



ADVENTIST HEALTH
ST. HELENA

COMMUNITY HEALTH
NEEDS ASSESSMENT

2022

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, Adventist Health St. Helena 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 Conditions – Physical Health

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 community.benefit@ah.org.

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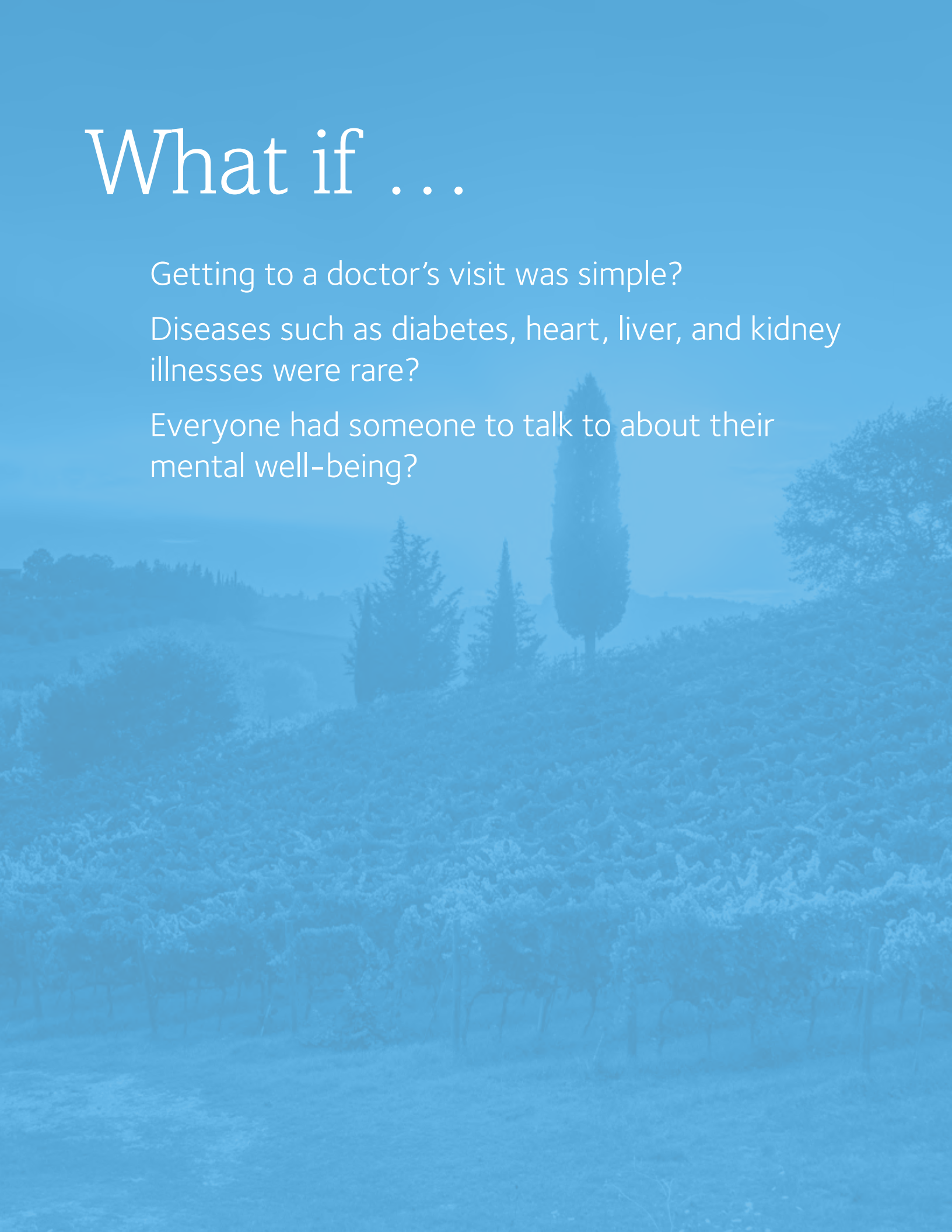
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What if ...

Getting to a doctor's visit was simple?

Diseases such as diabetes, heart, liver, and kidney illnesses were rare?

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 11 significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, health conditions – physical health, mental health, financial stability, health risk behaviors, housing, food security, environment & infrastructure, homelessness, COVID and education. 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 conditions – physical health 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 . . .

Getting to a doctor's visit was simple, thanks to good **Access to Care**

Diseases such as diabetes, heart, liver, and kidney illnesses were rare due to healthy opportunities that result in better **Health Conditions—Physical Health**

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

Getting to know our CHNA St. Helena service area*

The Adventist Health St. Helena service area exemplifies diversity and is known for beautiful vineyards, a culinary scene with renowned dining, and a popular tourist destination that brings visitors from across the country. Just over 196,000 residents call our service area home now, and the growth continues as the tranquility of this beautiful place becomes known.

Household income levels are slightly higher than the California average, with 54% of annual income going towards housing and transportation. Age ranges are consistent, with children ages 0 to 4 being the smallest population group at 5.3%, to age 65, the largest community group by age is those 65 and older, 19.7% of the population. The largest

groups by population are Caucasian, followed by LatinX and Black.

Let's begin with a look at important community member comments, facts and numbers that helped guide the decision-making onto a forward path to better health, longevity and wholeness.

*This service area represents Adventist Health St. Helena'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 Adventist Health St. Helena 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 look ahead, let's look back at a few highlights to see what we have learned and accomplished over the last three years, where we focused on mental health, access to care, health conditions and housing as our 2019 CHNA prioritized health needs.

When wildfires struck, the Mobile Health Van jumped in and distributed boxes of basic needs to victims, in addition to providing primary care services, prescription refills and COVID-19 testing and vaccinations

countywide. Adventist Health St. Helena then partnered with World Vision to distribute over \$500,000 of in-kind donations to the wildfire survivors.

Adventist Health St. Helena recognized the need for cancer screenings and more than 3,600 community members were screened, tested and provided with next-step guidance, based on their results.

It is this kind of support and engagement that helps to make our communities vibrant and healthy.

The COVID-19 global pandemic caused extraordinary challenges for Adventist Health St Helena, leading us to pivot our focus to helping patients and families stop the spread of the virus and provide free and accessible vaccines to everyone in our community.

Access to Care



COMMUNITY VOICES

- People noted that a lot of people are reluctant to take the ambulance because they don't have transportation to get back.
- "Rural areas are difficult to get transportation access."
- "No Lyft, afraid to drive too medical appointments."
- "People don't want to travel out of town for services."

The ability to access health care services is critical for any healthy community, and residents in our service area face challenges here. Community members note that residents are reluctant to take an ambulance because they are afraid they won't have transportation back. The uninsured rate is higher than that of California and some racial groups, such as Pacific Islanderers, have an even higher insured rate. Overall, 14.5 percent of residents 25 and older don't have a high school diploma and 12 percent of people have limited English proficiency, limiting their

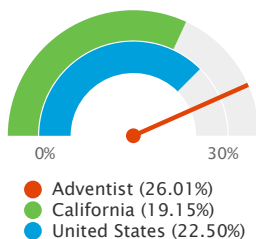
opportunity to access resources to learn about health matters, schedule appointments or get test results.

Public data shows that just 16.6% of St. Helena's population lives within a half mile of public transit. During focus groups, seniors noted that the lack of sidewalks makes it difficult to get to where they need to go, and inconvenient bus routes limit their ability to participate in their community.

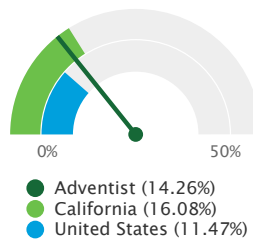
Data spells out concerns. Human engagement improves lives.

SECONDARY DATA INFOGRAPHIC STATS:

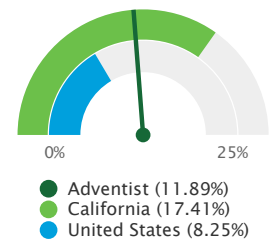
Percentage of Population Living in an Area Affected by a HPSA



Population Age 25+ with No High School Diploma, Percent



Population Age 5+ with Limited English Proficiency, Percent



Community Health Needs Survey:

Bay Area* 21% 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.

Molly's Angels

707-224-8971, 707-224-8885, mollysangels.com

Napa Valley Transportation Authority

707-259-8631, www.nvta.ca.gov

Blue Zones Project - Upper Napa Valley: Improve your health, live longer, and learn about Blue Zones Project, unv.bluezonesproject.com

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

Uninsured Population by Race, Total

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	4,572	220	498	432	40	2,827	959
Sonoma County, CA	10,215	1,084	258	1,243	375	10,209	2,327
California	547,635	126,535	33,530	261,111	10,979	768,688	223,444
United States	11,475,294	3,972,510	497,979	1,179,390	64,404	3,281,019	1,776,683

Health Conditions – Physical Health

COMMUNITY VOICES

- “It is important to recognize that while bringing many benefits to our community the wine and grape growing industry also brings impacts of industrial agriculture including substantial use of synthetic pesticides, herbicides and other contaminants that can get into our water supplies, soils and air, and unless managed in a considered way may not be consistent with long term public health goals of the community.”
- “The younger that people are getting diagnosed, it affects their journey on healthcare systems.”
- “There is a lack of nutritional education.”



A community with a higher-than-average burden of major health conditions, especially chronic conditions, poses social, environmental, and healthcare concerns, and the Adventist Health St. Helena service area faces some noteworthy challenges. Nearly 30 percent of the St. Helena population is obese, and cancer risk (7.3%) and cancer mortality rates (152 per 100,000) are higher than in California and the United States.

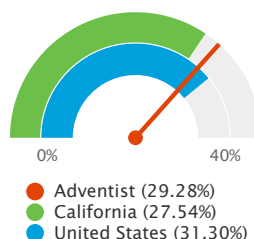
Residents believe that nine out of 10 people who are unhoused have a medical condition that prevents them from working. Families need physicals

for their children, but clinics are too far away, and the costs are a barrier to care. Vaping is of concern, even knowing that youth may be vaping without any parental awareness.

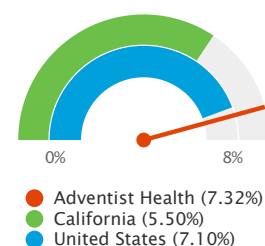
Death due to liver disease is higher here than in California and the United States, and chronic conditions in general are drivers of lower quality of life and higher healthcare expenditures. Knowing which conditions are driving reduced health and well-being is key to improving overall health.

SECONDARY DATA INFOGRAPHIC STATS:

Percentage of Adults Obese (BMI ≥ 30.0 kg/m²)



Percentage of Adults with Cancer



COMMUNITY VOICES

- “We have surprisingly high rate of cancer in Napa County. We know that obesity, alcohol consumption, some of those things can lead to cancer.”
- “High rate of cancer- breast, colon, kidney, leukemia, perhaps due to pesticides that they spray.”
- “Our society has become more sedentary... and sitting in front of computers a lot more.”
- Poor diet and excessive weight gain is seen as problem for residents of all ages, and is attributed by some to limited nutritional education.

Find Health Conditions – Physical Health resources in your community to live better, longer.

Parks & Recreation – City of Calistoga

707-942-2838, www.ci.calistoga.ca.us

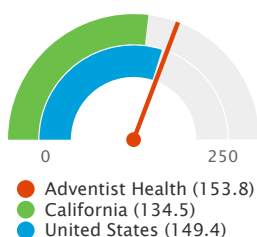
St. Helena Parks & Recreation

707-968-9222, www.cityofsthenana.org

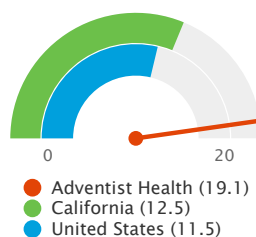
Blue Zones Project – Upper Napa Valley: Improve your health, live longer, and learn about Blue Zones Project, unv.bluezonesproject.com

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

Cancer Mortality,
Age-Adjusted Death Rate
(Per 100,000 Pop.)



Liver Disease Mortality,
Age-Adjusted Death Rate
(Per 100,000 Pop.)



Mental Health

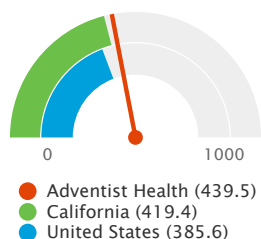
COMMUNITY VOICES

- “It’s hard for people with depression and anxiety to talk about or admit that they are having difficulties around mental wellbeing.”
- People shared that mental health services are extremely hard to get in Napa.
- We heard from community members there are not enough mental health providers to meet the needs, especially Spanish-speaking providers.
- People noted that the mental health crises, and the lack of crisis services, are impacting access to medical care in local emergency rooms

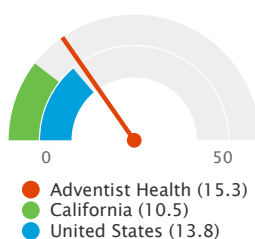


SECONDARY DATA INFOGRAPHIC STATS:

Violent Crime
Rate per 100,000 Pop.



Suicide,
Age-Adjusted Death Rate
(Per 100,000 Pop.)



Violent Crime Rate

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Adventist Health St. Helena	901	439.5
Lake County, CA	343	535.5
Napa County, CA	566	397.7
Sonoma County, CA	1,845	367.9
California	327,327	419.4
United States	2,445,671	385.6

Community Health Needs Survey:

Bay Area* 50% 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.

A recent survey showed that 50% of respondents see mental health as a top concern. They voiced fears that there is a shortage of mental health providers to meet needs – particularly those who are Spanish-speaking.

Residents shared fears of a future where, if mental health isn't addressed, rates of anxiety, depression and suicide in their community may increase.

In our Adventist Health St. Helena service area, 13.5% of adults report having poor mental health and 30% of Medicare beneficiaries have mental health and substance use conditions. Also among Medicare recipients, 4.6% have a substance use disorder, while 17.6% of the overall adult population binge drink.

Unemployment and high cost of living contributes to increased stress

by creating financial instability and barriers to basic needs like health services, food and housing. The suicide rate in our community (14.8 per 100,000) is higher than in California overall (10.5 per 100,000).

Through education, collective engagement, and community-driven changes, residents have the potential to experience mental well-being and a newfound sense of purpose.

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

Up Valley Family Centers of Napa County

707-965-5010, www.upvalleyfamilycenters.org

MENTIS

707-255-0966, www.mentisnapa.org

Blue Zones Project - Upper Napa Valley: Improve your health, live longer, and learn about Blue Zones Project, unv.bluezonesproject.com

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

Unemployment by Race, Total

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	419,208	18,586	21,101	22,755	0	87,119	29,602
Lake County, CA	1,629	51	164	7	0	447	132
Napa County, CA	1,720	124	59	175	0	327	137
Sonoma County, CA	7,948	259	207	284	12	1,341	1,004
California	402,121	110,197	13,728	144,492	5,681	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	20,879	541,963	564,122

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 Adventist Health St. Helena 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.

Kim Baldwin

Adventist Health St. Helena,
Emergency Director

Mark Bontrager

Partnership Healthplan,
Director

Jodi Brownfield

Adventist Health St. Helena,
Case Manager

Chris Canning

City of Calistoga,
Mayor

Mitch Celaya

City of Calistoga,
Chief of Police

Geoff Ellsworth

City of St. Helena,
Mayor

Celeste Giunta

COAD,
Ex. Director

Steve Herber, MD

Adventist Health St. Helena,
President

Ericka Iten

Adventist Health St. Helena,
Director of Strategy

Trina Justman

Adventist Health St. Helena,
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Indira Lopez-Jones

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Program Director

Barbara Nemko, PhD

Napa County Office of Education,
Superintendent

Julia Orr

Molly's Angels,
Executive Director

Oscar Ortiz

Napa County Sheriff Department,
Sheriff

James McCann

St. Helena,
City Manager

Joaquin Razo

Blue Zones Project
Upper Napa Valley,
Executive Director

Rob Weiss

Mentis,
Executive Director

II. About Us

A. Adventist Health St. Helena

Located in the beautiful Napa Valley, Adventist Health St. Helena is a 151-bed acute-care hospital with key service areas including 24-hour emergency care, Adventist Heart and Vascular Institute, Coon Joint Replacement Institute, Martin O'Neil Cancer Center and Behavioral Health units. We are proud to serve a rural area that ordinarily would not have access to many of the advanced medical services we offer.



B. Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

C. Adventist Health Community Benefit & Well-Being Approach to CHNA

Adventist Health is committed to health, wholeness and hope in the communities across our system, which includes improving well-being. Diseases of despair including mental health, substance abuse, suicide and chronic illness continue to escalate.

America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet some of the most important indicators, like how long we live, are areas where we don't make the top 25. It's time we stop thinking of health as something we get at the doctor's office and rather as something that

starts within our families, schools, places of worship and workplaces—in our playgrounds, parks, and in the air we breathe, the food we eat and the water we drink. The more we see the problem of health in this way, the more opportunities we have to improve it.

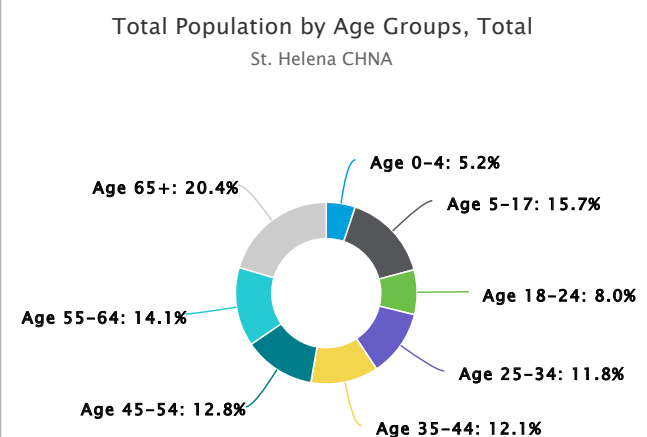
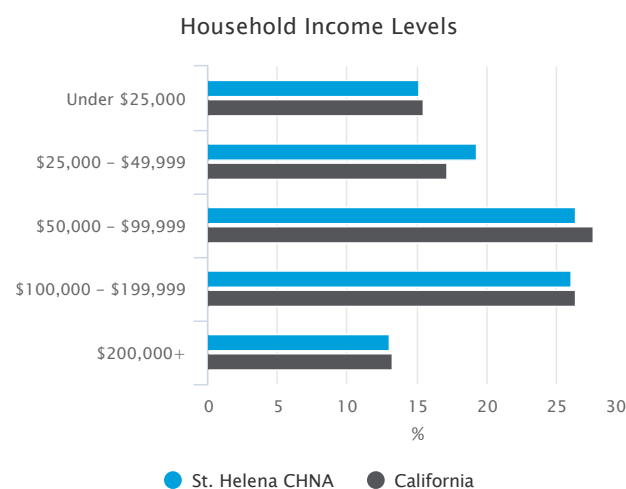
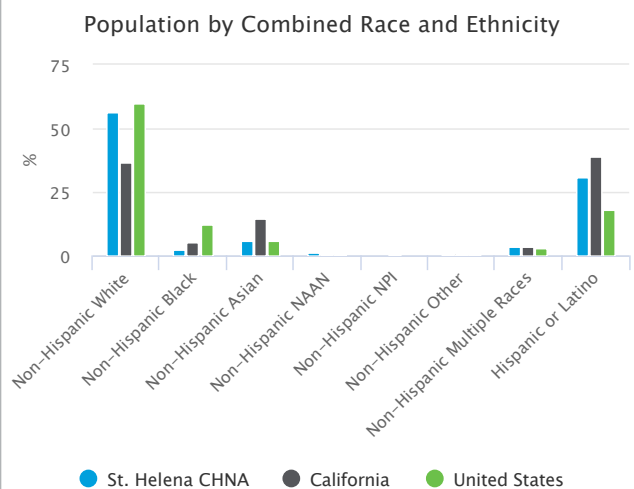
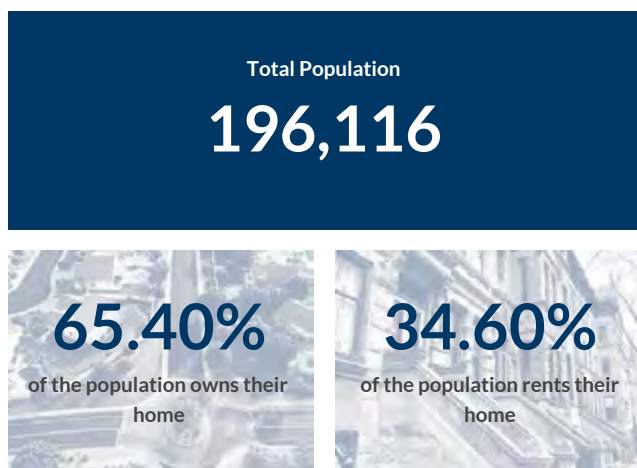
The conditions in which we live, work and play have an enormous impact on our health long before we ever see a doctor—these are the principles of well-being. A key aspect of our strategy to support individual, organizational and community well-being is our relationship with Blue Zones®, a pioneer in taking a systemic and environmental approach to improving the well-being of entire cities and communities. Together, we have built the Well-Being Division, an entity within our organization that exists to empower everyone, everywhere to live longer, better lives.

D. Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health St. Helena'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 Adventist Health St. Helena CHNA market has a total population of 196,116 (based on the 2020 Decennial Census). The largest city in the service area is Napa city, with a population of 76,987. The service area is comprised of the following zip codes: 94567, 95423, 95467, 94515, 94576, 94508, 95451, 94599, 94574, 95457, 95453, 94503, 94559, 94558, 95422, 95443, 95461.



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 Conditions- Physical Health	See Sections III.C - E
Mental Health	See Sections III.C - E
Lower Priority Needs	
Financial Stability 211bayarea.org/napa/income-expenses/	Community members noted having to choose between rent and other household expenses, and that the high cost of living is a major burden. 83% of surveyed community members indicated that financial stability is a major health problem.
Health Risk Behaviors 211bayarea.org/napa/substance-abuse/	This area has higher smoking and substance use disorder rates than the rest of the state, and more than one in five adults is physically inactive.
Housing 211bayarea.org/napa/housing/	68% of surveyed community members said housing costs are a top health need. Interviewees noted the high cost of housing and limited housing stock as major concerns.
Food Security 211bayarea.org/napa/food/	The percent of students receiving free and reduced-price school meals is higher than the national average, and interviewees said that reasonably priced health food is difficult to find.
Environment & Infrastructure 211bayarea.org/napa/transportation/	Limited public transportation, long drives to services, and an environment designed for cars were seen as problems by residents. 17% said this was a health need.
Homelessness 211bayarea.org/napa/housing/	Nearly 60% of residents said homelessness was a health need. The limited housing options and relatively few services for the unhoused have lead this to be a chronic problem in the area.
COVID 211bayarea.org/napa/health-care/	48% of surveyed residents identified COVID as a community health need.
Education 211bayarea.org/napa/education/	69% of 4 th grader students are not proficient in Language Arts. 62% of the population is without any type of college degree. 24% of surveyed residents identified this as a community health need.

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, 12 focus groups were conducted with 78 participants, and 16 key informant interviews were held. Survey data was gathered from the Bay Area 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

- ▶ Six (6) focus groups
- ▶ Forty-nine (49) people participated

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

KEY INFORMANTS

- ▶ Ten (10) 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 St. Helena, American Canyon Police Department, Calistoga Fire Department, Calistoga Joint Unified School District, Catholic Charities' Nightingale Center, Chateau Calistoga Mobile Home Park, City of Calistoga, Mentis, Molly's Angels, Napa County Department of Health & Human Services, Napa County Department of Public Health, Napa Valley Grape Growers Foundation, Napa Valley Transportation Authority, Partnership Health Plan of California and Up Valley Family Centers

REPRESENTED RACE/ETHNICITIES

Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Agricultural workers, civic government, community-based healthcare workers focusing on behavioral health, education, first responders, health & human services, providers, law enforcement, low-income, medically underserved, minority populations, older adults, Public Health, students and the unhoused populations.

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

SURVEY RESULTS

REGION & STATEWIDE SUMMARY

Bay Area: Survey Results of Top Needs

See Section V. B. for more information.

Needs	St. Helena	Statewide
Financial Stability	83%	83%
Housing-Cost	68%	63%
Housing-Unhoused	59%	55%
Mental Health	50%	48%
COVID	48%	47%
Food Security	29%	31%
Education	24%	24%
Access to Care	21%	22%
Financial Stability-Employment	18%	23%
Environment & Infrastructure-Transportation	17%	15%
Access to Care-Senior Care	16%	15%





C. Access to Care

Being able to access medical services when needed is a fundamental aspect of healthy community. Our community faces some challenges in this regard. One in four people (25.2%) in the community served by Adventist Health St. Helena lives in a geographic area designated as a Health Professional Shortage Area (HPSA). This is compared to 19.2% in California and 22.5% in US.

While the uninsured rate (6.3%) is lower than that of California (7.2%) and the United States (8.7%), some racial groups have significant barriers. The Native Hawaiian or Pacific Islander people within this community have a 16.7% uninsured rate.

16.6% of the population live within half a mile of public transportation, compared to 62.3% in California and 34.8% in the United States. This is

extremely low and is a substantial difficult for many, especially low wage earners and the elderly.

Overall, 14.5% of persons 25 and older in this community are living without a high school diploma, and that rate jumps to 40% for Hispanics. 12.3% of persons 5 and older have limited English proficiency, a higher rate than in other parts of the United States, thereby isolating a large portion of the population from services and opportunities. 33.8% of Hispanics within this population have limited English proficiency. Limited educational experience and limited English proficiency make successful engagement with the highly technical, complex health care system very difficult. The rate of uninsured residents in this area is 6.25% compared to 7.23% in California and 8.73% across the county.



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PRIMARY COMMENTS

FOCUS GROUPS COMMENTS (PARAPHRASED FROM PRIMARY DATA INTERVIEW NOTES)

- People noted that many reluctant to take the ambulance because they don't have transportation to return home.
- People stated that getting transportation is hard, and it can impact accessing services or getting medication
- Community members shared that some have to travel as far as San Jose for dental appointments.
- Increased community education about available public transportation, and extending public transportation services beyond areas frequented by tourists, were seen as important options to consider.
- Many shared that the local shuttle doesn't go to St. Helena, but the public bus does, and it all depends if you catch the bus on time.
- Community members with limited mobility struggle accessing public transportation.
- It was noted that that there's transportation going to Napa but nothing towards Santa Rosa.

KEY INFORMANT COMMENTS

- "Rural areas are difficult to get transportation access."
- "No Lyft, afraid to drive to medical appointments."
- "Transportation to food distribution sites, especially for older adults."
- "People don't want to travel out of town for services."
- "If you're in Calistoga and you want to take advantage of some county services in Napa, you know the bus runs once every hour, and that's not the most convenient for some folks. If you needed to take public transit up to a hospital, that's near impossible."
- "People are having to spend a chunk of their day commuting. That commute time can be longer because, if you are a nurse, and you're working 6am to 7pm, you're not with the rest of the commuters. But if you work a 12-hour shift, and then you drive for an hour or two, you're exhausted and you're not going to prioritize exercise."
- "Carpooling can be an issue when the person who owns the car gets sick or gets COVID-19."

Secondary Data Summary

Access to Care

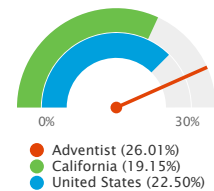
Availability - Primary Care - Primary Care Shortage Areas

This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Within the report area, there are 53,291 people living in a Health Professional Shortage Area of primary care, dental or mental health professionals. This represents 26.01% of the total population.

Report Area	Total Population (ACS 2019 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a HPSA	Percentage of HPSA Population Underserved
Adventist Health St. Helena	204,878	53,291	26.01%	52.26%
Lake County, CA	64,276	59,295	92.25%	52.09%
Napa County, CA	138,572	1,662	1.20%	100.00%
Sonoma County, CA	496,801	57,675	11.61%	13.16%
California	39,346,023	7,536,309	19.15%	56.64%
United States	326,569,308	73,467,356	22.50%	53.70%

Percentage of Population Living in an Area Affected by a HPSA



Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: HPSA



Primary Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database May 2021

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Adventist Health St. Helena

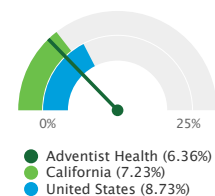
Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.

In the report area 6.36% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less than the state average of 7.23%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Adventist Health St. Helena	199,245	12,672	6.36%
Lake County, CA	63,581	4,642	7.30%
Napa County, CA	136,811	8,025	5.87%
Sonoma County, CA	492,417	29,765	6.04%
California	38,838,726	2,806,173	7.23%
United States	321,525,041	28,058,903	8.73%

Uninsured Population, Percent

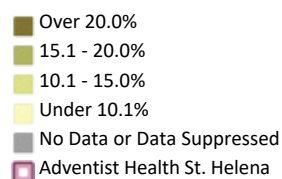


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: Tract



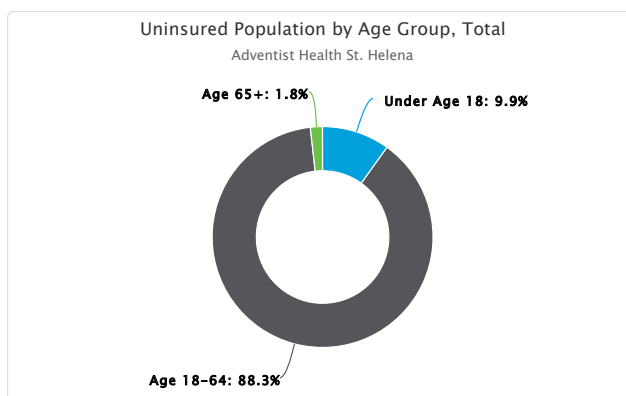
Uninsured Population, Percent by Tract, ACS 2016-20



Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

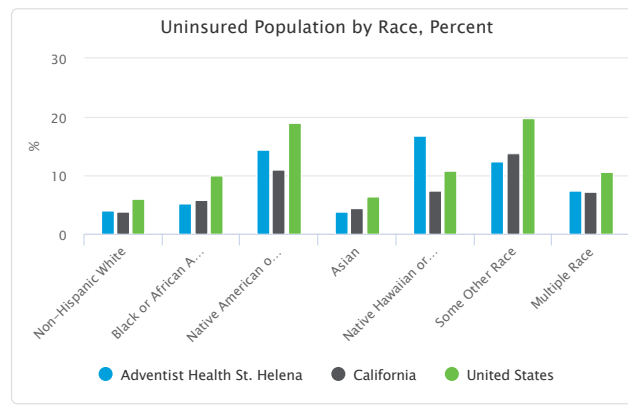
Report Area	Under Age 18	Age 18-64	Age 65+
Adventist Health St. Helena	1,259	11,189	224
Lake County, CA	422	4,108	112
Napa County, CA	837	7,076	112
Sonoma County, CA	3,786	25,208	771
California	308,355	2,439,126	58,692
United States	4,016,835	23,640,483	401,585



Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.

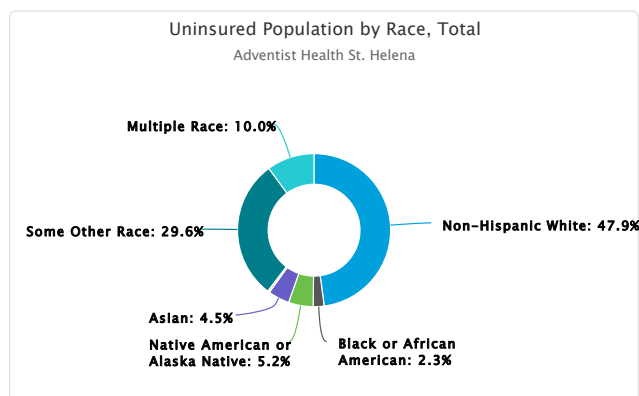
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	4.02%	5.25%	14.44%	3.81%	16.88%	12.50%	7.47%
Sonoma County, CA	3.32%	13.46%	5.97%	5.89%	23.60%	15.59%	6.72%
California	3.87%	5.85%	11.02%	4.50%	7.47%	13.82%	7.24%
United States	5.93%	9.94%	18.99%	6.44%	10.79%	19.79%	10.67%



Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

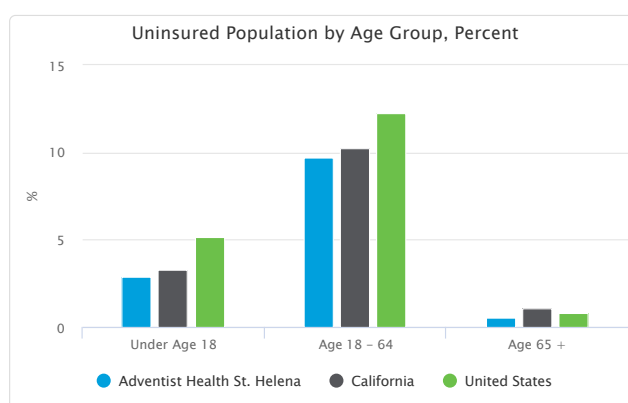
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	4,572	220	498	432	40	2,827	959
Sonoma County, CA	10,215	1,084	258	1,243	375	10,209	2,327
California	547,635	126,535	33,530	261,111	10,979	768,688	223,444
United States	11,475,294	3,972,510	497,979	1,179,390	64,404	3,281,019	1,776,683



Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.

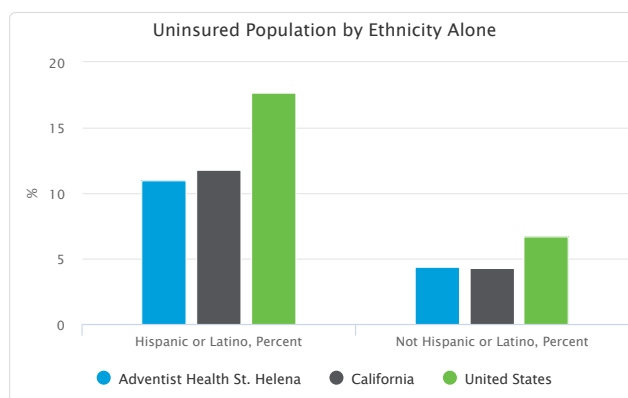
Report Area	Under Age 18	Age 18 - 64	Age 65 +
Adventist Health St. Helena	2.86%	9.72%	0.56%
Lake County, CA	3.02%	11.70%	0.77%
Napa County, CA	2.76%	8.76%	0.44%
Sonoma County, CA	3.65%	8.61%	0.80%
California	3.26%	10.24%	1.06%
United States	5.18%	12.26%	0.79%



Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.

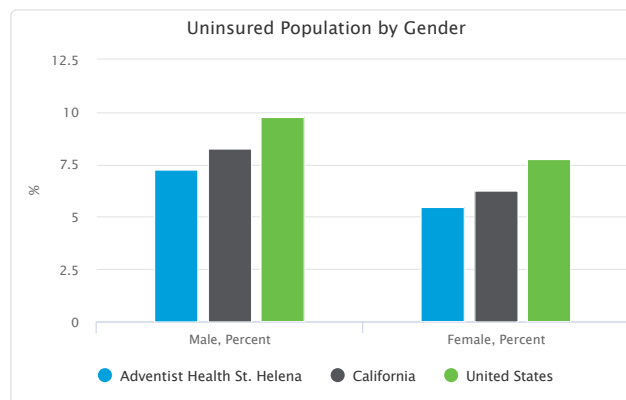
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Adventist Health St. Helena	6,629	6,043	10.98%	4.35%
Sonoma County, CA	15,530	14,235	11.69%	3.96%
California	1,793,633	1,012,540	11.79%	4.29%
United States	10,382,464	17,676,439	17.72%	6.72%



Uninsured Population by Gender

This indicator reports the uninsured population by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
Adventist Health St. Helena	7,176	5,496	7.26%	5.47%
Sonoma County, CA	16,266	13,499	6.78%	5.34%
California	1,580,869	1,225,304	8.25%	6.23%
United States	15,300,004	12,758,899	9.74%	7.76%

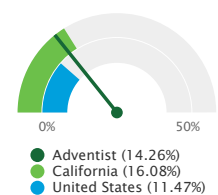


Barriers - Health Literacy - Educational Attainment

Within the report area there are 20,495 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 14.26% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes ([Freudenberg & Ruglis, 2007](#)).

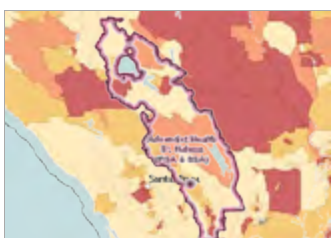
Report Area	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent
Adventist Health St. Helena	143,721	20,495	14.26%
Lake County, CA	46,482	6,403	13.78%
Napa County, CA	98,006	14,162	14.45%
Sonoma County, CA	359,119	39,039	10.87%
California	26,665,143	4,286,538	16.08%
United States	222,836,834	25,562,680	11.47%

Population Age 25+ with No High School Diploma, Percent

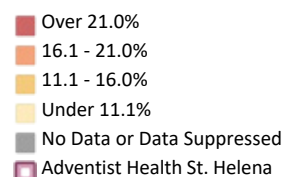


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: Tract

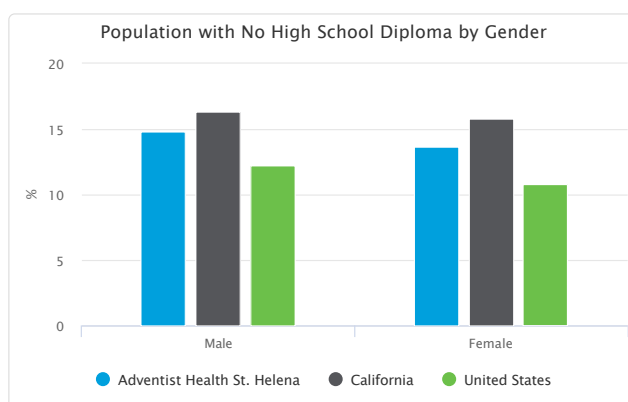


Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2016-20



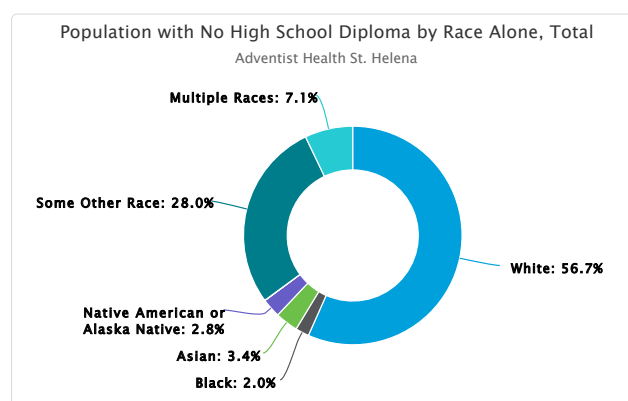
Population with No High School Diploma by Gender

Report Area	Male	Female	Male, Percent	Female, Percent
Adventist Health St. Helena	10,509	9,986	14.86%	13.68%
Lake County, CA	3,373	3,030	14.74%	12.84%
Napa County, CA	7,147	7,015	14.81%	14.10%
Sonoma County, CA	20,700	18,339	11.98%	9.84%
California	2,135,833	2,150,705	16.34%	15.82%
United States	13,141,042	12,421,638	12.19%	10.80%



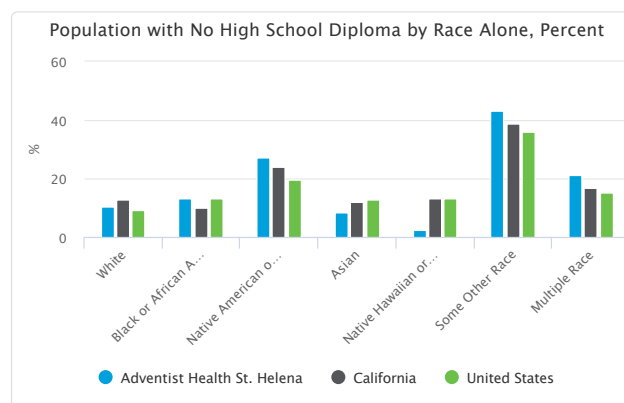
Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Adventist Health St. Helena	11,612	414	690	579	5	5,740	1,455
Lake County, CA	3,744	231	172	490	5	1,360	401
Napa County, CA	7,938	183	518	89	0	4,380	1,054
Sonoma County, CA	17,373	678	1,927	651	126	15,983	2,301
California	1,977,822	151,677	510,287	49,513	13,418	1,312,799	271,022
United States	15,123,109	3,547,596	1,655,662	327,426	51,083	3,624,534	1,233,270



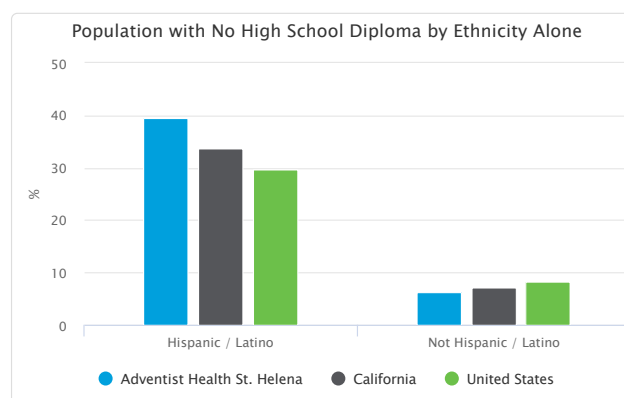
Population with No High School Diploma by Race Alone, Percent

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	10.56%	13.35%	27.27%	8.34%	2.38%	43.19%	21.40%
Lake County, CA	10.00%	21.33%	33.31%	23.18%	38.46%	33.88%	23.25%
Napa County, CA	10.84%	9.07%	13.65%	6.88%	0.00%	46.93%	20.77%
Sonoma County, CA	6.26%	12.24%	21.28%	12.28%	10.39%	42.62%	12.37%
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
Adventist Health St. Helena	13,613	6,882	39.54%	6.30%
Lake County, CA	2,544	3,859	34.52%	9.87%
Napa County, CA	11,069	3,093	40.79%	4.36%
Sonoma County, CA	26,186	12,853	34.46%	4.54%
California	3,025,438	1,261,100	33.80%	7.12%
United States	10,134,213	15,428,467	29.74%	8.17%

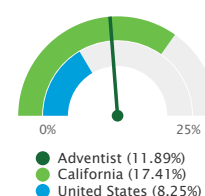


Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 191,159 total population aged 5 and older in the report area, 22,730 or 11.89% have limited English proficiency.

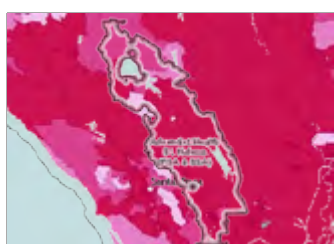
Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Adventist Health St. Helena	191,159	22,730	11.89%
Lake County, CA	60,562	3,511	5.80%
Napa County, CA	131,730	19,219	14.59%
Sonoma County, CA	472,319	51,560	10.92%
California	36,936,941	6,432,102	17.41%
United States	306,919,116	25,312,024	8.25%

Population Age 5+ with Limited English Proficiency, Percent

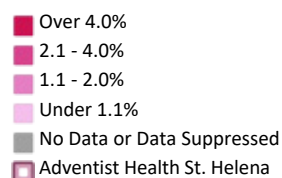


Note: This indicator is compared to the state average.

Data Source: US Census Bureau, [American Community Survey](#), 2016-20. Source geography: Tract



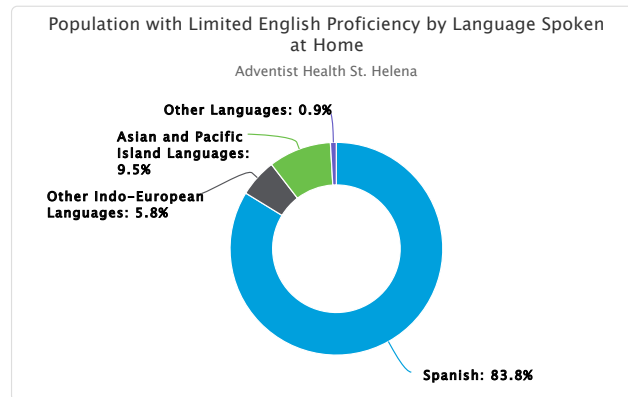
Population with Limited English Proficiency, Percent by Tract, ACS 2016-20



Population with Limited English Proficiency by Language Spoken at Home

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by language spoken at home in the report area.

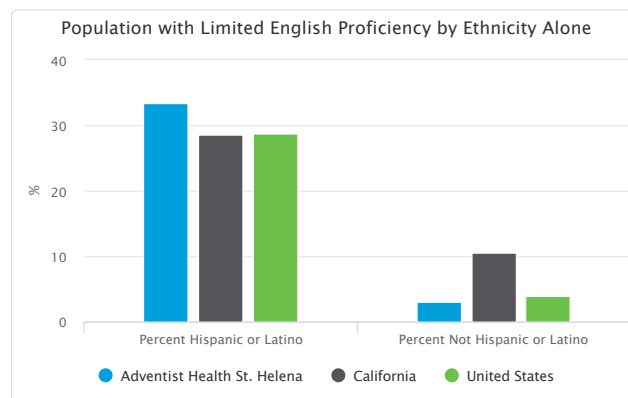
Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
Adventist Health St. Helena	19,038	1,317	2,170	205
Lake County, CA	3,084	249	178	0
Napa County, CA	15,954	1,068	1,992	205
Sonoma County, CA	42,789	2,514	5,619	638
California	4,083,013	499,656	1,720,073	129,360
United States	15,949,582	3,422,525	4,886,876	1,053,041



Population with Limited English Proficiency by Ethnicity Alone

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by ethnicity alone in the report area.

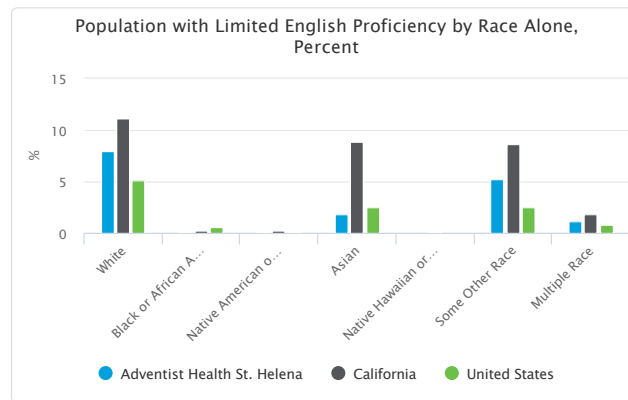
Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Adventist Health St. Helena	18,696	4,034	33.40%	2.98%
Lake County, CA	2,915	596	23.67%	1.24%
Napa County, CA	15,781	3,438	36.05%	3.91%
Sonoma County, CA	41,972	9,588	33.95%	2.75%
California	4,048,196	2,383,906	28.56%	10.47%
United States	15,590,137	9,721,887	28.69%	3.85%



Population with Limited English Proficiency by Race Alone, Percent

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

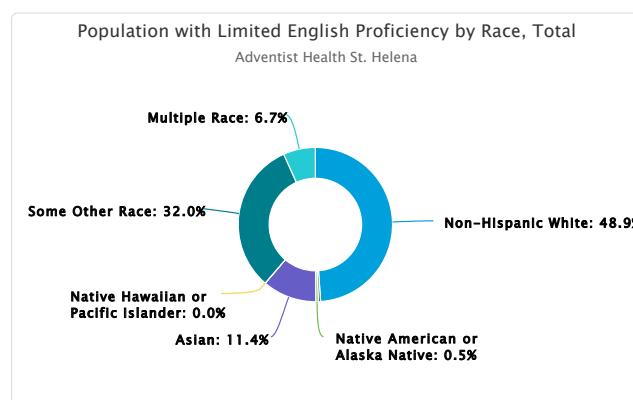
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	7.95%	0.08%	0.09%	1.85%	0.00%	5.20%	1.09%
Lake County, CA	3.36%	0.08%	0.00%	0.48%	0.00%	3.13%	0.49%
Napa County, CA	10.14%	0.08%	0.13%	2.50%	0.00%	6.17%	1.38%
Sonoma County, CA	3.82%	0.24%	0.19%	1.85%	0.04%	7.87%	0.91%
California	11.14%	0.23%	0.21%	8.84%	0.08%	8.58%	1.77%
United States	5.12%	0.55%	0.09%	2.55%	0.03%	2.48%	0.82%



Population with Limited English Proficiency by Race, Total

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	11,121	107	119	2,582	2	7,272	1,527
Lake County, CA	1,564	36	0	223	2	1,459	227
Napa County, CA	9,557	71	119	2,359	0	5,813	1,300
Sonoma County, CA	13,198	824	648	6,394	134	27,220	3,142
California	2,323,258	47,356	43,331	1,842,890	17,098	1,788,369	369,800
United States	11,134,122	1,196,004	202,081	5,545,968	71,524	5,388,974	1,773,351



D. Health Conditions – Physical Health

Having a population with a higher-than-average burden of major health conditions, especially chronic conditions, is a social, environmental, and healthcare difficulty for any community. The presence of one or more chronic conditions in particular is a driver of lower quality of life and greater healthcare expenditures. To improve a communities' overall health, knowing which health conditions are driving reduced health and wellness is critical.

About a third of the population (29%) is obese. This is a slightly higher rate of obesity than in California (28%). Prevalence of coronary heart disease (6%) is higher than in California (5%) and the same as in the United States.

There is a slightly higher heart disease mortality rate (145.3 per 100k) than in California (141.3). Prevalence of lung diseases (6.6%) is higher than in California (4.7%) and the same as in the United States. Mortality from lung disease (34.6 per 100k) is higher than in California (30.5).

Cancer risk (7.3%) as well as cancer mortality (153.8 per 100k) are higher than in California (5.5%, 134.5) and the United States (7.1%, 149.4). Cancer mortality is especially elevated for persons who are American Indian or Alaskan Natives. When cultural or racial minorities, who are already at greater risk of health disparities, have a clear increased disease burden it is important to note.

Death due to liver disease is higher than in California and in the United States as a whole, with 19.1 deaths per 100k in St. Helena compared to 12.5 in California and 11.5 in the US.



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PRIMARY COMMENTS

FOCUS GROUPS

- Poor diet and excessive weight gain is seen as problem for residents of all ages, and is attributed by some to limited nutritional education.

KEY INFORMANT COMMENTS

- “It is important to recognize that while bringing many benefits to our community the wine and grape growing industry also brings impacts of industrial agriculture including substantial use of synthetic pesticides, herbicides and other contaminants that can get into our water supplies, soils and air, and unless managed in a considered way may not be consistent with long term public health goals of the community.”
- “The younger that people are getting diagnosed, it affects their journey on healthcare systems.”
- “The younger that people are getting diagnosed, it affects their journey on healthcare systems.”
- “There is a lack of nutritional education.”
- “We have surprisingly high rate of cancer in Napa County. We know that obesity, alcohol consumption, some of those things can lead to cancer.”



- “High rate of cancer– breast, colon, kidney, leukemia, perhaps due to pesticides that they spray.”
- “Our society has become more sedentary... and sitting in front of computers a lot more.”
- “Diabetes and obesity has increased drastically. It impacts employees and then trickles down to their families. Workers having to do insulin out in the fields. They struggle to keep their medications at safe temperatures.”
- “Our daily diets have increased in the eating of processed and sugary foods.”
- “I’ve seen an increase in heart disease.”
- There are no safe walkways outside in local neighborhoods, in the eyes of some.
- Some noted that people aren’t aware that most cancers can be prevented
- “During the pandemic, the food pantries would be accessible to the community twice a month and just starting a couple of months ago, they reduced it down to once a month. So there is a reduction in the free food that people have access to.”

Secondary Data Summary

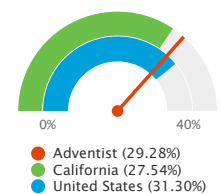
Health Conditions

Obesity & Diabetes - Obesity

This indicator reports the number and percentage of adults age 18 and older who are obese, defined as having a body mass index (BMI) ≥ 30.0 kg/m², calculated from self-reported weight and height.

Report Area	Total Population (2019)	Adult Obesity (BMI ≥ 30.0 kg/m ²) (Crude)	Adult Obesity (BMI ≥ 30.0 kg/m ²) (Age-Adjusted)
Adventist Health St. Helena	199,326	29.28%	No data
Lake County, CA	64,386	32.40%	32.30%
Napa County, CA	137,744	28.50%	28.60%
Sonoma County, CA	494,336	27.10%	27.10%
California	39,512,223	27.54%	27.71%
United States	328,239,523	31.30%	31.30%

Percentage of Adults Obese (BMI ≥ 30.0 kg/m²)

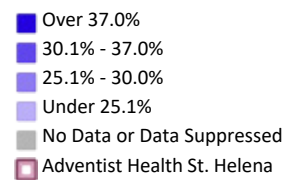


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract



Obese (BMI ≥ 30), Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

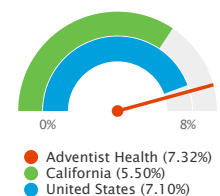


Cancers - Cancer

This indicator reports the number and percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have any other types (besides skin) of cancer.

Report Area	Total Population (2019)	Percentage of Adults with Cancer
Adventist Health St. Helena	199,326	7.32%
Lake County, CA	64,386	8.00%
Napa County, CA	137,744	6.60%
Sonoma County, CA	494,336	7.20%
California	39,512,223	5.50%
United States	328,239,523	7.10%

Percentage of Adults with Cancer

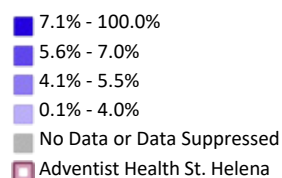


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019. Source geography: Tract



Cancer, Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019



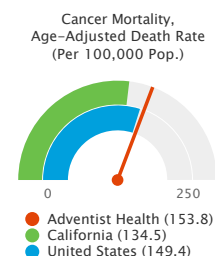
Cancers - Cancer Mortality

This indicator reports the 2016-2020 five-year average rate of death due to malignant neoplasm (cancer) 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 cancer is a leading cause of death in the United States.

Within the report area, there are a total of 2,317 deaths due to cancer. This represents an age-adjusted death rate of 153.8 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)
Adventist Health St. Helena	202,206	2,317	229.1	153.8
Lake County, CA	64,322	926	287.9	181.1
Napa County, CA	139,253	1,412	202.8	141.6
Sonoma County, CA	498,277	4,890	196.3	136.6
California	39,444,803	298,283	151.2	134.5
United States	326,747,554	2,998,371	183.5	149.4

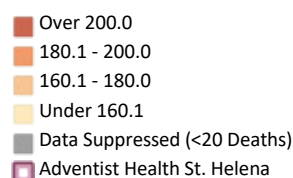


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County



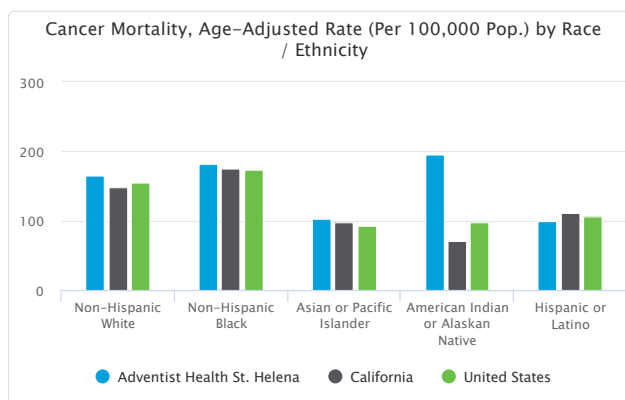
Cancer Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20



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

This table reports the age-adjusted rate death due to cancer per 100,000 people for the 5-year period 2016-2020 by race and by Hispanic origin.

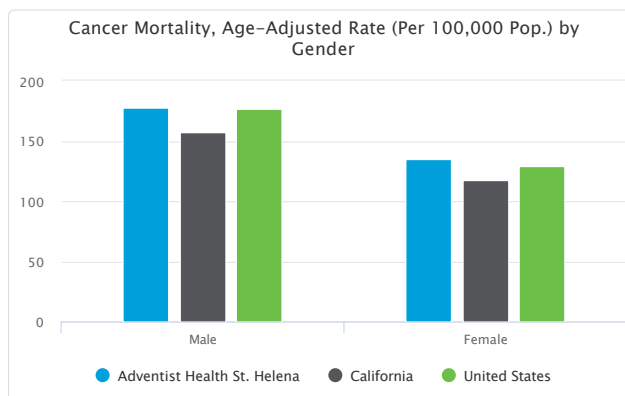
Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Adventist Health St. Helena	164.8	182.8	102.8	195.6	98.7
Lake County, CA	190.0	247.3	No data	195.9	85.3
Napa County, CA	149.7	153.6	102.8	No data	102.5
Sonoma County, CA	141.1	109.0	99.3	80.1	107.2
California	148.6	175.2	98.5	70.9	111.9
United States	154.8	174.3	93.0	97.1	106.8



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

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

Report Area	Male	Female
Adventist Health St. Helena	177.4	135.2
Lake County, CA	206.5	158.8
Napa County, CA	164.3	124.6
Sonoma County, CA	155.3	123.2
California	157.3	117.9
United States	177.1	128.9

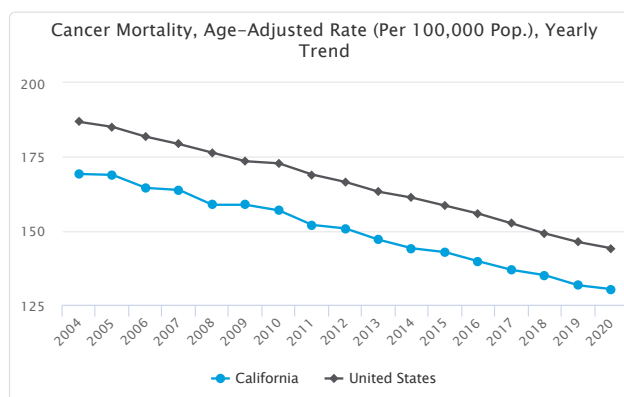


Cancer Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

The table below shows age-adjusted death rates due to cancer 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	169.2	168.9	164.5	163.8	158.8	158.8	156.9	152.0	150.8	147.0	144.1	142.8	139.7	136.8	135.0	131.6	130.3
United States	186.8	185.1	181.8	179.3	176.4	173.5	172.8	169.0	166.5	163.2	161.2	158.5	155.8	152.5	149.1	146.2	144.1

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



Kidney & Liver Diseases - Liver Disease Mortality

This indicator reports the 2016-2020 five-year average rate of death due to liver disease 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 liver disease is a leading cause of death in the United States.

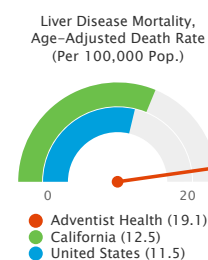
Within the report area, there are a total of 252 deaths due to liver disease. This represents an age-adjusted death rate of 19.1 per every 100,000 total population.

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)
Adventist Health St. Helena	202,206	252	24.9	19.1
Lake County, CA	64,322	162	50.4	37.5
Napa County, CA	139,253	94	13.5	10.8
Sonoma County, CA	498,277	322	12.9	9.9
California	39,444,803	27,757	14.1	12.5
United States	326,747,554	221,126	13.5	11.5

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



E. Mental Health

Based on the collected primary data, our service area is facing challenges in providing an adequate amount of mental health services to residents due to professionals leaving the field. This secondary data indicates they are also seeing considerable mental health risks and a substantial need for services.

Risk factors which contribute to and exacerbate mental health challenges are numerous. Stress and trauma due to violent crime are above the rate in both California and the United States, with homicides, rape, robbery, and aggravated assaults reported at 439.5 per 100,000 versus California at 419.4 and US at 385.6. Unemployment also contributes to increased stress levels for individuals and families, as it creates financial instability, barriers to health services, nutritious food, education, housing, and risks to overall health and wellness. The unemployment rate of 6.13% in St. Helena is above that in the United States (5.38%). Unemployment rate increases dramatically for Native American/Alaska Natives (14.86%) and for Black or African Americans (9.59%), which can be a direct cause of greater health disparities for racial and cultural minority groups.

Among Medicare recipients, 4.8% have a drug or substance use disorder, which is above both California and the US rates. 17.5% of the adult population binge drink. This indicator is similar to that of California and slightly above the rate in the US (16.7%). Taken together this data suggests an increased risk for elderly community members.



13.5% of adults report having poor mental health in St. Helena, with 30% of Medicare beneficiaries having mental health and substance use conditions. Strikingly, the suicide rate is higher than both the rate in California and in the United States, with 15.3 deaths by suicide per 100,000 versus California at 10.5 and United States at 13.8. Overall rates of deaths of despair (55.9), which include intentional self-harm, alcohol-related disease, and drug overdose are higher than both California (37.1) and the United States (47). This shows the risk of poor mental health outcomes across the community.



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PRIMARY COMMENTS

FOCUS GROUPS

- People shared that mental health services are extremely hard to get in Napa.
- We heard from community members there are not enough mental health providers to meet the needs, especially Spanish-speaking providers.
- People noted that the mental health crises, and the lack of crisis services, are impacting access to medical care in local emergency rooms
- COVID fostered social isolation, which affected the mental health of many community members.
- There are long waiting lists for mental health services, which is a problem for people in crisis.
- COVID is seen as a driver for the increased need in services.
- People share that there needs to be services available 24/7. You are not going to get any real help during after hours, holidays, weekends.
- Older people are seen as having less access to technology for communication., increasing their social isolation.
- Suicide attempts are perceived by some to be increasing. While there is free therapy in schools the waitlist is full and people shared that woman need options and places to move into after domestic abuse tragedies.

KEY INFORMANT COMMENTS

- "Increase suicide rates, attempts, especially in teenage girls. Isolation due to COVID."
- "We all are feeling an extra level of tension in our daily lives. It enters your life, home, workplace and affects those around you. Some of the effects that happen is that you often drink more, and then you have more problems with people showing up late for work or absenteeism. Those who abuse alcohol sometimes leads to abuse within the homes. Everything has a ripple effect. You can have a great employee, but if they don't recognize these symptoms of stress than they're getting disciplined, and it just compounds the problem rather than getting the help they need."
- "There's not enough flexibility when farmworkers need to go and seek help."
- "It's hard for people with depression and anxiety to talk about or admit that they are having difficulties around mental wellbeing."
- "People are reporting that their well-being has never been lower."
- "If you don't have a stable, safe place to live or affordable place to live it impacts you, and leads to anxiety, depression, health issues, and educational issues, this we know."
- "Stress is impacting the farm working community, they're feeling an extra level of tension in their daily lives."
- "We are seeing a lot of COVID related anxiety."
- "There's an increased rate of homelessness, this is impacting their ability to think clearly."
- "There are no mental health shelters to help those in need."
- "We need to get our families united around getting kids to spend more time outdoors than inside on-screen time."
- "Our community's mental health has gotten worse across all ages, and we're seeing an increased need for mental health services because of depression, anxiety, and other issues."
- "I've seen collective trauma from the pandemic and wildfires."
- "We are seeing an increase in children feeling sad and hopeless."
- "There is a waitlist for kids needing mental health."

Secondary Data Summary

MENTAL HEALTH

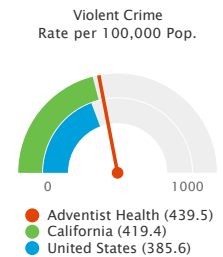
Risk Factors - Stress & Trauma - Violent Crime Rate

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, 901 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 439.5 per 100,000 residents is higher than the statewide rate of 419.4 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.)
Adventist Health St. Helena	901	439.5
Lake County, CA	343	535.5
Napa County, CA	566	397.7
Sonoma County, CA	1,845	367.9
California	327,327	419.4
United States	2,445,671	385.6



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
- Adventist Health St. Helena

Risk Factors - Stress & Trauma - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 6,142, or 6.13% 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.

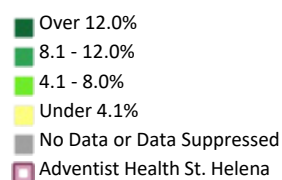
Report Area	Labor Force	Number Unemployed	Unemployment Rate
Adventist Health St. Helena	100,267	6,142	6.13%
Lake County, CA	26,743	2,819	10.54%
Napa County, CA	74,102	3,350	4.52%
Sonoma County, CA	266,216	12,297	4.62%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Note: This indicator is compared to the state average.

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



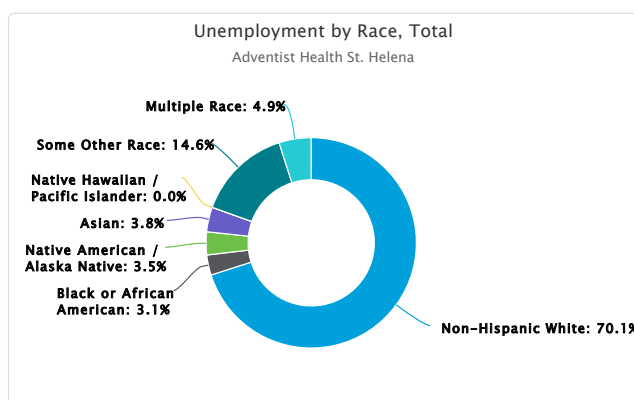
Unemployed Workers, Percent by Tract, ACS 2016-20



Unemployment by Race, Total

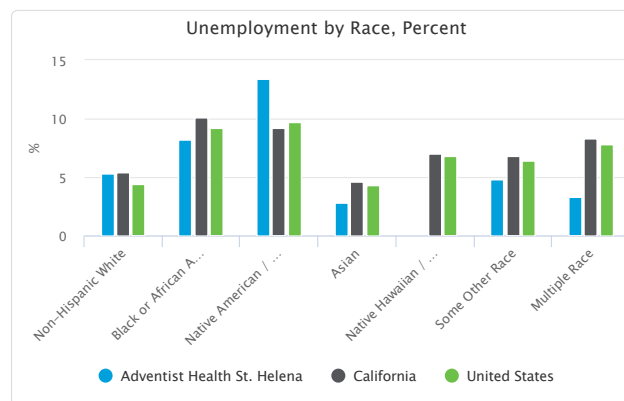
Data Source: US Census Bureau, American Community Survey, 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Adventist Health St. Helena	419,208	18,586	21,101	22,755	0	87,119	29,602
Lake County, CA	1,629	51	164	7	0	447	132
Napa County, CA	1,720	124	59	175	0	327	137
Sonoma County, CA	7,948	259	207	284	12	1,341	1,004
California	402,121	110,197	13,728	144,492	5,681	193,399	115,127
United States	4,432,807	1,853,375	115,397	421,021	20,879	541,963	564,122



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
Adventist Health St. Helena	5.28%	8.19%	13.36%	2.78%	0.00%	4.79%	3.29%
Lake County, CA	8.74%	12.00%	16.47%	2.20%	0.00%	13.29%	13.23%
Napa County, CA	4.51%	8.86%	11.68%	3.03%	0.00%	3.76%	2.84%
Sonoma County, CA	4.72%	5.50%	7.82%	2.31%	1.09%	3.82%	6.24%
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%



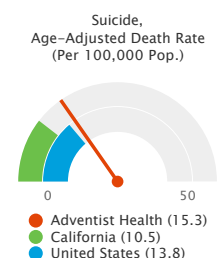
Health Outcomes - Deaths of Despair - Suicide Mortality

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 resummized 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 166 deaths due to suicide. This represents an age-adjusted death rate of 15.3 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)
Adventist Health St. Helena	202,206	166	16.4	15.3
Lake County, CA	64,322	86	26.7	26.4
Napa County, CA	139,253	82	11.8	10.3
Sonoma County, CA	498,277	367	14.7	13.4
California	39,444,803	21,677	11.0	10.5
United States	326,747,554	233,972	14.3	13.8

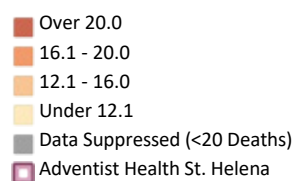


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County



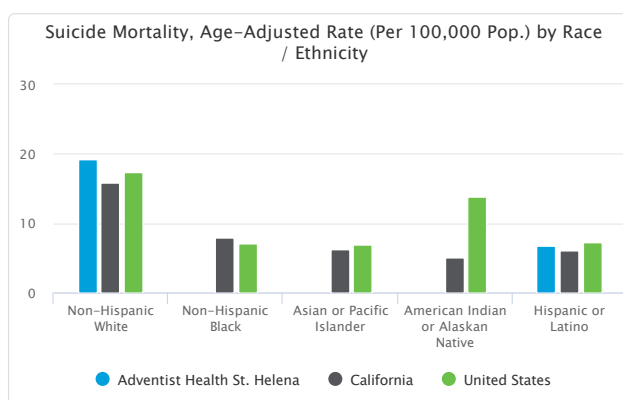
Suicide Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20



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
Adventist Health St. Helena	19.2	No data	No data	No data	6.7
Lake County, CA	27.2	No data	No data	No data	No data
Napa County, CA	14.3	No data	No data	No data	No data
Sonoma County, CA	15.9	No data	No data	No data	6.7
California	15.9	7.9	6.2	5.0	6.1
United States	17.4	7.1	6.9	13.8	7.2

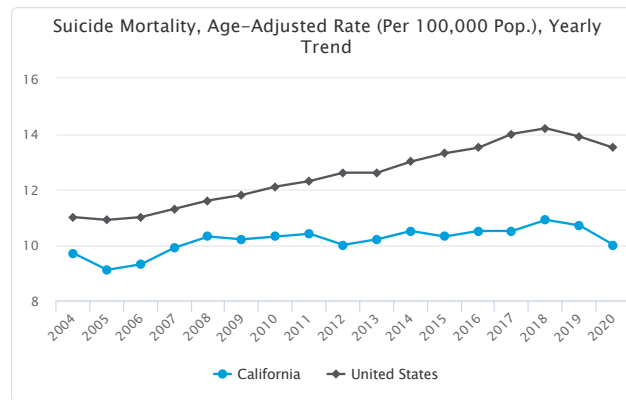


Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

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

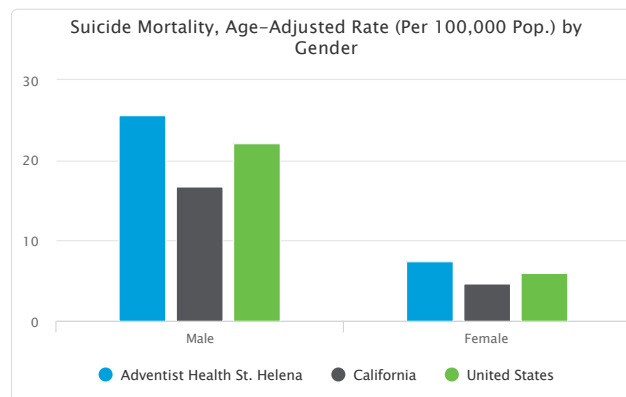
Note: No county data available. See data source and methodology for more details.



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
Adventist Health St. Helena	25.6	7.4
Lake County, CA	43.5	No data
Napa County, CA	17.5	No data
Sonoma County, CA	19.8	7.4
California	16.7	4.6
United States	22.2	6.0

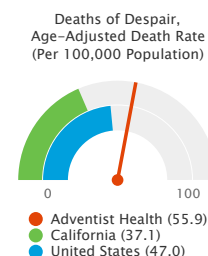


Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", 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 death of despair is an indicator of poor mental health.

Within the report area, there were 670 deaths of despair. This represents an age-adjusted death rate of 55.9 per every 100,000 total population.

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)
Adventist Health St. Helena	202,206	670	66.3	55.9
Lake County, CA	64,322	427	132.8	110.7
Napa County, CA	139,253	254	36.5	31.2
Sonoma County, CA	498,277	1,135	45.6	41.1
California	39,444,803	78,447	39.8	37.1
United States	326,747,554	806,246	49.4	47.0

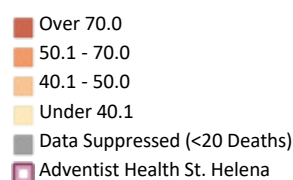


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County



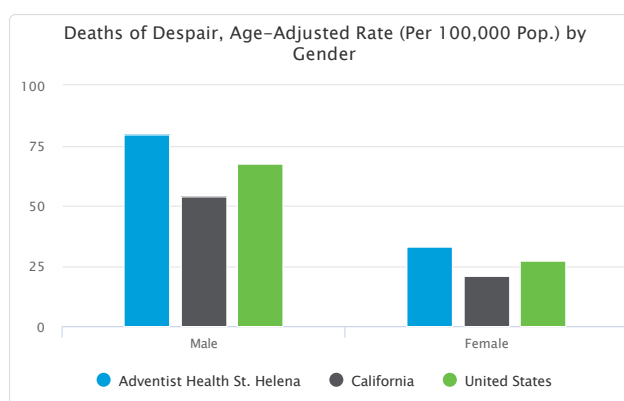
Deaths of Despair, Age Adj. Rate (Per 100,000 Pop.) by County, CDC NVSS 2016-20



Deaths of Despair, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

This table reports the age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 people for the 5-year period 2016-2020 by gender.

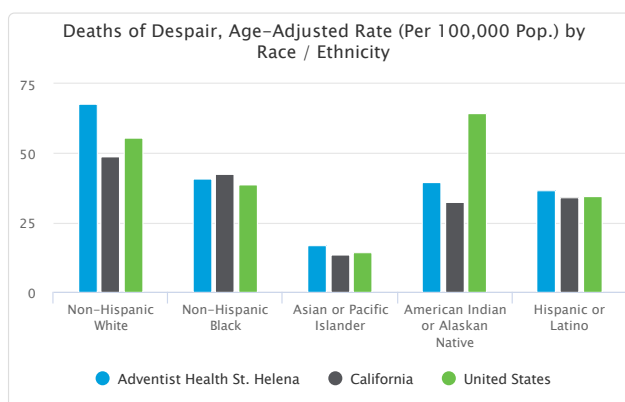
Report Area	Male	Female
Adventist Health St. Helena	79.6	32.8
Lake County, CA	149.1	73.5
Napa County, CA	48.3	14.6
Sonoma County, CA	56.6	26.3
California	54.0	20.9
United States	67.7	27.3



Deaths of Despair, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

This table reports the age-adjusted rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 people for the 5-year period 2016-2020 by race and by Hispanic origin.

Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
Adventist Health St. Helena	67.7	40.7	16.8	39.7	36.8
Lake County, CA	111.9	No data	No data	No data	83.2
Napa County, CA	41.1	No data	No data	No data	23.9
Sonoma County, CA	47.9	40.8	16.8	39.7	26.5
California	48.9	42.6	13.5	32.3	34.0
United States	55.6	38.6	14.3	64.3	34.6

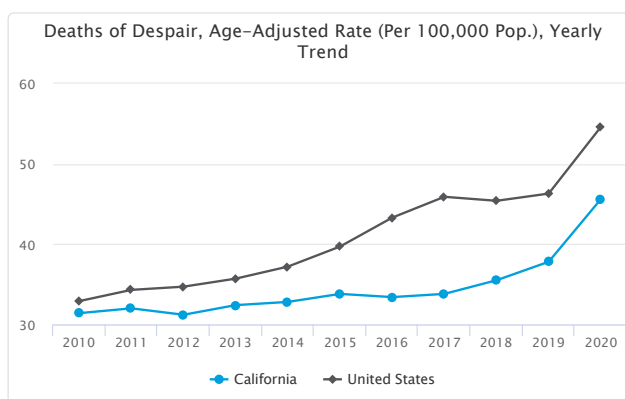


Deaths of Despair, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend

The table below shows age-adjusted death rates due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 population over time.

Report Area	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
California	31.4	32.0	31.2	32.4	32.8	33.8	33.4	33.8	35.5	37.8	45.6
United States	32.9	34.3	34.7	35.7	37.2	39.7	43.3	45.9	45.4	46.3	54.6

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



F. Written Comments

We value your input in our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about 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 the list of significant identified needs was prioritized (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 community.benefit@ah.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
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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



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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

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.

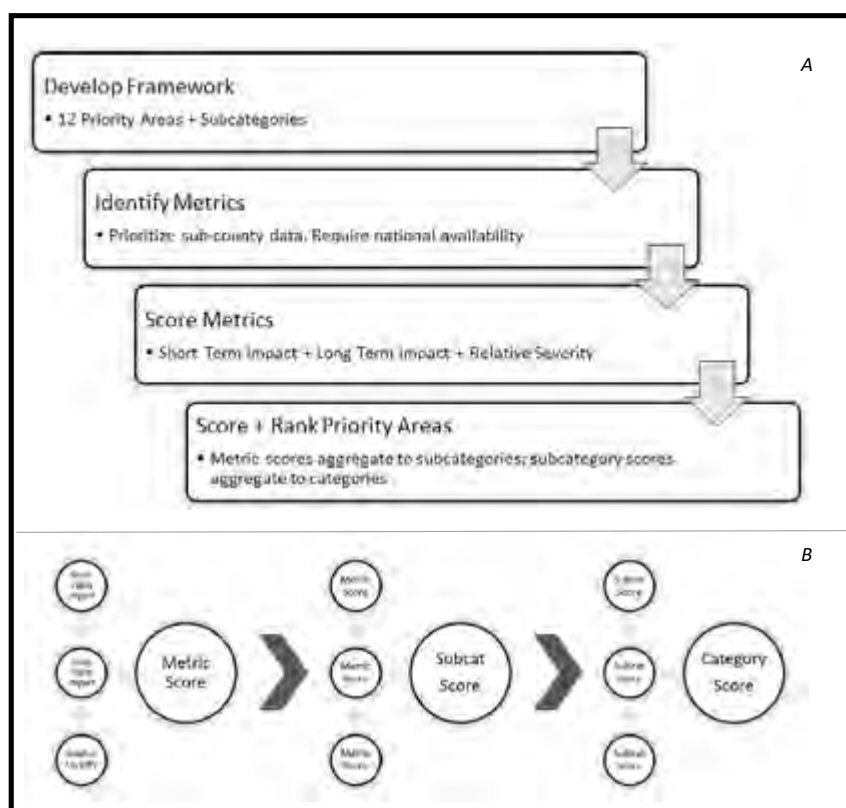


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

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 status²) and a long-term goal (length of life, measured by life expectancy at birth³). 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 framework⁴.

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.

$$SubC_c = \sum_c \frac{SubC}{n}$$

$$Cat_c = \sum_c \frac{SubC}{n}$$

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.

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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 table 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

METHODOLOGY 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 were 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 12 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 your 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 insure 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 individuals 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. Adventist Health St. Helena 2019 Implementation Strategy Evaluation of Impact



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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)

Berkeley 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 policy makers 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 support 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, safe people and safe children.

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 requires 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 from 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 preferred affordable healthy foods, 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 that 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 small choices can make a significant difference in combatting 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 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 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 20, 2022 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2022.



Thank you for reviewing our 2022 Community Health Needs Assessment. We are proud to serve our local community, and are committed to making it a healthier place for all.

Steven Herber, MD, FACS
Adventist Health St. Helena

COMMUNITY HEALTH NEEDS ASSESSMENT