ADVENTIST HEALTH HANFORD & SELMA

COMMUNITY HEALTH NEEDS ASSESSMENT

2022

Adventist Health Hanford

Adventist Health Selma

Executive Summary

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

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

For 2022, the Central Valley Network (CVN) comprised of Adventist Health's four hospitals located in Hanford, Tulare, Reedley and Selma 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:

Financial Stability

Food Security

Mental Health

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

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

Description of Hospital and Community Served (see Section II)

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

Data Collection and Analysis (see Section IV)

Prioritization Process (see Section IV)

Next Steps (see Section IV.C)

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

Table of Contents

I. SUMMARY 3

Executive Summary 3
Community Vision Summary 7
A. Committee Members, Community Input and Goal of CHNA 7
B. Community Served 8
- Demographics
- Map

C. Overview of Activities Since 2019 CHNA 9
D. Identified High Priority Needs 10
- Financial Stability
  - Community Voices
  - Public Data
  - Survey Data
  - Community Resources
- Food Security
  - Community Voices
  - Public Data
  - Community Resources
  - Survey Data
- Mental Health
  - Community Voices
  - Public Data
  - Survey Data
  - Community Resources

E. Identity of Steering Committee Hospital(s) and Partner Organizations 16

II. ABOUT US 18

A. Adventist Health Hanford & Selma 18
B. Adventist Health 18
C. Adventist Health Community Benefit & Well-Being Approach to CHNA 18
D. Who We Serve 19

III. SIGNIFICANT IDENTIFIED HEALTH NEEDS, PRIMARY, SECONDARY DATA & WRITTEN COMMENTS 20

A. Significant Identified Health Needs 20
B. Primary, Secondary, and Survey Data Overview 20
- Survey Results
  - Region & Statewide Summary
- Description of Participants
  - Focus Groups
  - Key Informants

C. Financial Stability 22
- Primary Comments
  - Focus Groups
  - Key Informants
- Secondary Data Summary

D. Food Security 34
Primary Comments
Focus Groups
Key Informants
Secondary Data Summary
E. Mental Health 42
Primary Comments
Focus Groups
Key Informants
Secondary Data Summary
F. Written Comments 52
G. Data Limitations 52
H. Full Secondary Data Report 52

IV. IDENTIFICATION OF COMMUNITY'S PRIORITY HEALTH NEEDS 54

A. Criteria and Process Used for Prioritization of Health Needs 54
Prioritized Criteria
Prioritization Process
B. Next Steps 54

V. PROCESS AND METHODS TO CONDUCT THE CHNA 56

A. Secondary Data Methodology 56
Methodology
Full Data Report
B. Survey Methodology and Questions 62
C. Focus Group and Key Informant Guide 63
D. Adventist Health's Central Valley Network (CVN) Evaluation of 2019 CHNA 67
Read more about the Community Health Plan Update
E. Purpose of the Community Health Needs Assessment (CHNA) Report 67
F. CHNA Consultants Used to Conduct the Assessment 68
Identity and Qualifications
Adventist Health Community Well-Being Team
Berkeley IGS
CARES
Center for Behavioral Health Integration

VI. GLOSSARY OF TERMS DEFINITION OF HEALTH NEEDS 70

VII. APPROVAL PAGE 72

What if . . .

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

Healthy food choices were easy and available to all individuals and families?

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

Community Vision Summary

Taking a step toward a healthier, better life

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

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

This CHNA involved interviews with city & county governments, community health organizations, education, faith community, Fresno County Department of Public Health, healthcare leadership, healthcare providers, Kings County Department of Public Health, National Association for the Advancement of Colored People (NAACP), older adults, substance abuse organizations, transportation, Tulare County Department of Public Health and public safety. 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 nine significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, COVID, education, 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: financial stability, food security and mental health.

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

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

What if . . .

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**

Healthy food choices were easy and available to all individuals and families with support in getting nutritious meals, leading to better **Food Security**

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

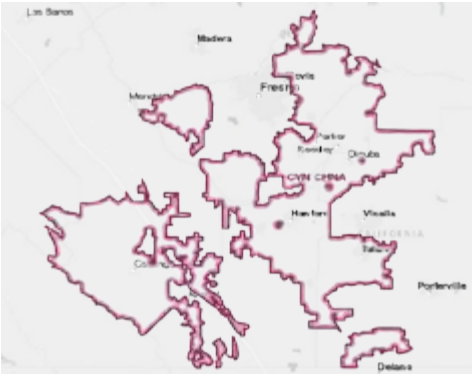
Getting to know Adventist Health's Central Valley Network

The Central Valley Network (CVN) is comprised of four cities: Hanford, Tulare, Reedley and Selma. The CVN is home to a total population of 530,375 residents with the majority age group being children (5-17), making up 22.2% of the population.

Centrally located between northern and southern California, CVN's geographic region is one of its biggest assets benefiting farmland businesses as well as residents pursuing recreational activities such as a short road trip to Yosemite National Park or the cool coastlines of Monterey Bay and Big Sur.

This young population is vibrant with festivals, events and small businesses. Of the population, 64.68% are Hispanic. The median household income is $60,367 of which 59.22% is spent on housing and transportation. Among this population, 27.23% of children live in poverty and 2.70% 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.



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 Hanford, Selma, Reedley and Tulare hospitals collectively focused on financial stability, food security and mental health.

Working together with the community, we created strategies designed to educate and break down barriers to care and well-being for Central Valley residents. Through our collaboration with Central Valley Health Transport, we provided more than 17,700 roundtrip services allowing community members to seek the care they needed. In response to COVID-19, we made sure these services were provided virtually as well. In response to the need and lack of providers in our rural community, we worked to ensure 86 new providers were added to our network since 2019.

With our collaboration with Kings Gospel Mission and Tulare Lighthouse Rescue Mission, more than 30 individuals have received recuperative board and care services. Additionally, we were able to help a total of 706 students across our network through local community colleges, university and trade school programs gain hands-on experience allowing a pipeline of opportunities that increase the well-being of our younger generation.

The COIVD-19 global pandemic caused extraordinary challenges for Adventist Health Hanford, Selma, Reedley and Tulare hospitals 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.

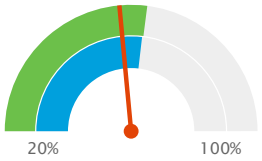
Financial Stability

COMMUNITY VOICES

- Certain parts of the community have very limited access to grocery stores, some interviewees noted.
- Low wages are seen as a driver toward fiscal insecurity.
- People stated that there are mental health consequences to not having enough money.
- Childcare costs are seen to take up a significant amount of family income.
- A college education is no longer seen as a guaranteed way to secure a good income.
- Low wages are believed to lead many to leave the area.
- It's seen as impossible to save for a house when paying very high rental costs.

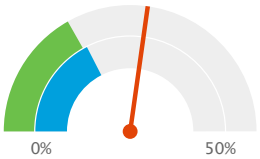
SECONDARY DATA INFOGRAPHIC STATS:

Labor Force Participation Rate



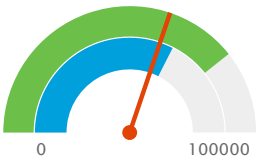
- CVN CHNA (57.62%)
- California (63.29%)
- United States (62.97%)

Percent Population Under Age 18 in Poverty



- CVN CHNA (27.23%)
- California (16.80%)
- United States (17.48%)

Median Household Income



- CVN CHNA ($60,367)
- California ($78,672)
- United States ($64,994)

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

Kings County Human Services Agency
countyofkings.com/departments/human-services-agency

Kings Partnership for Prevention
kpfp.org

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

Community Health Needs Survey:

Central Valley* 76% 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.

Residents have much to be proud of, from agriculture that feeds families across the nation to booming warehouses filled with new employees. This vision was planted years ago, yet residents struggle to meet basic needs.

Concerns include low wages leading to fiscal insecurity and immigrant workers facing barriers to care due to work schedules. Others noted residents are faced with deciding between going to work to pay their bills or going to the doctor. Input suggested housing and insufficient funds can impact mental and physical health.

Analysis shows the labor force participation rate (57.62%) is lower than that of California (63.29%) and the United States (62.97%). The unemployment rate (8.42%) is higher than the state and the nation. The child poverty rate is extremely high at 27.23%, higher than that of California (16.8%). Childhood poverty is evident, and the median household income of $60,367 is below California's rate.

Unemployment is known to create financial instability and barriers to basic services. Despite these real challenges and concerns, Central Valley residents are eager to be a part of the change that will ensure a brighter future of health, wholeness and hope.

Employment - Labor Force Participation Rate

Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Adventist Health Central Valley Network	395,183	227,698	**57.62%**
California	31,403,964	19,875,973	63.29%
United States	261,649,873	164,759,496	62.97%

Food Security

COMMUNITY VOICES

- Interviewees said the cost of living had increased since COVID started.
- People are paying double for food in rural communities; it requires reliable transportation to go to urban areas to shop for groceries, which is said to be a challenge for many.
- There was a worry amongst interviewees that families have to ration their food.
- Healthier food can be more expensive, which is viewed as a barrier.
- More farmers markets are seen as a way to increase local food access.

Central Valley residents are surrounded by the richness of their region and the technology that delivers farm-fresh foods. Growth also leads to job creation that supports families.

Residents were asked for input on the affordability and accessibility of food. They noted that they pay double for food in rural communities, transportation to urban areas is needed to secure groceries, food pantries don't have access to fresh veggies, and some are rationing their food. Limited choices lead to residents settling for processed foods.

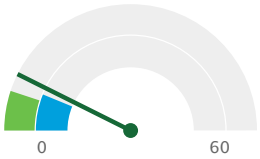
Surveys documented an extremely high number of residents living in poverty (19.22%) which is considerably higher than in California overall. Racial disparities in poverty rates exist – for example, one in three Native Hawaiian or Pacific Islanders in the community live in poverty.

Farmers' markets provide healthy foods, but residents' food budgets are low, so families still struggle. Free or reduced-price lunch programs represent 75.84% of public schools' students, which is higher than the state average of 59.18%.

Agriculture that feeds the globe and open-minded residents are keys to working together, addressing needs today and beyond.

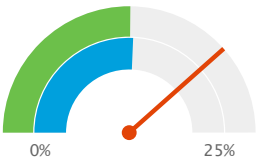
SECONDARY DATA INFOGRAPHIC STATS:

SNAP-Authorized Retailers, Rate (Per 10,000 Population)



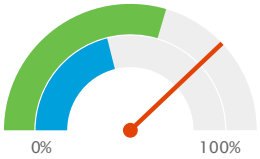
- CVN CHNA (8.84)
- California (6.11)
- United States (7.47)

Population in Poverty, Percent



- CVN CHNA (19.22%)
- California (12.58%)
- United States (12.84%)

Percentage of Students Eligible for Free or Reduced Price School Lunch



- CVN CHNA (75.84%)
- California (59.18%)
- United States (42.16%)

COMMUNITY HEALTH NEEDS SURVEY

Central Valley* 34% of those surveyed selected Food Security as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Find Food Security resources in your community to live better, longer.

Kings Community Action Organization
559-582-4386, kcao.org

Salvation Army
408-848-5373, hanford.salvationarmy.org/hanford_corps

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

COMMUNITY VOICES

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

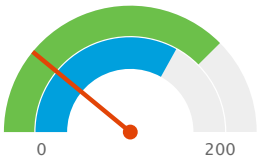
Mental Health

COMMUNITY VOICES

- People noted that there seems to be a lot of stigma around mental health issues.
- The educational system does not have enough people to support the kids with mental health issues, focus group participants indicated.
- Interviewees said if people are more anxious and depressed, they may turn to drugs and alcohol.
- No inpatient treatment centers are believed to be in the area.
- The social isolation that accompanied COVID is seen as a mental health challenge for some.
- COVID may have made some residents less likely to go to healthcare appointments, per interviewees.

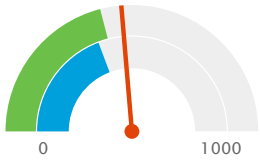
SECONDARY DATA INFOGRAPHIC STATS:

Mental Health Care Providers, Rate per 100,000 Population



- CVN CHNA (43.82)
- California (150.31)
- United States (132.27)

Violent Crime Rate per 100,000 Pop.



- CVN CHNA (473.2)
- California (419.4)
- United States (385.6)

Violent Crime Rate

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Adventist Health Central Valley Network	2,475	**473.2**
California	327,327	419.4
United States	2,445,671	385.6

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

Champions Recovery Alternative Programs Inc.
559-583-9300, championsrecovery.org

Kings County Behavioral Health
559-852-2444, kcbh.org/contact-us.html

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

Community Health Needs Survey:

Central Valley* 49% of those surveyed selected Mental Health as a top health concern.

*Survey region is defined by the survey administrator.

See Section V. B. for more information.

Central Valley residents shared the mental health experiences they faced and the needs they continue to face as they struggle to overcome challenges. Thanks to input and commitment, the region is in a better position to help understand and address mental health.

Central Valley residents struggle with mental health to a greater extent than in California, in general, and the US. Deaths of despair includes deaths due to self-harm, alcohol-related disease, and drug overdose. These deaths are now at 43.4 per 100k people, and rates are higher than the rate elsewhere in California.

The rate of mental health providers is 43.82 per 100k people, compared to 150.31 in California and 132.27 in the state. As residents noted, there are no inpatient treatment options and insufficient substance abuse rehabilitation centers.

Residents are also challenged with a shortage of credentialed professionals who provide counseling and adolescent and adult mental health care, along with inpatient treatment centers designed specifically for teenagers.

It is encouraging that community voices are being heard as residents seek to identify opportunities for change and brighter futures.

Access to Mental Health Providers

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Adventist Health Central Valley Network	537,910	21	236	**43.82**
Fresno County, CA	1,008,654	170	1,639	162.49
Kings County, CA	152,486	5	76	49.84
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

What if . . .

It's not a prescription that changes your health?

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

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

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

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

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

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

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

We thank the Adventist Health Central Valley Network 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.

Valerie Alvarez
Adventist Health Central Valley Network
Well-Being Director

Lynne Ashbeck
Valley Children's Hospital
Corporate Chief Information Officer

Raul Ayala
Adventist Health Central Valley Network
Ambulatory Medical Director

Maria Bueno
Tulare Joint Union High School District
Assistant Superintendent

Miriam Cardenas
Kings Canyon Unified School District
Health Center Specialist

Jeff Garner
Kings Community Action Organization
Executive Director

Jim Hansen
Nazarene Church
Pastor

Kerry Hydash
Family Healthcare Network
Chief Executive Officer

Crystal Jackson
National Association for the Advancement of Colored People
President

Gurvinder Kaur
Adventist Health Central Valley Network
Medical Director

Andrea Kofl,
Adventist Health Central Valley Network
President

Julie Lefils
Kings Partnership for Prevention
Executive Director

Ruth Lopez
Valley Voices
Executive Director

Carlos Mendoza
Latin Chamber of Commerce
President

Donzia Morales
Santa Rosa Rancheria
Recreation Director

Joe Neves
Board of Supervisors
Supervisor

Darcy Pickens
Kings County Department of Public Health
Interim Director

Victor Rosas
Hanford Joint Unified School District
Superintendent

Frank Ruiz
Champions
Executive Director

Parker Sever
City of Hanford
Chief of Police

Fabian Uresti
Selma Fire Department
Fireman

Bobbie Wartson
Kings County Commission on Aging
Executive Director

Noah Whitaker
Tulare County Health & Human Services Agency
Homeless Initiatives Program Coordinator

Nicole Zieba
City of Reedley
City Manager

II. About Us

A. Adventist Health Hanford & Selma

Hanford, Located in the heart of California's rich San Joaquin Valley, Adventist Health Hanford is a 153-bed acute-care hospital with key services including 11 private birth center rooms, medical/surgical nursing care, ICU, 24-hour emergency care, surgery, joint replacement center, imaging and outpatient services. For nearly a century, Adventist Health has taken pride in providing innovative treatments and advanced care to Kings County and the surrounding areas.

Selma, Located in the central San Joaquin Valley, Adventist Health Selma is a 57-bed acute-care community hospital offering critical services to the community. The hospital offers services including a 24-hour emergency department, direct observation unit, surgery, laboratory, cardiology and imaging with CT, MRI and digital mammography. The Selma hospital offers modern treatment options to patients in need, providing the community with complete healthcare treatments.

B. Adventist Health

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

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

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

America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet some of the most important indicators, like how long we live, are areas where we don't make the top 25. It's time we stop thinking of health as something we get at the doctor's office and rather as something that starts within our families, schools, places of worship and workplaces—in our playgrounds, parks, and in the air we breathe, the food we eat and the water we drink. The more we see the problem of health in this way, the more opportunities we have to improve it.

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

D. Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Central Valley Network'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.

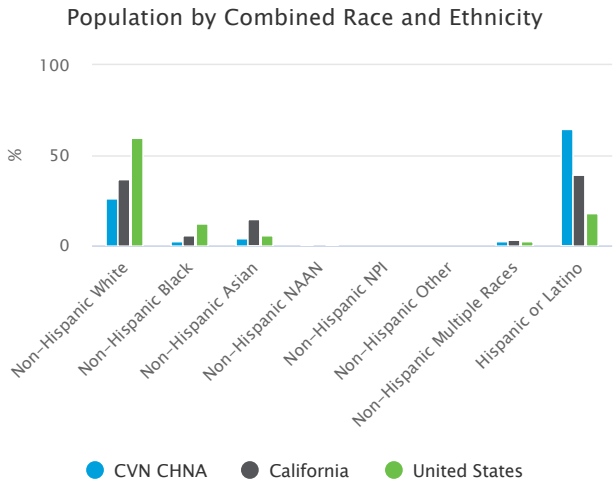
The CVN CHNA market has a total population of 537,932 (based on the 2020 Decennial Census). The largest city in the service area is Tulare, with a population of 59,312. The service area is comprised of the following zip codes: 93219, 93648, 93625, 93646, 93609, 93647, 93631, 93657, 93245, 93234, 93239, 93654, 93204, 93618, 93230, 93615, 93662, 93212, 93630, 93619, 93210, 93656, 93274.

Total Population

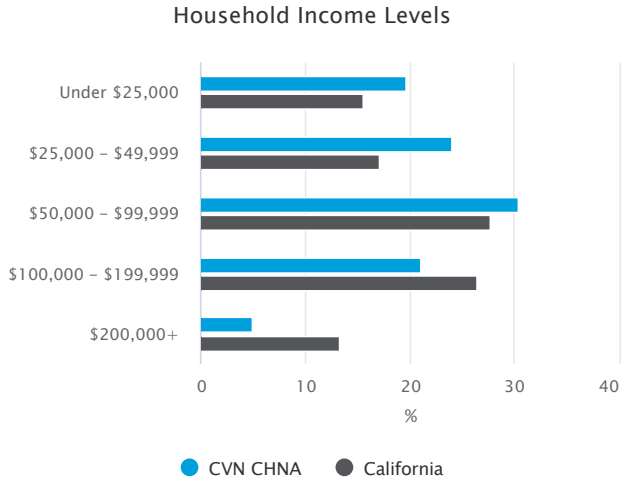
537,932

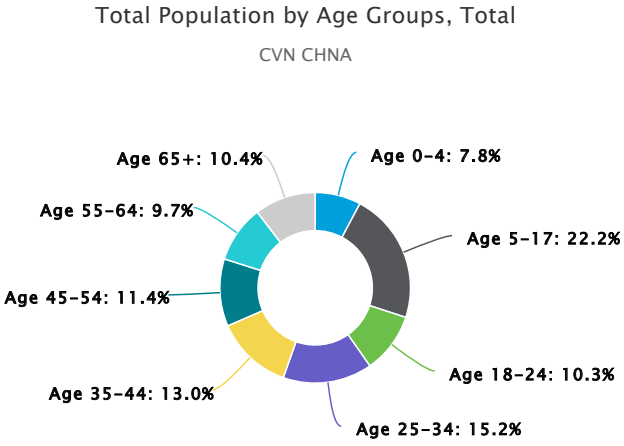
57.31%
of the population owns their home

42.69%
of the population rents their home



Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.





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 HEALTH NEEDS-CVN

High Priority Needs	
Food Security	**See Sections III.C - E**
Financial Stability	**See Sections III.C - E**
Mental Health	**See Sections III.C - E**
Lower Priority Needs	
Housing-Unhoused 211kingscounty.org/housing 211la.org/resources/site/central-valley-regional-center	54% of surveyed residents identified homelessness as a health need in the community, with many interviewees noting that being unhoused negatively affects the mental and physical health of people.
Housing-Cost 211kingscounty.org/housing 211la.org/resources/site/central-valley-regional-center	The limited housing stock, and high housing costs, push many into an unstably housed environment. Service needs for this group are very high, and the overall cost of living makes stable housing unrealistic for some community residents.
Health Conditions 211kingscounty.org/health 211la.org/resources/site/central-valley-regional-center	The prevalence rates of multiple chronic diseases is higher than the state average. Similarly, mortality rates for lung and liver disease are also elevated compared to California as a whole.
Education 211kingscounty.org/education 211la.org/resources/site/central-valley-regional-center	27% of surveyed residents said education is a health need in the community. Key informant interviewees said it is very difficult for schools in the area to provide the full range of support and services that children and families cannot get elsewhere.
COVID 211kingscounty.org/health 211la.org/resources/site/central-valley-regional-center	46% of surveyed residents identified COVID as a community health need.
Access to Care 211kingscounty.org/health 211la.org/resources/site/central-valley-regional-center	The number of healthcare providers per 100,000 people in this community is half the state rate. Interviewees noted transportation barriers to accessing services as well.
Health Risk Behaviors 211kingscounty.org/addictions 211la.org/resources/site/central-valley-regional-center	The adult smoking rate is higher than state and national averages, and only 25% of residents 65 years or older are up-to-date on core preventative services.

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, 7 focus groups were conducted with 52 participants, and 8 key informant interviews were held. Survey data was gathered from the Central Valley region (region name defined by survey administrator, UC Berkeley IGS). See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

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

FOCUS GROUPS

- Seven (7) focus groups
- Fifty-two (52) people participated

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

KEY INFORMANTS

- Eight (8) 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 Central Valley Network, Champions Recovery, City of Hanford, City of Reedley, Family Healthcare Network, Fresno County Department of Public Health, Kings Area Regional Transit, Kings County, Kings County Commission on Aging, Kings County Department of Public Health, Kings Partnership for Prevention, Kings County Sheriff's Department, Kings Tulare Homeless Alliance, National Association for the Advancement of Colored People (NAACP) and Tulare County Department of Public Health

REPRESENTED RACE/ETHNICITIES

Black, Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Aging, civic government and leadership, community-based organizations focusing on healthcare consumer, law enforcement, low-income, medically underserved, minority populations, substance abuse, transportation and unhoused populations

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

SURVEY RESULTS

REGION & STATEWIDE SUMMARY

Central Valley: Survey Results of Top Needs

See Section V. B. for more information.

Needs	CVN	Statewide
Financial Stability - Cost of Living	76%	83%
Housing-Cost	55%	63%
Housing-Unhoused	54%	55%
Mental Health	49%	48%
COVID	46%	47%
Food Security	34%	31%
Education	27%	24%
Employment	25%	22%
Access to Care - Primary	23%	23%
Access to Care - Senior	16%	15%
Environment & Infrastructure -Transportation	15%	15%

C. Financial Stability

Many of the health needs in the Central Valley 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 labor force participation rate (57.62%) is lower than that of California (63.29%) and the United States (62.97%). The unemployment rate is at 8.42% and is higher than both the state and the nation. Unemployment creates financial instability and barriers to access including insurance coverage, health services and education, healthy food, and other necessities that impact health status. The rate is higher for people of multiple races (11.27%) and people who chose some other race (10.49%).

The childhood poverty rate is extremely high at 27.23%, higher than that of California (16.8%) and US (17.48%). Racial disparity in childhood poverty is evident, with 67.13% of Native Hawaiian or Pacific Islander children aged 0-17, 26.76% of Black children, and 28.23% of Native American or Alaska Native children living in households with income below the federal poverty level.

The median household income is $60,367, which is below both the California rate and that of the nation, and poses a significant problem given the exceedingly high cost of living and housing costs in the area.

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PRIMARY COMMENTS

FOCUS GROUPS COMMENTS (PARAPHRASED FROM PRIMARY DATA INTERVIEW NOTES)

- Certain parts of the community are seen to have very limited access to grocery stores.
- Low wages are seen as a driver toward fiscal insecurity.
- People stated that there are mental health consequences to not having enough money.
- Childcare costs are seen to take up a significant amount of family income.
- A college education is no longer seen as a guaranteed way to secure a good income.
- People believe they have to make decisions, work and pay bills or go to the doctor.
- Many residents rely on cars for transportation, and the increase in car costs, while having fewer available used cars for sale, is a new financial burden, focus group members noted.
- Migrant workers, many stated, don't have time to get healthcare due to their work schedules.
- Even with working 40 hours a week people cannot afford necessities, interviewees said.
- Bus passes are seen as being expensive.
- People can't afford Wi-Fi (and government-funded free Wi-Fi is poor quality) which makes accessing some services more difficult, community members indicated.
- Financial instability is seen as a driver toward homelessness.
- Some parents may opt to just stay home due to the cost of childcare, interviewees stated.
- There is a strong belief that racial and cultural minorities have more difficulty getting good paying jobs than the dominant culture does.

KEY INFORMANT COMMENTS

- Low wages are believed to lead many to leave the area.
- It's seen as impossible to save for a house when paying very high rental costs.
- Affordable housing is seen as the biggest barrier to financial stability.
- People cited high housing costs being a major stressor that has an impact on the physical and mental health of residents.
- People coming into Kings County and not being able to find rentals or mid-range housing that is in a safe place or near good schools, is viewed as a hiring barrier.
- The increase in the cost of building supplies impacts the building of new housing units, focus group members said.
- A commitment to identifying and addressing the social determinants of health is seen as a critical way to improve health for all community members, regardless of where they live.
- Limited income leads to a great reliance on inexpensive, processed foods as a dietary staple, people said.

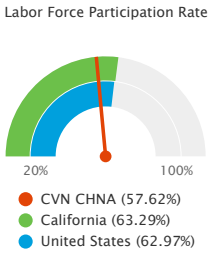
Secondary Data Summary

Financial Stability

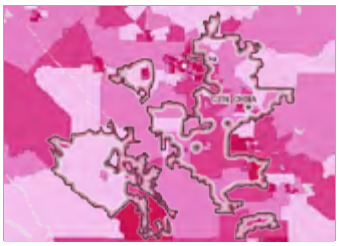
Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2016 – 2020 American Community Survey, of the 395,183 working age population, 227,698 are included in the labor force. The labor force participation rate is 57.62%.

Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
CVN CHNA	395,183	227,698	**57.62%**
Fresno County, CA	738,854	448,322	60.68%
Kings County, CA	114,212	58,639	51.34%
Monterey County, CA	331,824	198,818	59.92%
San Benito County, CA	47,587	31,984	67.21%
Tulare County, CA	337,076	204,090	60.55%
California	31,403,964	19,875,973	63.29%
United States	261,649,873	164,759,496	62.97%



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

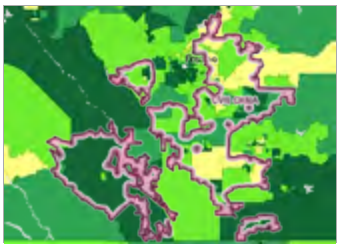
- Over 66.0%
- 60.1% - 66.0%
- 54.1% - 60.0%
- Under 54.1%
- No Data or Data Suppressed
- CVN CHNA

Employment - Unemployment

According to the most recent the American Community Survey estimates, total unemployment in the report area is 19,175, or 8.42% 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
CVN CHNA	227,698	19,175	**8.42%**
Fresno County, CA	448,322	39,697	8.85%
Kings County, CA	58,639	4,952	8.44%
Monterey County, CA	198,818	10,084	5.07%
San Benito County, CA	31,984	2,409	7.53%
Tulare County, CA	204,090	20,214	9.90%
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



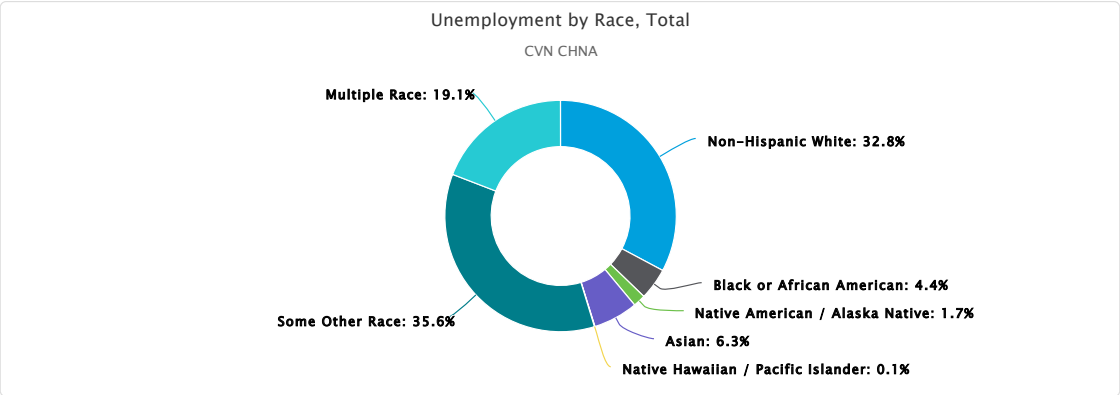
Unemployed Workers, Percent by Tract, ACS 2016-20

- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- CVN CHNA

Unemployment by Race, Total

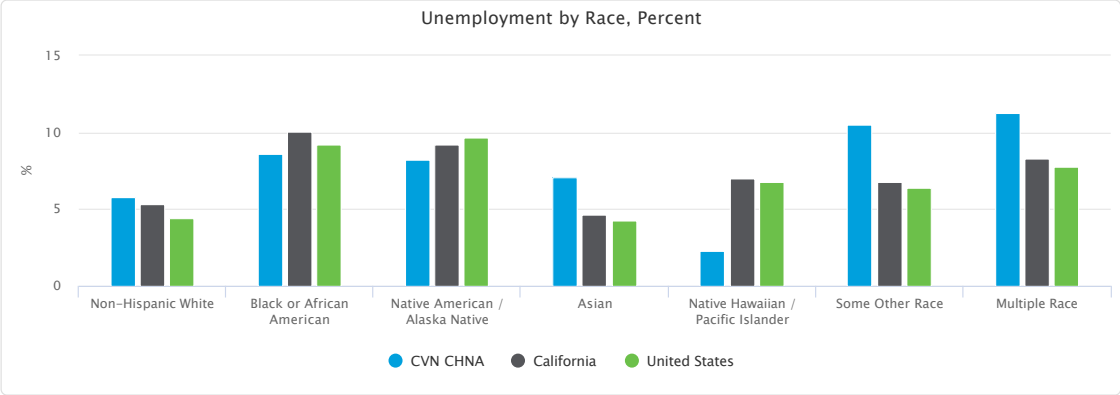
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
CVN CHNA	3,571	481	190	681	6	3,874	2,084
Fresno County, CA	8,548	3,295	680	3,557	19	6,912	4,441
Kings County, CA	1,358	232	37	88	6	1,026	502
Monterey County, CA	3,091	280	176	794	47	2,417	1,118
San Benito County, CA	550	37	29	75	7	342	170
Tulare County, CA	3,910	224	313	545	43	4,139	1,590
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



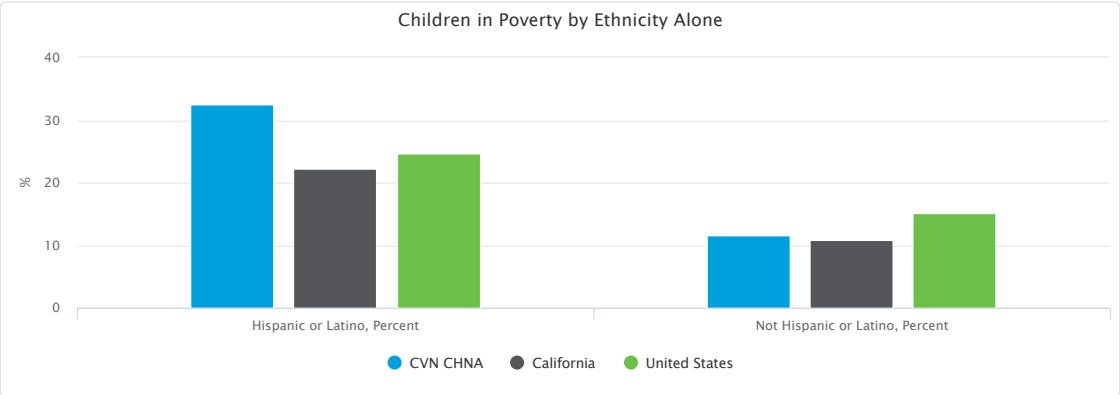
Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
CVN CHNA	5.77%	8.64%	8.19%	7.05%	2.30%	10.49%	11.27%
Fresno County, CA	6.20%	16.78%	13.98%	7.31%	2.66%	10.49%	12.51%
Kings County, CA	6.84%	7.25%	6.09%	3.49%	6.98%	11.43%	11.00%
Monterey County, CA	5.00%	6.66%	12.40%	6.07%	4.13%	3.69%	8.90%
San Benito County, CA	5.02%	10.08%	11.93%	8.06%	13.46%	9.56%	5.25%
Tulare County, CA	6.66%	6.91%	13.81%	6.97%	14.93%	10.60%	10.11%
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%

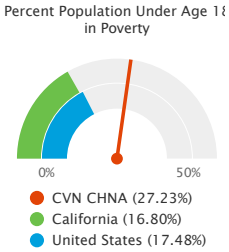


Income - Childhood Poverty Rate

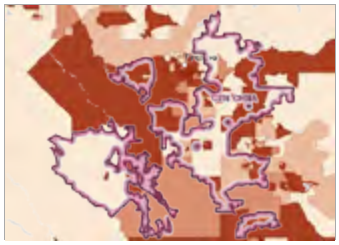
In the report area 27.23% or 42,712 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.



Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
CVN CHNA	509,415	156,831	42,712	**27.23%**
Fresno County, CA	973,165	277,081	81,804	29.52%
Kings County, CA	136,804	40,483	9,296	22.96%
Monterey County, CA	415,908	111,603	20,499	18.37%
San Benito County, CA	61,067	15,467	2,352	15.21%
Tulare County, CA	457,738	140,267	41,096	29.30%
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%



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



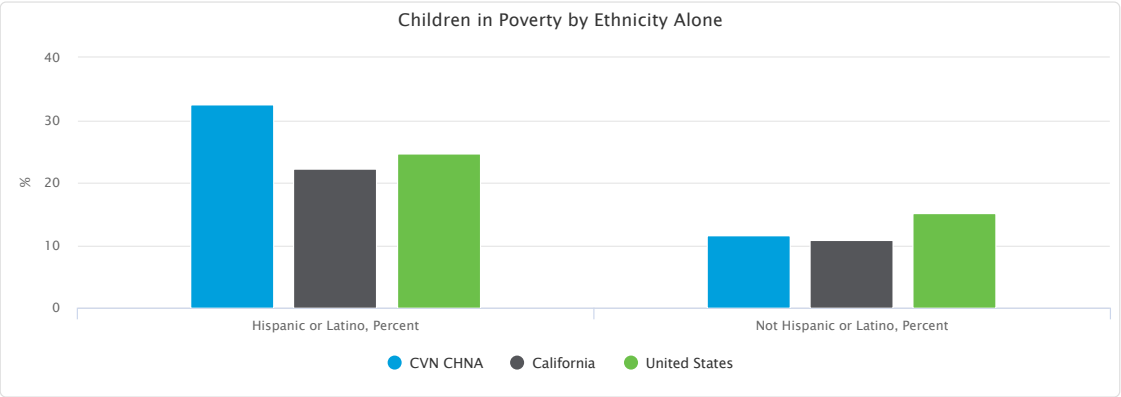
Population Below the Poverty Level, Children (Age 0-17), Percent by Tract
ACS 2016-20

- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- CVN CHNA

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.

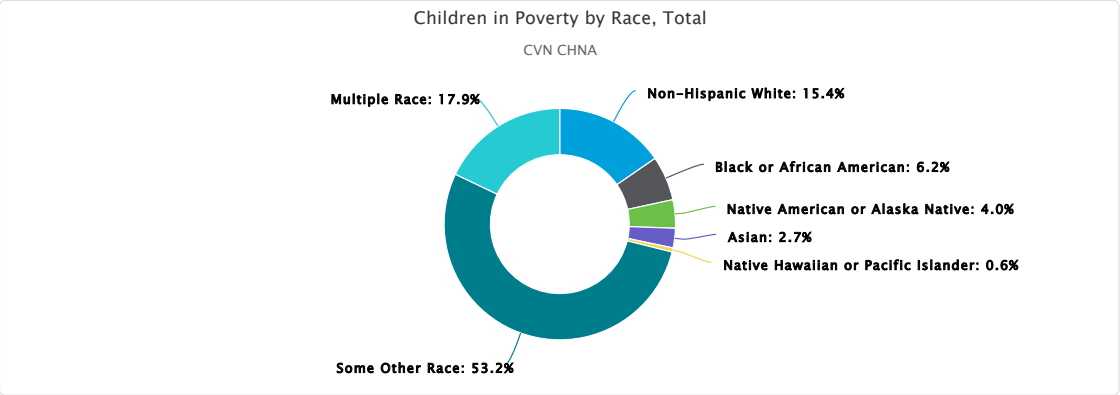
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
CVN CHNA	38,139	4,573	32.61%	11.55%
Fresno County, CA	61,026	20,778	34.28%	20.98%
Kings County, CA	7,864	1,432	28.99%	10.72%
Monterey County, CA	19,100	1,399	22.41%	5.31%
San Benito County, CA	2,053	299	18.27%	7.07%
Tulare County, CA	36,142	4,954	33.70%	15.01%
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

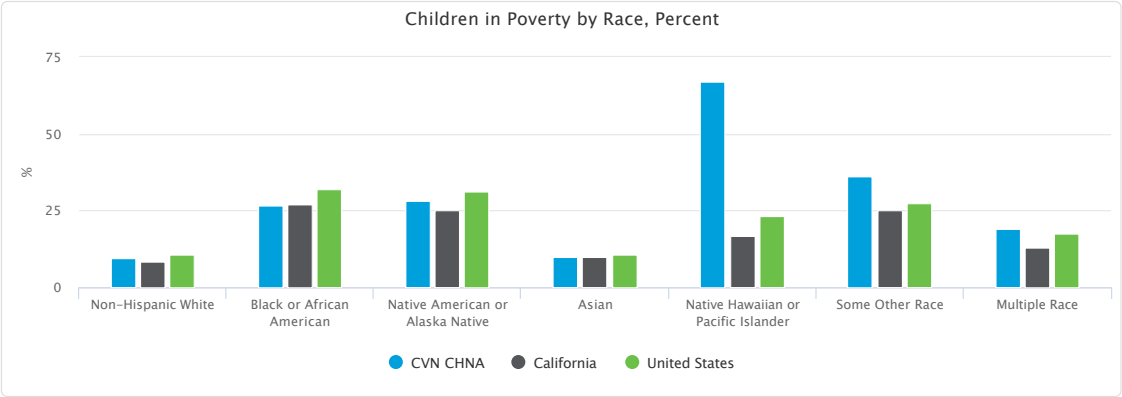
This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

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
CVN CHNA	2,579	1,044	665	460	96	8,922	3,002
Fresno County, CA	6,570	5,735	971	7,034	213	14,869	7,521
Kings County, CA	688	404	142	111	0	1,920	792
Monterey County, CA	536	520	128	108	36	13,614	1,407
San Benito County, CA	241	2	8	0	0	182	503
Tulare County, CA	2,941	861	855	1,084	142	10,185	2,761
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

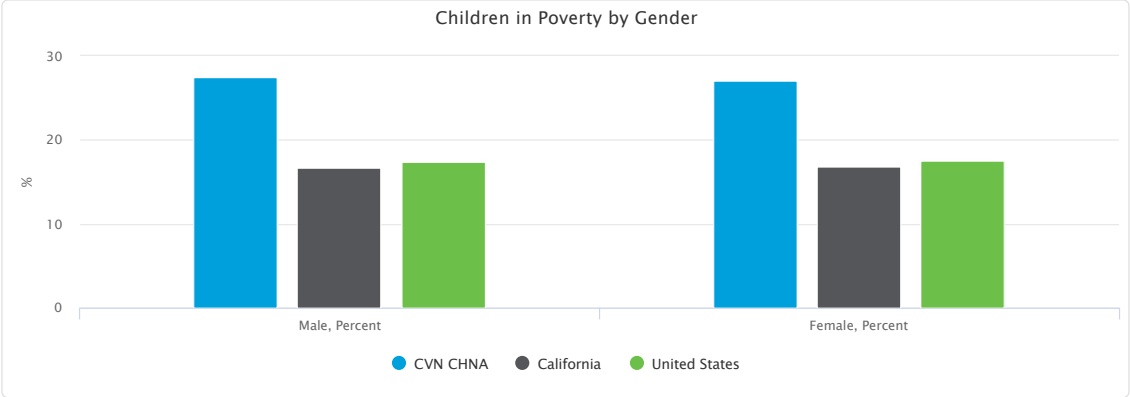
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
CVN CHNA	9.54%	26.76%	28.23%	9.79%	67.13%	36.26%	19.01%
Fresno County, CA	13.63%	45.33%	30.31%	24.53%	68.93%	35.37%	22.86%
Kings County, CA	7.80%	22.51%	20.49%	9.50%	0.00%	29.03%	16.25%
Monterey County, CA	3.13%	31.61%	15.90%	2.76%	10.59%	26.59%	13.11%
San Benito County, CA	7.35%	4.00%	7.92%	0.00%	No data	14.65%	16.23%
Tulare County, CA	12.52%	34.89%	47.63%	22.29%	87.12%	36.69%	20.29%
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.

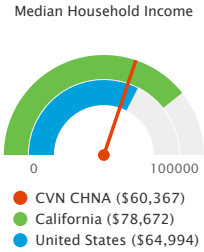
Report Area	Male	Female	Male, Percent	Female, Percent
CVN CHNA	21,931	20,781	27.42%	27.05%
Fresno County, CA	40,970	40,834	28.95%	30.12%
Kings County, CA	4,766	4,530	23.09%	22.83%
Monterey County, CA	10,634	9,865	18.71%	18.01%
San Benito County, CA	1,255	1,097	15.73%	14.65%
Tulare County, CA	21,641	19,455	30.21%	28.35%
California	753,182	727,467	16.73%	16.87%
United States	6,414,903	6,183,796	17.43%	17.54%



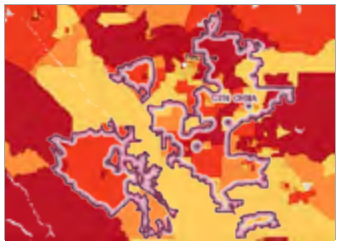
Income - Median Household Income

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 150,419 households in the report area, with an average income of $77,384 and median income of $60,367.

Report Area	Total Households	Average Household Income	Median Household Income
CVN CHNA	150,419	$77,384	**$60,367**
Fresno County, CA	310,097	$79,175	$57,109
Kings County, CA	43,604	$75,449	$61,556
Monterey County, CA	128,003	$104,485	$76,943
San Benito County, CA	18,389	$108,229	$85,808
Tulare County, CA	139,044	$72,092	$52,534
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



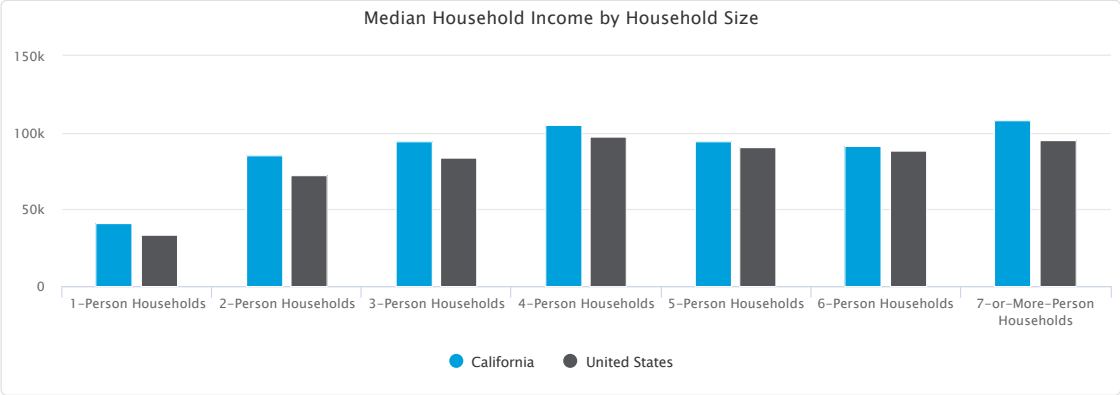
Median Household Income by Tract, ACS 2016-20

- Over $70,000
- $60,001 - $70,000
- $50,001 - $60,000
- Under $50,001
- No Data or Data Suppressed
- CVN CHNA

Median Household Income by Household Size

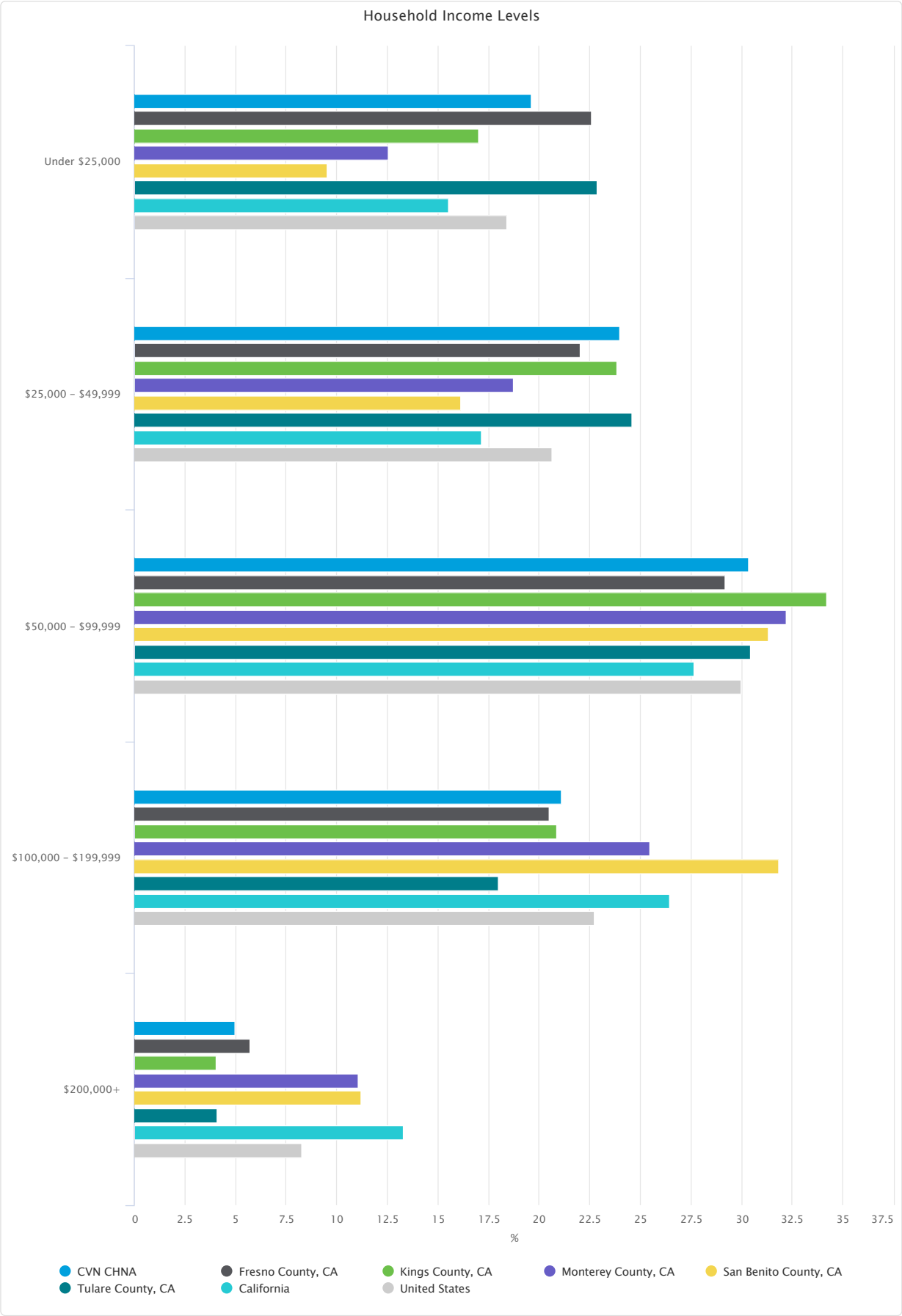
This indicator reports the median household income of the report area by household size.

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
CVN CHNA	No data	No data	No data	No data	No data	No data	No data
Fresno County, CA	$28,939	$64,322	$62,599	$71,529	$67,494	$68,729	$73,160
Kings County, CA	$34,535	$61,878	$66,741	$69,397	$70,192	$75,705	$75,042
Monterey County, CA	$43,899	$89,238	$87,560	$83,908	$80,590	$85,954	$106,301
San Benito County, CA	$45,542	$83,055	$98,197	$108,613	$108,010	$82,778	$149,821
Tulare County, CA	$29,089	$54,093	$55,115	$64,006	$56,943	$56,975	$85,947
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

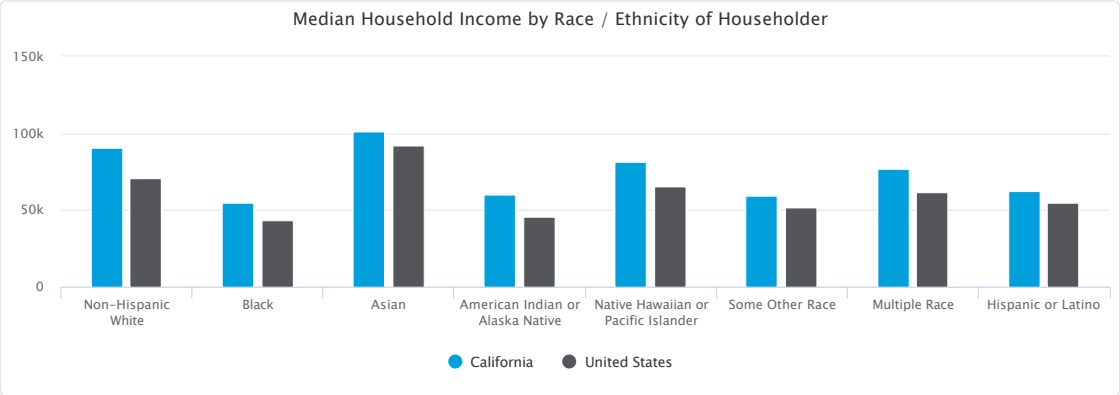
Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
CVN CHNA	19.61%	23.96%	30.35%	21.10%	4.98%
Fresno County, CA	22.60%	22.01%	29.19%	20.47%	5.73%
Kings County, CA	17.03%	23.85%	34.21%	20.85%	4.06%
Monterey County, CA	12.55%	18.71%	32.22%	25.47%	11.06%
San Benito County, CA	9.51%	16.13%	31.34%	31.84%	11.18%
Tulare County, CA	22.87%	24.57%	30.46%	18.00%	4.11%
California	15.51%	17.14%	27.66%	26.42%	13.27%
United States	18.41%	20.64%	29.95%	22.73%	8.26%


Household Income Levels
Under $25,000
$25,000 – $49,999
$50,000 – $99,999
$100,000 – $199,999
$200,000+
0
2.5
5
7.5
10
12.5
15
17.5
20
22.5
25
27.5
30
32.5
35
37.5
%
CVN CHNA
Fresno County, CA
Kings County, CA
Monterey County, CA
San Benito County, CA
Tulare County, CA
California
United States

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
CVN CHNA	No data	No data	No data	No data	No data	No data	No data	No data
Fresno County, CA	$70,763	$39,621	$68,274	$52,511	$45,595	$45,525	$57,763	$47,141
Kings County, CA	$74,918	$56,076	$80,530	$44,842	$98,864	$47,592	$72,188	$49,373
Monterey County, CA	$94,279	$69,458	$87,705	$71,602	$86,875	$57,862	$84,338	$62,876
San Benito County, CA	$104,277	$118,322	$128,750	$83,333	No data	$82,875	$83,480	$72,329
Tulare County, CA	$64,453	$44,708	$67,396	$37,632	No data	$47,520	$62,159	$46,063
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



D. Food Security

The percent of the Central Valley population living in poverty is extremely high (19.22%) and is considerably higher than the rate of poverty in California (12.58%) and in the US (12.84%). Struggling for basic financial security often leads to limited healthy dietary choices, as highly processed foods are less expensive. Some racial disparities in the rates of poverty exist, for example one in three Native Hawaiian or Pacific Islanders in the community are living in poverty. The number of farmers markets in the area that accept supplemental nutrition assistance, designed to provide nutrition benefits to supplement the food budget of needy families is extremely low and stands at 0.44 per 100k of low-income population as compared to 2.96 in California and 3.11 in the United States. The percentage of students eligible for the free or reduced-price school food program represents 75.84% of public-school students, which is higher than the state average of 59.18% and the nation's average of 42.16%. This means that more than three of four children in the Central Valley live in poverty.

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PRIMARY COMMENTS

FOCUS GROUPS

- Interviewees said the cost of living had increased since COVID started.
- People are paying double for food in rural communities. It requires reliable transportation to go to urban areas to shop for groceries, which is said to be a challenge for many.
- There was a worry amongst interviewees that families have to ration their food.
- Interviewees shared the concern that food stamps don't pay rent.
- Those experiencing homelessness can go to a homeless shelter but only for so many days. People also noted homeless benefits leave few healthy food options.
- Food pantries are not giving out lots of fresh veggies, interviewees claimed.
- People noted there are not a lot of community gardens due to the lack of water.
- Interviewees cited the irony of having food shortages in an agricultural community.

KEY INFORMANT COMMENTS

- Healthier food can be more expensive, which is viewed as a barrier.
- Limited access to fresh fruits and vegetables is seen as a problem for many.
- More farmers markets are seen as a way to increase local food access.

- There are not believed to be a lot of healthy options for people that are on the go.
- Some community members are said to have to choose between safety and food.
- People noted community food pantries have helped many in having adequate food for their families.
- You have to drive a long way to get to healthy food stores, interviewees said.
- Limited food choices and limited income lead to eating more highly processed foods, it was stated, which increases the rate of obese and overweight community members.

Secondary Data Summary

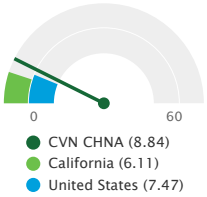
Food Security

Food Access - SNAP-Authorized Retailers

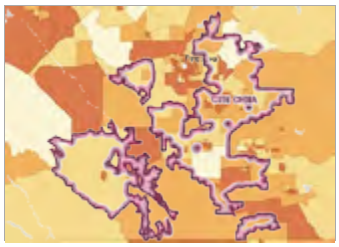
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits. The report area contains a total of 476 SNAP-authorized retailers with a rate of 8.84.

Report Area	Total Population (2020)	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers, Rate per 10,000 Population
CVN CHNA	539,325	476	**8.84**
Fresno County, CA	1,000,918	921	9.20
Kings County, CA	152,692	119	7.79
Monterey County, CA	430,906	278	6.45
San Benito County, CA	64,052	23	3.59
Tulare County, CA	468,675	453	9.67
California	39,365,480	24,047	6.11
United States	332,898,996	248,526	7.47

SNAP-Authorized Retailers, Rate (Per 10,000 Population)



Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2021. Source geography: Tract

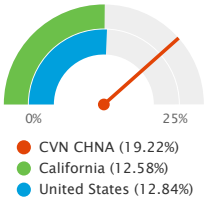


SNAP-Authorized Retailers Access, Rate per 10,000 Population by Tract, USDA 2021

- Over 12.0
- 6.1 - 12.0
- Under 6.0
- No SNAP-Authorized Retailers
- No Population or No Data
- CVN CHNA

Report Area	Total Population	Population in Poverty	Population in Poverty, Percent
CVN CHNA	509,415	97,897	**19.22%**
Fresno County, CA	973,165	202,296	20.79%
Kings County, CA	136,804	21,908	16.01%
Monterey County, CA	415,908	50,052	12.03%
San Benito County, CA	61,067	5,709	9.35%
Tulare County, CA	457,738	99,610	21.76%
California	38,589,882	4,853,434	12.58%
United States	318,564,128	40,910,326	12.84%

Population in Poverty, Percent



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

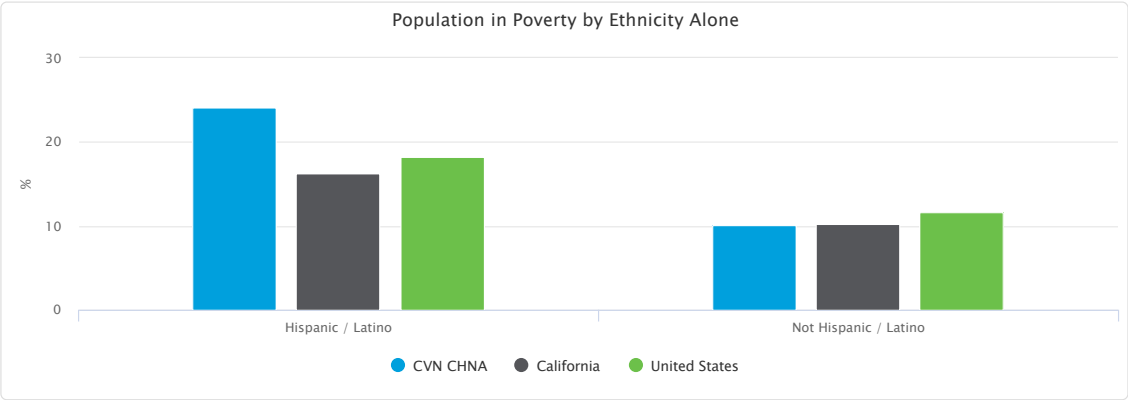
Population Below the Poverty Level, Percent by Tract, ACS 2016-20

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- CVN CHNA

Population in Poverty by Ethnicity Alone

This indicator reports the population in poverty in the report area by ethnicity alone.

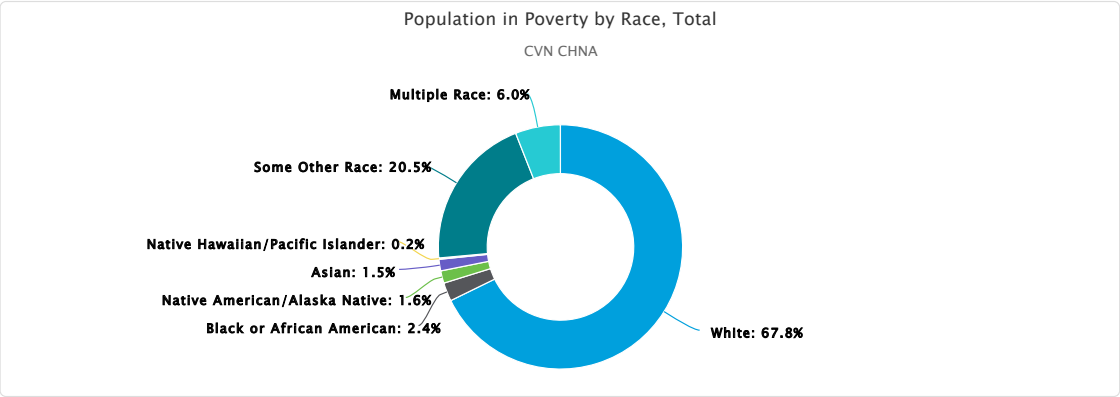
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
CVN CHNA	79,996	17,901	24.08%	10.11%
Fresno County, CA	133,315	68,981	25.65%	15.22%
Kings County, CA	16,055	5,853	21.04%	9.68%
Monterey County, CA	38,281	11,771	15.42%	7.02%
San Benito County, CA	4,414	1,295	11.99%	5.34%
Tulare County, CA	78,610	21,000	26.34%	13.18%
California	2,454,410	2,399,024	16.24%	10.22%
United States	10,642,653	30,267,673	18.29%	11.62%



Population in Poverty by Race, Total

This indicator reports the total population in poverty in the report area by race alone.

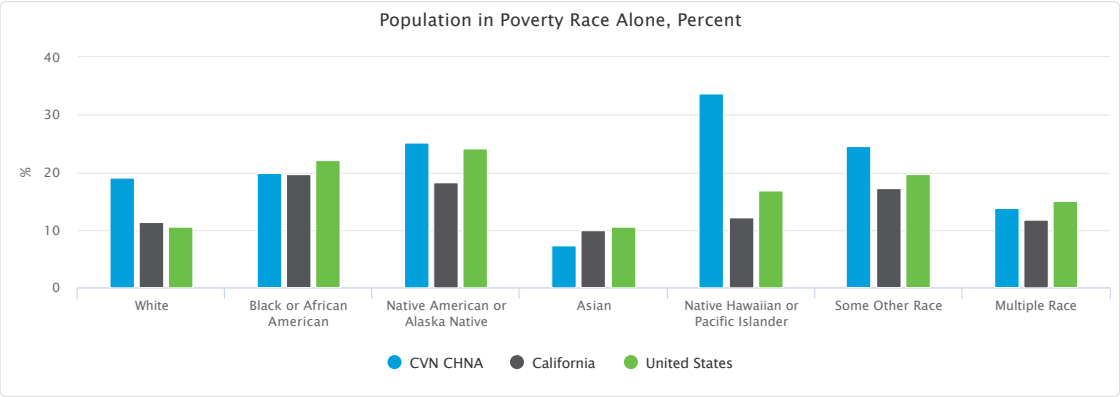
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
CVN CHNA	66,344	2,390	1,605	1,495	175	20,037	5,851
Fresno County, CA	114,236	13,652	3,021	18,766	422	36,652	15,547
Kings County, CA	14,322	1,158	380	388	6	4,153	1,501
Monterey County, CA	16,538	1,475	330	1,850	135	26,644	3,080
San Benito County, CA	4,096	57	9	31	0	683	833
Tulare County, CA	64,843	1,814	1,966	2,885	291	22,313	5,498
California	2,464,103	421,298	55,491	577,350	17,823	957,857	359,512
United States	23,820,939	8,726,814	626,766	1,917,691	99,642	3,234,981	2,483,493



Population in Poverty Race Alone, Percent

This indicator reports the percentage of population in poverty in the report area by race alone.

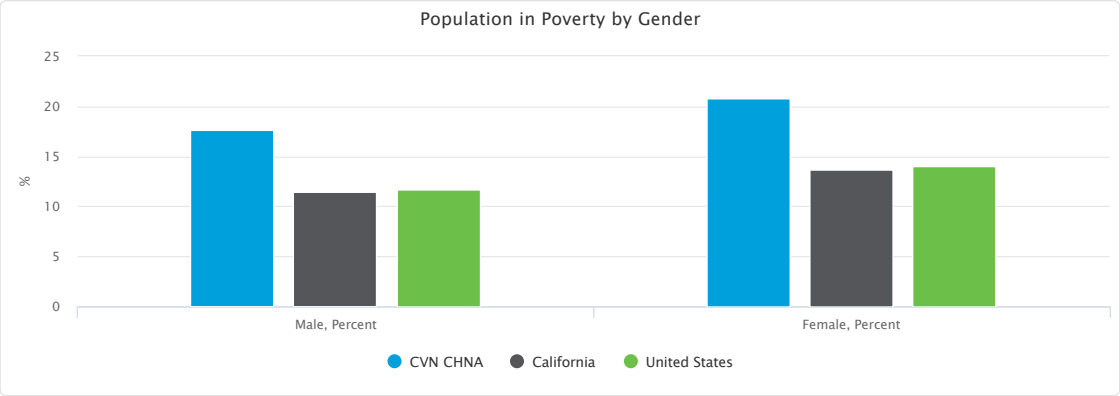
Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
CVN CHNA	19.18%	19.90%	25.13%	7.26%	33.78%	24.63%	13.74%
Fresno County, CA	19.43%	30.68%	26.86%	17.99%	29.26%	26.04%	18.75%
Kings County, CA	15.85%	17.60%	20.41%	7.24%	5.31%	20.18%	12.58%
Monterey County, CA	8.26%	17.85%	11.45%	7.60%	6.77%	17.80%	10.82%
San Benito County, CA	9.16%	11.20%	1.71%	1.79%	0.00%	11.01%	11.39%
Tulare County, CA	21.19%	24.72%	33.53%	16.86%	47.86%	26.45%	15.08%
California	11.38%	19.60%	18.36%	10.04%	12.19%	17.34%	11.74%
United States	10.60%	22.07%	24.13%	10.61%	16.81%	19.66%	15.08%



Population in Poverty by Gender

This indicator reports the population in poverty in the report area by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
CVN CHNA	45,210	52,687	17.65%	20.80%
Fresno County, CA	93,052	109,244	19.27%	22.28%
Kings County, CA	10,095	11,813	14.52%	17.56%
Monterey County, CA	22,965	27,087	11.09%	12.97%
San Benito County, CA	2,523	3,186	8.19%	10.53%
Tulare County, CA	46,457	53,153	20.37%	23.15%
California	2,194,991	2,658,443	11.50%	13.63%
United States	18,171,512	22,738,814	11.64%	13.99%

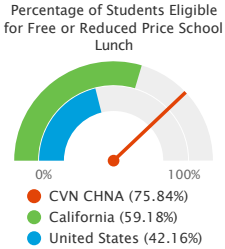


Economic Security - Free/Reduced Price Lunch

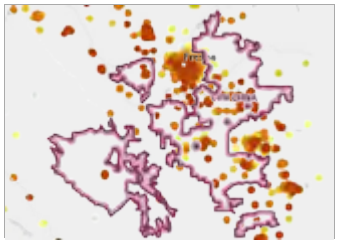
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Out of 75,281 total public school students in the report area, 57,073 were eligible for the free or reduced price lunch program in the latest report year. This represents 75.84% of public school students, which is higher than the state average of 59.18%.
Note: States with more than 80% records "not reported" are suppressed for all geographic areas, including hospital service area, census tract, zip code, school district, county, state, etc.

Report Area	Total Students	Students Eligible for Free or Reduced Price Lunch	Students Eligible for Free or Reduced Price Lunch, Percent
CVN CHNA	75,281	57,073	**75.84%**
Fresno County, CA	203,780	155,795	76.46%
Kings County, CA	29,072	20,607	70.93%
Monterey County, CA	77,394	58,000	74.97%
San Benito County, CA	10,864	6,333	58.40%
Tulare County, CA	102,366	77,789	75.99%
California	5,958,941	3,526,048	59.18%
United States	53,244,287	22,445,622	42.16%



Note: This indicator is compared to the state average.
Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2020-2021. Source geography: Address



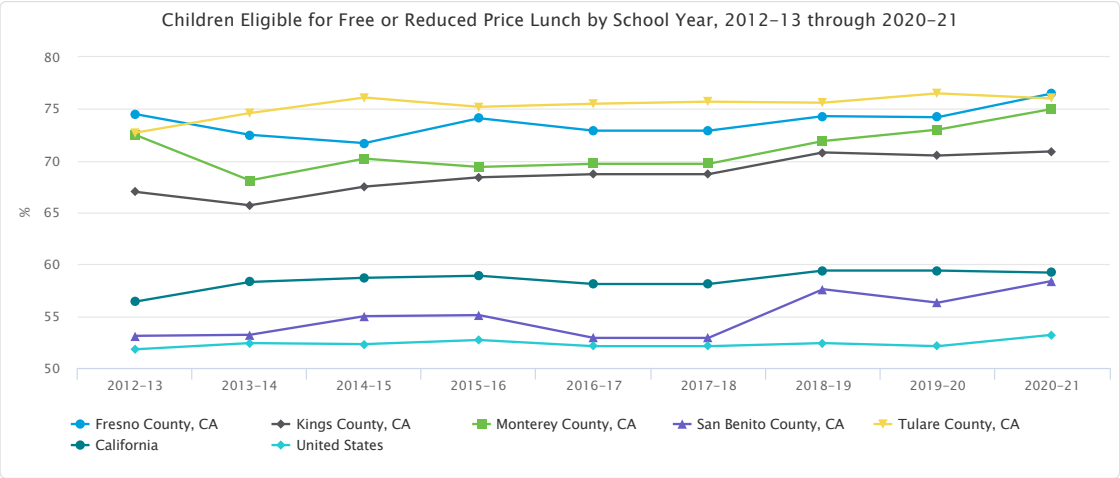
Students Eligible for Free or Reduced-Price Lunch, NCES CCD 2020-21

- Over 90.0%
- 75.1% - 90.0%
- 50.1% - 75.0%
- 20.1% - 50.0%
- Under 20.1%
- Not Reported
- CVN CHNA

Children Eligible for Free or Reduced Price Lunch by School Year, 2012-13 through 2020-21

The table below shows local, state, and national trends in student free and reduced lunch eligibility by percent.
Note: The states below have more than 80% public schools labeled as "not reported" in 2020-2021. For consistency, these states still have their values calculated with the limited records on all geographic levels (unless there is not a single record reported in the selected area). Use with caution when comparing to other years. This issue might occur in other states/years as well.
For 2020-2021, watch out for Alaska, Arizona, Delaware, District of Columbia, Illinois, Massachusetts, Montana, Ohio, Oregon, Tennessee, Virginia, American Samoa, and Northern Mariana Islands.

Report Area	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
CVN CHNA	70.4%	71.9%	73.3%	73.2%	71.7%	71.7%	73.2%	72.9%	75.8%
Fresno County, CA	74.5%	72.5%	71.7%	74.1%	72.9%	72.9%	74.3%	74.2%	76.5%
Kings County, CA	67.0%	65.7%	67.5%	68.4%	68.7%	68.7%	70.8%	70.5%	70.9%
Monterey County, CA	72.5%	68.1%	70.2%	69.4%	69.7%	69.7%	71.9%	73.0%	75.0%
San Benito County, CA	53.1%	53.2%	55.0%	55.1%	52.9%	52.9%	57.6%	56.3%	58.4%
Tulare County, CA	72.7%	74.6%	76.1%	75.2%	75.5%	75.7%	75.6%	76.5%	76.0%
California	56.4%	58.3%	58.7%	58.9%	58.1%	58.1%	59.4%	59.4%	59.2%
United States	51.8%	52.4%	52.3%	52.7%	52.1%	52.1%	52.4%	52.1%	53.2%

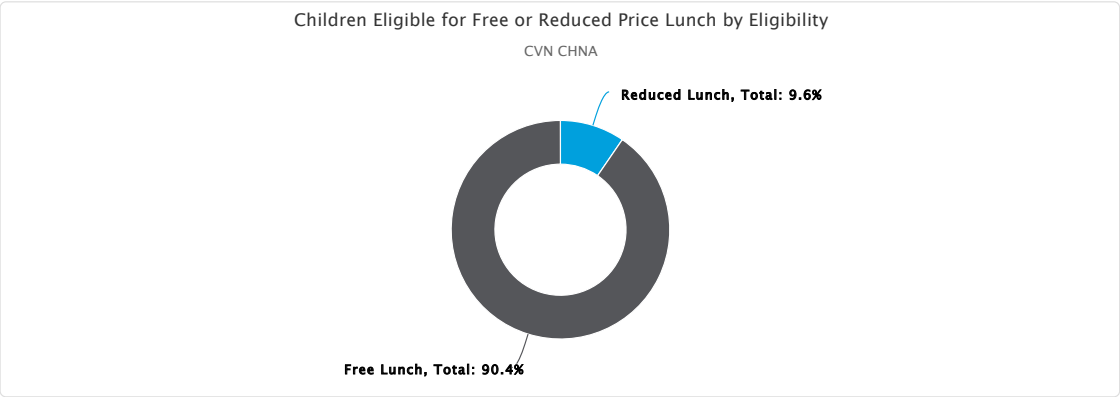


Children Eligible for Free or Reduced Price Lunch by Eligibility

The table below displays the number and percentage of students eligible for free or reduced price lunch by income eligibility category. Percentages in the table below are out of the total student population.
Note: States with more than 80% records labeled as "not reported" are suppressed for all geographic areas.

Report Area	Free Lunch, Total	Free Lunch, Percent	Reduced Lunch, Total	Reduced Lunch, Percent
CVN CHNA	51,603	68.5%	5,471	7.3%
Fresno County, CA	136,772	67.1%	19,023	9.3%
Kings County, CA	18,864	64.9%	1,743	6.0%
Monterey County, CA	51,860	67.0%	6,140	7.9%
San Benito County, CA	5,729	52.7%	604	5.6%
Tulare County, CA	70,610	69.0%	7,179	7.0%
California	3,140,705	52.7%	385,343	6.5%
United States	19,950,407	37.5%	1,952,641	3.7%

The chart below displays the percentage of the students in each eligibility category out of the total number of students eligible for free or reduced price lunch.



E. Mental Health

Access to mental health (MH) providers in the Central Valley is extremely limited. The rate of MH providers is 43.82 per 100k people, as compared to 150.31 in California and 132.27 in the United States. Inability to access licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent or adult mental health severely curtail prevention, treatment, and crisis management related to mental health.

Currently 8.57% of the Central Valley population does not have health insurance, which is above the rate in California (7.23%). 8.73% is the US rate.

Risk factors that increase the likelihood of coping with stress and trauma for the residents of the Central Valley include a greater rate of violent crime than in California and the United States. At 473.2 per 100k people, the residents of the Central Valley must cope more often with homicides, rape, robbery, and aggravated assaults in their community. Stress and trauma resulting from unemployment are also elevated in this area, and at 8.42%, it is higher than both California's rate of 6.18% and the US rate of 5.38%.

Several mental health outcomes show that the residents of the Central Valley are struggling with mental health to a greater extent than in California in general and the US. The percentage of adults with poor mental health is higher in the Central Valley (16.1%) than in California (12.5%) and in the US (13.6%). Deaths of despair, which include any deaths due to intentional self-harm, alcohol-related disease, and drug overdose are at 43.4 per 100k people and are elevated than the rate in the rest of the state of California (37.1).

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PRIMARY COMMENTS

FOCUS GROUPS

- People noted that there seems to be a lot of stigma around mental health issues.
- The educational system does not have enough people to support the kids with mental health issues, focus group participants indicated.
- Interviewees said if people are more anxious and depressed, they may turn to drugs and alcohol.
- No inpatient treatment centers are believed to be in the area.
- There was a concern there are not enough substance abuse rehab centers in the area, with only one taking private insurance.
- There is believed to be a need for increased mental health services for teenagers.
- If resources were available for mental health, it would improve the health of the community overall, interviewees stated.
- The community may need help getting connected to the resources that are available already, per interviewees.
- Financial burdens are seen to increase mental health stressors.
- Addictions have increased in the eyes of interviewees due to mental health stressors.

KEY INFORMANT COMMENTS

- The social isolation that accompanied COVID is seen as a mental health challenge for some.
- COVID may have made some residents less likely to go to healthcare appointments, per interviewees.
- Some noted that the news every day causes depression and anxiety and leads to not eating well and not taking care of your health.
- A sedentary, home-based life is seen to potentially make exercise less common for some
- The high cost of housing was regularly called out as a major cause of anxiety

Secondary Data Summary

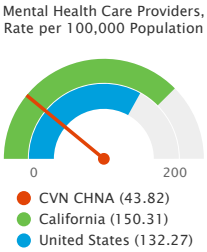
MENTAL HEALTH

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

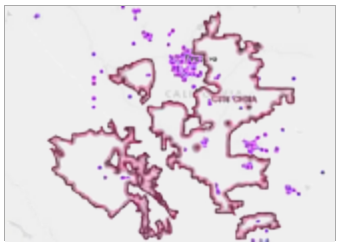
This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, 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 236 mental health providers with a CMS National Provider Identifier (NPI). This represents 43.82 providers per 100,000 total population.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
CVN CHNA	537,910	21	236	**43.82**
Fresno County, CA	1,008,654	170	1,639	162.49
Kings County, CA	152,486	5	76	49.84
Monterey County, CA	439,035	44	675	153.75
San Benito County, CA	64,209	2	23	35.82
Tulare County, CA	473,117	34	547	115.62
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27



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



Mental Health Providers, All, CMS NPPES July 2022

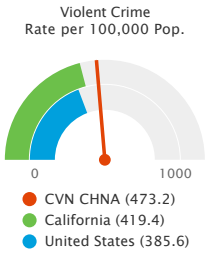
- Mental Health Providers, All, CMS NPPES July 2022
- CVN CHNA

Risk Factors - Stress & Trauma - Violent Crime Rate

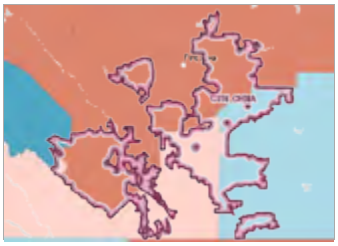
This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and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

In the report area, 2,475 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 473.2 per 100,000 residents is higher than the statewide rate of 419.4 per 100,000.
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
CVN CHNA	2,475	**473.2**
Fresno County, CA	5,264	541.8
Kings County, CA	668	443.4
Monterey County, CA	1,828	420.6
San Benito County, CA	176	298.7
Tulare County, CA	1,756	381.8
California	327,327	419.4
United States	2,445,671	385.6



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



Violent Crime, Rank by County, CHR 2022

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

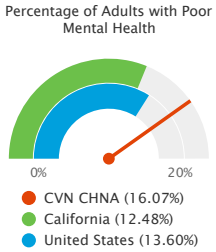
Health Outcomes - Anxiety & Depression - Poor Mental Health

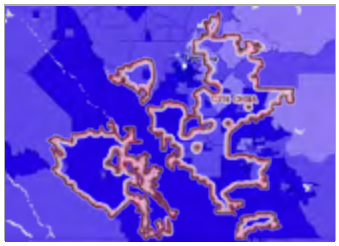
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good. Data were from the 2019 Behavioral Risk Factor Surveillance System (BRFSS) annual survey.

Within the report area, there were 16.07% of adults 18 and older who reported poor mental health in the past month of the total population.

Report Area	Total Population (2019)	Adults with Poor Mental Health (Crude)	Adults with Poor Mental Health (Age-Adjusted)
CVN CHNA	503,170	**16.07%**	No data
Fresno County, CA	999,101	14.50%	14.20%
Kings County, CA	152,940	14.70%	14.10%
Monterey County, CA	434,061	13.20%	12.90%
San Benito County, CA	62,808	12.60%	12.40%
Tulare County, CA	466,195	15.30%	14.90%
California	39,512,223	12.48%	12.39%
United States	328,239,523	13.60%	13.90%

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





Poor Mental Health, Prevalence Among Adults Age 18+ by Tract, CDC BRFSS PLACES Project 2019

- Over 16.0%
- 13.1% - 16.0%
- 10.1% - 13.0%
- Under 10.1%
- No Data or Data Suppressed
- CVN CHNA

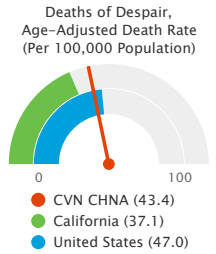
Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.

Within the report area, there were 1,100 deaths of despair. This represents an age-adjusted death rate of 43.4 per every 100,000 total population.

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
CVN CHNA	530,535	1,100	41.5	**43.4**
Fresno County, CA	992,718	2,080	41.9	43.1
Kings County, CA	151,377	314	41.5	43.8
Monterey County, CA	434,740	779	35.8	34.7
San Benito County, CA	61,625	107	34.7	34.0
Tulare County, CA	465,133	946	40.7	43.5
California	39,444,803	78,447	39.8	37.1
United States	326,747,554	806,246	49.4	47.0

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



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

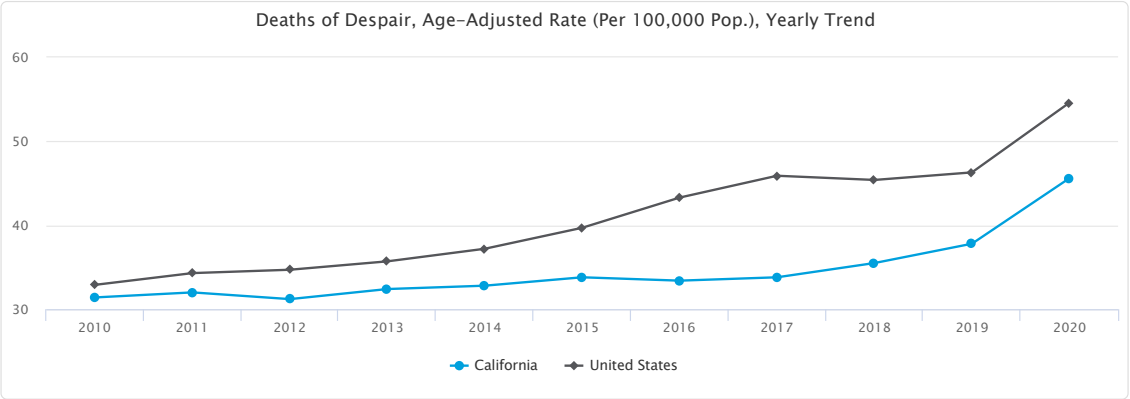
- Over 70.0
- 50.1 - 70.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<20 Deaths)
- CVN CHNA

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

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

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

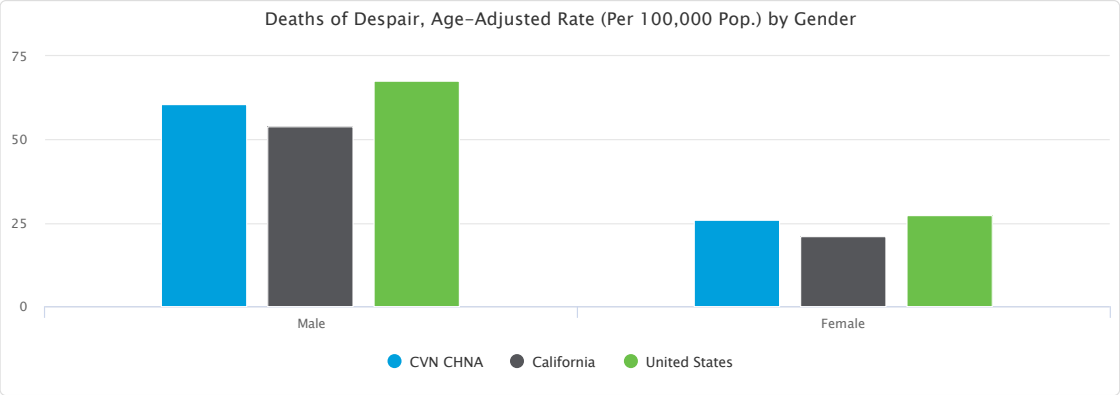
Note: No county data available. See data source and methodology for more details.



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

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

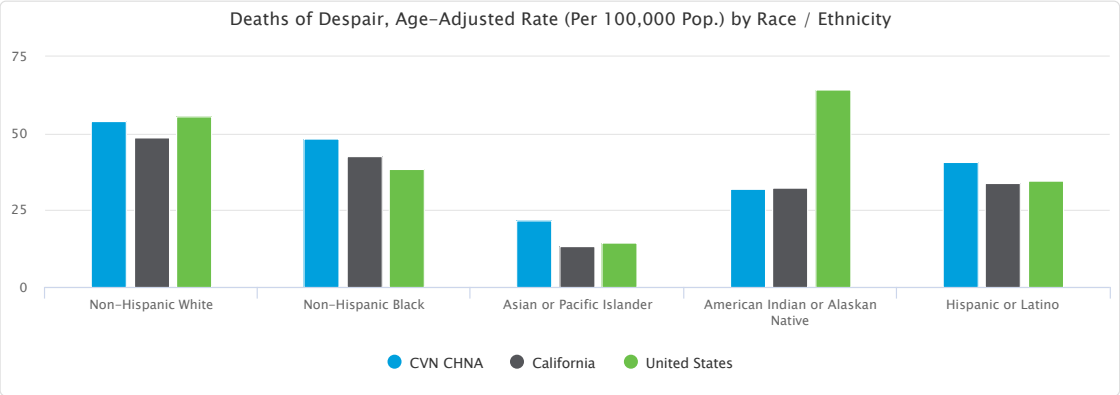
Report Area	Male	Female
CVN CHNA	60.6	25.9
Fresno County, CA	61.7	25.1
Kings County, CA	56.2	29.6
Monterey County, CA	50.9	18.4
San Benito County, CA	49.5	17.9
Tulare County, CA	63.9	23.7
California	54.0	20.9
United States	67.7	27.3



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

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

Report Area	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	American Indian or Alaskan Native	Hispanic or Latino
CVN CHNA	54.0	48.4	21.8	32.0	40.6
Fresno County, CA	54.5	48.4	21.8	32.6	39.6
Kings County, CA	50.7	No data	No data	No data	42.7
Monterey County, CA	48.3	46.9	12.9	No data	27.9
San Benito County, CA	41.9	No data	No data	No data	34.4
Tulare County, CA	57.1	No data	No data	30.7	40.2
California	48.9	42.6	13.5	32.3	34.0
United States	55.6	38.6	14.3	64.3	34.6



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

Intentional Alignment

Identifying our community needs, common goals, and unifying objectives brings about successful outcomes through partnering and collaboration.

CRITERIA FOR CONSIDERING WHICH HEALTH NEED TO ADDRESS

Operations

Tracked and shared progress/data

'Quick Wins' through collaboration

Political willingness

Partners Resources Assets

Existing orgs/programs addressing all/parts of Need

CBO's are focused on this Need

Community willingness

Finance

Gov. or public funding available when applying collaboratively

Available grants for this *Need*

Need meets the vision/mission of Gov. or philanthropic orgs

Equity

Current Orgs/programs addressing *Need* with Safety-Net pop.

Everyone will benefit

Addressing *Need* could lessen absenteeism at work/school

PRIORITIZATION TOOL #2

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

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

example

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

V. Process and Methods to Conduct the CHNA

A. Secondary Data Methodology

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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

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

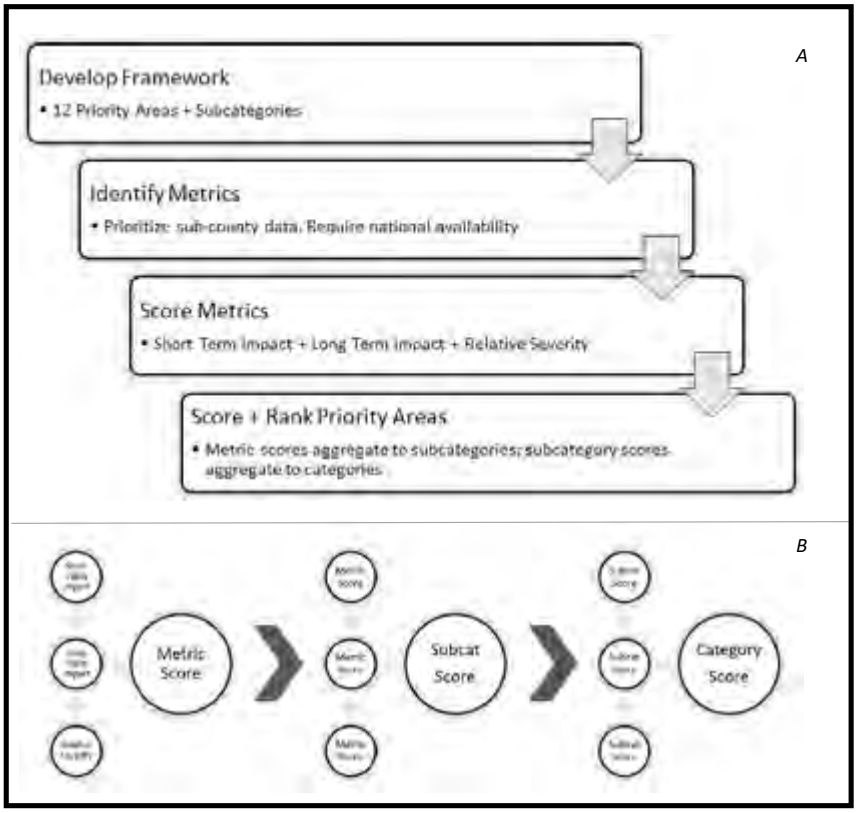

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Framework Development

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

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

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

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- Healthy People 2030 Leading Health Indicators

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

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

Metric Scoring

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

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

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

---

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

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Transformation of Correlation Scores

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

Category Scores

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

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

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

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

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

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

Presentation of Results

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

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

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Limitations

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

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

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

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

References

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

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

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

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

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

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

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

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

B. Survey Methodology and Questions

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

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

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

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

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

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

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

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

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

SURVEY QUESTION

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

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

NEEDS CROSSWALK

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

C. Focus Group and Key Informant Methodology and Guide

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

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

Deductive analysis of all focus groups and key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CAREs. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Focus group and key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments 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.

FOCUS GROUP FACILITATOR'S SCRIPT

WELCOME

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

ACTIVITY EXPLANATION

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

TALLY RESPONSES:

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

Question Prompters

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

QUESTIONS:

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

  If not, why is that?

  Who is most affected by this?

CLOSING QUESTION:

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

CONCLUSION:

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

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

TOPIC-SPECIFIC PROMPTS

ACCESS TO CARE

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

CHRONIC CONDITIONS/PHYSICAL HEALTH

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

How do you know?

HEALTH RISK BEHAVIORS

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

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

MENTAL HEALTH

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

FOOD SECURITY

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

How common of a problem do you think this is?

What is being done to help?

INFRASTRUCTURE

What transportation barriers exist in your community?

COMMUNITY VITALITY

What are the best things about living here?

PHYSICAL ENVIRONMENT

What kind of access do you have to nature?

What limits people's access to the outside world?

COMMUNITY SAFETY

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

What is being done to address these safety concerns?

HOUSING

What are the biggest housing problems facing your community?

What impact do these problems cause?

FINANCIAL STABILITY

What kind of job opportunities are there around here?

EDUCATION

How would you describe the educational opportunities for kids?

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

INCLUSION & EQUITY

How culturally diverse is your community?

How well does your community embrace this diversity?

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

D. Adventist Health Central Valley Network (CVN) 2019 Implementation Strategy Evaluation of Impact

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

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

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

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

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

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

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit "Amy" Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

BERKELEY INSTITUTE OF GOVERNMENTAL STUDIES (IGS)

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

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

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

G. Cristina Mora & Eric Schickler...IGS
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Mark Di Camillo
Berkeley IGS Poll Director
mdicamillo@berkeley.edu

www.igs.berkeley.edu/about

CARES

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

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

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

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

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

CENTER FOR BEHAVIORAL HEALTH INTEGRATION

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

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

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

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

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

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

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

VI. Glossary of Terms Definition of Health Needs

Glossary of Terms

ACCESS TO CARE:

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

COMMUNITY SAFETY:

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

COMMUNITY VITALITY:

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

EDUCATION:

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

ENVIRONMENT & INFRASTRUCTURE:

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

FINANCIAL STABILITY:

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

FOOD SECURITY:

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

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

HEALTH CONDITIONS:

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

Andrea Kofl
President, Central Valley Network

COMMUNITY HEALTH NEEDS ASSESSMENT

ADVENTIST HEALTH
HANFORD & SELMA