



ADVENTIST HEALTH
UKIAH VALLEY

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 Howard Memorial, Mendocino Coast and Ukiah Valley 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

Financial Stability

Health Risk Behaviors

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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What if ...

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

Families and individuals had jobs and the financial resources they needed to live a safe and healthy life?

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



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 community-based organizations, community health organizations, County Office of Education, early

childhood development, Farm Bureau, government agencies, healthcare, housing, Hispanic populations, Mendocino County Department of Public Health, probation, older adults and unhoused populations. 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 10 significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, community safety, education, employment, financial stability, food security, health conditions, health risk behaviors, housing and mental health. The Steering Committee then selected high priority needs based on severity and prevalence, intentional alignment around common goals, feasibility

of potential interventions, and opportunities to maximize available resources over a three-year period, which were: access to care, financial stability and health risk behaviors.

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

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

What if . . .

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

Families and individuals had jobs and the financial resources they needed to live safe and healthy lives, with access to organizations that can help when needed to ensure **Financial Stability**

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

Getting to know Mendocino CHNA service area*

From spectacular ocean views, redwood forests, and picturesque towns, the CHNA service area is a breathtaking community with a total population of 116,095. Throughout the County people enjoy activities such as the Mendocino Art Center, Theatre Company, and music and film festivals.

The median household income is \$56,401. The largest segment of the population (37.2%) is made up of residents aged over age 55. The community is known as a location focused on the well-being of its residents with support in the built environment, grocery stores and access to care while also implementing a Blue Zones Project.

Among this population, 59.95% of an individual's income is spent on housing and transportation, while

20.66% of children live in poverty and 6.67% of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

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

**This service area represents Adventist Health Howard Memorial, Mendocino Coast and Ukiah Valley'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 Mendocino 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 from our 2019 CHNA prioritized health needs to see what we've accomplished and learned since then. Over the last three years, Adventist Health Mendocino Coast, Ukiah Valley and Howard Memorial hospitals collectively focused on mental health, substance abuse and workforce development.

Working together with the community, we created strategies designed to educate and break down barriers to care and well-being for Mendocino County residents. One of our biggest collaborations involved merging

the Mendocino County Trauma Informed Network of Care with our Adverse Childhood Experiences (ACEs) Community Resilience Team. Additionally, we continued our Safe Rx Mendocino Coalition designed to reduce substance abuse in Mendocino County. As a collaborative total, 156 doses of Naloxone were successfully administered to community members in need as well as a small handful of community members were able to connect to substance use counseling and treatment services through our Ukiah Medicine program.

Despite the challenges due to

COVID-19, we were still able to continue our Physical Therapy Assistance Program (PTAP) which has helped students not only meet their educational requirements, but also gain hands-on experience for post-graduation opportunities since 2019.

The COVID-19 global pandemic caused extraordinary challenges for Adventist Health Mendocino Coast, Ukiah Valley and Howard Memorial, leading us to pivot our focus to helping patients and families stop the spread of the virus, and provide access to free vaccines for all throughout the county.

Access to Care

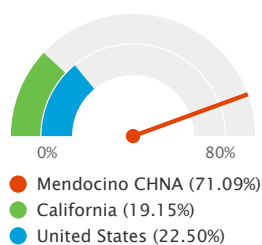


COMMUNITY VOICES

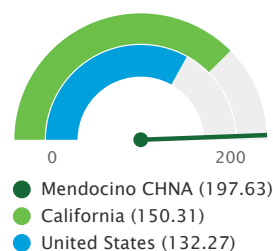
- People said it is difficult to attract doctors to this area. The clinics have bought homes and land to have apartments for doctors that come to this area. The clinic does this to help with housing needs for professionals.
- If a doctor doesn't understand addiction/culture then the problem is either undertreated, not treated and then poor outcomes and then ineffective. This concern was called out by focus group participants.
- Access to care, especially specialty care in rural areas, is seen as a major problem for many.
- Waiting times are seen as quite long to see a primary care physician and folks on the coast struggle with this to a considerable extent.
- If you have a chronic condition, you can't wait 3-4 months for services, which some are expected to do, interviewees noted.

SECONDARY DATA INFOGRAPHIC STATS:

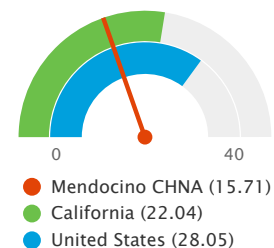
percentage of Population Living in an Area Affected by a HPSA



Mental Health Care Providers, Rate per 100,000 Population



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



**Community Health
Needs Survey:**

California North Coast*

29% 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.**

Dial-A-Ride

mendocinotransit.org/dial-a-ride

Get Connected Get Help with 211, Powered by people
in your community, available 24/7, 877-734-7794,
211mendocino.org

The people of Mendocino County face challenges, but they also have much to be proud of, including their willingness to search for ways to strengthen their communities.

Community members recently voiced their concerns through a survey. They noted that transportation problems impact their access to medical appointments, such as primary care providers, optometry and dermatology. Wait times to see a primary care provider are long and are especially challenging for coastal residents.

Survey results revealed community members are experiencing challenges in accessing care, with 25% of respondents identifying Access to Care as a significant need. The percentage of the population living in a health professional shortage area is extremely high (71.1%). There is a shortage of mental health providers and fewer intensive care beds. The rate of uninsured residents in this area is 8.68% compared to 7.23% in California and 8.73% across the county.

The area is beauty and, alongside with this challenge, provides opportunities for change. With awareness and commitment, families can achieve access to care and thrive.

Population with No High School Diploma by Gender

Report Area	Male	Female	Male, Percent	Female, Percent
Mendocino CHNA	5,724	4,965	14.78%	12.28%
Mendocino County, CA	4,433	3,836	14.61%	12.11%
California	2,135,833	2,150,705	16.34%	15.82%
United States	13,141,042	12,421,638	12.19%	10.80%

Financial Stability

COMMUNITY VOICES

- People said there are not enough jobs here that pay enough to afford the price of housing.
- Many noted it's difficult to find work and that this is true for nearly everyone, but especially the elderly.
- The stress of unstable housing is said to affect the health and mental health of all family members.
- Local wages do not support successfully paying rent or buying a house, community leaders stated.
- There is a belief that some youth will choose dealing marijuana rather than traditional paid employment as they can make more money that way.



Mendocino residents of all ages and races face a variety of overwhelming concerns. Responses to their reality can then lead to physical and mental health fears, along with facing unattainable housing, high unemployment rates and low annual incomes.

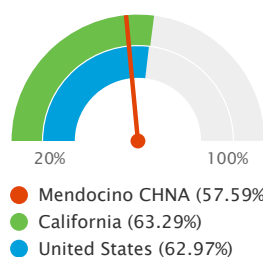
With their input, the evidence becomes very clear. Lack of work, housing costs and limited housing options can create an environment of despair. In Mendocino County, 21% of children aged 0 to 17 are living in households with income below

the federal poverty level. The rate of unemployment is 7.62%, which is higher than in California and the United States. Unemployment rates increase significantly for Black persons, at 22.5%. 11% of Native American or Alaska Natives live in poverty.

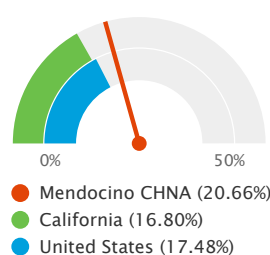
Shortages of housing and jobs alone unveil the impact of poverty and the heavy burden that it creates for this community. With commitment and courage, there can be health services, healthy food and affordable housing.

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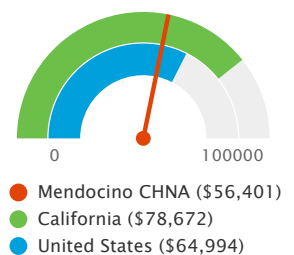
Labor Force Participation Rate



Percent Population Under Age 18 in Poverty



Median Household Income



**Community Health
Needs Survey:**

California North Coast*

79% of those surveyed
selected Financial Stability
as a top health concern.

*Survey region is defined by
the survey administrator.

See Section V. B. for more information.

**Find Financial Stability
resources in your community
to live better, longer.**

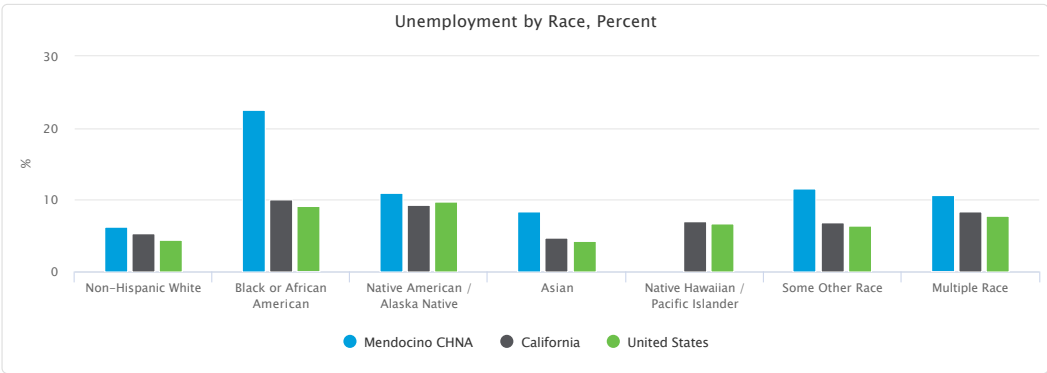
CalWORKS

cdss.ca.gov/calworks

City of Ukiah Senior Citizen Monthly Discount

707-463-6228, cityofukiah.com/utility-services

Get Connected Get Help with 211, Powered by people
in your community, available 24/7, 877-734-7794,
211mendocino.org



Health Risk Behaviors

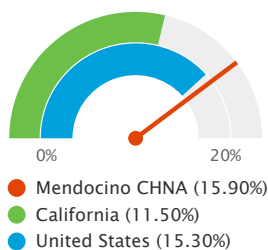
COMMUNITY VOICES

- Poor dietary habits driven by limited incomes are seen as a problem.
- Inpatient and rehab centers are typically believed to be full, requiring people to leave the area to get help.
- Mental health is the biggest cause of homelessness and addiction in the eyes of some interviewees.
- Drug and alcohol use is seen as a problem primarily for low-income residents.
- Services for Spanish-speaking residents are more difficult to find, as noted by those interviewed.

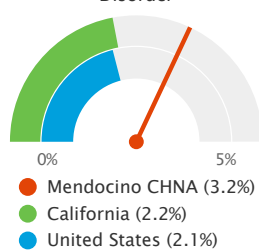


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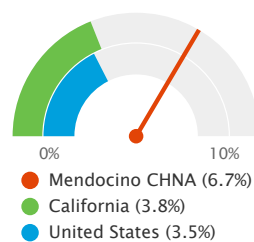
Percentage of Adults who are Current Smokers



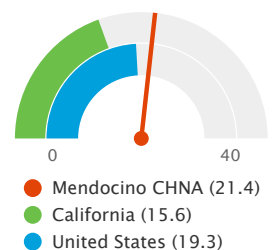
Percentage of Medicare Beneficiaries with Alcohol Use Disorder



Percentage of Medicare Beneficiaries with a Drug or Substance Use Disorder



Teen birth rate per 1,000 female population, ages 15-19



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

CalFresh

cdss.ca.gov/calfresh

County of Mendocino- Community Wellness

707-472-2611, mendocinocounty.org/government/public-health/community-wellness

Get Connected Get Help with 211, Powered by people in your community, available 24/7, 877-734-7794, 211mendocino.org

Mendocino County is known for its spectacular ocean views, redwood forests, picturesque towns and family-friendly community. With its family-friendly reputation for caring for the community, Mendocino County residents and local organizations support the well-being of its community with efforts made in the built environment, grocery stores and access to care.

Such an environment nudges individuals to engage in positive activities, helping residents' well-being

stay in the higher ranks. However, some behaviors can threaten better health, such as smoking and substance use. For example, 15.9% of the population smoke tobacco, which is a higher rate than in California (11.5%). The teen birth rate is 21.4 per 1,000 females, which is greater than the state's teen birth rate of 15.6 and the national rate of 19.3. The percentage of infants with low birth weight is significantly greater, with Mendocino's rate at 15.1% compared to the state at 6.9%.

Community members have expressed concern about the future of their families', friends' and coworkers' overall well-being, sharing concerns about community members not eating well due to limited incomes, drug abusers facing a social stigma that results in avoiding help, vaping among adolescents and residents leaving the area for care due to provider shortages. Yet, despite these genuine concerns, residents are eager to roll up their sleeves and find solutions to reduce the health risk behaviors in their community.

Tobacco - Current Smoking

Report Area	Total Population (2019)	Adult Current Smokers (Crude)	Adult Current Smokers (Age-Adjusted)
Mendocino CHNA	111,304	15.90%	No data
Mendocino County, CA	86,749	14.30%	14.80%
California	39,512,223	11.50%	11.54%
United States	328,239,523	15.30%	15.70%

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 Mendocino 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.

Megan Barber Allende

Community Foundation of Mendocino County, President/CEO

Nephele Barrett

Mendocino Council of Governments
Executive Director

Patty Bruder

North Coast Opportunities
Executive Director

Jill Damien

Mendocino Community Health Clinic,
Inc. Chief Operating Officer

Misty Davidson

Cahto Tribe
Resident Opportunity Self-Sufficiency
Coordinator

Neil Davis

City of Ukiah

Elizabeth Elliott

Northern Circle Indian Housing Authority
Executive Director

Trina Fitzgerald

Round Valley Tribal TANF

Minerva Flores

Mendocino College Director

Tiffany Gibson

Adventist Health Howard Memorial,
Mendocino Coast and Ukiah Valley
Well-Being Director

Jessica Grinberg

Mendocino Coast District
Hospital Board Chair

Michelle Hutchins

Mendocino County Office of Education
Superintendent

Victoria Kelly

Redwood Community Services
Chief Operating Officer

Debra Kubin

Ukiah Unified School District
Superintendent

Ryan LaRue

Rural Communities Housing
Development Commission

Judy Leach

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Anne Molgaard

Mendocino County Department of
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Miranda Ramos

Alliance for Rural Communities HEALTH

Jayma Spence

Mendocino County Family
Resource Center

Tina Tyler-O'Shea

Blue Zones
Executive Director

Micheline White

Mendonoma Health Alliance

Ted Williams

Mendocino County Board of Supervisors
Supervisor

II. About Us

A. Adventist Health Ukiah Valley

Adventist Health Ukiah Valley is a 78-bed, nonprofit hospital located in the seat of Mendocino County. As the largest and most comprehensive healthcare facility in the county, the level IV trauma center hospital offers a complete range of healthcare services, including surgical procedures in its hospital-based and ambulatory surgery center and an emergency department with a physician on duty 24 hours a day.



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,

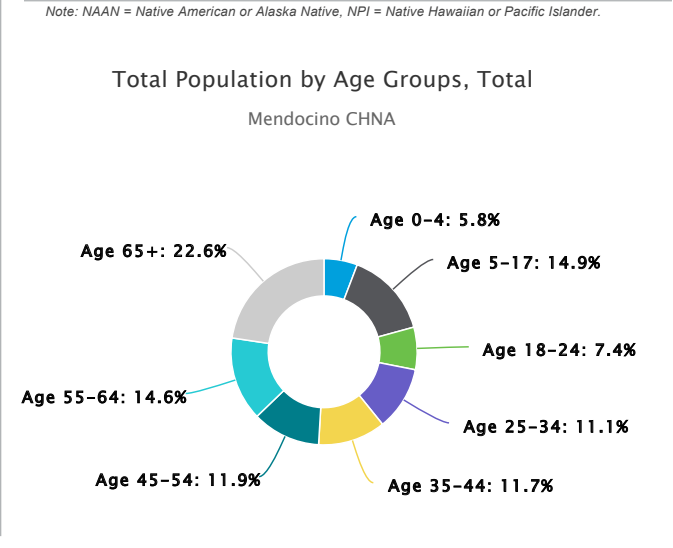
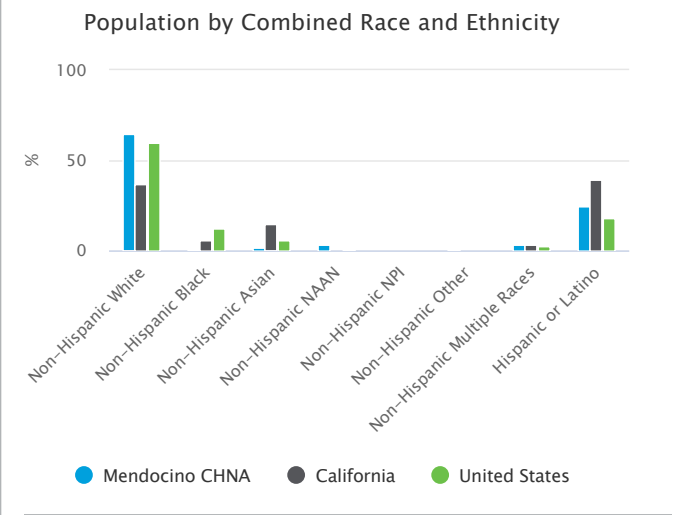
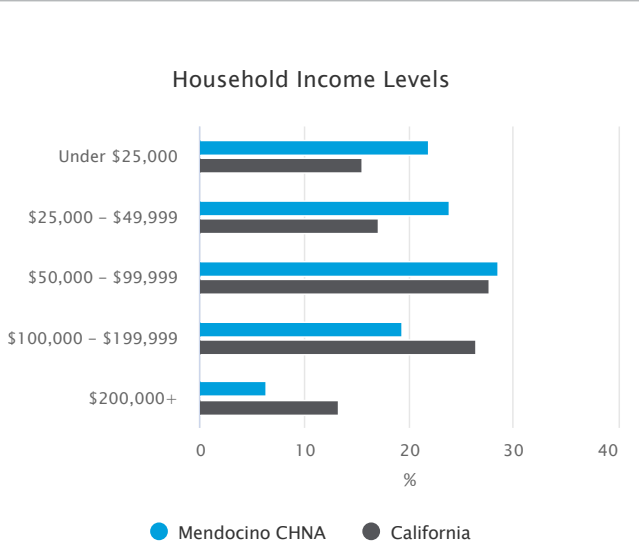
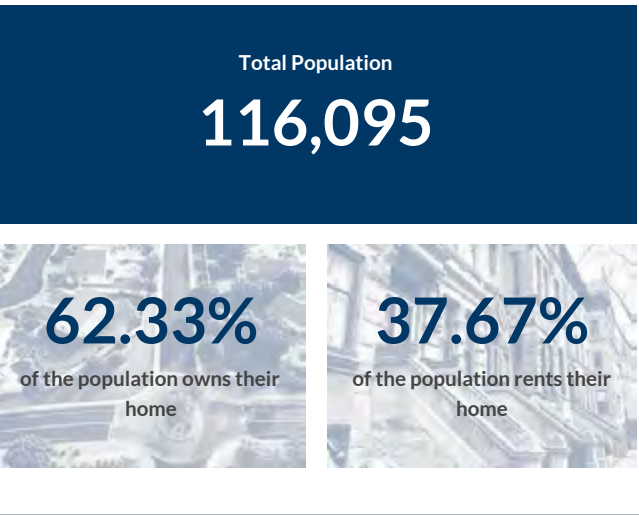
places of worship and workplaces—in our playgrounds, parks, and in the air we breathe, the food we eat and the water we drink. The more we see the problem of health in this way, the more opportunities we have to improve it. The conditions in which we live, work and play have an enormous impact on our 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 wellbeing 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 Howard Memorial, Mendocino Coast and Ukiah Valley'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 Howard Memorial, Mendocino Coast and Ukiah Valley CHNA market has a total population of 116,095 (based on the 2020 Decennial Census). The largest city in the service area is Ukiah, with a population of 16,075. The service area is comprised of the following zip codes: 95415, 95463, 95410, 95445, 95460, 95428, 95488, 95449, 95437, 95425, 95453, 95589, 95427, 95456, 95469, 95459, 95468, 95432, 95490, 95429, 95417, 95482, 95587, 95466, 95470, 95494, 95420, 95454, 95585.



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
Financial Stability	See Sections III.C - E
Health Risk Behaviors	See Sections III.C - E
Lower Priority Needs	
Community Safety 211mendocino.org/legal-assistance/	This community has higher rates of violent crime, death due to motor vehicle crashes, and deaths due to unintentional injury than the rest of California.
Housing-Unhoused 211mendocino.org/housing-homeless-services/	There are many drivers towards homelessness and a patchwork service system makes stable housing difficult to obtain and keep. 53% of surveyed residents identified homelessness as a health need in the community.
Housing-Cost 211mendocino.org/housing-homeless-services/	Inadequate housing stock and excessive housing costs affect many people in this region and influence the ability to draw in new people and retain current residents. 48% of surveyed residents identified homelessness as a health need in the community.
Health Conditions 211mendocino.org/health-care/	The prevalence rates of kidney disease and obesity are higher than the state average. Similarly, mortality rates for lung disease and the rate of people with cancer are also elevated compared to California as a whole.
Education 211mendocino.org/education/	Under-resourced and overtaxed schools make it difficult to provide adequate education for local students. This has a ripple effect throughout the community.
Employment 211mendocino.org/income-expenses/	30% of surveyed residents identified COVID as a community health need.
Food Security 211mendocino.org/food/	71% of students are eligible for free and reduced price school meals, and the overall poverty rate exceeds state and national averages.
Mental Health 211mendocino.org/mental-health/	Increased rates of anxiety, hostility, and overall aggression are seen as signs of poor mental health throughout the community. 44% of surveyed residents consider mental health 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, 9 focus groups were conducted with 40 participants, and 7 key informant interviews were held. Survey data was gathered from the North Coast region (region name defined by survey administrator, UC Berkeley IGS). See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

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

FOCUS GROUPS

- ▶ Nine (9) focus groups
- ▶ Forty (40) people participated

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

KEY INFORMANTS

- ▶ Seven (7) 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 Howard Memorial, Adventist Health Mendocino Coast, Adventist Health Ukiah Valley, Building Bridges, Head Start, Housing Action Team, Mendocino Area Parks Association, Mendocino County Department of Public Health, Mendocino County Office of Education, Mendocino County Probation Department, Mendocino County Farm Bureau, Mendocino Health Alliance, Rural Communities Housing Development Corporation, and Willits Senior Center

REPRESENTED RACE/ETHNICITIES

Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Civic government & leadership, community-based organizations focusing on early education, education, low-income, medically underserved, minority populations, older adults, provider, substance use, students, workforce representatives, unhoused populations

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

SURVEY RESULTS

REGION & STATEWIDE SUMMARY

California North Coast: Survey Results of Top Needs

See Section V. B. for more information.

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





C. Access to Care

Mendocino County residents face a number of barriers to accessing healthcare when needed. On the provider, community, and individual side there are factors that make it more difficult to prevent and treat healthcare conditions in a manner that can be expected in other parts of the state and the county. The percentage of the population living in a geographic area designated as a health professional shortage area is extremely high (71.1%) and is significantly larger than both the rate in California (19.15%) and in the United States (22.5%). A deficit of mental health providers is also evident. Additionally, there are fewer intensive care unit hospital beds in Mendocino County (15.71 per 100k people) than in California (22.04) and in the country (28.05).

While the adult population of Mendocino County with no high school degree (13.5%) is below that of California (16.1%), it is still above the nation's rate of 11.5%, and for some races within Mendocino this rate is much higher. 28.7% of Native American or Alaska Natives, 20.7% of Multiple races, and 46.8% of those of some other races have no high school diploma. The rate of uninsured residents in this area is 8.68% 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 said it is difficult to attract doctors to this area. The clinics have bought homes and land to have apartments for doctors that come to this area. The clinic does this to help with housing needs for professionals.
- Waiting times are seen as quite long to see a primary care physician and folks on the coast struggle with this to a considerable extent.
- If a doctor doesn't understand addiction/culture then the problem is either undertreated, not treated and then poor outcomes and then ineffective. This concern was called out by focus group participants.
- Transportation problems make it difficult for people to attend medical appointments, interviewees said.
- Specialty services, like optometry, dermatology, ENT, and dentistry, are especially difficult to access, focus group participants noted.
- Some are known to travel as far as Santa Rosa to get the medical care they need.
- Problems finding doctors, especially Primary Care, have gotten worse during COVID, it was stated.
- There is a need for more bilingual medical professionals, in the eyes of community members.
- Telehealth does help, but some people interviewed don't like getting on their computer or prefer human contact.
- Older adults in rural areas are considered challenged in accessing many types of necessary services.

KEY INFORMANT COMMENTS

- If you have a chronic condition, you can't wait 3-4 months for services, which some are expected to do, interviewees noted.
- Access to care, especially specialty care in rural areas, is seen as a major problem for many.
- Medical emergencies are seen as difficult to respond to in rural areas.
- Healthcare has decreased over time –services are seen as being bare bones and ineffective.
- There continues to be some opposition to virtual healthcare visits, and the elderly and younger adults were identified as two groups feeling this way.
- Residents often have to drive to Santa Rosa in Sonoma County to get specialty medical services, interviewees said.

Secondary Data Summary

Access to Care

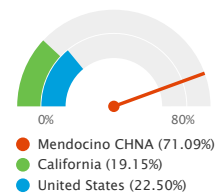
Availability - Primary Care - Primary Care Shortage Areas

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 82,518 people living in a Health Professional Shortage Area of primary care, dental or mental health professionals. This represents 71.09% 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
Mendocino CHNA	116,075	82,518	71.09%	27.62%
Humboldt County, CA	136,101	136,101	100.00%	18.71%
Lake County, CA	64,276	59,295	92.25%	52.09%
Mendocino County, CA	87,110	67,727	77.75%	23.07%
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
- Mendocino CHNA

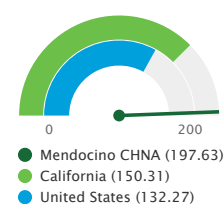
Availability - Mental Health Care - Mental Health Providers

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

Within the report area there are 229 mental health providers with a CMS National Provider Identifier (NPI). This represents 197.63 providers per 100,000 total population.

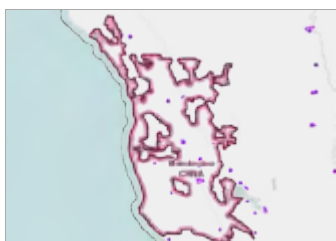
Report Area	Total Population (2020)	Number of Providers	Providers, Rate per 100,000 Population
Mendocino CHNA	116,070	229	197.63
Humboldt County, CA	136,463	376	275.53
Lake County, CA	68,163	88	129.10
Mendocino County, CA	91,601	192	209.60
Sonoma County, CA	488,863	664	135.83
California	39,538,223	59,430	150.31
United States	334,735,155	442,757	132.27

Mental Health Care Providers, Rate per 100,000 Population



Note: This indicator is compared to the state average.

Data Source: Centers for Medicare and Medicaid Services, [CMS - National Plan and Provider Enumeration System \(NPPES\)](#), July 2022. Source geography: Address



Mental Health Providers, All, CMS NPPES July 2022

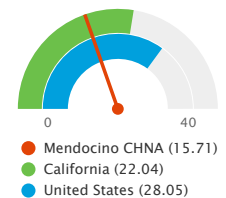
- Mental Health Providers, All, CMS NPPES July 2022
- Mendocino CHNA

Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports information about the availability of hospital beds across the United States. The data behind this layer comes from Definitive Healthcare; the group is providing their proprietary hospital bed count data "in order to enable observation of the care capacity of hospitals across the country as cases of COVID-19 proliferate". In the report area, the amount of Intensive Care Unit hospital beds is 17 in total or 15.71 per 100,000 population.

Report Area	Total Population (2018)	Licensed Beds	Staffed Beds	ICU Beds	Licensed Beds, Rate per 100,000 Pop.	Staffed Beds per 100,000 Pop.	ICU Beds, Rate per 100,000 Pop.
Mendocino CHNA	111,671	174	129	17	156.05	116.35	15.71
Humboldt County, CA	136,373	276	233	27	202.39	170.85	19.80
Lake County, CA	64,382	62	50	8	96.30	77.66	12.43
Mendocino County, CA	87,606	142	100	14	162.09	114.15	15.98
Sonoma County, CA	499,942	817	824	82	163.42	164.82	16.40
California	79,114,090	162,424	161,604	17,438	205.30	204.27	22.04
United States	654,334,868	1,872,694	1,602,386	183,514	286.20	244.89	28.05

Intensive Care Unit Hospital Beds Rate per 100,000 Population

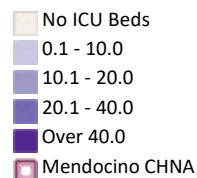


Note: This indicator is compared to the state average.

Data Source: Definitive Healthcare. Accessed via Hospital Beds Dashboard on Esri's COVID-19 GIS Hub. 2020. Source geography: County



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

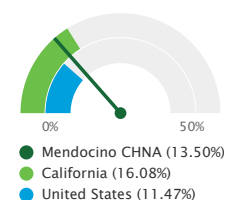


Barriers - Health Literacy - Educational Attainment

Within the report area there are 10,689 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 13.50% 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
Mendocino CHNA	79,176	10,689	13.50%
Humboldt County, CA	93,120	8,745	9.39%
Lake County, CA	46,482	6,403	13.78%
Mendocino County, CA	62,022	8,269	13.33%
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

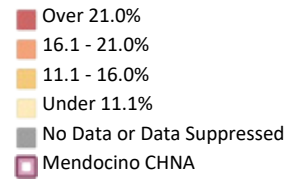


Note: This indicator is compared to the state average.

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

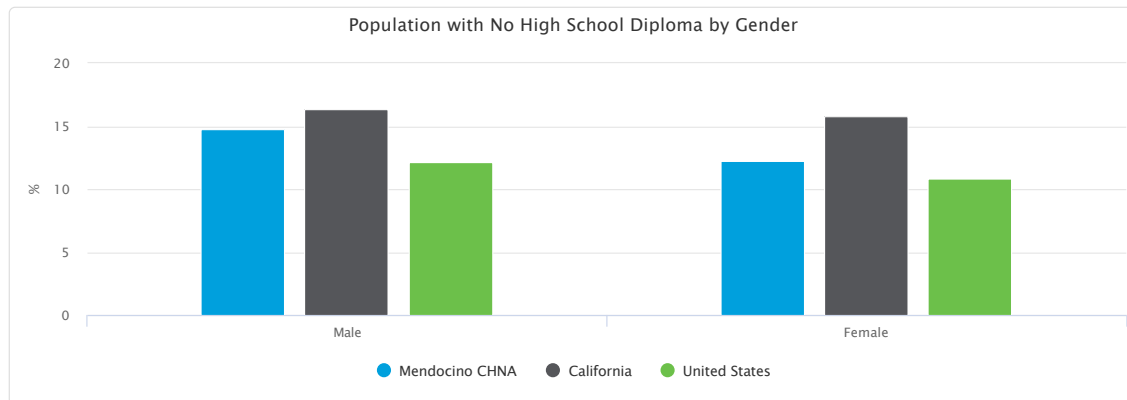


Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2016-20



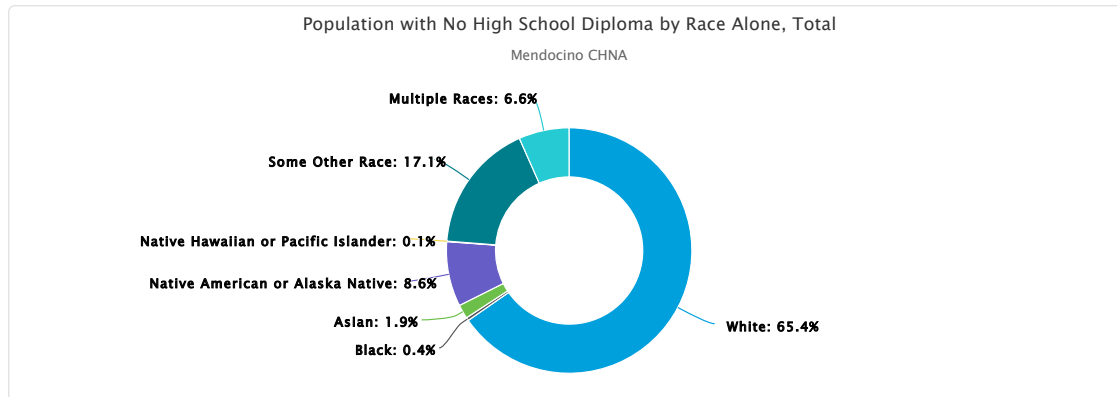
Population with No High School Diploma by Gender

Report Area	Male	Female	Male, Percent	Female, Percent
Mendocino CHNA	5,724	4,965	14.78%	12.28%
Humboldt County, CA	5,265	3,480	11.42%	7.40%
Lake County, CA	3,373	3,030	14.74%	12.84%
Mendocino County, CA	4,433	3,836	14.61%	12.11%
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%



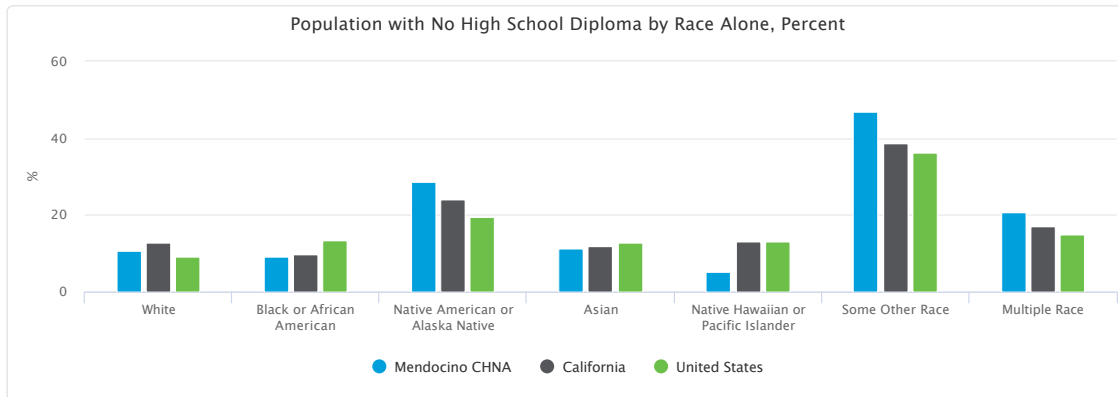
Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Mendocino CHNA	6,987	43	198	914	7	1,830	710
Humboldt County, CA	5,954	349	385	662	119	836	440
Lake County, CA	3,744	231	172	490	5	1,360	401
Mendocino County, CA	5,624	31	100	569	2	1,385	558
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



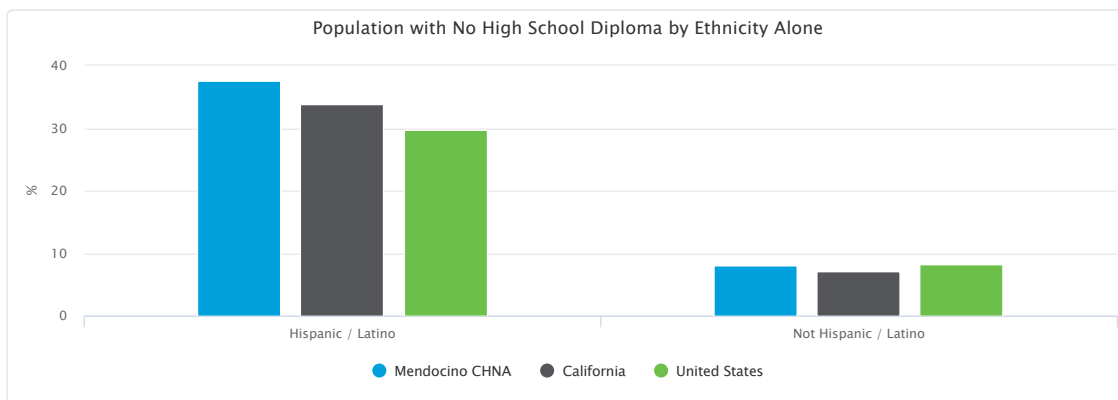
Population with No High School Diploma by Race Alone, Percent

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	10.54%	9.05%	28.74%	11.41%	5.26%	46.76%	20.70%
Humboldt County, CA	7.71%	31.36%	17.44%	17.01%	28.07%	25.46%	8.82%
Lake County, CA	10.00%	21.33%	33.31%	23.18%	38.46%	33.88%	23.25%
Mendocino County, CA	10.77%	12.02%	24.12%	7.64%	1.56%	47.27%	19.84%
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
Mendocino CHNA	5,450	5,239	37.54%	8.10%
Humboldt County, CA	1,781	6,964	21.64%	8.20%
Lake County, CA	2,544	3,859	34.52%	9.87%
Mendocino County, CA	4,250	4,019	36.36%	7.98%
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%



D. Financial Stability

Many of the health needs in Mendocino County are directly or indirectly related to financial stability. When an individual or family is struggling financially, it greatly affects their ability to maintain adequate physical and mental health. There are several challenges to financial stability for community members, and progress in any given community need should be measured with that in mind.

The rate of labor force participation in Mendocino County is 57.59% and is slightly lower than in California (63.29%) and in the US (62.97%). The rate of unemployment in Mendocino County is 7.62% and is higher than that of California (6.18%) and the United States (5.38%). Unemployment rate increases significantly for Black persons and stands at 22.52%.

In Mendocino County, 21% of children aged 0 to 17 are living in households with income below the Federal Poverty Level. Poverty creates barriers to access including health services, healthy foods, and other necessities that contribute to health status. Racial discrepancies in childhood poverty is also evident. A third of Native Americans or Alaska Natives and 26.3% of children of Multiple Races live in poverty.



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PRIMARY COMMENTS

FOCUS GROUPS

- People said there are not enough jobs here that pay enough to afford the price of housing.
- Many noted it's difficult to find work and that this is true for nearly everyone, but especially the elderly.
- The stress of unstable housing is said to affect the health and mental health of all family members.
- High housing costs and limited housing options are seen as a burden for many, especially low-income community members.
- Many families are believed to be sharing housing to make it affordable.
- Rental companies are asking for income that is 3x the amount of rent, as experienced by some interviewees.
- Historically, this area has been resistant to growth and change, per some interviewees.
- Some reported stable families have left the community to go out of state.
- There is a belief that educated residents are likely to leave the area to find better jobs.



KEY INFORMANT COMMENTS

- Local wages do not support successfully paying rent or buying a house, community leaders stated.
- There is a belief that some youth will choose dealing marijuana rather than traditional paid employment as they can make more money that way.
- Good paying jobs are seen as paying \$15–20 an hour, which is a problem for much of the population.
- Local businesses are also not paying people what they deserve, in the eyes of some interviewees.
- Mendocino County has a cost-of-living index that's equivalent to Napa County, which some feel is not widely known.
- One problem interviewees noted was a lack of wage-earning opportunities.

Secondary Data Summary

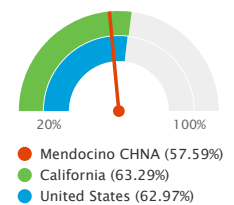
Financial Stability

Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2016 – 2020 American Community Survey, of the 97,592 working age population, 56,163 are included in the labor force. The labor force participation rate is 57.59%.

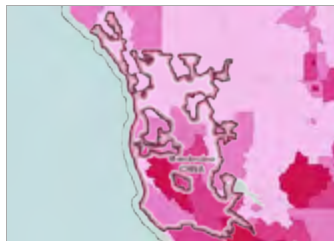
Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Mendocino CHNA	97,592	56,163	57.59%
Humboldt County, CA	112,898	67,211	59.53%
Lake County, CA	52,240	26,743	51.19%
Mendocino County, CA	70,805	40,905	57.77%
Sonoma County, CA	410,911	266,216	64.79%
California	31,403,964	19,875,973	63.29%
United States	261,649,873	164,759,496	62.97%

Labor Force Participation Rate

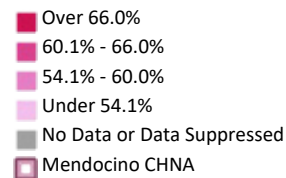


Note: This indicator is compared to the state average.

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



Labor Force, Participation Rate by Tract, ACS 2016-20



Employment - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 4,278, or 7.62% 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.

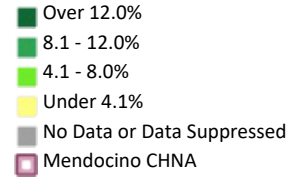
Report Area	Labor Force	Number Unemployed	Unemployment Rate
Mendocino CHNA	56,163	4,278	7.62%
Humboldt County, CA	67,211	6,074	9.04%
Lake County, CA	26,743	2,819	10.54%
Mendocino County, CA	40,905	3,536	8.64%
Sonoma County, CA	266,216	12,297	4.62%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	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



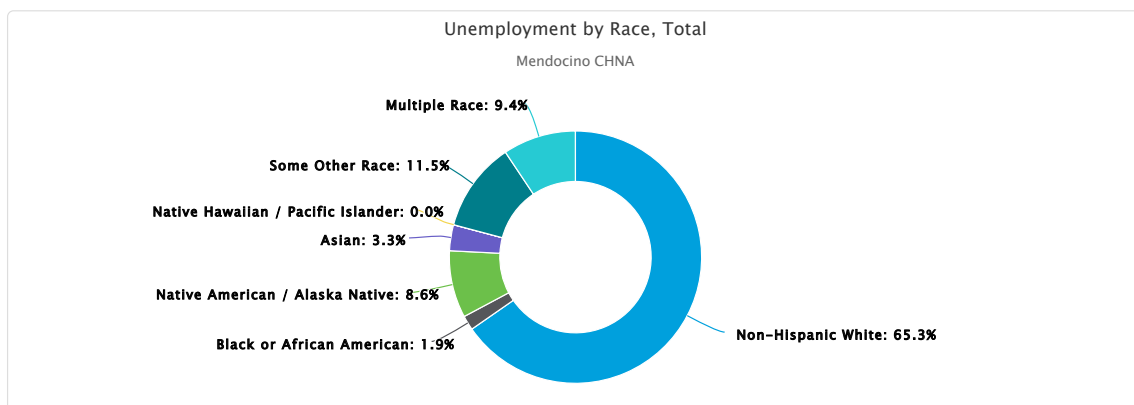
Unemployed Workers, Percent by Tract, ACS 2016-20



Unemployment by Race, Total

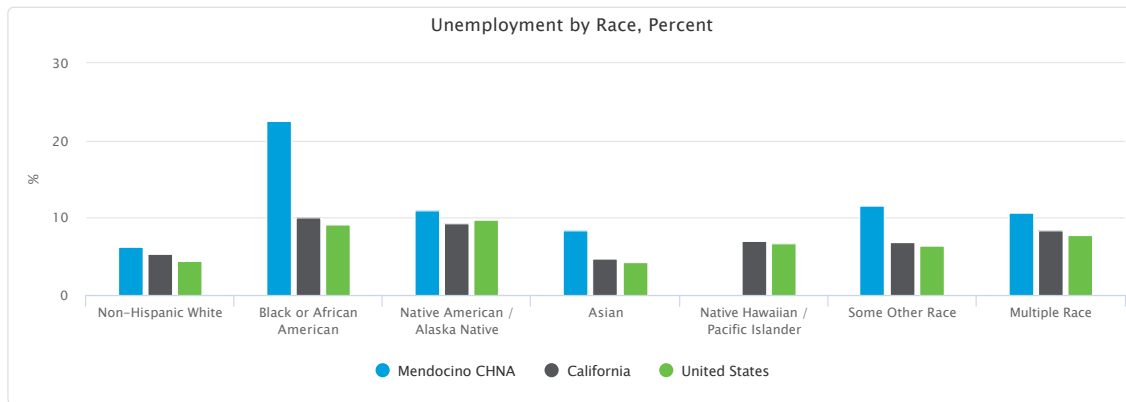
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	2,078	59	274	106	0	365	298
Humboldt County, CA	3,665	151	325	324	3	619	528
Lake County, CA	1,629	51	164	7	0	447	132
Mendocino County, CA	1,872	59	235	98	0	265	295
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
Mendocino CHNA	6.23%	22.52%	11.00%	8.31%	0.00%	11.53%	10.66%
Humboldt County, CA	7.29%	20.19%	12.42%	16.53%	0.95%	16.79%	12.88%
Lake County, CA	8.74%	12.00%	16.47%	2.20%	0.00%	13.29%	13.23%
Mendocino County, CA	7.07%	29.50%	12.79%	9.68%	0.00%	11.54%	12.89%
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%

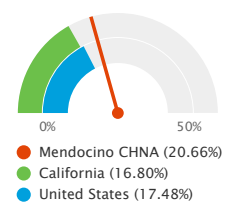


Income - Childhood Poverty Rate

In the report area 20.66% or 4,637 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

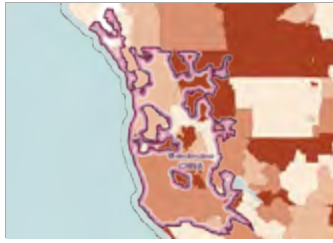
Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
Mendocino CHNA	108,032	22,442	4,637	20.66%
Humboldt County, CA	132,842	25,373	5,082	20.03%
Lake County, CA	63,025	12,928	3,156	24.41%
Mendocino County, CA	85,619	18,343	4,104	22.37%
Sonoma County, CA	489,796	95,374	10,010	10.50%
California	38,589,882	8,815,673	1,480,649	16.80%
United States	318,564,128	72,065,774	12,598,699	17.48%

Percent Population Under Age 18 in Poverty

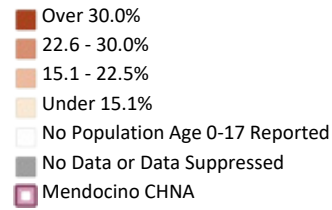


Note: This indicator is compared to the state average.

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



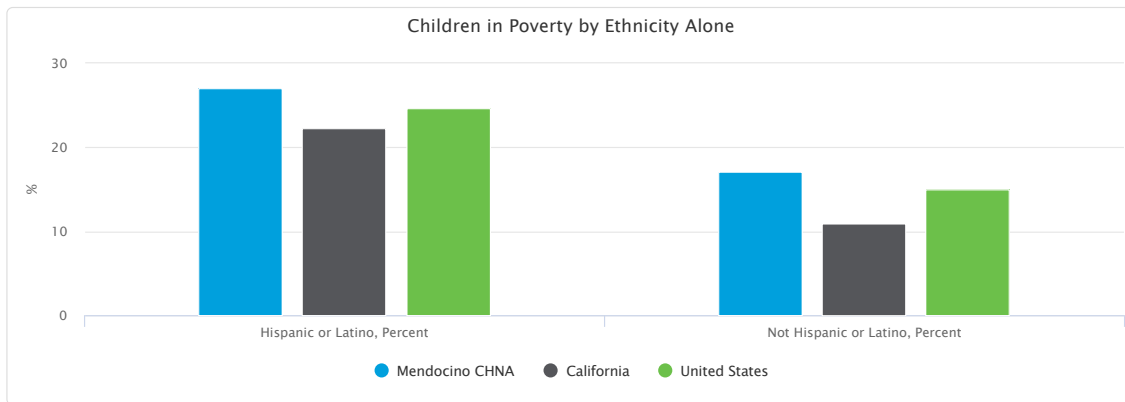
Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2016-20



Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone.

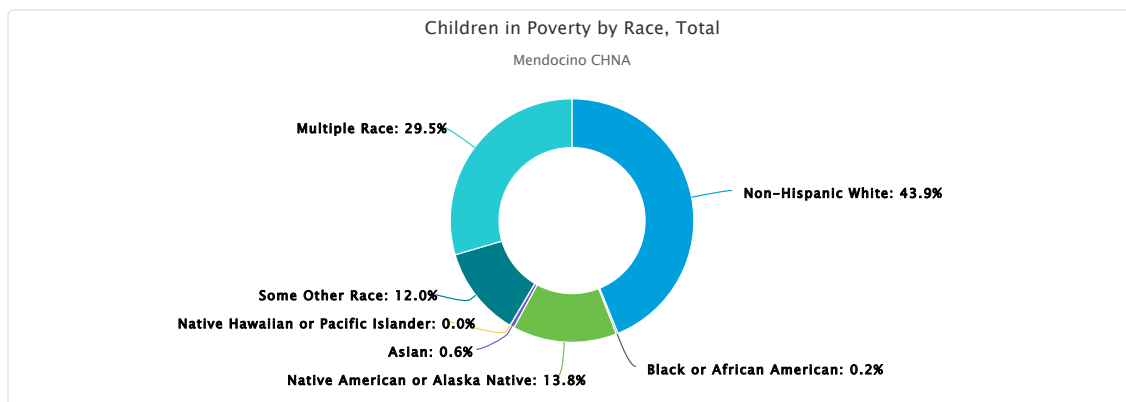
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Mendocino CHNA	2,516	2,121	26.99%	17.16%
Humboldt County, CA	1,037	4,045	20.93%	19.81%
Lake County, CA	984	2,172	20.31%	26.87%
Mendocino County, CA	2,299	1,805	28.72%	17.46%
Sonoma County, CA	6,619	3,391	15.94%	6.30%
California	1,013,787	466,862	22.32%	10.92%
United States	4,487,018	8,111,681	24.68%	15.05%



Children in Poverty by Race, Total

This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

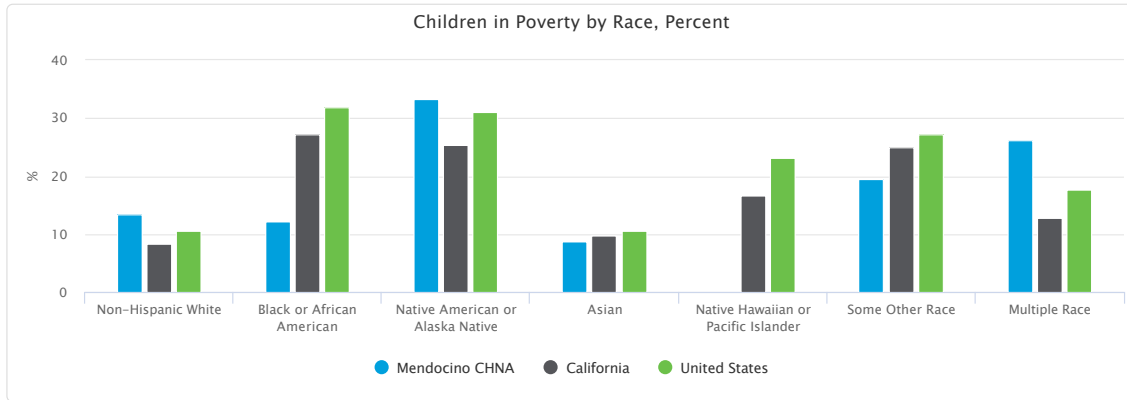
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	1,343	7	424	18	0	366	904
Humboldt County, CA	2,068	0	741	439	69	293	954
Lake County, CA	1,470	184	371	25	0	832	165
Mendocino County, CA	1,208	7	287	18	0	303	826
Sonoma County, CA	2,273	194	60	202	43	4,450	1,202
California	182,435	124,650	17,742	106,168	5,141	378,293	149,598
United States	3,805,465	3,169,873	214,829	388,057	34,982	1,282,237	1,163,442



Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race alone.

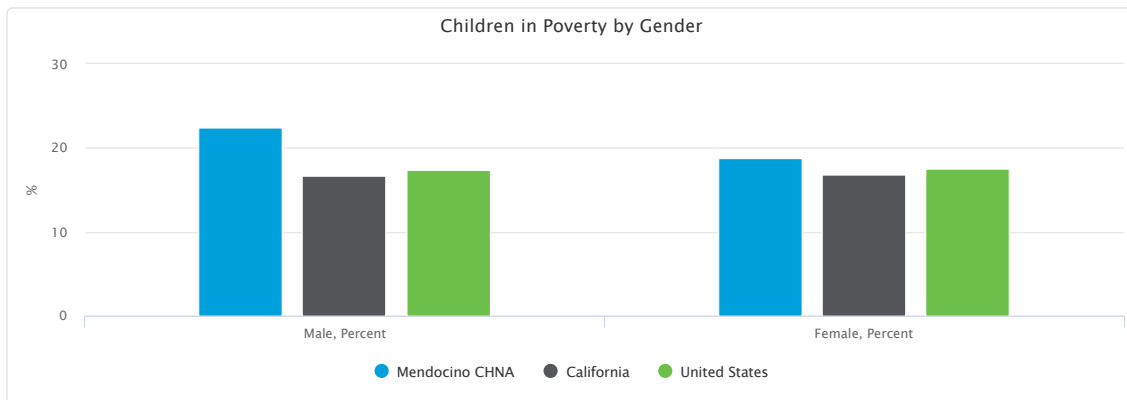
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	13.39%	12.28%	33.23%	8.82%	0.00%	19.48%	26.29%
Humboldt County, CA	13.79%	0.00%	50.55%	45.45%	85.19%	20.87%	23.34%
Lake County, CA	22.48%	44.12%	49.14%	18.80%	No data	32.73%	13.90%
Mendocino County, CA	14.91%	19.44%	29.74%	10.11%	0.00%	24.53%	28.01%
Sonoma County, CA	5.50%	11.75%	7.59%	6.03%	32.58%	22.12%	9.06%
California	8.30%	27.13%	25.30%	9.84%	16.73%	24.94%	12.86%
United States	10.58%	31.80%	31.16%	10.58%	23.24%	27.24%	17.63%



Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender.

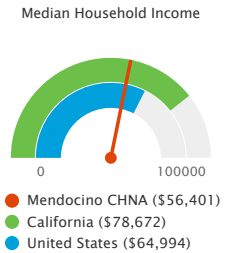
Report Area	Male	Female	Male, Percent	Female, Percent
Mendocino CHNA	2,543	2,094	22.48%	18.81%
Humboldt County, CA	2,498	2,584	19.47%	20.60%
Lake County, CA	1,547	1,609	22.97%	25.98%
Mendocino County, CA	2,277	1,827	24.61%	20.10%
Sonoma County, CA	4,655	5,355	9.60%	11.43%
California	753,182	727,467	16.73%	16.87%
United States	6,414,903	6,183,796	17.43%	17.54%



Income - Median Household Income

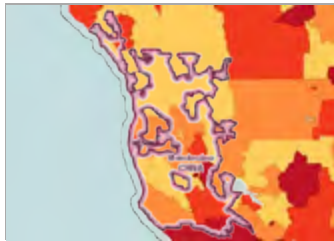
This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 43,608 households in the report area, with an average income of \$78,245 and median income of \$56,401.

Report Area	Total Households	Average Household Income	Median Household Income
Mendocino CHNA	43,608	\$78,245	\$56,401
Humboldt County, CA	54,120	\$70,922	\$49,235
Lake County, CA	25,508	\$72,862	\$49,254
Mendocino County, CA	34,164	\$74,102	\$52,915
Sonoma County, CA	188,958	\$113,067	\$86,173
California	13,103,114	\$111,622	\$78,672
United States	122,354,219	\$91,547	\$64,994

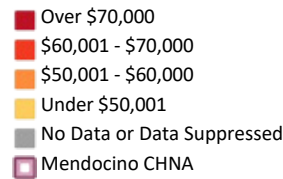


Note: This indicator is compared to the state average.

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



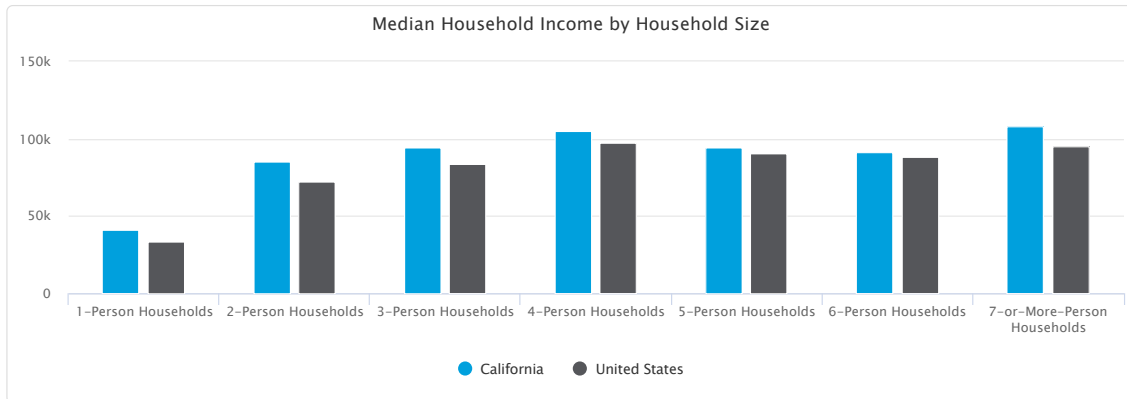
Median Household Income by Tract, ACS 2016-20



Median Household Income by Household Size

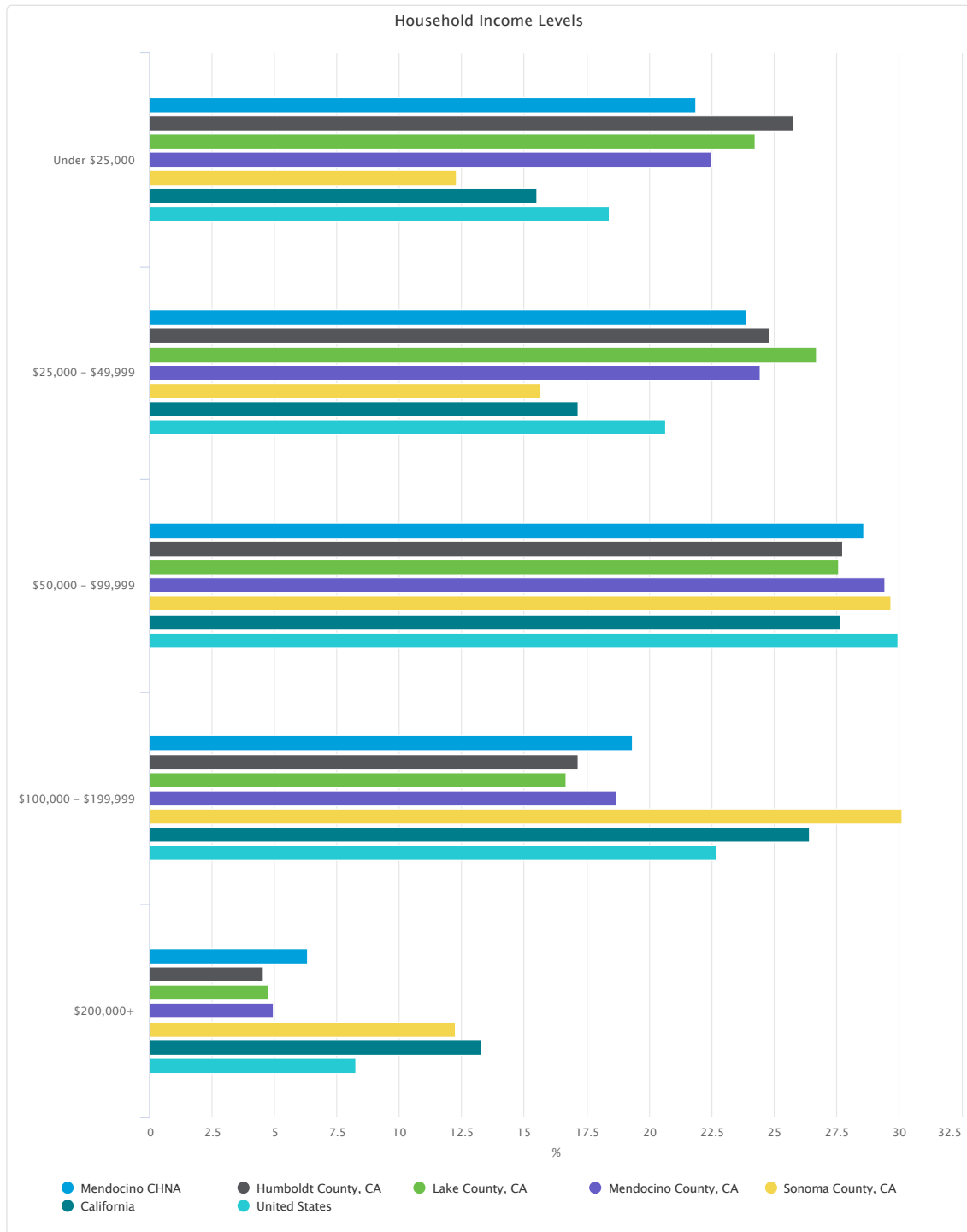
This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Mendocino CHNA	No data	No data	No data	No data	No data	No data	No data
Humboldt County, CA	\$25,414	\$57,200	\$66,250	\$79,930	\$96,679	\$87,939	\$88,700
Lake County, CA	\$26,246	\$56,659	\$68,108	\$65,316	\$77,972	\$72,582	\$46,103
Mendocino County, CA	\$26,592	\$64,976	\$62,656	\$66,332	\$67,281	\$79,519	\$97,928
Sonoma County, CA	\$42,608	\$97,172	\$105,169	\$119,463	\$97,342	\$112,321	\$140,898
California	\$40,788	\$85,056	\$94,221	\$104,973	\$94,232	\$91,578	\$107,797
United States	\$33,265	\$72,238	\$84,033	\$97,660	\$90,979	\$88,413	\$94,924



Household Income Levels

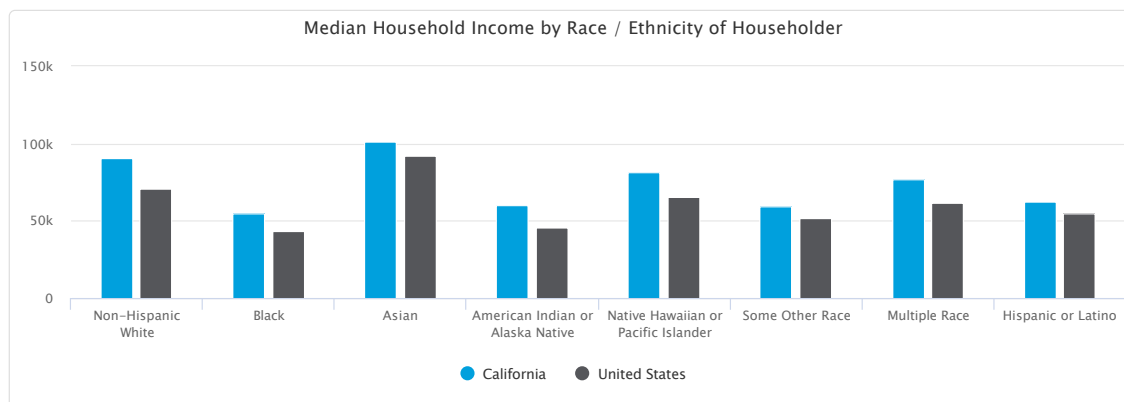
Report Area	Under \$25,000	\$25,000 - \$49,999	\$50,000 - \$99,999	\$100,000 - \$199,999	\$200,000+
Mendocino CHNA	21.85%	23.90%	28.59%	19.33%	6.34%
Humboldt County, CA	25.78%	24.81%	27.73%	17.14%	4.54%
Lake County, CA	24.24%	26.71%	27.60%	16.69%	4.76%
Mendocino County, CA	22.52%	24.44%	29.43%	18.67%	4.94%
Sonoma County, CA	12.27%	15.67%	29.67%	30.13%	12.26%
California	15.51%	17.14%	27.66%	26.42%	13.27%
United States	18.41%	20.64%	29.95%	22.73%	8.26%



Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Mendocino CHNA	No data	No data	No data	No data	No data	No data	No data	No data
Humboldt County, CA	\$51,234	\$30,263	\$38,456	\$32,813	No data	\$42,094	\$53,640	\$42,645
Lake County, CA	\$51,120	\$30,991	\$45,833	\$22,961	No data	\$46,400	\$35,972	\$46,362
Mendocino County, CA	\$55,532	\$68,550	\$75,652	\$56,164	\$26,776	\$53,214	\$33,647	\$48,333
Sonoma County, CA	\$90,510	\$72,582	\$90,369	\$90,781	\$84,365	\$65,584	\$82,193	\$73,912
California	\$90,496	\$54,976	\$101,380	\$60,182	\$81,682	\$59,287	\$76,733	\$62,330
United States	\$70,843	\$43,674	\$91,775	\$45,877	\$65,804	\$51,900	\$61,870	\$54,632



E. Health Risk Behaviors

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

15.9% of the population are current tobacco smokers. This is a higher rate than both California (11.5%) and the US (15.3%). There is also a slightly elevated rate of adult binge drinking, with Mendocino County's rate of 18.07% above California (17.27%) and the US (16.7%). Similarly, the rate of Medicare beneficiaries with alcohol use disorder (3.2%) is larger than both California (2.2%) and the US (2.1%).

The percentage of Medicare beneficiaries with a drug or substance use disorder (6.7%) is almost double that of the US. The percentage of opioid drug claims is 6.8% compared to California (4.2%) and the US (4.4%).

The teen birth rate is 21.4 per 1000 females and is greater than the state's teen birth rate of 15.6 and the national rate of 19.3. The percentage of infants with low birth weight is also significantly greater, with Mendocino's rate at 15.1% as compared to the state (6.9%) and the nation (8.2%).



The percentage of females ages 65 and older who are up to date on core preventative services such as influenza vaccine and a mammogram is 28.6% and is lower than the rate in California (32.7%). Similarly, for males 28.7% of older males in Mendocino County are up to date on core preventative services as compared to 29.2% in the state.



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PRIMARY COMMENTS**FOCUS GROUPS**

- Poor dietary habits driven by limited incomes are seen as a problem.
- Inpatient and rehab centers are typically believed to be full, requiring people to leave the area to get help.
- Mental health is the biggest cause of homelessness and addiction in the eyes of some interviewees.
- It was widely recognized that an element of social stigma is holding drug abusers from seeking help.
- Vaping is seen as common among adolescents in high school.
- Substance use problems are seen as prevalent in this community, with inadequate services to meet the need.

KEY INFORMANT COMMENTS

- Drug and alcohol use is seen as a problem primarily for low-income residents.
- Services for Spanish-speaking residents are more difficult to find, noted those interviewed.
- Substance use problems include the use of many different types of drugs, interviewees noted.
- The rate of substance abuse addiction death because of overdose is believed to be a lot higher today than it was 10–15 years ago.
- Stopping the import of drugs is seen as a difficulty for local law enforcement.
- There is a belief that drug use and homelessness are connected.
- There are a lot of drivers of crime that are believed to be related to substance abuse.

Secondary Data Summary

Health Risk Behaviors

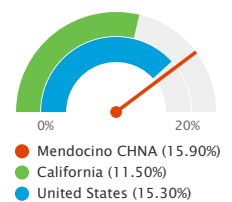
Tobacco - Current Smoking

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

Within the report area there are 15.90% adults who have smoked or currently smoke of the total population.

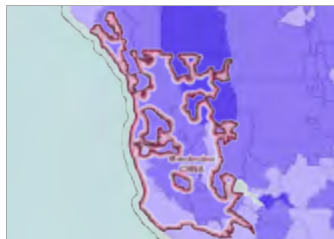
Report Area	Total Population (2019)	Adult Current Smokers (Crude)	Adult Current Smokers (Age-Adjusted)
Mendocino CHNA	111,304	15.90%	No data
Humboldt County, CA	135,558	14.60%	15.40%
Lake County, CA	64,386	15.80%	16.50%
Mendocino County, CA	86,749	14.30%	14.80%
Sonoma County, CA	494,336	11.10%	11.40%
California	39,512,223	11.50%	11.54%
United States	328,239,523	15.30%	15.70%

Percentage of Adults who are Current Smokers

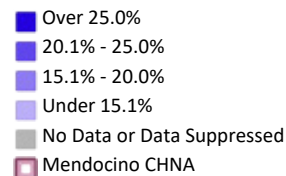


Note: This indicator is compared to the state average.

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



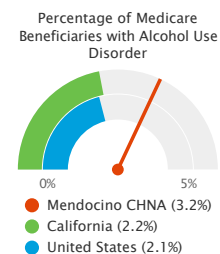
Current Smokers, Adult, Percentage of Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019



Alcohol - Alcohol Use Disorder

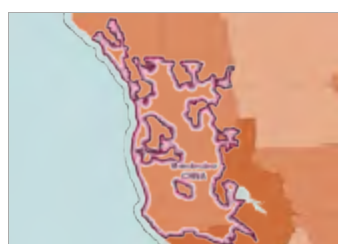
Within the report area, there were 753 beneficiaries with alcohol use disorder based on administrative claims data in the latest report year. This represents 3.2% of the total Medicare fee-for-service beneficiaries.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Alcohol Use Disorder	Percentage with Alcohol Use Disorder
Mendocino CHNA	23,422	753	3.2%
Humboldt County, CA	25,224	740	2.9%
Lake County, CA	15,147	499	3.3%
Mendocino County, CA	19,410	621	3.2%
Sonoma County, CA	48,391	1,631	3.4%
California	2,859,642	61,588	2.2%
United States	33,499,472	696,555	2.1%

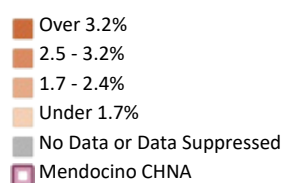


Note: This indicator is compared to the state average.

Data Source: Centers for Medicare & Medicaid Services, CMS - Chronic Conditions Warehouse, 2018. Source geography: County



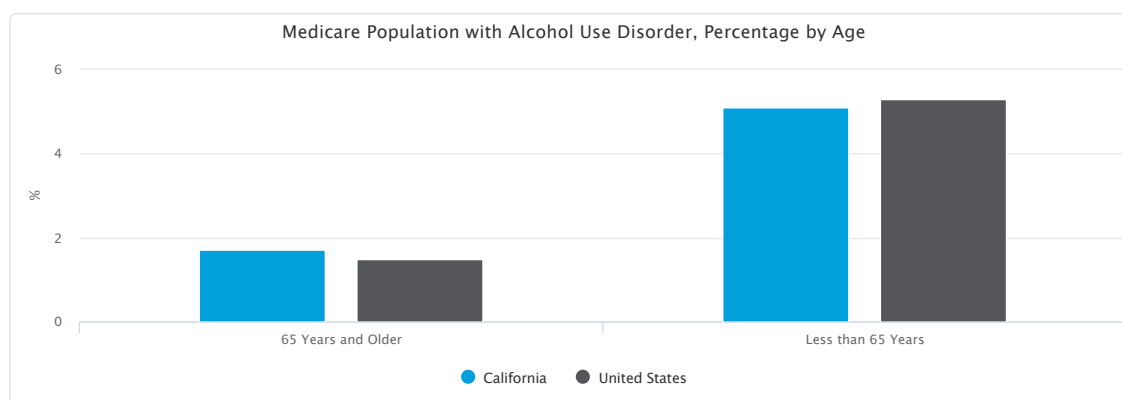
Beneficiaries with Alcohol Use Disorder, Percent by County, CMS 2018



Medicare Population with Alcohol Use Disorder, Percentage by Age

The table below displays the prevalence of alcohol use disorders among Medicare beneficiaries by age.

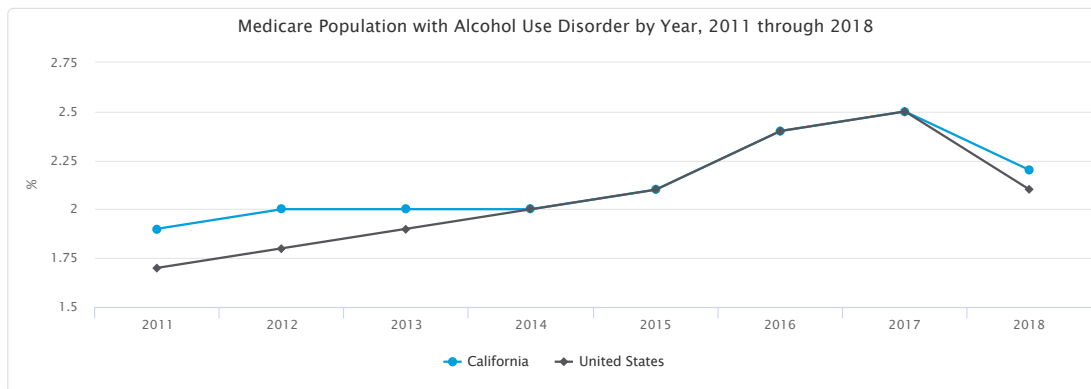
Report Area	65 Years and Older	Less than 65 Years
Humboldt County, CA	2.4%	5.7%
Lake County, CA	2.8%	5.2%
Mendocino County, CA	2.3%	8.2%
Sonoma County, CA	2.7%	8.1%
California	1.7%	5.1%
United States	1.5%	5.3%



Medicare Population with Alcohol Use Disorder by Year, 2011 through 2018

The table below displays the percentage of the Medicare fee-for-service population with alcohol use disorders over time.

Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Humboldt County, CA	2.4%	2.8%	2.9%	3.1%	3.2%	3.4%	3.5%	2.9%
Lake County, CA	3.3%	3.2%	3.4%	3.5%	3.7%	3.6%	3.8%	3.3%
Mendocino County, CA	2.9%	3.1%	3.0%	3.1%	3.3%	3.5%	3.6%	3.2%
Sonoma County, CA	2.1%	2.4%	2.5%	2.7%	2.8%	3.2%	3.9%	3.4%
California	1.9%	2.0%	2.0%	2.0%	2.1%	2.4%	2.5%	2.2%
United States	1.7%	1.8%	1.9%	2.0%	2.1%	2.4%	2.5%	2.1%

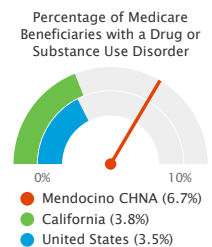


Illicit Drugs - Substance Use Disorder

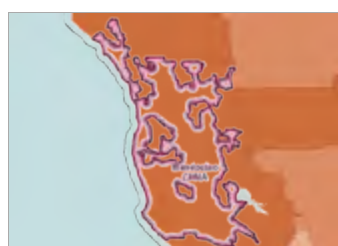
This indicator reports the percentage of the Medicare fee-for-service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program.

Within the report area, there are a total of 1,561 beneficiaries with substance use disorder. This represents 6.7% of the Medicare fee-for-service beneficiaries.

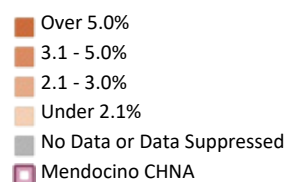
Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
Mendocino CHNA	23,422	1,561	6.7%
Humboldt County, CA	25,224	1,291	5.1%
Lake County, CA	15,147	1,011	6.7%
Mendocino County, CA	19,410	1,316	6.8%
Sonoma County, CA	48,391	2,434	5.0%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%



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



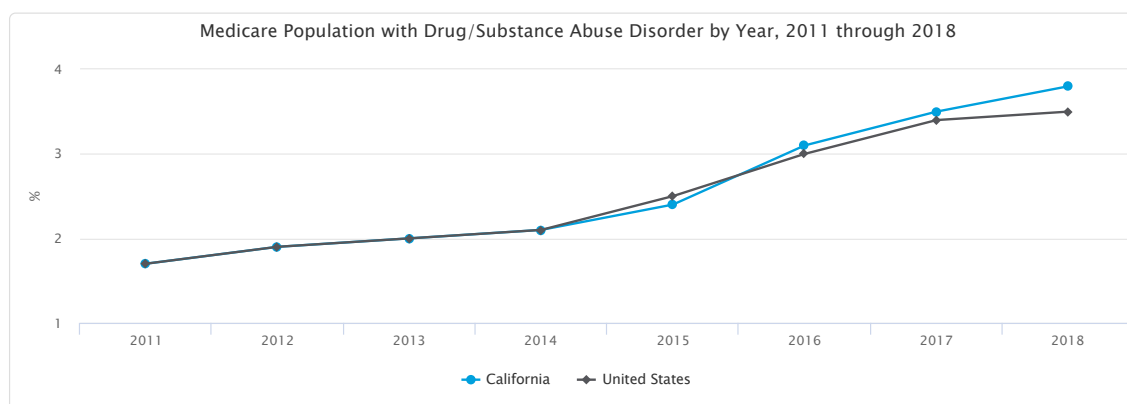
Beneficiaries with Drug/Substance Use Disorder, Percent by County, CMS 2018



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

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

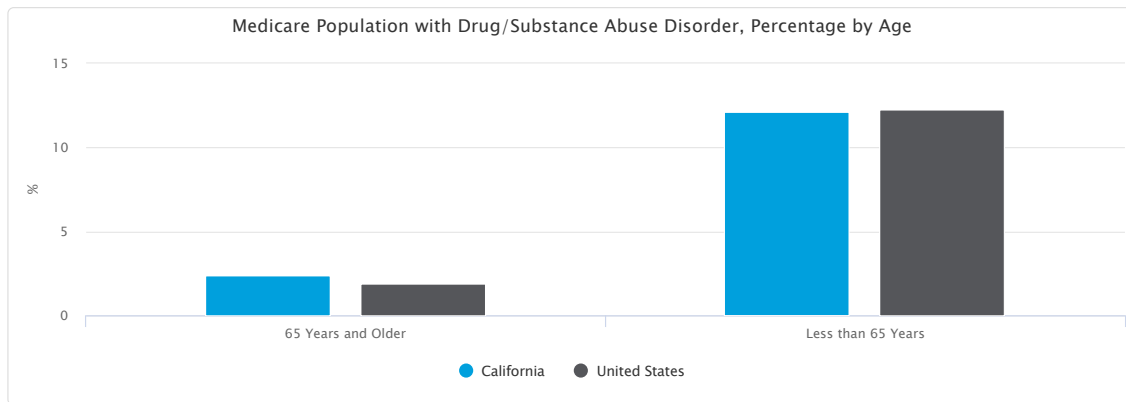
Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Humboldt County, CA	2.3%	2.6%	2.9%	3.4%	3.9%	4.2%	4.7%	5.1%
Lake County, CA	3.9%	4.2%	4.2%	4.6%	5.2%	6.3%	6.9%	6.7%
Mendocino County, CA	2.9%	3.3%	3.7%	4.0%	4.8%	6.3%	7.1%	6.8%
Sonoma County, CA	1.9%	2.3%	2.4%	2.6%	2.7%	3.6%	4.6%	5.0%
California	1.7%	1.9%	2.0%	2.1%	2.4%	3.1%	3.5%	3.8%
United States	1.7%	1.9%	2.0%	2.1%	2.5%	3.0%	3.4%	3.5%



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

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

Report Area	65 Years and Older	Less than 65 Years
Humboldt County, CA	3.1%	14.9%
Lake County, CA	4.1%	17.0%
Mendocino County, CA	4.1%	21.1%
Sonoma County, CA	3.3%	16.7%
California	2.4%	12.1%
United States	1.9%	12.3%



Reproductive Health - Teen Birth Rate

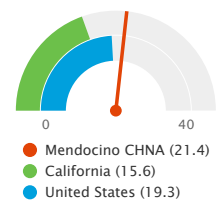
This indicator reports the seven-year average number of births per 1,000 female population age 15-19. Data were from the National Center for Health Statistics - Natality files (2014-2020) and are used for the 2022 County Health Rankings.

In the report area, of the 21,730 total female population age 15-19, the teen birth rate is 21.4 per 1,000, which is greater than the state's teen birth rate of 15.6.

Note: Data are suppressed for counties with fewer than 10 teen births in the time frame.

Report Area	Female Population Age 15-19	Teen Births, Rate per 1,000 Female Population Age 15-19
Mendocino CHNA	21,730	21.4
Humboldt County, CA	31,236	12.9
Lake County, CA	11,545	29.5
Mendocino County, CA	17,014	22.2
Sonoma County, CA	104,114	9.7
California	17,568,967	15.6
United States	144,216,216	19.3

Teen birth rate per 1,000 female population, ages 15-19

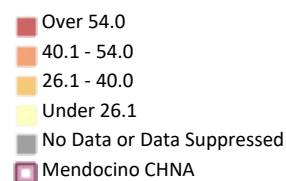


Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via County Health Rankings. 2014-2020. Source geography: County



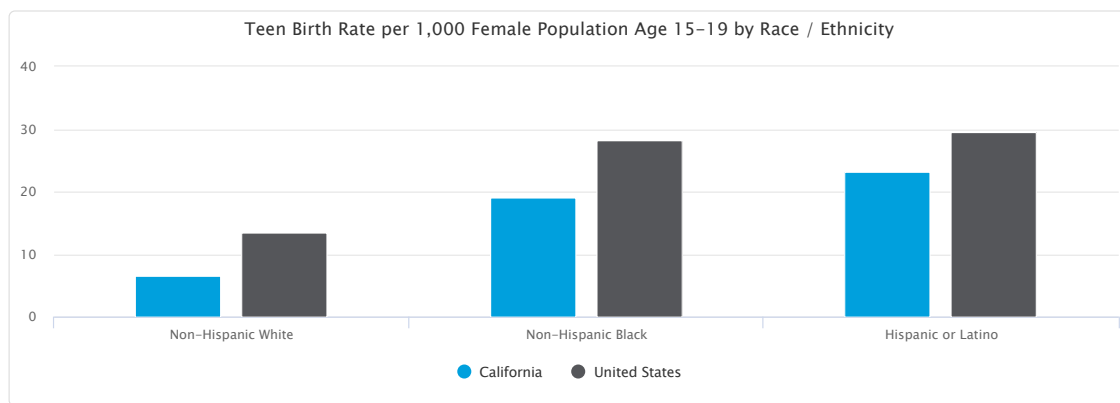
Teen Births, Rate Per 1,000 Live Births by County, CDC NVSS 2014-2020



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

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

Report Area	Non-Hispanic White	Non-Hispanic Black	Hispanic or Latino
Humboldt County, CA	10.2	11.7	17.1
Lake County, CA	20.9	No data	41.6
Mendocino County, CA	14.7	No data	28.0
Sonoma County, CA	3.1	8.4	17.9
California	6.6	19.1	23.2
United States	13.5	28.2	29.6



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 the previous CHNA Report or adopted implementation strategy were received.

G. Data Limitations

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



Scan the QR code for the
full Secondary Data Report





IV. Identification of Community's Priority Health Needs

A. Criteria and Process Used for Prioritization of Health Needs

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

The first part of this series involved Adventist Health System staff and a consultant presenting the primary and secondary data analysis findings to the Steering Committee. The primary data collection included focus groups, key informant interviews, and a community survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a

90-minute data presentation of these results, highlighting the top five needs for each data source and the supporting data that led to their inclusion (see Section V for methodology). A conversation about the findings was a part of these data reviews, but the determination of priority needs was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the high priority needs selection. At the end of the meeting the Steering Committee was provided with two prioritization tools, data slides and a robust secondary data report to review before the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership and to complete a brief poll a few days prior to the prioritization

meeting. The poll allowed them to identify the three-to-five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee (see Prioritization Tools #1 and #2).

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

B. Next Steps

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically

identifies and implements evidence-based solutions and programs to address our priority needs.

We believe the power of community transformation lies in the hands of the community. The voices we have

heard have an impact and influence the next steps of creating a strategy to improve the health needs of the community for all. If you would like to learn more, share ideas or stay connected, please contact us at 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.

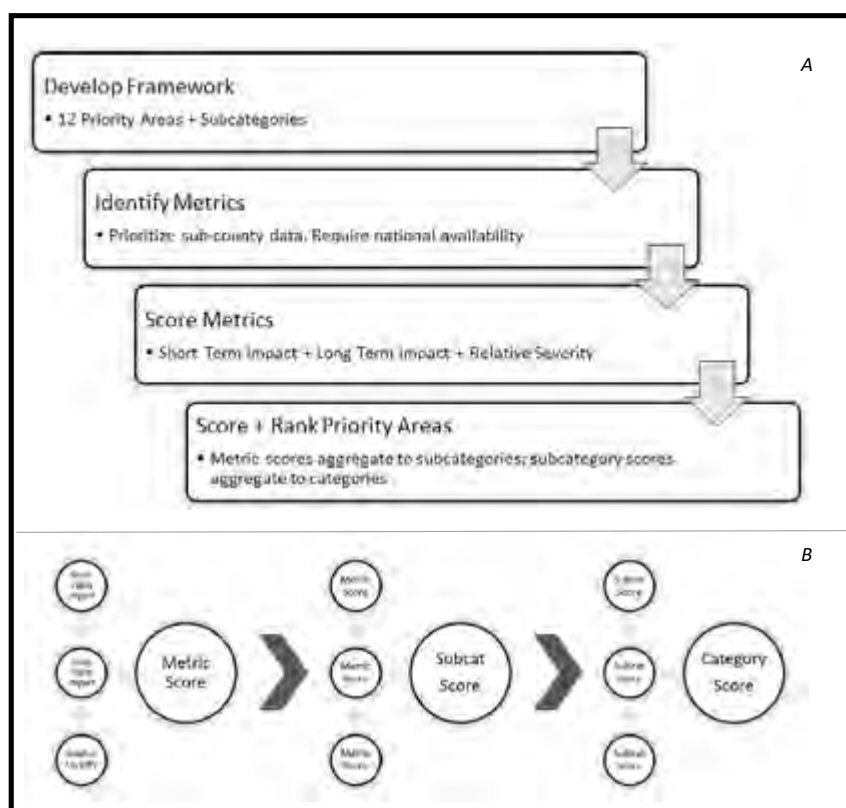


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

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 percentage points at the 95% confidence level.

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

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

SURVEY QUESTION

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

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

NEEDS CROSSWALK

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

C. Focus Group and Key Informant Methodology and Guide

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

The semi-structured interview guides (see Section V) used for both types of interviews were nearly identical. All focus groups and interviews began with participants identifying up to five high priority community health needs from their perspective, chosen from a standard list provided by the facilitator. This standard list was comprised of common community health needs based on the larger framework of social determinants of health used for secondary data collection (see Section V). The facilitators — a team of Adventist Health System staff and a consultant — then moved through a series of questions for each identified need, focusing on depth of need, examples of the impact of the need,

attempts at addressing the need historically, barriers to reducing the need, and reasonable improvement goals over three years. The only variation in the focus group and key informant interview guides was the inclusion of additional prompts for key informants allowing for greater depth of response. A notetaker was present for each focus group and key informant interview, and all interviews were recorded. Note documents and audio recordings were provided to the qualitative analysis team, which were Adventist Health System staff and a consultant, to facilitate analysis. Focus groups were conducted in teams of two, with a lead facilitator and a notetaker. All focus groups were conducted in English or Spanish. In some cases, the facilitator was provided by a Steering Committee member, either due to language needs, expertise with a specific community group, or both.

Deductive analysis of all focus groups and key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CAREs. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Focus group and key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments 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 you're facing in trying to stay healthy.
- ▶ More about a Community Health Needs Assessment report
 - The Community Health Needs Assessment is a public document and represents the collaborative work between community agencies and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address

key community health needs.

▶ Your Acknowledgment

- We'll be asking you questions today and you're free to answer only the questions you're comfortable with.
- Please know that notable quotes/comments from today's meeting could appear in the CHNA and will be labeled as an Anonymous Community Quote – please rest assured that we won't share any names.
- *"Today's Focus Group is being recorded to ensure we capture all the concerns, thoughts and ideas about the health and well-being of your community. Some comments might be highlighted in the CHNA report and will not list the 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 Ukiah Valley 2019 Implementation Strategy Evaluation of Impact



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about the full Community
Health Plan Update

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

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

key community health needs.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement

that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (<https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf>). The required written IS plan is set forth in a separate written document.

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

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

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit “Amy” Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

BERKELEY INSTITUTE OF GOVERNMENTAL STUDIES (IGS)

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
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Mark Di Camillo
Berkeley IGS Poll Director
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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 conditions 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.

Judson Howe

Adventist Health Ukiah Valley

COMMUNITY HEALTH NEEDS ASSESSMENT