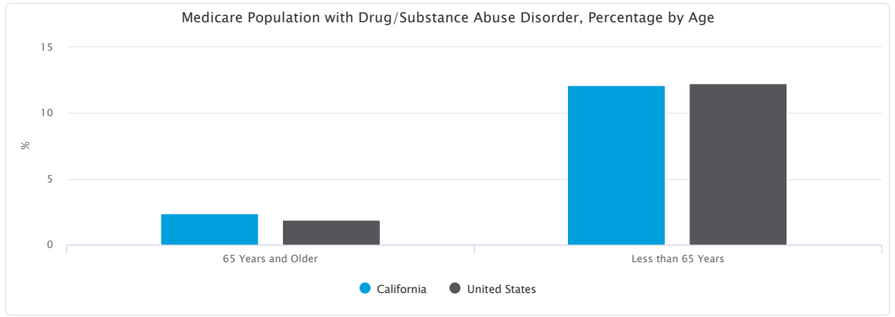
Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Lake County, CA	3.9%	4.2%	4.2%	4.6%	5.2%	6.3%	6.9%	6.7%
Mendocino County, CA	2.9%	3.3%	3.7%	4.0%	4.8%	6.3%	7.1%	6.8%
California	1.7%	1.9%	2.0%	2.1%	2.4%	3.1%	3.5%	3.8%
United States	1.7%	1.9%	2.0%	2.1%	2.5%	3.0%	3.4%	3.5%



Medicare Population with Drug/Substance Abuse Disorder, Percentage by Age

This indicator reports the prevalence of drug or substance use disorders among Medicare beneficiaries by age.

Report Area	65 Years and Older	Less than 65 Years
Lake County, CA	4.1%	17.0%
Mendocino County, CA	4.1%	21.1%
California	2.4%	12.1%
United States	1.9%	12.3%

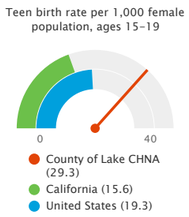


Reproductive Health - Teen Birth Rate

This indicator reports the seven-year average number of births per 1,000 female population age 15-19. Data were from the National Center for Health Statistics - Natality files (2014-2020) and are used for the 2022 County Health Rankings.

In the report area, of the 11,871 total female population age 15-19, the teen birth rate is 29.3 per 1,000, which is greater than the state's teen birth rate of 15.6.
Note: Data are suppressed for counties with fewer than 10 teen births in the time frame.

Report Area	Female Population Age 15-19	Teen Births, Rate per 1,000 Female Population Age 15-19
County of Lake CHNA	11,871	**29.3**
Lake County, CA	11,545	29.5
Mendocino County, CA	17,014	22.2
California	8,784,781	15.6
United States	72,151,590	19.3



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via County Health Rankings. 2014-2020. Source geography: County

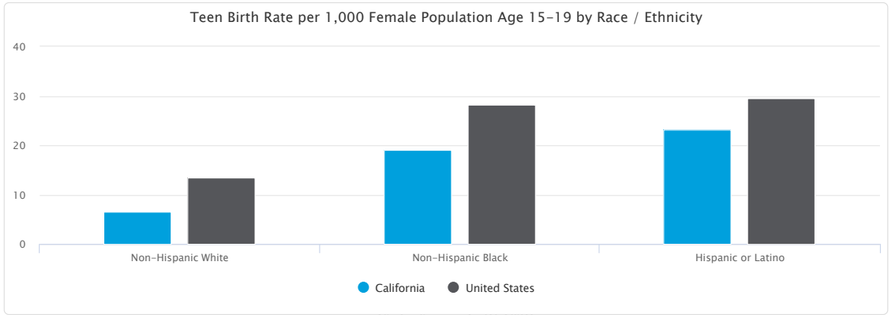
Teen Births, Rate Per 1,000 Live Births by County, CDC NVSS 2014-2020

- Over 54.0
- 40.1 - 54.0
- 26.1 - 40.0
- Under 26.1
- No Data or Data Suppressed
- County of Lake CHNA

Teen Birth Rate per 1,000 Female Population Age 15-19 by Race / Ethnicity

This indicator reports the 2014-2020 seven-year average teen birth rate per 1,000 female population age 15-19 by race / ethnicity.

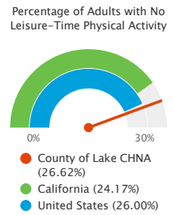
Report Area	Non-Hispanic White	Non-Hispanic Black	Hispanic or Latino
Lake County, CA	20.9	No data	41.6
Mendocino County, CA	14.7	No data	28.0
California	6.6	19.1	23.2
United States	13.5	28.2	29.6



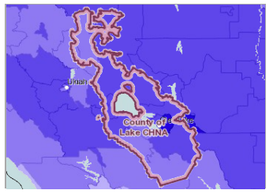
Physical Inactivity - Physical Inactivity

This indicator reports the number and percentage of adults age 18 and older who answered “no” to the following question: “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?”

Report Area	Total Population (2019)	Adults with No Leisure-Time Physical Activity (Crude)	Adults with No Leisure-Time Physical Activity (Age-Adjusted)
County of Lake CHNA	66,366	**26.62%**	No data
Lake County, CA	64,386	27.40%	26.70%
Mendocino County, CA	86,749	25.60%	25.10%
California	39,512,223	24.17%	24.28%
United States	328,239,523	26.00%	25.60%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract



No Leisure-Time Physical Activity, Percentage of Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

- Over 32.0%
- 24.1% - 32.0%
- 18.1% - 24.0%
- Under 18.1%
- No Data or Data Suppressed
- County of Lake CHNA

E. Mental Health

Preventative, responsive, and accessible care for mental health difficulties is crucial for a healthy community. Access to mental health professionals, including professionals specializing in psychiatry, psychology, child, adolescent, or adult mental health, as well as clinical social workers, are quite limited in our Lake County CHNA service area. There are 131.27 mental health care providers per 100,000 people in the service area, compared to 150.31 in California and 132.27 in the United States. Similar to the shortage of primary care providers, these low numbers mean that mental health services of all kinds are significantly more difficult to access.

Lack of medical insurance coverage, impacting access to care and a key driver of health status, is lower in this service area (7.4%) than in the United States (8.7%). That number increases to 9.4% for Black people, 11.9% for multi-race and 16.3% for Native Americans or Alaska natives.

Further risk factors related to substance use, stress and trauma are impacting the population of our Lake County service area. About 6.7% of Medicare beneficiaries have a drug- or substance-use disorder, compared to 3.8% in California and 3.5% the U.S. There is also a higher rate of violent crime (538.2 per 100,000 people) than both California (420.9) and the U.S. (386.5). Unemployment also increases stress, and with a much higher rate in our service area (10.4%) than California (6.2%) and the U.S. (5.4%), this is a significant risk factor for residents we serve. The Native American/Alaska Native population's unemployment rate is 16.3%, further increasing the stress on for this population.

More adults in the service area described themselves as having poor mental health (15.6%) than those in California on average (12.5%) and the U.S. (13.6%).

Concerning trends in mental health outcomes are evident. The rate of deaths by suicide is higher in our Lake County service area (26.3 per 100,000) than in California (10.5 per 100,000) and in the U.S. (13.8 per 100,000). The rate of deaths of despair —including death due to intentional self-harm, alcohol-related disease, and drug overdoses — are significantly higher in for our service area (109.8 per 100,000 people) than in California (37.1 per 100,000) and in the U.S. (47.0 per 100,000).

Scan QR Code for more information on the full Report

PRIMARY COMMENTS

FOCUS GROUPS

- There is a perceived increase in domestic violence in the area.
- There is a worry that community members are self-medicating to address mental health problems.
- COVID-19 has led to intense isolation, contributing to some people experiencing depression and anxiety, community members say. The problem is compounded by a lack of awareness of where people can seek mental health services.
- Poor access to mental health services has amplified the severity of the problem.
- There is a stigma attached to receiving mental health services, intensifing the problem for some.
- Substance abuse, especially when coupled with mental health problems, is seen as leading to long-term health problems for many in this area.
- The fires contributed to the mental health problem, some interviewees noted. Starting in 2015, thousands of houses were destroyed, and now people can't afford the rent, and they're experiencing greater levels of stress.
- Many community members equate mental health needs with substance abuse problems.
- Prevention services in schools, and community champions for mental health services, are seen as two major needs.
- The long-term impact of the 2015 wildfires is still seen as a driver for needing mental health services.

KEY INFORMANT COMMENTS

- It is believed the school system cannot provide adequate mental health services when they are needed for local children and adolescents.
- There are no dedicated providers available to treat people with mental health issues in the ER.
- Financial and social stressors are seen as major contributors to anxiety and depression
- There are long waitlists for services.
- There's been an increase in overdoses, per some interviewees.
- Like with healthcare providers, it's become difficult to recruit and retain mental health professionals.

Secondary Data Summary

MENTAL HEALTH

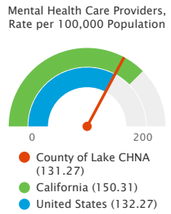
Risk Factors - Access to Care - Access to Mental Health Providers

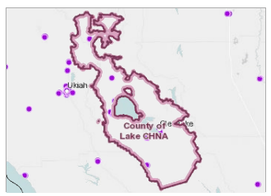
This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counselling, or child, adolescent, or adult mental health. The number of facilities that specialize in mental health are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Within the report area there are 92 mental health providers with a CMS National Provider Identifier (NPI). This represents 131.27 providers per 100,000 total population.

Report Area	Total Population (2020)		Number of Providers	Providers, Rate per 100,000 Population
County of Lake CHNA	69,917		92	**131.27**
Lake County, CA	68,163		88	129.10
Mendocino County, CA	91,601		192	209.60
California	39,538,223		59,430	150.31
United States	334,735,155		442,757	132.27

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). July 2022. Source geography: Address





Mental Health Providers, All, CMS NPPES July 2022

Mental Health Providers, All, CMS NPPES July 2022
County of Lake CHNA

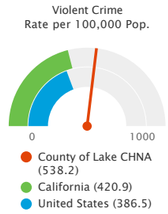
Risk Factors - Stress & Trauma - Violent Crime Rate

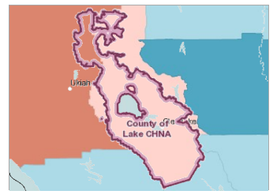
This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and 2016 FBI Uniform Crime Reports. This indicator is relevant because it assesses community safety.

In the report area, 354 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 538.2 per 100,000 residents is higher than the statewide rate of 420.9 per 100,000.
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
County of Lake CHNA	354	**538.2**
Lake County, CA	343	535.5
Mendocino County, CA	559	640.5
California	164,253	420.9
United States	1,240,534	386.5

Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014&2016. Source geography: County





Violent Crime, Rank by County, CHR 2022

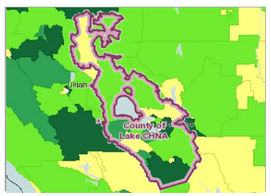
1st Quartile (Top 25%)
2nd Quartile
3rd Quartile
4th Quartile (Bottom 25%)
Bottom Quintile (Rhode Island Only)
No Data or Data Suppressed; -1
County of Lake CHNA

Risk Factors - Stress & Trauma - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 2,827, or 10.35% of the civilian non-institutionalized population age 16 and older. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

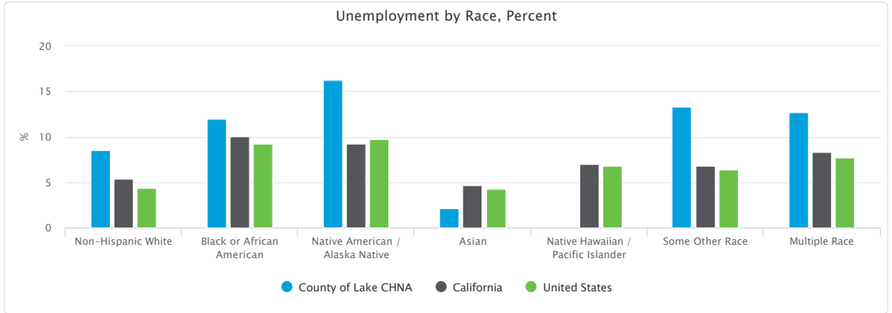
Report Area	Labor Force	Number Unemployed	Unemployment Rate
County of Lake CHNA	27,311	2,827	**10.35%**
Lake County, CA	26,743	2,819	10.54%
Mendocino County, CA	40,905	3,536	8.64%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract



Unemployment by Race, Percent

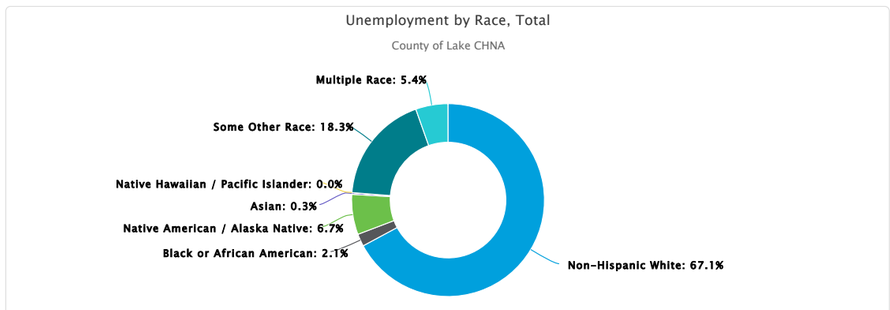
Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
County of Lake CHNA	8.56%	12.00%	16.27%	2.10%	0.00%	13.29%	12.73%
Lake County, CA	8.74%	12.00%	16.47%	2.20%	0.00%	13.29%	13.23%
Mendocino County, CA	7.07%	29.50%	12.79%	9.68%	0.00%	11.54%	12.89%
California	5.36%	10.08%	9.25%	4.65%	7.04%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.76%	6.43%	7.76%



Unemployment by Race, Total

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native			Some Other Race	Multiple Race
County of Lake CHNA	1,637	51	164			447	132
Lake County, CA	1,629	51	164			447	132
Mendocino County, CA	1,872	59	235			265	295
California	402,121	110,197	13,728			193,399	115,127
United States	4,432,807	1,853,375	115,397			541,963	564,122



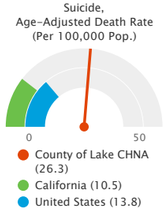
Health Outcomes - Deaths of Despair - Suicide Mortality

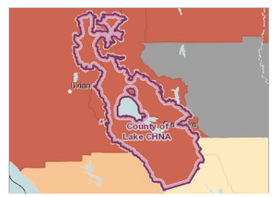
This indicator reports the 2016-2020 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Within the report area, there are a total of 88 deaths due to suicide. This represents an age-adjusted death rate of 26.3 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
County of Lake CHNA	65,993	88	26.7	**26.3**
Lake County, CA	64,322	86	26.7	26.4
Mendocino County, CA	87,212	105	24.1	22.4
California	39,444,803	21,677	11.0	10.5
United States	326,747,554	233,972	14.3	13.8

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County





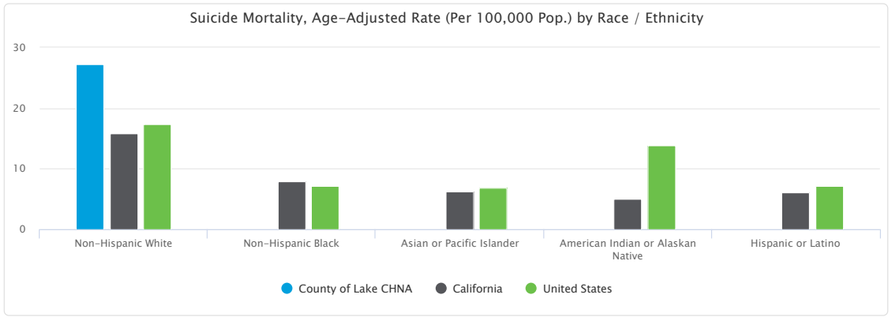
Suicide Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20

Over 20.0
16.1 - 20.0
12.1 - 16.0
Under 12.1
Data Suppressed (<20 Deaths)
County of Lake CHNA

Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

This table reports the age-adjusted rate of death due to suicide per 100,000 people by race and Hispanic origin.

Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
County of Lake CHNA	27.2	No data	No data	No data	No data
Lake County, CA	27.2	No data	No data	No data	No data
Mendocino County, CA	27.4	No data	No data	No data	No data
California	15.9	7.9	6.2	5.0	6.1
United States	17.4	7.1	6.9	13.8	7.2

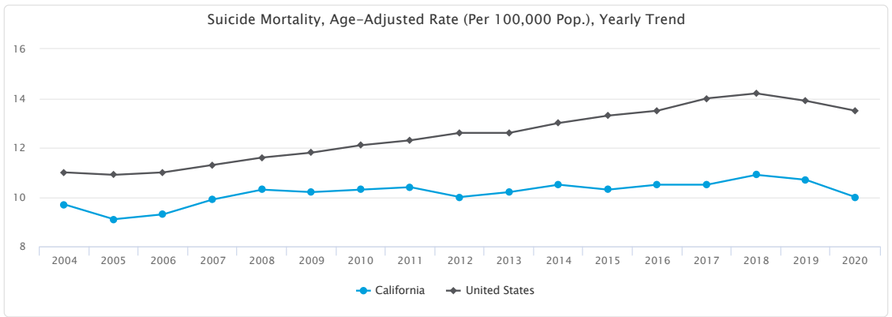


Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

This indicator reports the age-adjusted rate of death due to suicide per 100,000 people over time.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	9.7	9.1	9.3	9.9	10.3	10.2	10.3	10.4	10.0	10.2	10.5	10.3	10.5	10.5	10.9	10.7	10.0
United States	11.0	10.9	11.0	11.3	11.6	11.8	12.1	12.3	12.6	12.6	13.0	13.3	13.5	14.0	14.2	13.9	13.5

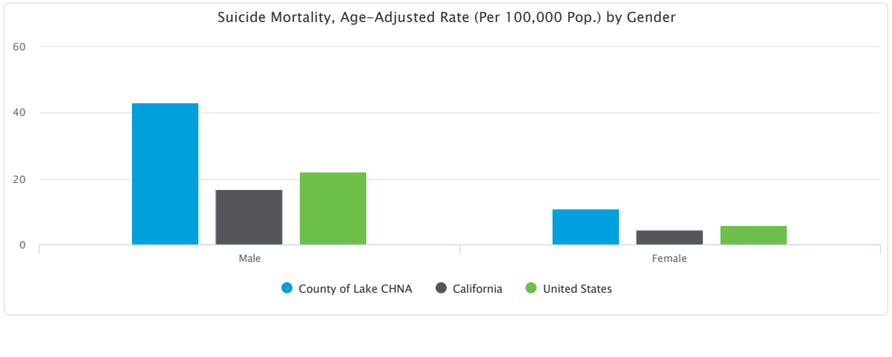
Note: No county data available. See data source and methodology for more details.



Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

This table reports the age-adjusted rate of death due to suicide per 100,000 people by gender.

Report Area	Male	Female
County of Lake CHNA	43.3	10.9
Lake County, CA	43.5	No data
Mendocino County, CA	34.6	10.9
California	16.7	4.6
United States	22.2	6.0



F. Written Comments

We value your input in our community health needs assessment and invite you to submit comments on this CHNA to SHCB@sutterhealth.org. At the time of this CHNA report development, no written comments about the previous CHNA Report or adopted implementation strategy were received.

G. Data Limitations

Focus group and key informant interviews were conducted solely with volunteers, which could affect the representativeness of the information collected. Broad-scale community engagement is difficult in geographically large, rural communities and large, high-population areas. Some of the secondary data sets used in this needs assessment were collected prior to COVID-19. The survey only sampled registered voters, leaving out a fully representative sample. As a result, it is not possible to know the full impact COVID-19 has had on the lives of the communities studied or the impact it had on data collection. It is likely sensitivity to COVID-19 affected focus group participation at a minimum. Despite these limitations, the data provided can be seen as an accurate reflection of community health needs.

Scan the QR code for the full Secondary Data Report

IV. Identification of Community's Priority Health Needs

A. Criteria and Process Used for Prioritization of Health Needs

The local Steering Committee (membership found in Section I. E) was responsible for identifying the community health needs to include in the new CHNA. To facilitate this process, a series of meetings were held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

The first part of this series involved Adventist Health System staff and a consultant presenting the primary and secondary data analysis findings to the Steering Committee. The primary data collection included focus groups, key informant interviews, and a community survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a 90-minute data presentation of these results, highlighting the top five needs for each data source and the supporting data that led to their inclusion (see Section V for methodology). A conversation about the findings was a part of these data reviews, but the determination of priority needs was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the high priority needs selection. At the end of the meeting the Steering Committee was provided with two prioritization tools, data slides and a robust secondary data report to review before the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership and to complete a brief poll a few days prior to the prioritization meeting. The poll allowed them to identify the three-to-five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee (see Prioritization Tools #1 and #2).

The prioritization meetings were designed to build consensus around the high priority community health needs identified by the steering committee members. The meetings were facilitated by Adventist Health System staff and relied on the CHNA data presented at the prior meeting, the poll results, and an extensive conversation between members. Each meeting concluded with committee members prioritizing the list of significant identified needs (with typically three-to-five needs selected as high-priority).

B. Next Steps

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically identifies and implements evidence-based solutions and programs to address our priority needs.

We believe the power of community transformation lies in the hands of the community. The voices we have heard have an impact and influence the next steps of creating a strategy to improve the health needs of the community for all. If you would like to learn more, share ideas or stay connected, please contact us at SHCB@sutterhealth.org.

PRIORITIZATION TOOL #1

CRITERIA FOR CONSIDERING WHICH HEALTH NEED TO ADDRESS

Operations
- Tracked and shared progress/data
- 'Quick Wins' through collaboration
- Political willingness

Partners Resources Assets
- Existing orgs/programs addressing all/parts of Need
- CBO's are focused on this Need
- Community willingness

Finance
- Gov. or public funding available when applying collaboratively
- Available grants for this *Need*
- Need meets the vision/mission of Gov. or philanthropic orgs

Equity
- Current Orgs/programs addressing *Need* with Safety-Net pop.
- Everyone will benefit
- Addressing *Need* could lessen absenteeism at work/school

PRIORITIZATION TOOL #2

Feasibility: High feasibility means there is alignment and/or resources in place to take actional steps to address this Need in a 1-3 year timeframe. Low feasibility means it will take more than 3 years to show a community benefit by addressing this Need.

Impact: High impact means the most community members, or the community members most in need, will benefit from addressing this Need. Low impact means this priority will not benefit a large part of the community, or that the people who will benefit are not in need.

example

	Less Impact	High Impact
High Feasibility	Community Vitality	Education Food Security Housing
Less Feasibility	Environment & Infrastructure	Mental Health

V. Process and Methods to Conduct the CHNA

A. Secondary Data Methodology

Center for Applied Research and Engagement Systems
University of Missouri Extension

212 Whitten Hall, Columbia, MO 65211
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University of Missouri Extension and Engagement

Introduction

Since the passage of the 2010 Patient Protection and Affordable Care Act, non-profit hospitals are required to complete a community health needs assessment (CHNA) at least every three years. The purpose of the CHNA is to better align the community benefit functions of non-profit hospitals with the needs of the communities which they serve. To this end, requirements for completing a CHNA are broadly defined by the Internal Revenue Service (IRS)[1] to include "identifying and prioritizing community health needs" (Pennel, 2015), which must involve the input from "broad interests of that community" (IRS). Best practices for CHNAs as defined by the CDC, the AHA Community Health Improvement (AHCI) and others all specify the inclusion of both primary and secondary data (Barnett, 2012; Institute of Medicine, 2010; Stoto & Ryan-Smith, 2015; AHCI, 2017). In practice, however, there is little consensus on how this data is used to define community health needs.

While much research exists on the subject of population health measurement, research findings specific to quantitative analysis in Community Health Needs Assessments are limited. Among the existing literature, authors find "wide-ranging diversity in CHNA approaches and report quality".

Best practices for utilizing secondary data

One reason for this is the lack of guidelines or even requirements for incorporating secondary data into an assessment of community needs. Despite this, evaluators agree that utilizing both primary and secondary data to prioritize community health needs is a "best practice".

Several common issues with secondary data which hinder its ability to define health priorities have been defined in the literature. These include the lack of data availability at the appropriate levels of disaggregation (both geographic and for population subgroups), the lack of real-time or current data, and the lack of appropriate benchmarks (Stoto, Davis, & Atkins, 2019).

This document describes the methodological approach used to identify health needs using secondary data.

Basic Approach

Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected which best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to the mission of "helping people live longer, better." These criteria include: impact on short-term health (well-being); impact on long-term health (life expectancy); and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being

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and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

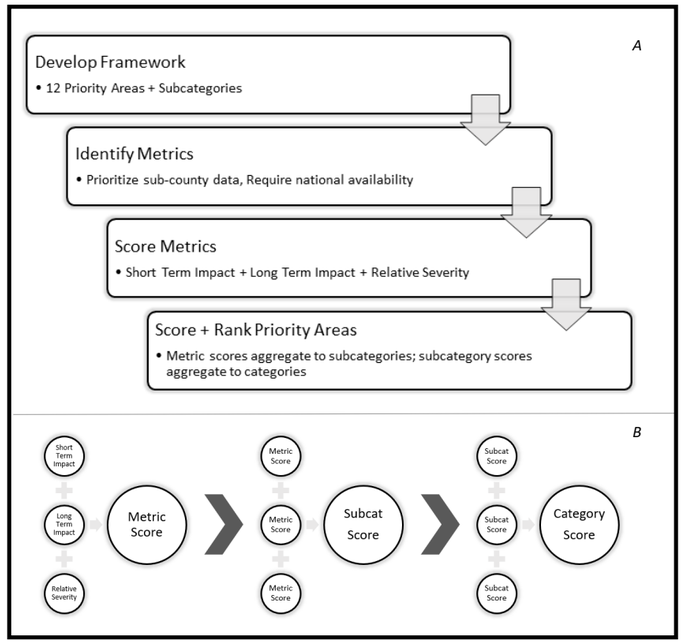

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Framework Development

A set of 12 priority conceptual areas were identified from a review of past cycle CHNAs. In order to generate a score or rank for these priority needs areas, our first task was to operationalize them by selecting appropriate data by which to measure each one. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well-Being
- County Health Rankings & Roadmaps

[1] https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

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- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period, and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency, and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. Indicators which did not correspond into the 12 categories were not included in the analysis. Additionally, indicators representing similar concepts (e.g., poverty, childhood poverty, household poverty) were reduced to a single metric.

Next, indicators were grouped into subcategories within each priority health needs category. The final framework consists of more than 100 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022).

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life, and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status[2]) and a long-term goal (length of life, measured by life expectancy at birth[3]). This approach was adopted in part to reflect the hospital system's mission of "helping people live longer, better".

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework[4].

To address the third criterium, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

[2] Source: BRFSS PLACES 2018 Poor Mental Health Days + Poor Physical Health Days
[3] Source: CDC NCHS USA LEEP
[4] Removal was preferred over inverting the score direction since indicators were selected which theoretically represented conditions for good health. One example of this removal occurred with the metric "access to grocery stores", where a lower density of grocery stores correlated with a higher life expectancy and well-being. It is predicted that this relationship is due to confounding factors or a limitation of the measurement definition selected, and not an indication that a higher density of grocery stores causes worse health.

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Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a *final* score for each metric, we calculate the weighted average of the short-term and long-term score and apply the z-score as an adjustment factor.

$$M_c = (ST_s + LT_s) * Z_{cs}$$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short-term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long-term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities which perform better than average for a metric will see scores adjusted down (lower priority), and communities which perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$$SubC_c = \sum_c \frac{SubC}{n} \qquad Cat_c = \sum \frac{SubC}{n}$$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and 1 is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum "real" subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores, category scores may be compared with category scores; however subcategory scores and category scores cannot be compared.

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Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are major drivers of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community-level, availability of data to represent some priority health need concepts are limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data sets that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Data analysis found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or US total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (Spring, 2022), the latest available data on health behaviors, outcomes, and social determinants represented the 2019 calendar year, and in some cases, data were older still. Since the first aim of this work is to measure the *relationship* between certain factors and well-being and life expectancy, this temporal lag is of less importance. However, the significant events of 2020 and 2021 (e.g., the COVID-19 pandemic) are largely unrepresented in these data.

References

Association for Community Health Improvement. Community Health Assessment Toolkit. 2017. [cited 2018 Oct 28]. Available from: www.healthycommunities.org/assesstoolkit.

Barnett, K. (2012). Best practices for community health needs assessment and implementation strategy development: A review of scientific methods, current practice, and future potential. Atlanta, GA: Centers for Disease Control and Prevention.

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Castrucci, B. C., Rhoades, E. K., Leider, J. P., & Hearne, S. (2015). What gets measured gets done: an assessment of local data uses and needs in large urban health departments. *Journal of public health management and practice: JPHMP*, *21 Suppl 1*(Suppl 1), S38–S48. https://doi.org/10.1097/PHH.0000000000000169

Catholic Health Association of the United States. Assessing and Addressing Community Health Needs. 2015. [cited 2018 Oct 28]. Available from: https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs.

Institute of Medicine. For the public's health: the role of measurement in action and accountability. Washington, DC: National Academies Press; 2010.

Stoto, M. A., Davis, M. V., & Atkins, A. (2019). Beyond CHNAS: Performance Measurement for Community Health Improvement. *Egems (generating Evidence & Methods to Improve Patient Outcomes)*, *7*(1), 45. DOI: http://doi.org/10.5334/egems.312

Stoto, MA, Davis, MV and Atkins, A. Making Better Use of Population Health Data for Community Health Needs Assessments. *eGEMs*. 2019; 7(1): 44, pp. 1–9. DOI: https://doi.org/10.5334/egems.305

University of Wisconsin Population Health Institute. County health rankings and roadmaps. 2014. [cited 2018 Oct 28]. Available from: http://www.countyhealthrankings.org/.

B. Survey Methodology and Questions

The Berkeley IGS Poll is a regularly scheduled non-partisan survey of California public opinion conducted by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. A component of the University of California system's flagship Berkeley campus, IGS is the oldest organized research unit in the UC system and the state's oldest public policy research center.

METHODOLOGY: The poll is administered online by distributing email invitations to stratified random samples of California registered voters. The invitation provides respondents with a short summary of the poll's purpose, its sponsorship, how long the survey is likely to take and how the recipient's email was obtained.

The statistical tabulations in this volume are based on a Berkeley IGS Poll completed online in English and Spanish July 18-24, 2021, among 5,795 California registered voters by the Institute of Governmental Studies (IGS) at the University of California, Berkeley. Funding for the poll was provided in part by the Los Angeles Times.

The survey distributed email invitations to stratified random samples of the state's registered voters. Each email invited voters to participate in a non-partisan survey conducted by the University and provided a link to the IGS website where the survey was housed. Reminder emails were distributed to non-responding voters, and an opt-out link was offered to voters not wishing to participate and not wanting to receive further email invitations.

Samples of registered voters with email addresses were provided to IGS by Political Data, Inc., a leading supplier of registered voter lists in California. The email addresses of voters were derived from information contained on the state's official voter registration rolls. Prior to the distribution of the emails, the overall sample was stratified by age and gender in an attempt to obtain a proper balance of survey respondents across all major segments of the registered voter population.

To protect the anonymity of survey respondents, voters' email addresses and all other personally identifiable information derived from the original voter listing were purged from the data file and replaced with a unique and anonymous identification number during data processing. In addition, post-stratification weights were applied to align the overall sample of the registered voters to population characteristics of the state's registered voters.

The sampling error associated with the results from the survey is difficult to calculate precisely due to the effects of sample stratification and the post-stratification weighting. Nevertheless, it is likely that the results from the overall sample of registered voters are subject to a sampling error of approximately +/- 2 %age points at the 95% confidence level.

The survey question response options were based on the community health needs framework that also defined this work's secondary and primary data collection. In addition, survey response language was adjusted to be accessible to all community members.

The following list shows how response options correspond to the community needs framework.

SURVEY QUESTION

Please choose the five things from this list that make it hard for you and others in your community to be healthy.

- Not being able to see a doctor or go to a hospital
- Not enough good jobs
- Lack of transportation
- Lack of senior care
- Poor schools
- Not enough affordable housing
- Limited affordable, healthy food
- COVID-19
- Homelessness
- Mental Health
- Cost of Living

NEEDS CROSSWALK

- Access to Care-Primary Care
- Financial Stability-Employment
- Environment & Infrastructure-Transportation
- Access to Care-Senior Care
- Education
- Housing-Cost
- Food Security
- COVID
- Housing-Unhoused
- Mental Health
- Financial Stability-Cost of Living

C. Focus Group and Key Informant Methodology and Guide

Primary data collection was designed to gather first-person input on community health needs directly from community members. Between October 2021 – January 2022, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour virtual and/or in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering Committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides (see Section V) used for both types of interviews were nearly identical. All focus groups and interviews began with participants identifying up to five high priority community health needs from their perspective, chosen from a standard list provided by the facilitator. This standard list was comprised of common community health needs based on the larger framework of social determinants of health used for secondary data collection (see Section V). The facilitators — a team of Adventist Health System staff and a consultant — then moved through a series of questions for each identified need, focusing on depth of need, examples of the impact of the need, attempts at addressing the need historically, barriers to reducing the need, and reasonable improvement goals over three years. The only variation in the focus group and key informant interview guides was the inclusion of additional prompts for key informants allowing for greater depth of response. A notetaker was present for each focus group and key informant interview, and all interviews were recorded. Note documents and audio recordings were provided to the qualitative analysis team, which were Adventist Health System staff and a consultant, to facilitate analysis. Focus groups were conducted in teams of two, with a lead facilitator and a notetaker. All focus groups were conducted in English or Spanish. In some cases, the facilitator was provided by a Steering Committee member, either due to language needs, expertise with a specific community group, or both.

Deductive analysis of all focus groups and key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CARES. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Focus group and key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments was rolled up to the major category level. Axial coding, where common and highly relevant data codes were combined into themes, was conducted on all category and subcategory data, and major themes were developed for each of the top five-to-six categories/subcategories based on relative importance determined by the number of total codes and the review by the axial coding team.

Once major themes were identified, the primary data team, comprised of both facilitators and qualitative data analysts, reviewed themes and supporting data to determine the final community needs to include in the Steering Committee data reveal. The final needs were the themes that occurred most frequently, both in terms of the number of times specific needs were identified and the urgency, frequency, and intensity of the related comments. Combined with the identified survey and secondary data needs (the five largest needs of the 13 on which secondary data was collected), these themes represented the findings the Steering Committee used to determine (described in Section IV) the final set of high priority health needs included in this CHNA report. Primary interview data was presented as identified needs, a summary of the need, and supporting data taken from the qualitative analysis. Wherever possible, the supporting data was provided in the form of direct quotes from participants.

FACILITATOR'S SCRIPT

WELCOME

- Warmly introduce yourself and note taker
  - We're from Community Benefit Solutions.
  - If site host is present, thank them for bringing everyone together.
- Duration
  - Spend the next 90 minutes together (focus group).
  - Spend the next 60 minutes together (key informant).
- Share the "why" they are here and "what" we're asking of them
  - You're here today because we want to hear your opinions about the health needs of your community.
  - Every community has things that help people be healthy and things that make it harder to stay healthy.
  - This is part of a larger plan and your input will be put together with comments from others in your community into a Community Health Needs Assessment report. This will help your community organizations and leaders as they work toward identifying the challenges and barriers you're seeing so they can work to fix the problems you're facing in trying to stay healthy.
- More about a Community Health Needs Assessment report
  - The Community Health Needs Assessment is a public document and represents the collaborative work between community agencies and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.
- Your Acknowledgment
  - We'll be asking you questions today and you're free to answer only the questions you're comfortable with.
  - Please know that notable quotes/comments from today's meeting could appear in the CHNA and will be labeled as an Anonymous Community Quote – please rest assured that we won't share any names.
  - *"Today's Focus Group is being recorded to ensure we capture all the concerns, thoughts and ideas about the health and well-being of your community. Some comments might be highlighted in the CHNA report and will not list the individual's name."*
  - We want to hear from everyone, so please understand if we move from one comment to the next – we want to make sure everyone is heard.
  - Does anyone have any questions about this?
  - How about any problems being involved in this group?

ACTIVITY EXPLANATION

- We're going to do a brief exercise to start that will tell us what the biggest problems you see are.
  - Then we'll ask you questions about those problems.
  - As you look around the room, you'll see three posters on the wall.
  - They show photos of common problems people face, many of them related to health. (Editorial note: these photos portrayed social determinants of health, for participants to select from. In some cases participants were given printed versions of the photos when they requested them. This allowed all participants to be involved regardless of mobility.
  - Please take a few minutes to vote with the stickers you were given when you walked in.
  - *Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.*
  - *Which of these things causes the most problems for you or others who live here?*
  - *We're specifically interested in learning about things that make it hard for you or your family and friends to have good physical and mental health, and a good quality of life.*
  - Some of the descriptions are one word and really meant for you to share more with us about that – for instance, doctor - it could be, I can't get an appointment, there isn't a pediatrician near me.
  - We'll give you 10 minutes to walk around.

TALLY RESPONSES:

- Visually tally the votes and clearly call out the top five issues that were identified for the notetaker and audience to hear.
- Spend around 15 minutes going through these questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five minutes to wrap up at the end.
- Use the same prompting questions for each of the five identified issues.

Question Prompters

1. One of the topics that many people identified is _____. For those of you that think this is a health problem in your community:
2. Another topic many people identified is _____. For those of you that think this is a health problem in your community:
3. People also said that _____ is a problem. For those of you that think this is a health problem in your community:

QUESTIONS:

- Why is this a big concern?
- How do you see it affecting people around you?
- What have people tried to do to address this problem?
- What else do you think should be done?
- What are the biggest barriers to fixing this problem?
- If this problem got better, how would your community look different in 3 years?
- How has this problem been affected by COVID-19?
- Do you think this problem affects everyone in your community equally?

  If not, why is that?

  Who is most affected by this?

CLOSING QUESTION:

- Are there other important health needs in your community that we have not already addressed?
- (Let audience introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.)

CONCLUSION:

- Thank you all very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- Next year, we will publish the Community Health Needs Assessment, summarizing our findings and action plans identified with the community.

  If you would like us to send you a text or email with a link to that report, just provide us with your information on the way out.
- As a thank you to you all, we have a gift card for you as you leave. **Good health to you all!**

TOPIC-SPECIFIC PROMPTS

ACCESS TO CARE

What are the main things that stop people from seeing the doctor when they need to?

CHRONIC CONDITIONS/PHYSICAL HEALTH

What are the most common medical conditions that people have in your community?

How do you know?

HEALTH RISK BEHAVIORS

Personal choices can affect people's health at times. These can include not exercising enough, an unhealthy diet, smoking, drug use, unsafe driving habits, and many others.

What risky health behaviors do you think might affect your community?

MENTAL HEALTH

How can you tell that mental health problems are showing up in your community?

FOOD SECURITY

What examples have you seen of people struggling to have enough food to eat?

How common of a problem do you think this is?

What is being done to help?

INFRASTRUCTURE

What transportation barriers exist in your community?

COMMUNITY VITALITY

What are the best things about living here?

PHYSICAL ENVIRONMENT

What kind of access do you have to nature?

What limits people's access to the outside world?

COMMUNITY SAFETY

What are the biggest threats to your safety in your community?

What is being done to address these safety concerns?

HOUSING

What are the biggest housing problems facing your community?

What impact do these problems cause?

FINANCIAL STABILITY

What kind of job opportunities are there around here?

EDUCATION

How would you describe the educational opportunities for kids?

What about for people going to college or going back to school?

INCLUSION & EQUITY

How culturally diverse is your community?

How well does your community embrace this diversity?

What examples are there of times when diversity issues were not handled well?

D. Sutter Lakeside 2019 Implementation Strategy Evaluation of Impact

Scan QR Code to read more about the full Community Health Plan Update

E. Purpose of the Community Health Needs Assessment (CHNA) Report

The Community Health Needs Assessment (CHNA) is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document.

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

The Adventist Health Community Well-Being Team coordinated the data collection, analysis and writing for these reports. The Community Well-Being team members listed below encompass highly relevant and diverse experience in healthcare, philanthropy and foundation, Medicaid managed care and quality improvement, public health and community health, consumer insights research and community benefit reporting. Those team members include:

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit "Amy" Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

BERKELEY INSTITUTE OF GOVERNMENTAL STUDIES (IGS)

Berkley IGS promotes research, educational activities, and public service in the areas of American and California politics and broad domains of public policy. The Berkeley IGS Poll is a periodic survey of California public opinion on important matters of politics, public policy, and public issues. The poll, which is disseminated widely, seeks to provide a broad measure of contemporary public opinion, and to generate data for subsequent scholarly analysis.

The Matsui Center provides students with internships and real-world learning opportunities. The faculty-led research groups develop and support state-of-the-art research on critical issues facing the nation today. The Berkeley IGS Poll provides accurate, unbiased information on what California residents think and vote on.

UC Berkeley remains central to the most important governance actions and conversations unfolding today. American democracy faces deep and systemic challenges; by training the next generation of leaders and citizens, incubating policy-relevant research, and elevating critical public discussions, IGS is determined to be a part of the solution.

G. Cristina Mora & Eric Schickler...IGS
Co-Directors
igs@berkeley.edu
510-642-4465

Mark Di Camillo
Berkeley IGS Poll Director
mdicamillo@berkeley.edu

www.igs.berkeley.edu/about

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting, and collaboration systems that enable public, private, and nonprofit sector organizations to effectively address issues across topics like agriculture, the environment, business, community, health, safety, and youth. The CARES team integrates data, mapping, visualizations, and engagement tools to better serve communities and regions across the US, including vulnerable, rural, and underserved populations. CARES web-based technologies help organizations and policymakers make more informed decisions about access, address issues of equity, and support the allocation of public and private resources.

CARES staff have backgrounds in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration, and web-based content management. Additionally, significant experience in project management, user training and support, data documentation, and client design sessions directly supports the wide variety of projects at CARES.

Chris Barnett
(barnettc@missouri.edu) serves as director for CARES.

Angela Johnson
(johnsonange@missouri.edu) serves as assistant director and lead research project analyst for CARES.

For more information, please visit
careshq.org/about/

CENTER FOR BEHAVIORAL HEALTH INTEGRATION

The Center for Behavioral Health Integration is a small collaborative of mental health professionals and researchers providing evaluation, training, and program implementation support to human service organizations.

www.c4bhi.org
Project Lead: Patrick Kinner
Evaluation Consultant
Oct 2018 - Present 3 years 8 months
New England

Providing evaluation, research, writing, and strategic planning support throughout the world of human services.

Patrick Kinner joins Adventist Health as an Evaluation Consultant with more than 10 years of experience helping organizations collect high-quality data to improve their services and share their successes. He holds a vast background working with large health systems, state public health offices, and with innovative entrepreneurs and organizations to improve systems and services across the human service spectrum. Every passionate and committed organization has a gap between what they hope to accomplish and what they actually accomplish. As an evaluation consultant, Kinner identifies those gaps to collect data to understand the causes and help you use that data to change minds and turn heads. This can take the form of small-scale internal evaluation projects or long-term research efforts to test, validate, and publish your theory of change. His work has been instrumental in helping organizations secure additional funding and partnerships, and in making major structural changes in initiatives when necessary.

Project Lead: Keren Meital Kinner
Evaluation Consultant
January 2019 - Present
New England

Providing evaluation, data analysis and visualization services to human service organizations.

Keren's experience in the fields of mental health, education, and software development intersect as she helps organizations collect, understand, and act upon performance and cultural improvement data. In her role as a program evaluator, she focuses on quantitative and qualitative data analysis as well as data visualization through Tableau. With the help of regular and timely data visualization cycles, she helps organizations easily access and understand the latest information, inspect progress and back draw, and help identify new themes, gaps, learnings, and enhancements. Keren regularly works with universities, hospitals, health centers, and innovative entrepreneurs.

VI. Glossary of Terms, Definition of Health Needs

Glossary of Terms

ACCESS TO CARE:

Accessing care with reliable transportation at the right time and location is often a challenge. In addition, not having access to insurance, low-cost care, interpreters, and programming prevents many people from getting treatment. Helping families secure insurance, transportation and access through mobile health options can help them find the care they need.

COMMUNITY SAFETY:

Being safe in your neighborhood is key to developing a real sense of community: where neighbors engage and work toward the common goal of safety and friendship. This may include a formal neighborhood watch program with local police, or simply an ongoing awareness of what's happening, to ensure safe homes and safe people.

COMMUNITY VITALITY:

A sense of belonging, a place where people feel connected, where neighbors are encouraged to participate in their community across socioeconomic status, physical ability, race/ethnicity or other differences, and where businesses can thrive — this is the definition of community vitality. These are a few of the aspects of what makes a community a community, with neighbors supporting neighbors and preserving the quality of life for all to share.

EDUCATION:

Educational opportunities can deeply impact choices, quality of life and life span, from children to adults. Studies have documented that educational attainment affects health and develops a healthy sense of empowerment. As school-aged children grow in knowledge, so can parents – touching multiple generations with opportunities. Whether it is a kindergartener or a newcomer to the United States, education can improve futures.

ENVIRONMENT & INFRASTRUCTURE:

Clean water, clean air and accessible walkways and streets are key to healthy neighborhoods. Walking and biking require safe sidewalks and roads. In a digital world where access to high-speed internet provides opportunities to attend school, work, go to a doctor and conduct daily tasks, high-speed internet access is also an infrastructure necessity.

FINANCIAL STABILITY:

The definition of financial stability is broad and encompasses the ability to cover daily living expenses, allowing individuals to fully engage in life's opportunities. Things like safe housing, access to healthy foods and other necessities are impacted by financial stability. The gap between income and cost of living, along with a lack of stability, can be a barrier for individuals and families to securing the care and resources they need. Over time, the lack of financial means impacts health and physical, emotional, and social well-being.

FOOD SECURITY:

Food security is the ability of all people, at all times, to have physical, social and financial access to healthy and nutritious food. Food security also involves the ability to purchase affordable healthy foods, and to cook and store them.

Today, that is a goal and a challenge as costs increase and access to finding affordable healthy options is limited.

HEALTH CONDITIONS:

Obesity, heart disease, cancer and diabetes – examples of chronic diseases – are the leading causes of death and disability in the United States. The conditions in which we live contribute to our well-being and influence our choices, which can lead to potentially serious diseases. Access to clean and healthy food, water, air, safe schools, affordable housing, and reliable safety-net programs play a major role in the health and well-being of a community. These conditions can make a significant difference in combating the leading causes of death and disability in the United States, such as obesity, heart disease, cancer and diabetes.

HEALTH RISK BEHAVIORS:

Each day, decisions are made that impact lives – directly and indirectly. These manners range from abuse of drugs and alcohol to smoking to misuse of medications. Relying on unhealthy food choices is another example of a behavior that can be a life-threatening health risk. But life changes, such as consistent physical exercise and healthier food choices, when supported by financial stability, equitable social conditions, and a healthy natural and built environment, offer the opportunity to change direction and live healthier lives. Sometimes, it's our opportunities and choices that lead to some of these serious diseases. Often, the conditions in which we live can influence and contribute to our health. Access to healthy foods, green space for exercise, quality of our air and schools, affordable housing and the reliability of safety-net programs often play a role in community health.

HOUSING:

The definition of housing varies from person to person, as individuals and families struggle to find safe housing – a place to rest and live that is affordable and in good condition. Today, families face a shortage of housing stock, long wait lists and complicated steps required to secure a place to live. Families may find that they can't afford housing, so they double up with another family or remain in a home that is too small or even unsafe. Efforts continue to address these very real concerns and to seek solutions.

INCLUSION & EQUITY:

The definition of inclusion and equity includes fairness, justice, prosperity, and opportunity – for all people of all ages to feel welcomed, with a fair chance to participate, thrive, and reach their full potential. Inclusion and equity reflect those social conditions, systems, and policies that make it so all individuals in a community have equal opportunities to live good lives.

MENTAL HEALTH:

Mental health includes our psychological, social and emotional well-being. It affects how we think, feel and act and sometimes leads to behaviors like self-harm or self-medication. Mental health is important at every stage of life, and not knowing when or where to ask for help often leaves children, teens, adults and families feeling alone and helpless.

VII. Approval Page

2022 CHNA Approval

This community health needs assessment was adopted on October 19, 2022 by the Sutter Health Bay Hospitals Board. The final report was made widely available on December 31, 2022.

COMMUNITY HEALTH NEEDS ASSESSMENT