Mercy Medical Center Redding
2019 Community Health Needs Assessment

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EXECUTIVE SUMMARY

Rooted in Dignity Health's mission, vision and values, Mercy Medical Center Redding (MMCR) is dedicated to delivering community benefit with the engagement of its management team, Community Board and other key stakeholders within the community. The Board is composed of community members who provide stewardship and direction for the hospital as a community resource.

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Dignity Health's Mercy Medical Center Redding. The significant health needs identified in this report will help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of California Senate Bill 697 that not-for-profit hospitals conduct a community health needs assessment at least once every three tax years.

MMCR is located off of California Interstate 5, and serves a service area population of 205,975 residents. Shasta County is a rural county with the residents being spread out over approximately 3,775 square miles. The majority of individuals served reside in Shasta County. However, there are community health services available to bordering communities in Trinity and Shasta counties. While MMCR focuses community health programs and services on its primary service area, it does not exclude the needs of those residing in neighboring communities, following its commitment to raise the common good and improve the quality of life for all.

MMCR is committed to involving residents in the community needs assessment process while being good stewards of limited resources. MMCR took into consideration available internal and external resources and partnered with outside individuals and organizations as appropriate throughout the CHNA process. In an effort to reach a cross-section of the population, the 2019 CHNA utilized a mixed-methods approach that included the collection of secondary or quantitative data from existing data sources and community input or qualitative data from key stakeholder focus groups, surveys, and meetings with community stakeholders. The process was iterative as both the secondary and primary data were used to help inform each other. The advantage of using this approach is that it validates data by cross-verifying from a multitude of sources. The health needs assessment process aimed to gain a thorough understanding of the medically underserved, low-income and minority populations living in MMCR's service area. Using a convenience sampling (non-probability sampling) approach, locations were selected based on the perception of being able to encounter our medically underserved, low-income and minority populations.

The health needs were identified through the data collection process and focus group participants were asked to help prioritize the health needs for the community. They were asked to choose three needs that they believed to be the most significant for the community in terms of having the greatest impact on the population and are not being met very well right now in the community. They were asked to consider the following factors when prioritizing the needs: size or scale of problem; severity

of problem; disparity and equity; known effective interventions; resource feasibility and sustainability; and community acceptability of intervention. For a health indicator to be a considered a health need, a health outcome, or a health factor it had to meet two criteria; first, existing data had to demonstrate that the service area had a health outcome or factor rate worse than the State rate, demonstrate a worsening trend when compared to Tehama County data in recent years, or indicate an apparent health disparity; second, the health outcome or factor had to be mentioned in a substantial way in at least two primary data collection sources which were focus groups, surveys, or stakeholder meetings.

After a review of all available primary and secondary data, and taking into consideration the focus group participants' discussions, ranking and prioritization process, the following areas were identified as the areas of the most significant need for the community:

- Alcohol and other Substance Abuse (including Tobacco Use)
- Child Abuse
- Communicable Diseases
- Diabetes
- Mental Health
- Tobacco Use

While there are potential resources available to address the identified needs of the community, the needs are too significant for any one organization. The community has many marginalized, under represented individuals. In order to reach out to the underrepresented individuals, open collaboration needs to begin with community organizations, local government, local business leaders and other institutions in order to make a substantial and upstream impact. Shasta County is home to a wealth of organizations, businesses, and nonprofits that currently offer programs and services in several of the identified significant health needs areas, including domestic violence, food programs, housing, mental health, and senior services to name a few. MMCR will continue to build community capacity by strengthening partnerships among local community-based organizations.

MMCR did not collaborate with other hospitals to conduct the CHNA. MMCR and Dignity Health staff led the process, and MMCR did not use outside consultants. This CHNA report was adopted by the North State Service Area community board in June 2019 (tax year 2018), and follows the previous CHNA report adopted in May 2018 (tax year 2017). This report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at Mercy Medical Center Redding's Community Health Office. Written comments on this report can be submitted to the Mercy Medical Center Redding's Community Health Office, 2175 Rosaline Ave., CA 96001 or by e-mail to alexis.ross@dignityhealth.org.

MISSION, VISION AND VALUES

Mercy Medical Center Redding (MMCR) is a member of Dignity Health, a 40 hospital faith-based organization providing health care services in California, Nevada and Arizona. Mercy Medical Center Redding is licensed for 266-beds and has approximately 1,800 employees. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons and demonstrates compassion for our sisters and brothers who are powerless.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

COMMUNITY DEFINITION

MMCR is located at the tip of the Sacramento River Valley in Redding, California and serves as a regional referral center for far Northern California. While the majority of individuals served reside in Shasta County there are community health services available to bordering communities in Tehama and Trinity Counties. MMCR serves a primary service area population of 205,975 residents. Shasta County is a rural county with the residents being spread out over approximately 3,775 square miles. Due to the rural nature of the county access to care is a consistent barrier for the many residents who are medically underserved and low-income and minority populations. The following zip codes make up the core service area for MMCR:

Zip Code	*City*	*County*
96001	Redding	Shasta
96002	Redding	Shasta
96003	Redding	Shasta
96007	Anderson	Shasta
96019	Shasta Lake	Shasta
96022	Cottonwood	Shasta
96073	Palo Cedro	Shasta
96080	Red Bluff	Tehama
96088	Shingletown	Shasta
96093	Weaverville	Trinity

Population Density & Demographics

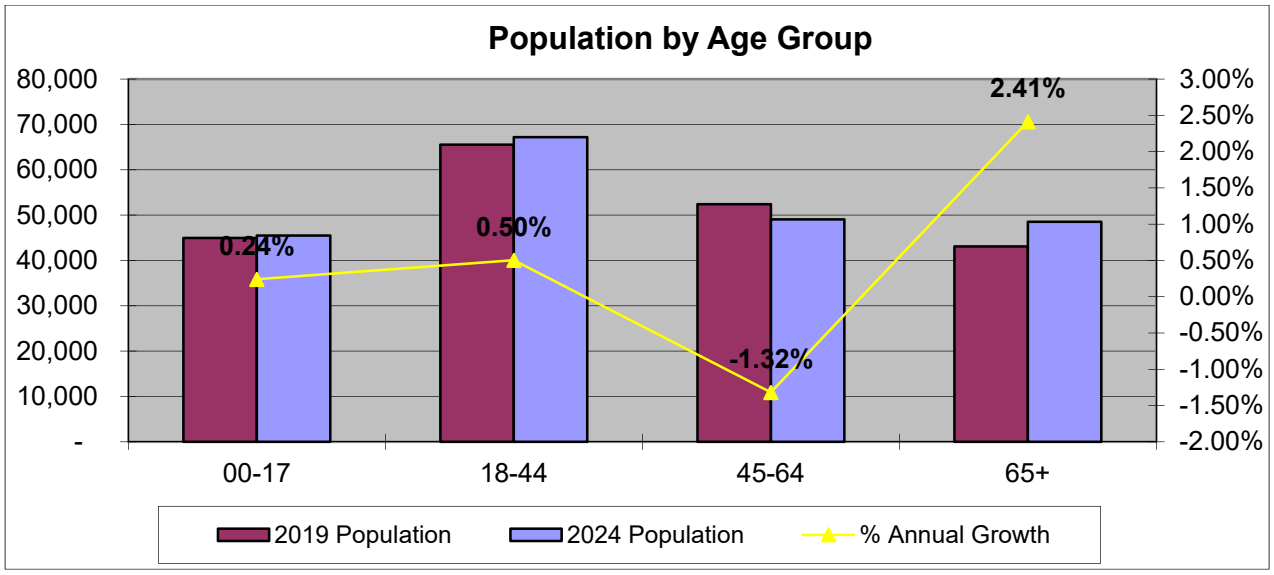
The service area's population remains relatively flat with growth between 2010 and 2019 being 1.9%, while California has grown 6.8% within the same timeframe. Additionally, MMCR serves a rural population with approximately 54.5 people per square mile, while California has approximately 256.5 people per square mile.

	Core Service Area	California
2010 Population	202,075	37,253,937
2019 Population	205,975	39,964,848
Change in population	3,900	2,710,911
Percent Change	1.9%	6.8%
Land in Square Miles	3,775	155,779
Population Density	54.5	256.5

Age Distribution

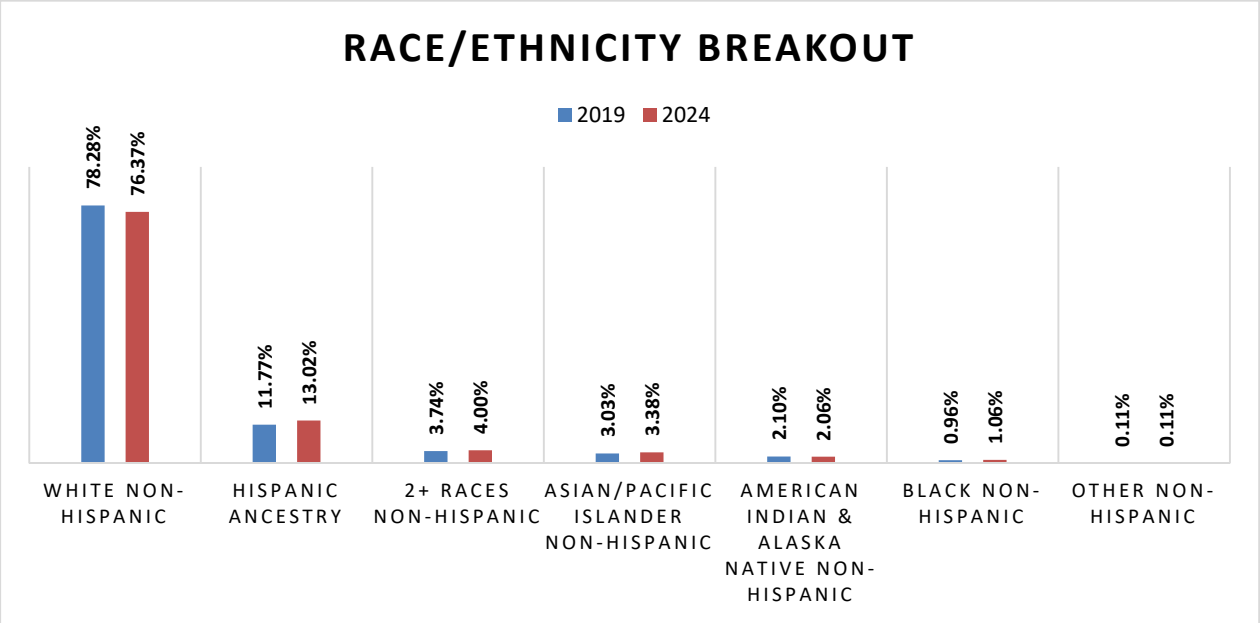
Age and sex distribution within MMCR's service area indicates that 51% are female and 49% are male and that there are more individuals that are 65 and over (20.92%) as compared to California (14.49%) and this age segment is projected to experience an annual growth rate of 2.41%. The largest age segment within MMCR's service area are those between the ages of 18 to 44, accounting for 65,531 individuals or 31.82% of the service area population.

	MMCR Service Area Population					California Population	
Age Group	***2019***	***% of Total***	***2024***	***% of Total***	***% of Annual Growth***	***2019***	***% of Total***
0-17	44,952	21.82%	45,494	21.64%	0.24%	9,168,028	22.94%
18-44	65,531	31.82%	67,195	31.96%	0.50%	15,001,417	37.54%
45-64	52,410	25.44%	49,044	23.32%	-1.32%	10,004,232	25.03%
65 and Over	43,082	20.92%	48,537	23.08%	2.41%	5,791,171	14.49%
Total	**205,975**	**100.0%**	**210,270**	**100.0%**	**0.39%**	**39,964,848**	**100.00%**



Race and Ethnicity

The majority of the service area population is Caucasian. The next largest segment of the population is Hispanic and is anticipated to grow by 1.25% over the next five years.



Other pertinent demographics for MMCR's service area are listed below:

- Median Income: $50,350
- Uninsured: 13.1%
- Unemployment: 3.9%
- No HS Diploma: 18.2%
- Medicaid Population: 28.7% - *Does not include individuals dually-eligible for Medicaid and Medicare*

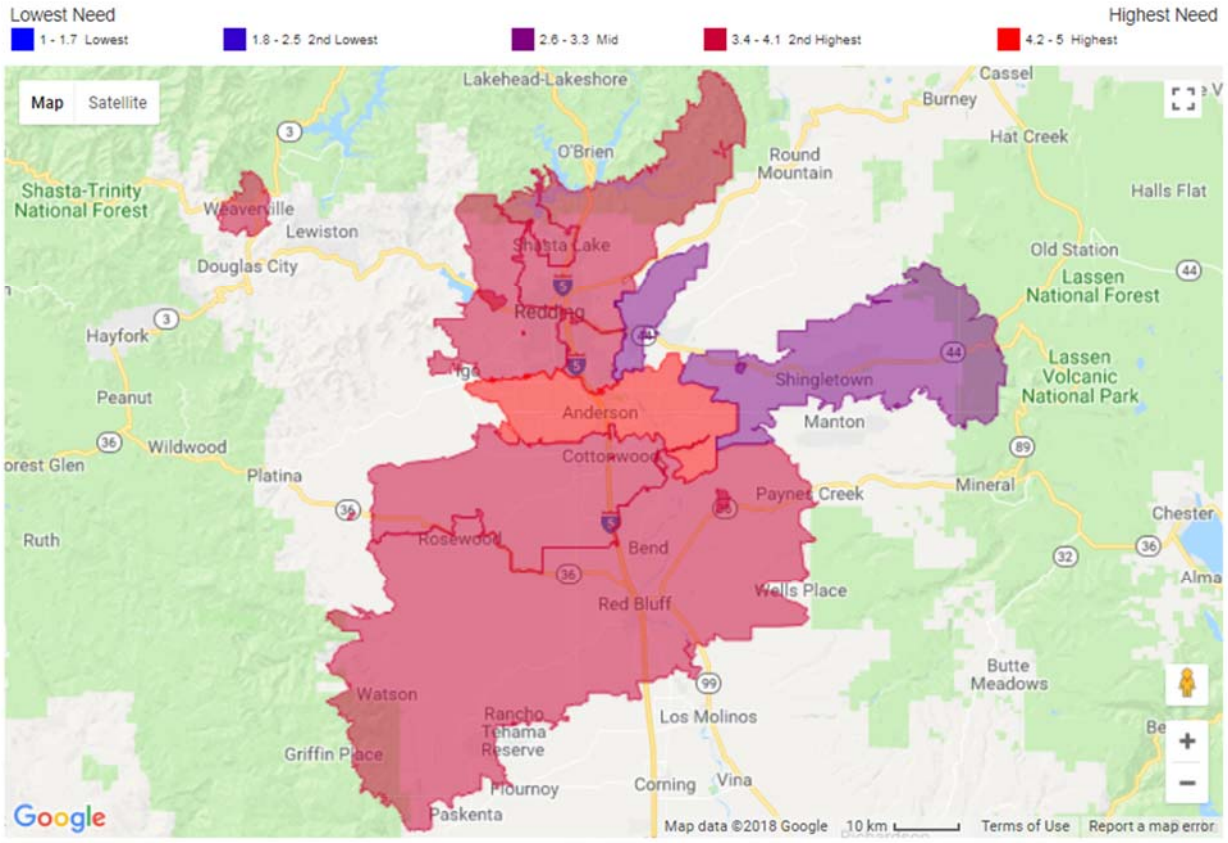
Community Needs Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Barriers to Healthcare Access	Indicator(s): Underlying causes of health disparity
Income	Percentage of households below poverty line, with head of household age 65 or more
	Percentage of families with children under 18 below poverty line
	Percentage of single female-headed families with children under 18 below poverty line
Culture/Language	Percentage of population that is minority (including Hispanic ethnicity)
	Percentage of population over age 5 that speaks English poorly or not at all
Education	Percentage of population over 25 without a high school diploma
Insurance	Percentage of population in the labor force, aged 16 or more, without employment
	Percentage of population without health insurance
Housing	Percentage of households renting their home

Scores range from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor and are then averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores. The CNI map and ZIP code-specific scores are outlined on the following page.

Community Need Index Map



Mean(zipcode): 3.5 / Mean(person): 3.7 CNI Score Median: 3.6 CNI Score Mode: 3.4,3.6,3.8

Zip Code	CNI Score	Population	City	County	State
96001	3.4	34276	Redding	Shasta	California
96002	3.8	33701	Redding	Shasta	California
96003	3.6	45611	Redding	Shasta	California
96007	4.2	23014	Anderson	Shasta	California
96019	3.8	10100	Shasta Lake	Shasta	California
96022	3.6	15993	Cottonwood	Tehama	California
96073	2.6	4013	Palo Cedro	Shasta	California
96080	4	29524	Red Bluff	Tehama	California
96088	3	4995	Shingletown	Shasta	California
96093	3.4	3803	Weaverville	Trinity	California

ASSESSMENT PROCESS AND METHODS

MMCR is committed to involving and informing the residents in the community health needs assessment process while being good stewards of limited resources. The CHNA is conducted at least every three years and identifies the health needs of residents by acknowledging ongoing health concerns within the community. MMCR conducted the needs assessment at the facility level using community health staff to oversee the process. By conducting the CHNA internally the hospital was able to gain a better insight into the specific needs of the community while conserving financial resources to be used to deliver direct community health programs and services for the community.

MMCR took into consideration available internal and external resources and partnered with outside individuals and organizations as appropriate throughout the CHNA process. Based on this assessment, issues of greatest concern were identified and the hospital determined the areas to commit resources to, thereby focusing outreach efforts to continually improve the health status of the community we serve.

In an effort to reach a cross-section of the population, the 2019 CHNA utilized a mixed-methods approach that included the collection of secondary or quantitative data from existing data sources and community input or qualitative data from key stakeholder focus groups, surveys, and meetings with community stakeholders. The process was reiterative as both the secondary and primary data were used to help inform each other. The advantage of using this approach is that it validates data by cross-verifying from a multitude of sources.

Primary Data Sources

Primary data can be described as data that is collected or observed directly from first-hand experience. The primary data for the MMCR needs assessment was obtained through the use of focus groups and a convenience sampling health survey in an effort to gain a thorough understanding of the medically underserved, low-income and minority populations most often served.

MMCR looked to community based organizations to represent their respective clientele throughout the CHNA process wherever appropriate, to understand the services underrepresented populations are accessing. Focus group meetings were conducted with individuals and groups that represented the broad interests of the community. These representatives included public health and individuals with knowledge of medical underserved, low-income, and minority populations. Listed below are the community stakeholders from whom input was sought (listed in alphabetical order):

- City of Redding
- First 5 Shasta
- Health Shasta Collaborative
- Public Health Advisory Board
- Reach Higher Shasta
- Redding Rancheria
- Shasta Community Health Center
- Shasta County Health & Human Services Agency, Children's Services
- Shasta County Health & Human Services Agency, Public Health
- Shasta Health Assessment and Redesign Collaborative
- Strengthening Families Collaborative

These active community members represent a multidisciplinary cross section of organizations and individuals that work with all facets of the community and are well versed in the specific needs and the health disparities of each subgroup of the population. The focus groups were facilitated in April, 2019 by community health leadership. On average, each focus group took approximately one hour to complete. The facilitator guided each group through an in-depth discussion by first reviewing and adding topics of health need. Participants were then asked to prioritize the health areas that were just identified. Focus group participants were also asked to complete a brief community health perception ranking process. A copy of the facilitator packet with accompanying survey tools are listed in Appendix A. It is important to note that the survey process was not intended to capture a statistically representative sample of the community due to the rural nature of the service area.

Secondary Data Sources

Secondary data can be described as data that has already been collected and published by another party. The secondary data for the 2019 CHNA was obtained from a variety of sources to create a comprehensive community profile and to identify health disparities and barriers to accessing care. Every effort was made to obtain the most current and reliable data. Data by zip code, if available, and county data were analyzed for comparison purposes with the State of California, other counties within California, and with Healthy People 2020 targets when available. Sources included (but were not limited to): Community Commons, Centers for Disease Control & Prevention, U.S. Census data, and the University of Wisconsin Population Health Institute.

ASSESSMENT DATA AND FINDINGS

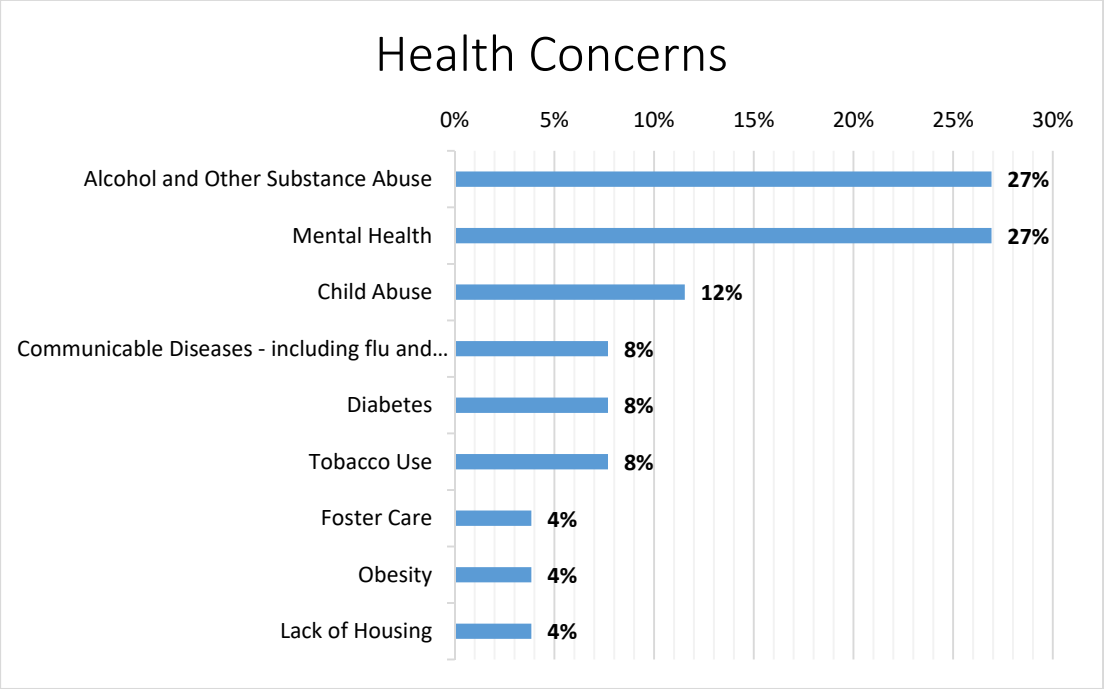
In order to help streamline the CHNA process, previous assessments were built upon and the existing health needs of the community were used as a starting point for the data collection portion of the assessment. The results of the primary data collection revealed the perceived health concerns, risk behaviors, and availability of community services from the community's perspective. Listed below, in alphabetical order, are the health needs from the previous assessment that were utilized to begin the primary data collection portion of the CHNA process. The individual results of the surveys are listed on the following pages.

- Access to Care
- Alcohol and Other Substance Abuse
- Cancer
- Cardiovascular Disease
- Child Abuse
- Chronic Liver Disease & Cirrhosis
- Chronic Lower Respiratory Diseases
- Communicable Diseases
- Diabetes
- Domestic Abuse
- Foster Care
- Homicide
- Lack of Housing
- Mental Health
- Nutrition
- Obesity
- Perinatal Health
- Physical Activity
- Pneumonia & Influenza
- Suicide
- Tobacco Use
- Unintentional Injuries

Survey: Perceived Health Concerns

The health concerns discussed during the focus groups was a pre-populated list of health concerns that were based on previous assessments. Focus group participants were asked the question "in your opinion, what are the top three health concerns in this community".

The following bar chart displays the aggregate total number of votes for whether or not participants perceived the health issue as a concern for the community, either from their personal perspective as a community member or as a representative of the clients their organization serves. Health concerns that received zero votes are omitted from the graph. Additional health concern categories that respondents identified were captured in the focus group results and will be included in any future CHNA surveys.



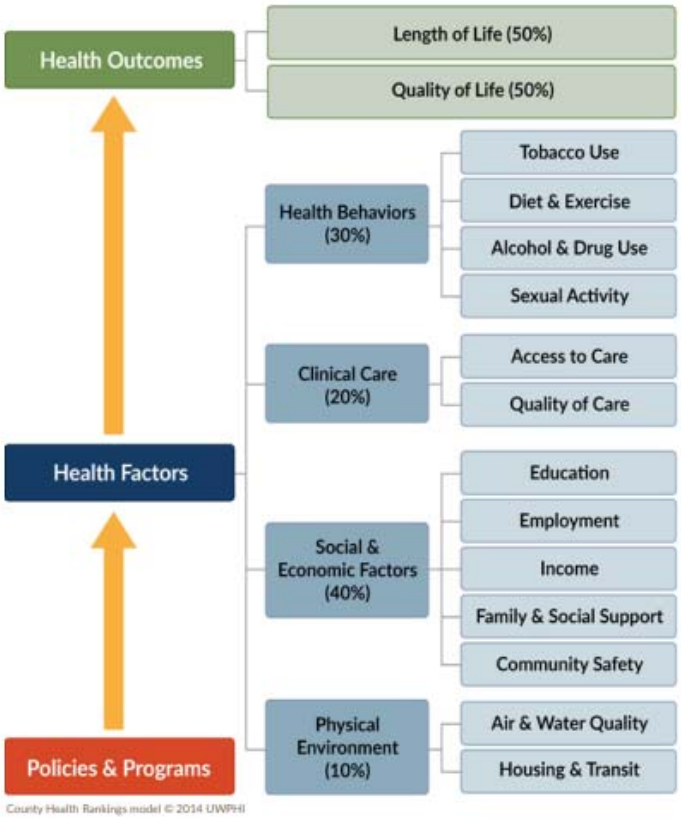
Alcohol/other substance abuse and mental health were among the tier one health needs identified by this method, with 54% of the respondents indicating that these areas are a significant need in the community. Tier two health needs identified were: child abuse, communicable diseases, diabetes, and tobacco use. All of those received an additional 36% of respondents agreeing that they are significant issues.

County Health Rankings

The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute[1]. The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births. The rankings are determined by the following factors:

> *Health Outcomes: "The overall ranking in health outcomes represent how healthy a county is right now. They reflect the physical and mental well-being of residents within a community through measures representing length of life and quality of life."*
>
> *Health Factors: "The overall ranking in health factors represent many things that influence how well and how long we live. Health Factors represent those things we can modify to improve the length and quality of life for residents. They are predictors of how healthy our communities can be in the future."*

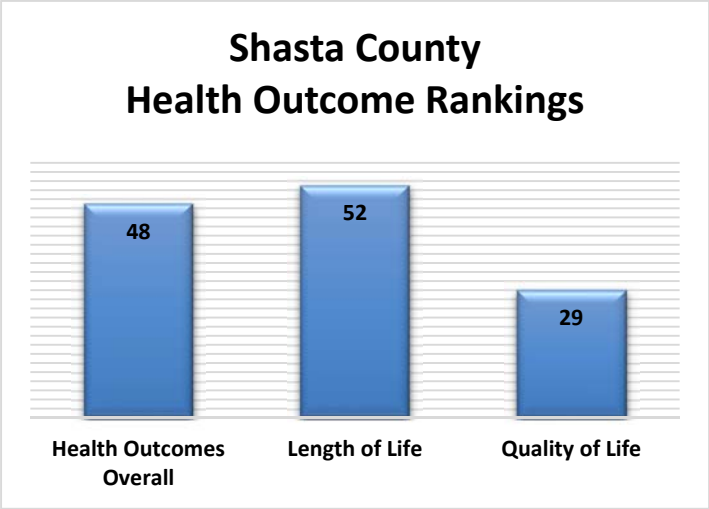
The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.



[1] County Health Rankings

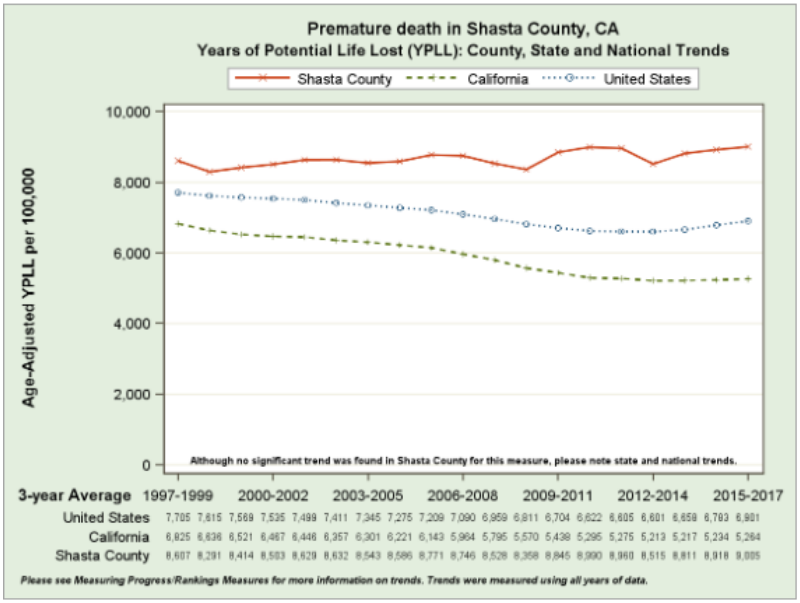
Health Outcomes

Shasta County is ranked 48th out of 58 counties in California for overall Health Outcomes, which includes Length of Life and Quality of Life. Length of Life is ranked 52nd and Quality of Life is ranked 29th. This places Shasta County in approximately the bottom 20 percent of counties overall.



Length of Life

In a measure of premature deaths among the population , 9,000 years of potential life are lost before age 75 per 100,000 population in Shasta County compared to 5,300 years of potential life lost per 100,000 population in California as a whole[2].



[2] County Health Rankings

Leading Causes of Death

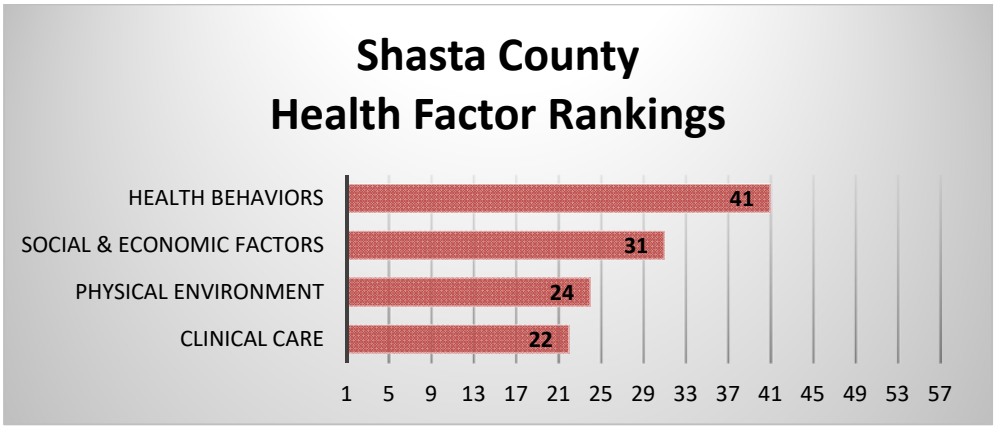
Listed below are is the age-adjusted death rate for the California Department of Public Health, health status indicators between 2015-2017. The rank is compared to 57 other counties in California[3] and Shasta County is higher than the State in most categories. Values listed in red indicate that the Shasta County rate is higher than the State rate. In addition, cells highlighted in gray indicate the current rate is higher than the County's previously reported rate.

Rank	Leading Causes of Death (2015-2017)	Shasta County Age-Adjusted Death Rate	California Deaths Age-Adjusted Death Rate	HP 2020 National Objective	Shasta County Previous Rate (2012-2014)
56	All Causes	918.0	610.3	*Not Established*	876.7
56	All Cancers	183.6	137.4	161.4	182.6
55	Coronary Heart Disease	127.0	87.4	103.4	121.2
54	Chronic Lower Respiratory Disease	66.3	32.0	*Not Established*	74.4
44	Accidents (unintentional injuries)	58.8	32.2	36.4	59.9
58	Alzheimer's Disease	55.7	35.7	*Not Established*	44.8
56	Lung Cancer	45.7	27.5	45.5	46.0
43	Cerebrovascular Disease (Stroke)	42.4	36.3	34.8	44.0
51	Suicide	24.0	10.4	10.2	21.4
47	Drug Induced Deaths	22.8	12.7	11.3	27.4
38	Diabetes	22.3	21.2	*Not Established*	18.9
46	Female Breast Cancer	21.0	18.9	20.7	21.0
39	Prostate Cancer	20.8	19.4	21.8	23.8
46	Chronic Liver Disease & Cirrhosis	18.3	12.2	8.2	18.2
40	Motor Vehicle Traffic Crashes	17.2	9.5	12.4	13.3
46	Influenza/Pneumonia	17.0	14.2	*Not Established*	12.6
56	Colorectal Cancer	16.7	12.5	14.5	15.6
45	Firearm Related Deaths	15.1	7.9	9.3	14.3
31	Homicide	5.9	5.2	5.5	6.2

[3] California Department of Public Health

Health Factors

Shasta County is ranked 31st out of 58 counties in California for overall Health Factors, which includes Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment[4]. The full County Health Rankings & Roadmaps report is listed in Appendix B. The chart below illustrates Shasta County's ranking per Health Factor category:



Health Needs Data Review

The following section contains a review of data available for each of the health needs that were identified as an output of the overall CHNA process. For a health indicator to be a considered a health need, it had to meet two criteria; first, existing data had to demonstrate that the service area had a health outcome or factor rate worse than the State rate, demonstrate a worsening trend when compared to Tehama County data in recent years, or indicate an apparent health disparity. Second, the health outcome or factor had to be mentioned in a substantial way in at least two primary data collection sources which were focus groups, surveys, or stakeholder meetings. Where available, statistical data, data source, accompanying focus group comments, and the process utilized for collection are included in each identified health need subsection.

Access to Care

Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Efforts are continually being made to assist more people in accessing affordable, quality health care; however, limitations to health care access can greatly impact people's ability to reach their full potential, negatively affecting their quality of life.

The U.S. Department of Health and Human Services (HHS) designates certain areas as being medically underserved. They are known as Health Professional Shortage Areas (HPSA). There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). There is another designation known as a Medically Underserved Area (MUA); they are areas or populations

[4] County Health Rankings

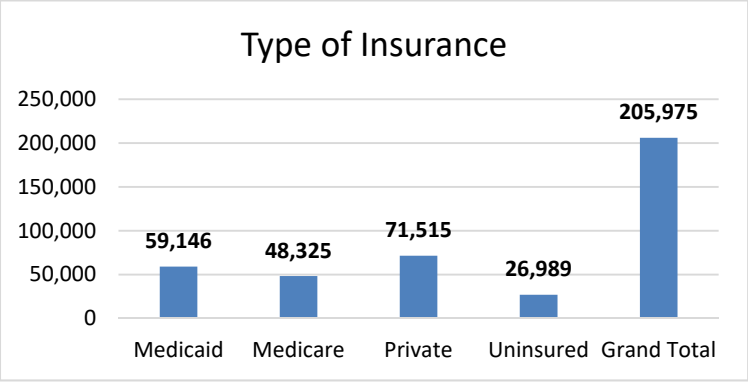
designated by the U.S. Department of Health and Human Services as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population. Shasta County is both a Health Professional Shortage Area (HPSA) and a Medically Underserved Area (MUA). Therefore it is extremely important that the hospital work with community organizations, local government, local business leaders and other institutions to help increase access to critical services for the community. All available shortage area maps for California are located in Appendix C.

Shasta County's ratio of primary care, mental health, and dental providers to residents was worse than the State[5]. In addition, residents may experience difficulties scheduling appointments due to the shortage of health professionals in the area.

Health Professional	Shasta County	California
Primary Care Physicians 2019	1,410:1	1,270:1
Mental Health Providers 2019	330:1	310:1
Dentists 2019	1,370:1	1200:1

Insurance Coverage Estimates

Health insurance coverage can be a key element in an individual's ability to access health care services. For individuals and families, health insurance both enhances access to health services and offers financial protection against high expenses that are relatively unlikely to be incurred as well as those that are more modest but are still not affordable to some. To a great extent, the costs and consequences of uninsured and unstably insured populations are hidden and difficult to measure and the health effects may be absorbed by families in the form of diminished physical and psychological well-being, productivity, and income[6]. The following insurance coverage estimates for the Hospital's service area uses multiple proprietary and public data sets to estimate the counts of covered lives by insurance type[7].



[5] County Health Rankings
[6] National Institutes of Health
[7] The Claritas Company, IBM Corporation 2019

Access to Care Focus Group Comments

Strengths

- MMCR continuing to recruit physicians and specialists to area
- ED Navigators

Challenges

- Cost of care
- Increase capacity for integrated care model
- Physician shortage
- Length of time to get in to see doctor or specialist
- Transportation

Opportunities

- Introduce incentives for healthcare professionals to stay in the area

Alcohol and other Substance Use (including Tobacco Use)

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values[8].

Alcohol Consumption

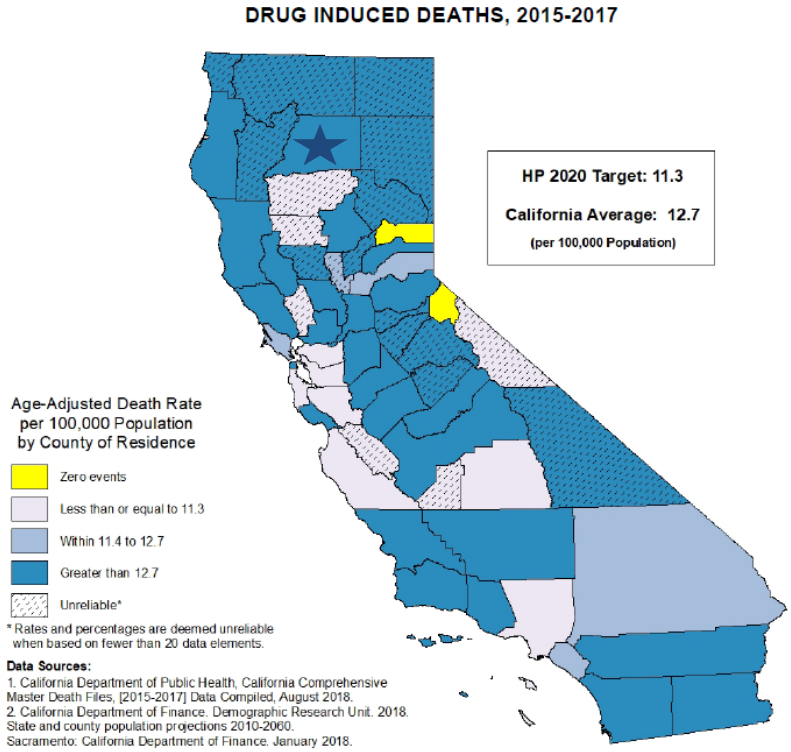
Excessive drinking is associate with significant increases in short-term risks to health and safety and the risk increases as the amount of drinking increases[9]. Shasta County residents exhibit a slightly higher rate of excessive drinking than the State. Shasta County's rate is 19% which is similar to the rate for the State (18%). Additionally, the number of alcohol-impaired driving deaths in Shasta County is significantly higher than the State. Excessive alcohol use may also be an indicator of other significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

Health Behavior	Shasta County	California
Excessive Drinking	19%	18%
Alcohol-impaired deaths	43%	30%

[8] Healthy People 2020
[9] Centers for Disease Control and Prevention

Drug Induced Deaths

The California Department of Public Health County Health Status Profiles indicates the age-adjusted death rate for drug induced deaths for Shasta County is 22.8 per 100,000 population. This rate is higher than the State (12.7).



Opioid Overdose

The California Department of Public Health County Health Opioid Overdose Surveillance Dashboard provides a data tool with enhanced data visualization and integration of statewide and geographically-specific non-fatal and fatal opioid-involved overdose and opioid prescription data[10]. The data indicates the age-adjusted death rate for opioid induced deaths for Shasta County is 14.1 per 100,000 while the state of California experienced 5.5 deaths per 100,000 people. Additional opioid related data is illustrated below.

[10] California Department of Public Health

Tobacco Use

Tobacco use is the leading cause of preventable death and can lead to disease and disability that harms nearly every organ of the body[11]. Adult tobacco use in Shasta County is 14% and is higher than the State rate of 11%[12]. It is important to note that California's adult cigarette smoking rate varies by population density, with higher rates predominantly in rural counties.

Addiction/Substance Abuse/Tobacco Use Focus Group Comments

Strengths

- Community working together to address opioid concerns

Challenges

- Education Awareness
- Funding
- Staffing

Opportunities

- Interagency collaboration
- Prevention education
- Culturally sensitive screenings for harmful substance use
- Find ways to expand substance use treatment

Cancers

Shasta County was ranked 56 out of 58 counties for deaths due to all cancers with an age-adjusted rate of 183.6 which is higher than the State at 137.4[13]. Additionally, lung cancer, female breast cancer, prostate cancer, and colorectal cancer were listed in the top 20 leading causes of death in Shasta County and are all higher than the State rate for each cancer type.

Rank	Leading Causes of Death (2015-2017)	Shasta County Age-Adjusted Death Rate	California Deaths Age-Adjusted Death Rate	HP 2020 National Objective
56	All Cancers	183.6	137.4	161.4
56	Lung Cancer	45.7	27.5	45.5
46	Female Breast Cancer	21.0	18.9	20.7
39	Prostate Cancer	20.8	19.4	21.8
56	Colorectal Cancer	16.7	12.5	14.5

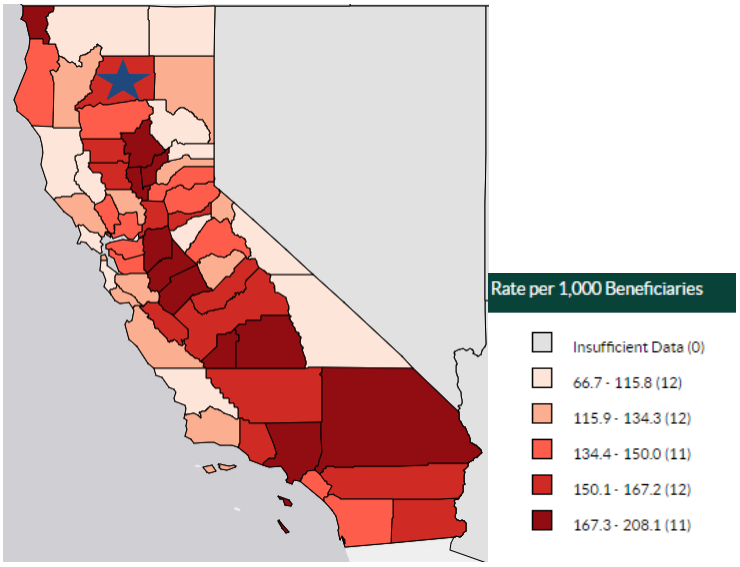
[11] Center for Disease Control and Prevention
[12] County Health Rankings
[13] California Department of Public Health

Cardiovascular Disease

Shasta County was ranked 55th out of 58 counties in California for deaths from coronary heart disease. Nationally, heart disease is the leading cause of death for both men and women and coronary heart disease is the most common type of heart disease, killing over 370,000 people annually[14].

Rank	Leading Causes of Death (2015-2017)	Shasta County Age-Adjusted Death Rate	California Deaths Age-Adjusted Death Rate	HP 2020 National Objective	Shasta County Previous Rate (2012-2014)
55	Coronary Heart Disease	127.0	87.4	103.4	121.2

Additionally, deaths from heart disease disproportionately affect the elderly. In 2014-2016, the total cardiovascular disease hospitalization rate was 158.7 per 1,000 Medicare Beneficiaries, 65+. All Races/Ethnicities, and both genders.



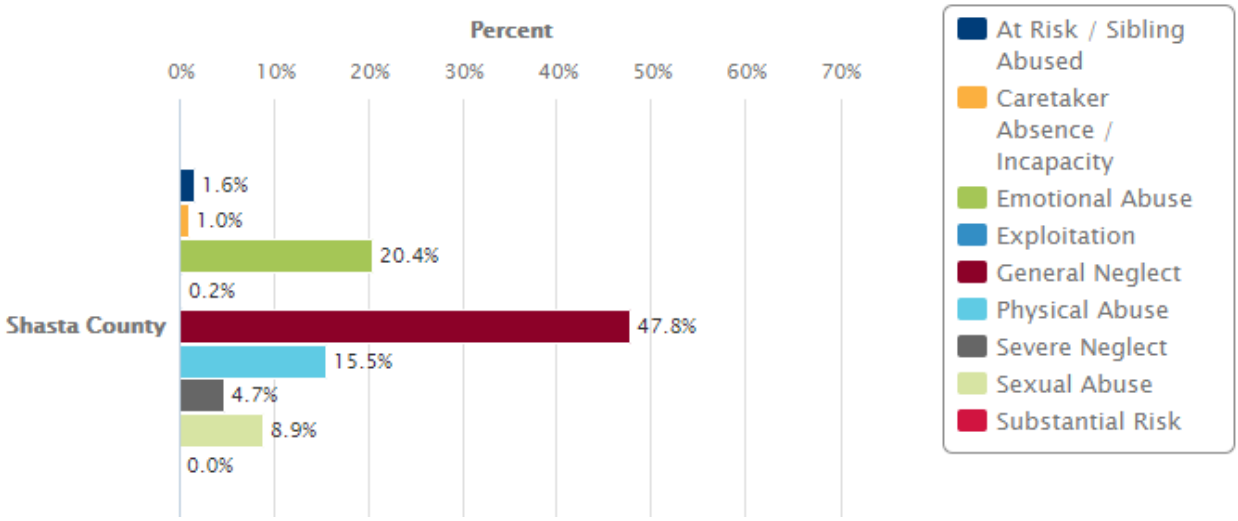
Child Abuse/Neglect

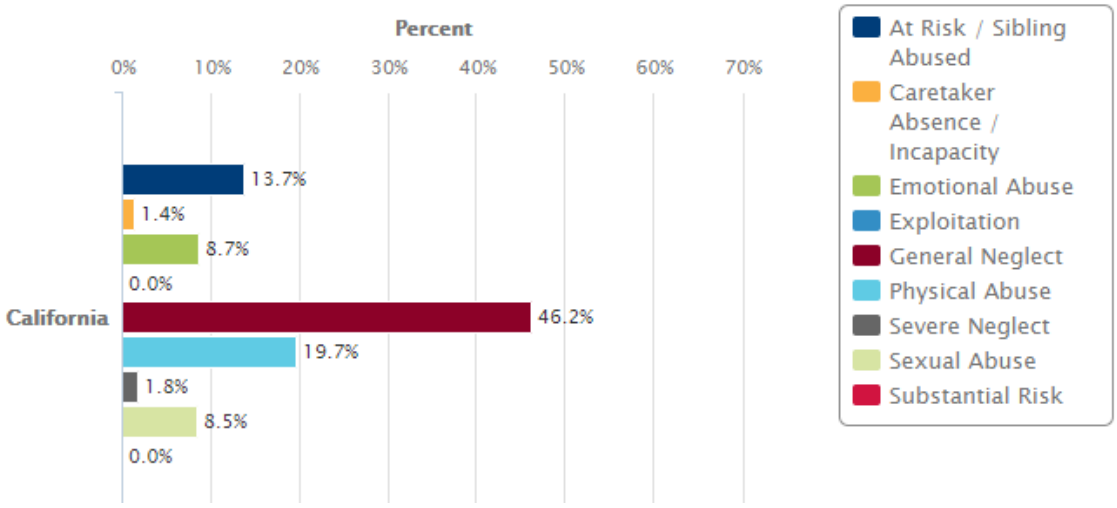
In 2015, there were 3,401 total reports of child abuse in Shasta County. Children who are abused or neglected, including those who witness domestic violence, also are more likely to experience cognitive, emotional, and behavioral problems, such as anxiety, depression, substance abuse, delinquency, difficulty in school, and early sexual activity. In addition, child maltreatment can disrupt brain and physical development, particularly when experienced in early childhood, increasing the risk for health problems in adulthood, e.g., heart disease, cancer, obesity, depression, and suicide,

[14] Centers for Disease Control and Prevention

among others. Children who are abused or neglected also are more likely to repeat the cycle of violence by entering into violent relationships as teens and adults or by abusing their own children[15].

Child Abuse Reports – 2015 Data





[15] Lucile Packard Foundation for Children's Health

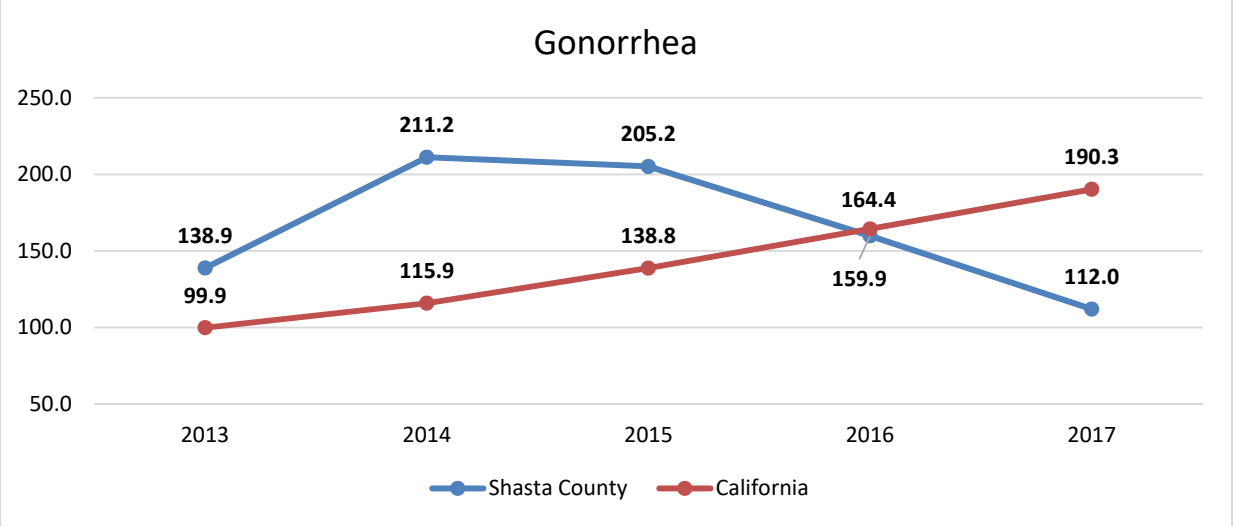
Communicable Diseases

Many reportable diseases can be prevented through vaccination of vulnerable populations, or through the use of protective measures, such as condoms for the prevention of sexually-transmitted diseases.

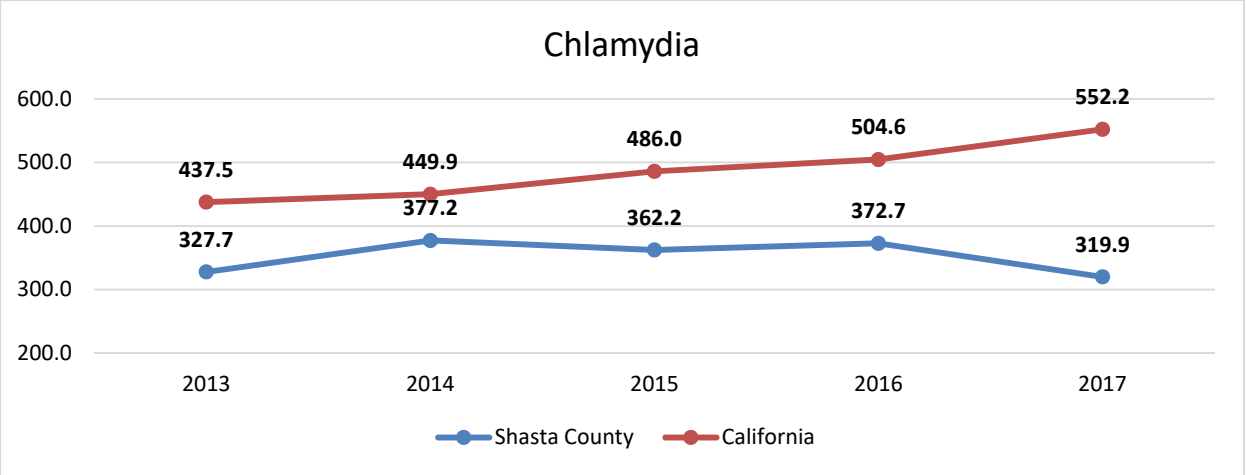
Vaccine Preventable Disease – 2017 Case Counts[16]

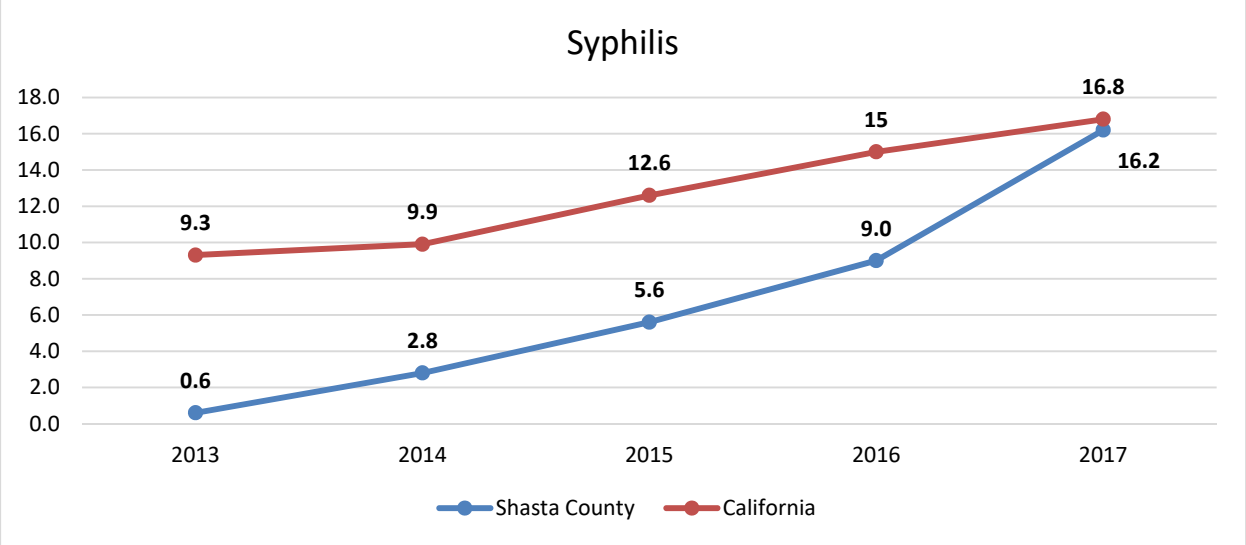
Vaccine-Preventable Diseases	Shasta County	California
Hepatitis A	1	948
Hepatitis B	1	126
Measles	0	15
Meningococcal Disease	1	61
Mumps	0	189
Pertussis	2	3,155
Rubella	0	1
Tetanus	0	2
Varicella (Chickenpox)	0	42

Sexually Transmitted Diseases – Incidence rates per 100,000 population

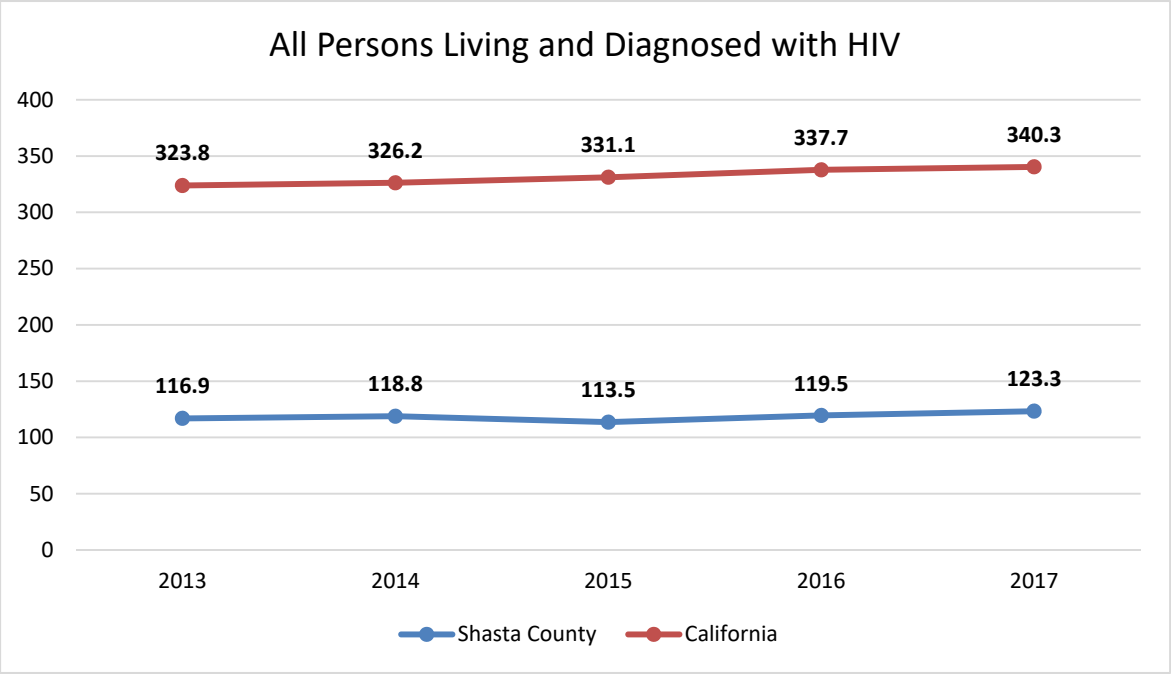


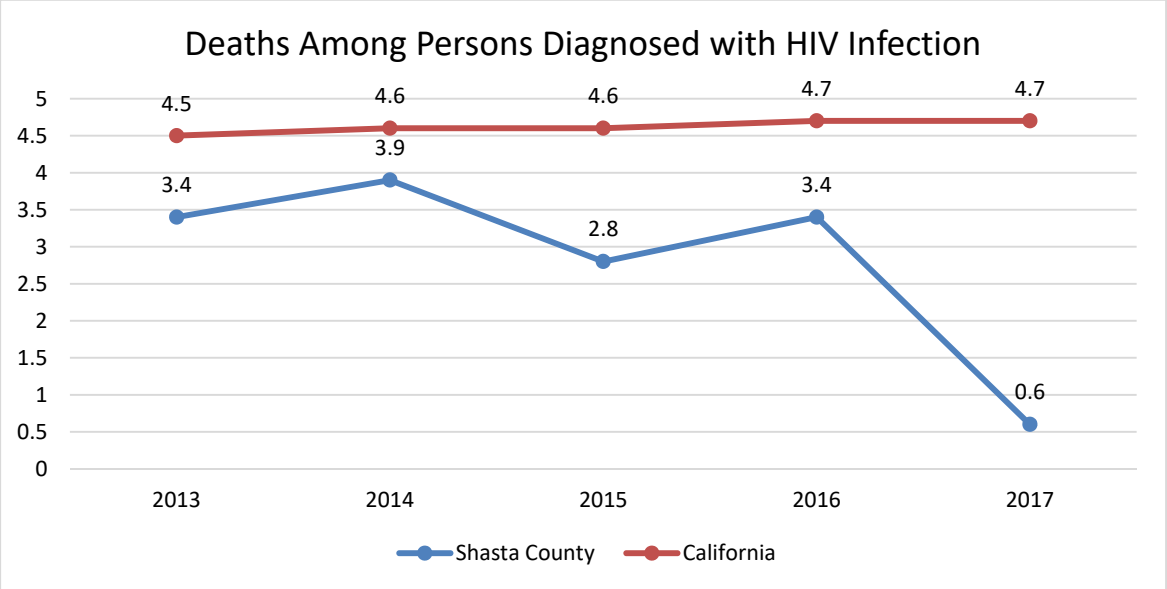
[16] California Department of Public Health – vaccine-preventable disease summary


Chlamydia
600.0
500.0
400.0
300.0
200.0
437.5
449.9
486.0
504.6
552.2
327.7
377.2
362.2
372.7
319.9
2013
2014
2015
2016
2017
Shasta County
California


Syphilis
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
9.3
9.9
12.6
15
16.8
0.6
2.8
5.6
9.0
16.2
2013
2014
2015
2016
2017
Shasta County
California

HIV/AIDS – Incidence rates per 100,000 population[17]

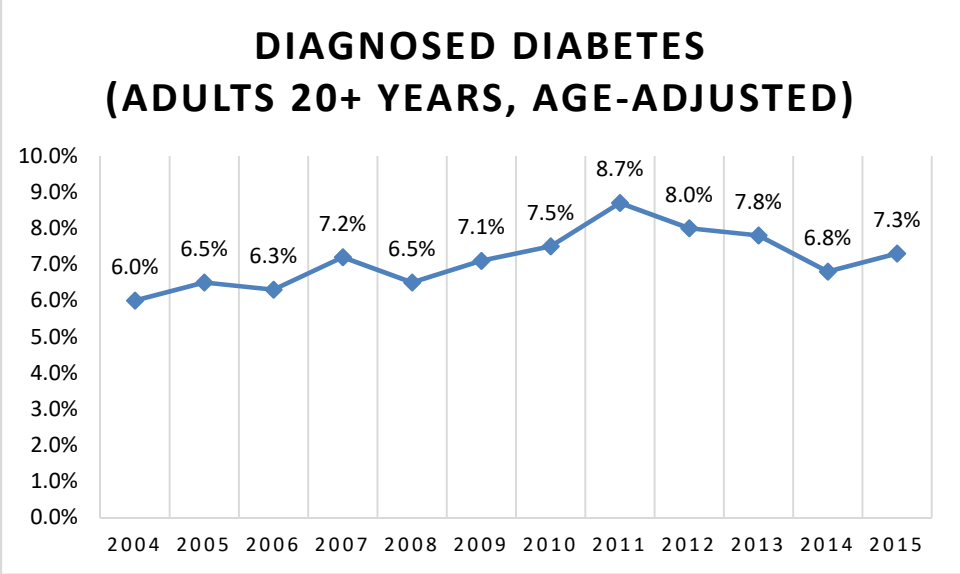




[17] California Department Public Health

Diabetes

Diabetes is an important marker for a range of health behaviors. This can be a valuable source of data for communities in understanding the toll that risky health behaviors can take on their population[18]. Diabetes puts individuals at risk for further health issues and increased costs of medical care and possibly disability, and premature death. Shasta County has a slightly lower rate (7.3%) than the State rate (9.6%) of individuals aged 20 and over who received a diabetes diagnosis. Even though Shasta County's rate of diagnosed diabetes is lower than the State, diabetes is listed in the leading causes of death in Shasta County indicating a sustained health need.

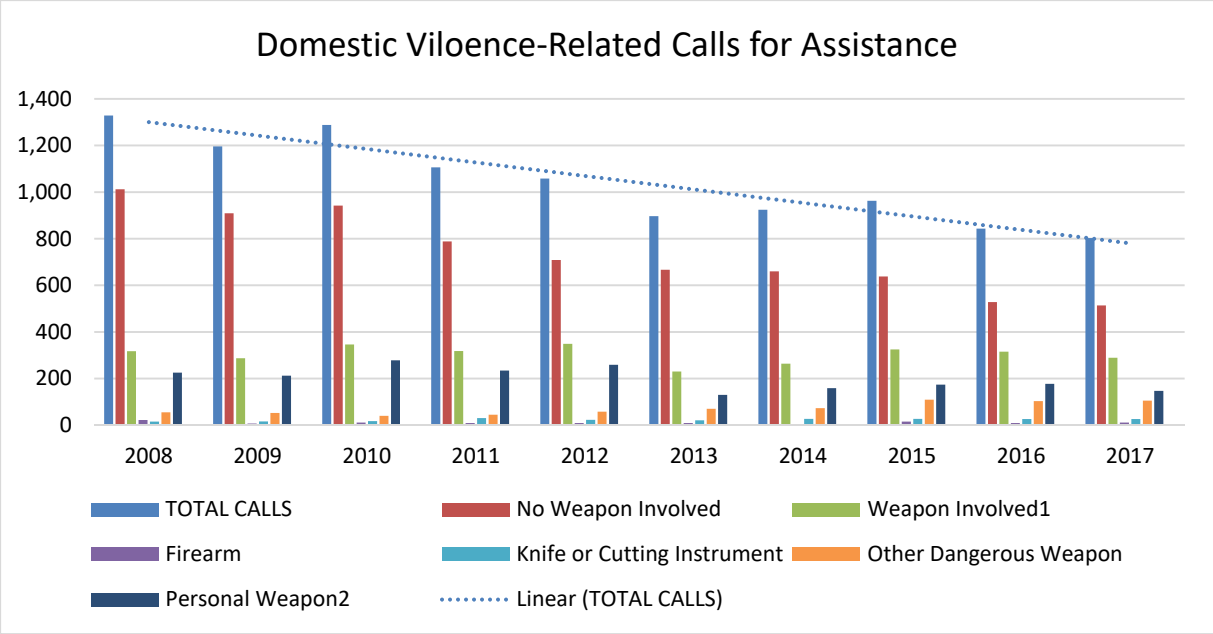


Domestic Violence

Violence between intimate partners or former partners in dating or marriage relationships can result in physical injury, psychological trauma, and even death. Violence may include intimidation, physical assault, battery, sexual assault, emotional abuse, stalking, and other abusive behavior. In the United States, an average of 20 people experience intimate partner physical violence every minute. This equates to more than 10 million abuse victims annually[19]. These figures are considered underestimates, as many victims do not report it.

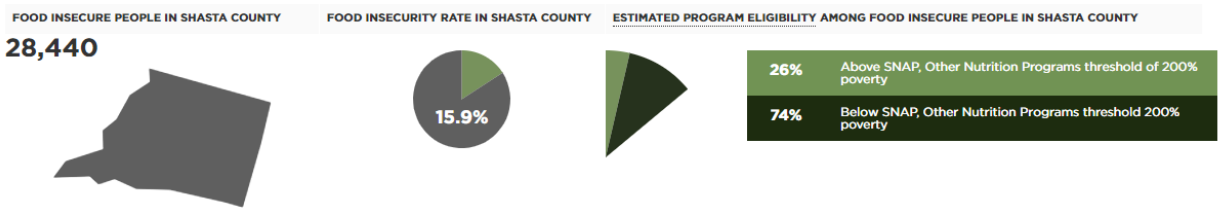
The number of domestic violence-related calls for assistance in Shasta County has declined since 2008[20], however, domestic violence remains a sustained issue in the community.

[18] County Health Rankings
[19] National Coalition Against Domestic Violence
[20] Department of Justice



Food Insecurity

Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods[21]. Based on data from *Feeding America*, the food insecurity rate in Shasta County is 15.9%, an estimated 28,440 food insecure people. In Shasta County, 26% of the population were above and 74% were below SNAP and other Nutrition Programs threshold of 200% of the poverty level.

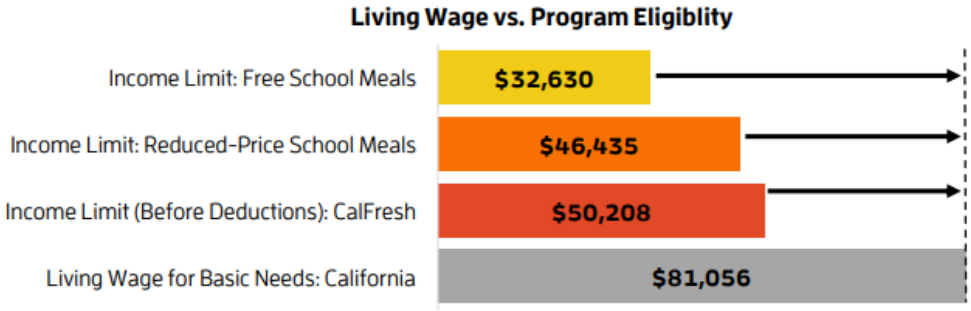


Data from *California Food Policy Advocates* also found that[22]:

- 98% of low-income students in Shasta County benefit from free or reduced-price meals during the school year but not during summer
- 55% of low-income Public Schools in Shasta County did not have access to an open summer meal site within a one-mile radius

[21] Feeding America
[22] California Food Policy Advocates

While the data from *California Food Policy Advocates* focused on Californians with incomes below 200% of the official federal poverty measure ($51,500 for a household/family size of four[23]), food insecurity also affects households with higher incomes. In many California communities, the official federal poverty measure does not reflect the true level of need – and neither do program eligibility criteria based on that measure. Below is a comparison of the maximum allowable income (before deductions) for CalFresh, income limits for school meal programs, and the living wage deemed necessary to meet the basic needs of a family of four in California.



Mental Health

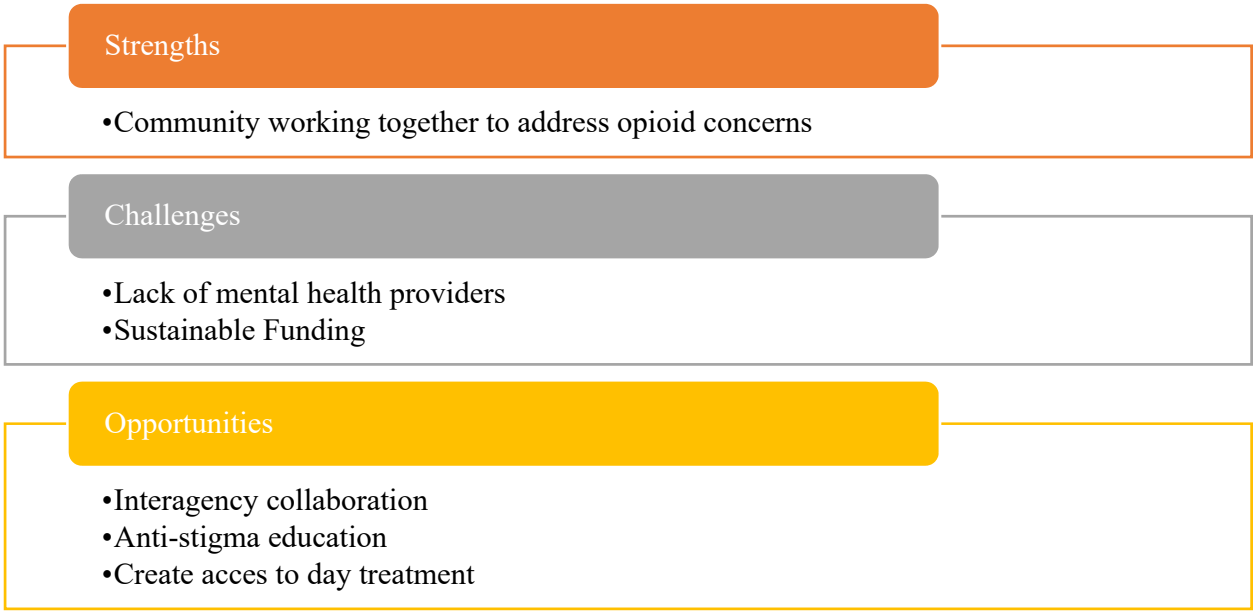
Mental health is described as a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

There is a lack of access to mental health services in MMCR's service area due, in part, to a lack of providers and ongoing sustainable funding for services. Compared to California, Shasta County has a lower rate of providers relative to the population. Shasta County residents report slightly higher rates of reported mentally unhealthy days and frequent mental distress days[24].

Measurement	Shasta County	California
Mental Health Providers 2019	330:1	310:1
Average number of mentally unhealthy days reported in the last 30 days	4.1	3.5
Percentage of adults reporting 14 or more days of poor mental health per month	12%	11%

[23] Families USA 2019 Federal Poverty Guidelines
[24] County Health Rankings

Mental Health Focus Group Comments



PRIORITIZED DESCRIPTION OF SIGNIFICANT HEALTH NEEDS

After the health needs were identified, focus group participants were asked to prioritize the needs. They were asked to choose three needs that they believed to be the most significant for the community in terms of having the greatest impact on the population and are not being met very well right now in the community. They were asked to consider the following definitions for prioritizing the needs:

- Size or scale of problem – the number, percentage, or rate of people affected
- Severity of problem – the degree to which the problem leads to death, disability or impairs one's quality of life. Also consider the risk of exacerbating the problem by not addressing at the earliest opportunity.
- Disparity and equity – the need has a disproportionate impact on a vulnerable segment of the community (subgroups of age, sex, race/ethnicity, geographic region)
- Known effective interventions - how likely it is that interventions will be successful in preventing or reducing the consequences of a problem; the potential to reach populations at greatest risk; and the ability of the community at large to mobilize to support the intervention.
- Resource feasibility and sustainability - consider what programs are currently in place to address the problem; consider the ability of organizations to reasonably impact the issue given available resources (i.e., availability of current or potential monetary, human, organizational, and/or community resources)
- Community acceptability – what does the community-at-large feel is important to address (i.e., evidence that it is important to community stakeholders)

After a review of all available primary and secondary data, and taking into consideration the focus group participants' discussions, ranking and prioritization process, the following areas were identified as the six areas of the most significant need for the community:

- Alcohol and other Substance Abuse (including Tobacco Use)
- Child Abuse
- Communicable Diseases
- Diabetes
- Mental Health

OVERALL THEMES OF THE CHNA

Reducing Health Disparities

Across the service area and in California, minorities and low-income families and individuals suffer disproportionately from lack of access to health care and a myriad of health problems linked to socio-economic status and race/ethnicity. A complex and interrelated set of individual, provider, health system, societal, and environmental factors contribute to disparities in health and health care. In Shasta County, this disparity is most evident in the areas of cultural and linguistic barriers to patient-provider communication for the Hispanic population. The results of the CHNA will be used, where possible, to highlight the health disparities and propose actions that can begin to alleviate them in the annual community health implementation plan.

Understanding the Complexity of Health Drivers

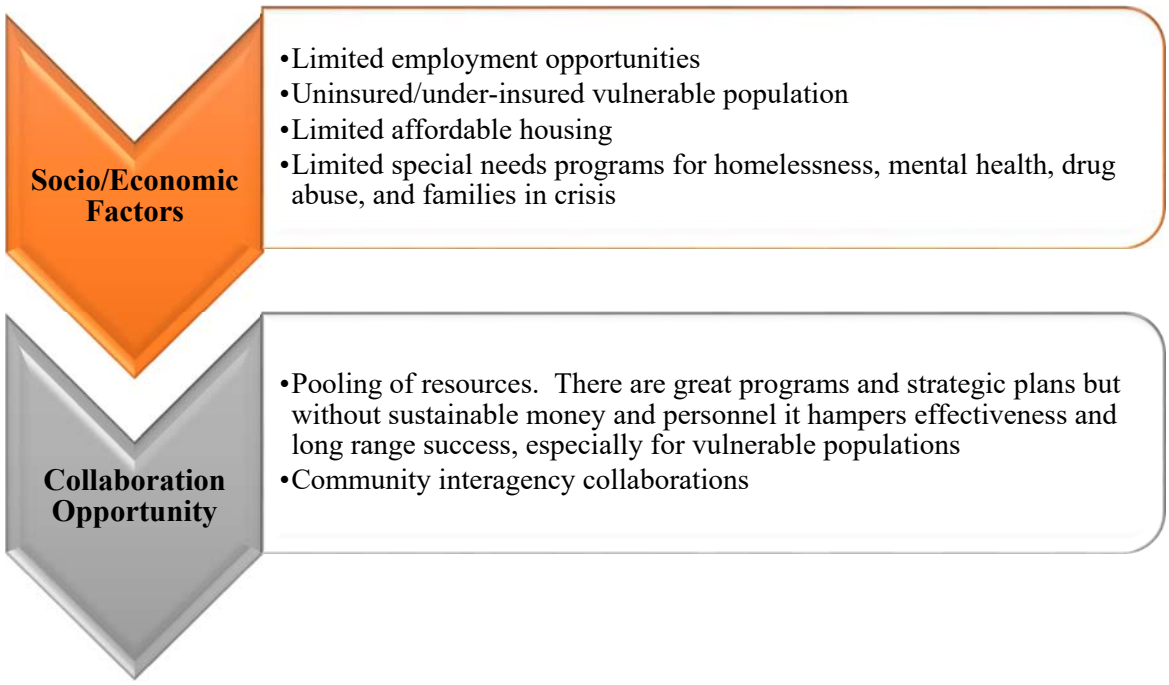
There is a lack of understanding among the public about the connection between social and environmental factors, access to care, and chronic disease management. Improving the public's understanding of complex health issues necessitates the collection of accurate data now and into the future. In developing this CHNA, the hospital identified the key stakeholders who are working diligently on these issues and asked them to contribute their data and expertise. The hospital will use this information to create key data indicators that can be used to measure the community's progress in improving these health issues. The results of the CHNA will be used to inform the hospital's annual community health implementation plan and through continued collection of data and public education, increase the community's understanding of the link between particular health issues and overall health and well-being.

Leveraging Opportunities

The CHNA is a critical planning document for the hospitals, and also a call to action for the entire community. The hospitals have a large role to play but, every individual and organization in the community can contribute to turning the curve on the identified significant health needs and other important health issues. Through the focus groups, some information was collected about the many important efforts already underway in the community.

In addition to the themes already mentioned above focus group participants were asked, from their perspective, to identify overarching challenges and opportunities for collaboration to help impact the

social determinants of heath for the community. Specific items around socio/economic factors and collaboration opportunities that emerged throughout the CHNA process are listed below:



It will take a groundswell of commitment from individuals and organizations, adding their resources and strength to other local efforts, if we are to be successful in making critical shifts in the overall health of the community and reduce health disparities.

RESOURCES POTENTIALLY AVAILABLE TO ADDRESS NEEDS

While resources are available to address the needs of the community, the needs are too significant and diverse for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and institutions. Shasta County is home to a wealth of organizations, businesses, and nonprofits including MMCR. The table below illustrates potential resources available for the significant health needs in Shasta County:

Significant Health Need	Potential Community Resource
Alcohol and Drug Abuse	Alcoholics Anonymous Empire Recovery Center Narcotics Anonymous Perinatal Substance Abuse Treatment Shasta County Alcohol & Drug Program Visions of the Cross
Child Abuse	Child and Family Services Extreme Love Strengthening Families Collaborative
Diabetes	Chronic Disease Self-Management Program Diabetes Self-Management Program Shasta Community Health Center
Communicable Diseases	Health & Human Services Agency
Mental Health	Hill Country Community Clinic Nurse Family Partnership programs Stand Against Stigma and Brave Faces campaigns
Tobacco Use	Tobacco Recovery Self-Management Quit for Good Smoking Cessation Program Second Wind Smoking Cessation Program Project Ex Teen Cessation Program

IMPACT OF ACTIONS TAKEN SINCE THE PRECEDING CHNA

Access to Care, Alcohol and Other Substance Abuse, Cancer, Child Abuse, Chronic Disease, Mental Health, Obesity & Physical Activity, Safety and Violence were identified as significant health needs in the 2018 CHNA. Since the preceding CHNA several improvements in health behaviors, health outcomes, resources and services have been made in collaboration with the Mobilizing for Action through Planning and Partnerships (MAPP) steering committee of Shasta County. In addition, MMCR's annual Community Benefit Reports and Plans describe actions and impacts in greater detail. The most recent report is available at http://www.dignityhealth.org/cm/content/pages/community-benefit-reports.asp.

Below are examples of the programs developed through collaborative efforts with community based organizations that represent actions taken since the preceding CHNA that directly address identified significant health needs:

Access to Care

- Care navigation and electronic referrals to community based organizations were implemented through the Coordinated Community Network Initiative (CCNI)
- Emergency Department based patient navigator program focused on assisting patients who rely on the emergency department for non-urgent needs. The navigators assist patients with scheduling follow-up appointments and any other barriers that may create obstacles with accessing care. This program represents a unique collaboration between Partnership Health Plan, a Medi-Cal insurance plan, and the hospital.

Alcohol and Other Substance Use

- Tobacco cessation classes
- Creation of a community collaborative focused on prevention of harmful substance use
- Expansion of treatment options and availability of medically assisted treatment and detoxification services for residents with substance use disorders

Cancer

- Lung Cancer Screenings
- Hospital-sponsored support groups for cancer provide an opportunity for patients and family members to share their concerns while learning to manage their condition
- Annual no-cost prostate screenings are provided to the community and allow routine screening for low-income/vulnerable populations
- Through a partnership with the local FQHC, the Stanford Self-Management Resource Center's Cancer Thriving and Surviving program is offered on-site at the hospital

Chronic Disease

- Exercise and education provided to patients during rehabilitation from a cardiac related event or surgery

- Increased awareness and understanding of the connection between adverse childhood experiences (ACE) and chronic disease
- The Stanford Model Chronic Disease Self-Management Program (CDSMP) titled Healthier Living, is an evidence-based chronic disease education program. This six-week long workshop is intended to educate participants about lifestyles changes and increase their self-efficacy managing their chronic disease(s) increasing their quality of life.
- The Diabetes Empowerment Education Program (DEEP) is an evidence-based diabetes education program for people with diabetes or pre-diabetes. This six-week long workshop is intended to educate participants about lifestyles changes and the day-to-day challenges of living with diabetes and the way it affects your quality of life.

Mental Health

- Funding through the community grants program was provided to local non-profit agencies in the areas of mental health and substance abuse to support community based organizations who are providing services to underserved populations to improve the quality of life for community residents.

Obesity & Physical Activity

- Participate on the Health Shasta Collaborative that promotes healthy eating and physically active lifestyles through environmental, policy, and organizational changes.
- Nutrition classes with Registered Dietician
- Research evidence-based physical activity programs and explore viability of offering to community through partnerships.

Safety and Violence

- Human Trafficking (HT) initiative focuses on:
    - Educating staff to identify and respond to victims within the hospital;
    - Provide victim-centered, trauma-informed care;
    - Collaborate with community agencies to improve quality of care;
    - Access critical resources for victims; and
    - Provide and support innovative programs for recovery and reintegration
- Continued collaboration with a local non-profit organization for the development of a Children's Legacy Center to ensure that children who are sexually or physically abused, trafficked, or are severely neglected receive services in a compassionate manner that does not re-traumatize the victim.

Ongoing collaboration with internal and external key stakeholders, post-acute care services, and the Care Coordinators has proven to be integral when addressing community needs outside the walls of the hospital.

APPENDIX A

FOCUS GROUP FACILITATOR PACKET AND SURVEYS

Dignity Health North State – Mercy Medical Center Redding
2019 Focus Group Instructions/Questions

ROOM PREP:

- Arrange room in small circle / horseshoe or combine tables; set up flip charts
- Place markers and nametags near entrance; pass out surveys, ballpoint pens, and stickers

INTRODUCTORY REMARKS (5 Minutes):

- Welcome and thanks
- What the project is about: We are conducting a Community Health Needs Assessment for Mercy Medical Center Redding, required by the IRS and the State of California.
- The purpose is to identify unmet health needs in our community, extending beyond patients.
- Ultimately, the intent is to use the information to understand and invest in community health strategies that will lead to better health outcomes.
- Why we're here (refer to agenda flipchart page):
    - Talk about impact of various other things that influence health
    - Hear from you about which community assets you are already aware of that can help address the identified health needs, and what community assets might still be needed
    - Please make yourself a nametag so that we can address one another appropriately.

WHAT WE'LL DO WITH THE INFORMATION YOU TELL US TODAY:

- Your responses will be summarized and your name will not be used to identify your comments.
- Your organization will be identified in the final report as having contributed input to the community assessment.
- Notes and summary of all focus group discussions will go to the hospital.
- Community input from focus groups and interviews will be considered, along with quantitative data on disease prevalence and socio-economic factors, to prioritize significant health needs for our report.
- The hospital will make decisions about which needs the hospital can best address, and how the hospital may collaborate or complement other community outreach work already being done in the community.

HOUSEKEEPING:

- Feel free to eat
- Focus group will end at _____ o'clock
- Silence cell phones
- Bathroom location

GUIDELINES/GROUND RULES:

- Don't wait to be called on.
- No right or wrong answers; we want to hear it all.
- Discussion –ask each other questions if you are unsure of what others mean
- Take turns being the first to jump in; Want to hear from everybody
- Please talk one at a time and hold side conversations for afterwards.
- It's OK to disagree, just be respectful. I may interrupt – [don't mean to be disrespectful; lots to cover, want to get you out on time.]

FOCUS GROUP SESSION

HEALTH NEEDS (5 Minutes):

When the hospital completed the 2018 Community Health Needs Assessment, the following significant health needs were identified (show list on flipchart page).

A. Are there any needs to add? Why?
B. Are there any needs you would say are not as significant now as in 2018? Why?

PRIORITIZING HEALTH NEEDS (10 Minutes):

A. Please think about the three needs (including any added ones) you believe are the most significant. These are the needs that you think have the greatest impact on the population and are not being met very well right now in Shasta County. You'll find some sticky colored dots on the table; once you've decided which three of these needs you think are the most important, please come on up here and put one sticky dot next to each one of those three.

Please consider the following definitions for weighting the needs:

- Size or scale of problem – the number, percentage, or rate of people affected
- Severity of problem – the degree to which the problem leads to death, disability or impairs one's quality of life. Also consider the risk of exacerbating the problem by not addressing at the earliest opportunity.
- Disparity and equity – the need has a disproportionate impact on a vulnerable segment of the community (subgroups of age, sex, race/ethnicity, geographic region)
- Known effective interventions - how likely it is that interventions will be successful in preventing or reducing the consequences of a problem; the potential to reach populations at greatest risk; and the ability of the community at large to mobilize to support the intervention.
- Resource feasibility and sustainability - consider what programs are currently in place to address the problem; consider the ability of organizations to reasonably impact the issue given available resources (i.e., availability of current or potential monetary, human, organizational, and/or community resources)
- Community acceptability – what does the community-at-large feel is important to address (i.e., evidence that it is important to community stakeholders)

Instruction to facilitator(s) – Each question should be written out on a separate easel pad for ease of recording answers

STRENGTHS (5 Minutes):

- **Thinking about the health needs that you just prioritized, what are our communities' strengths or what is working well today in addressing these needs?**

CHALLENGES (10-15 Minutes):

- **Again, thinking about the health needs that you just prioritized, what are our challenges and weaknesses?** *Prompts if they are having trouble thinking of anything:* transportation, housing, built environment incl. unsafe neighborhoods, lack of facilities/vendors, proximity to unhealthy things, policies/laws , cultural norms, stigma, lack of awareness, income challenges, lack of education, mental health and/or substance abuse issues, being victims of abuse, bullying, or crime.
    - **How do we overcome these challenges?**

- **What are some of the existing community resources could be used to address these health issues and inequities?** *Prompts if they are having trouble thinking of anything:* resources could include community organizations, religious and cultural organizations, characteristics of the community such as community cohesiveness, physical or built community characteristics such as parks, markets, or health centers, or other resources.

SOCIAL DETERMININTS (5-10 Minutes):

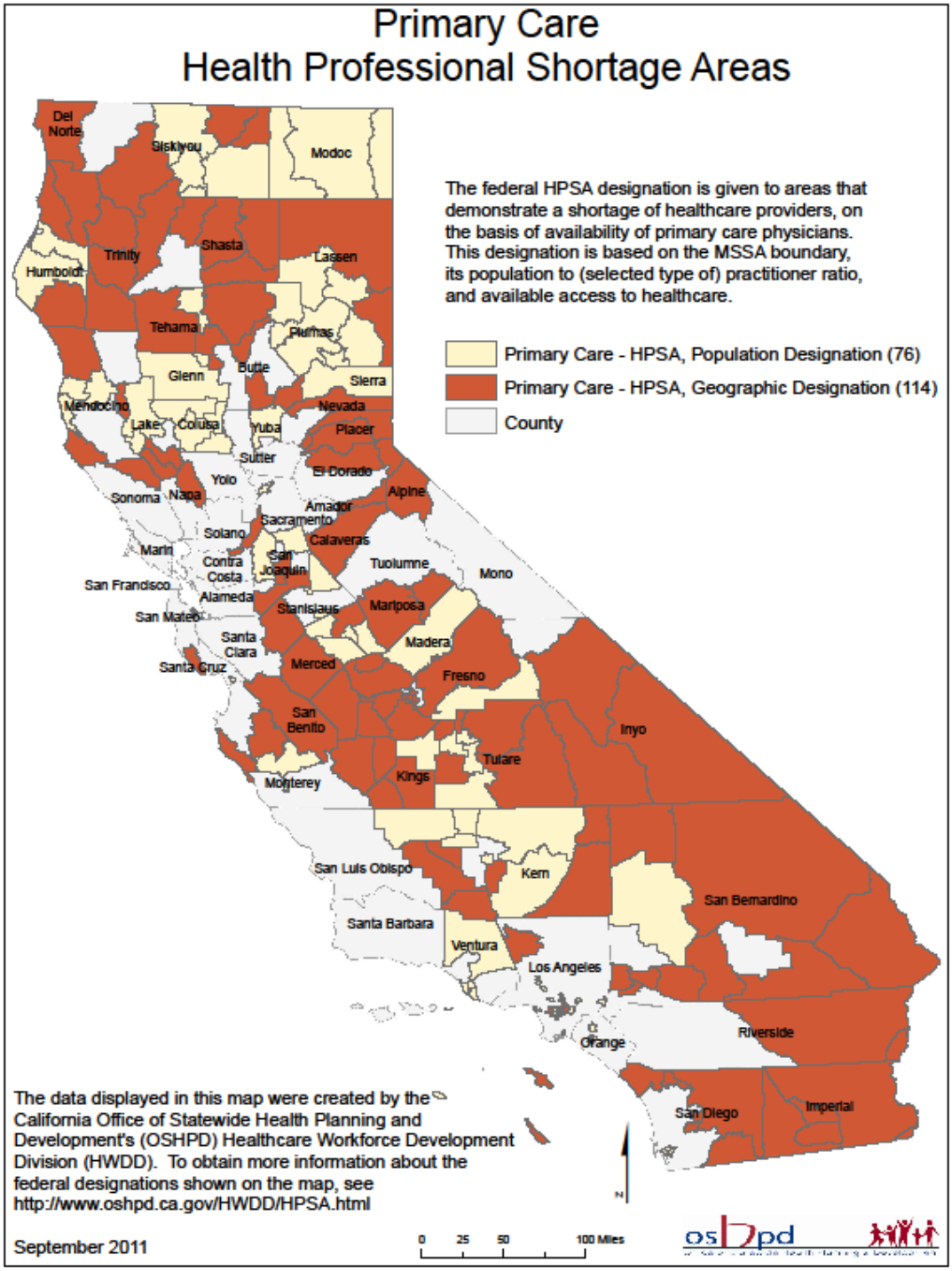
- **What socio/economic factors do you think have the biggest influence on these issues for the community? How and why?** *Prompts if they are having trouble thinking of anything:* income and social status; education; physical environment; social support networks; employment; housing; access to health care; food security

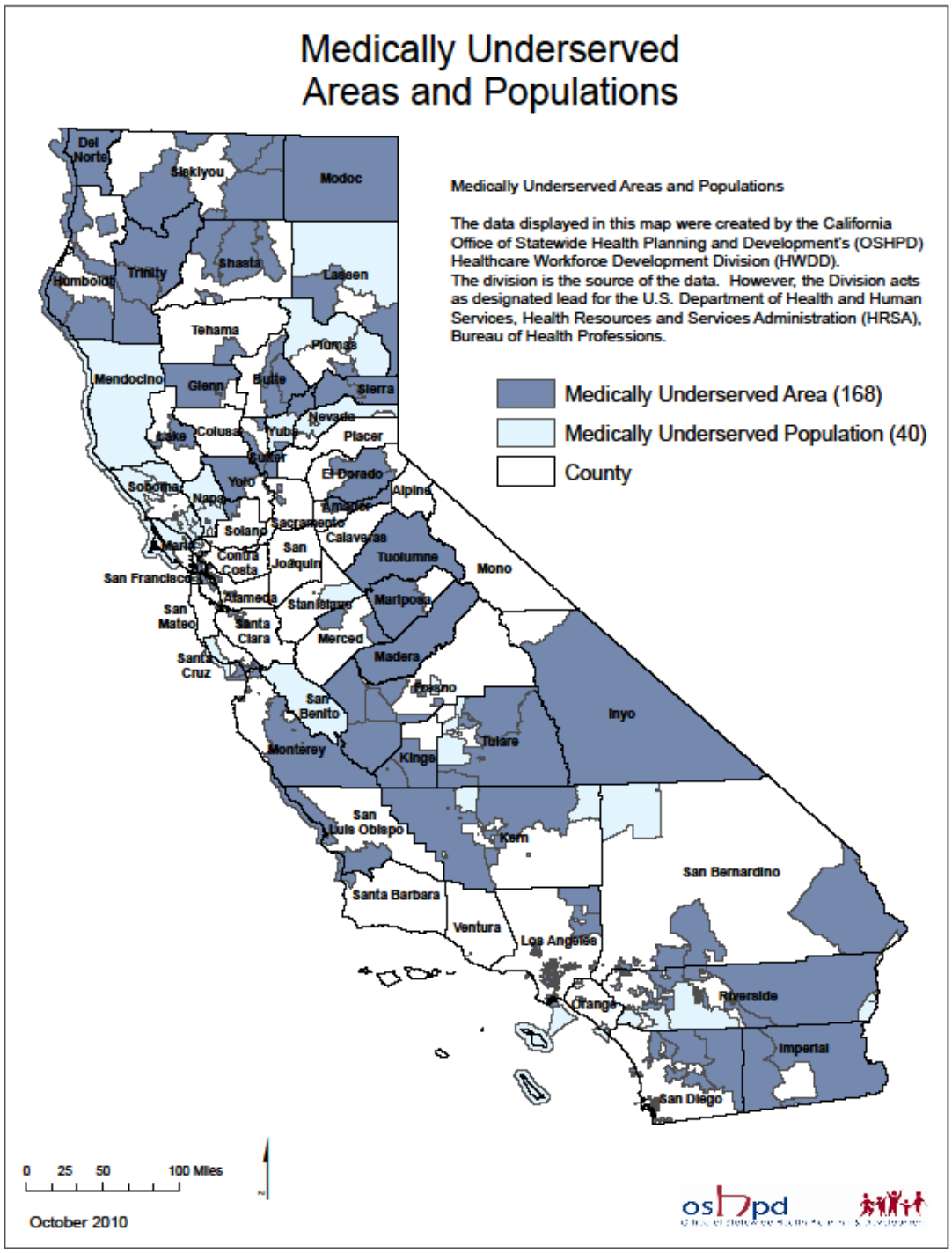
COLLABORATION (5 Minutes):

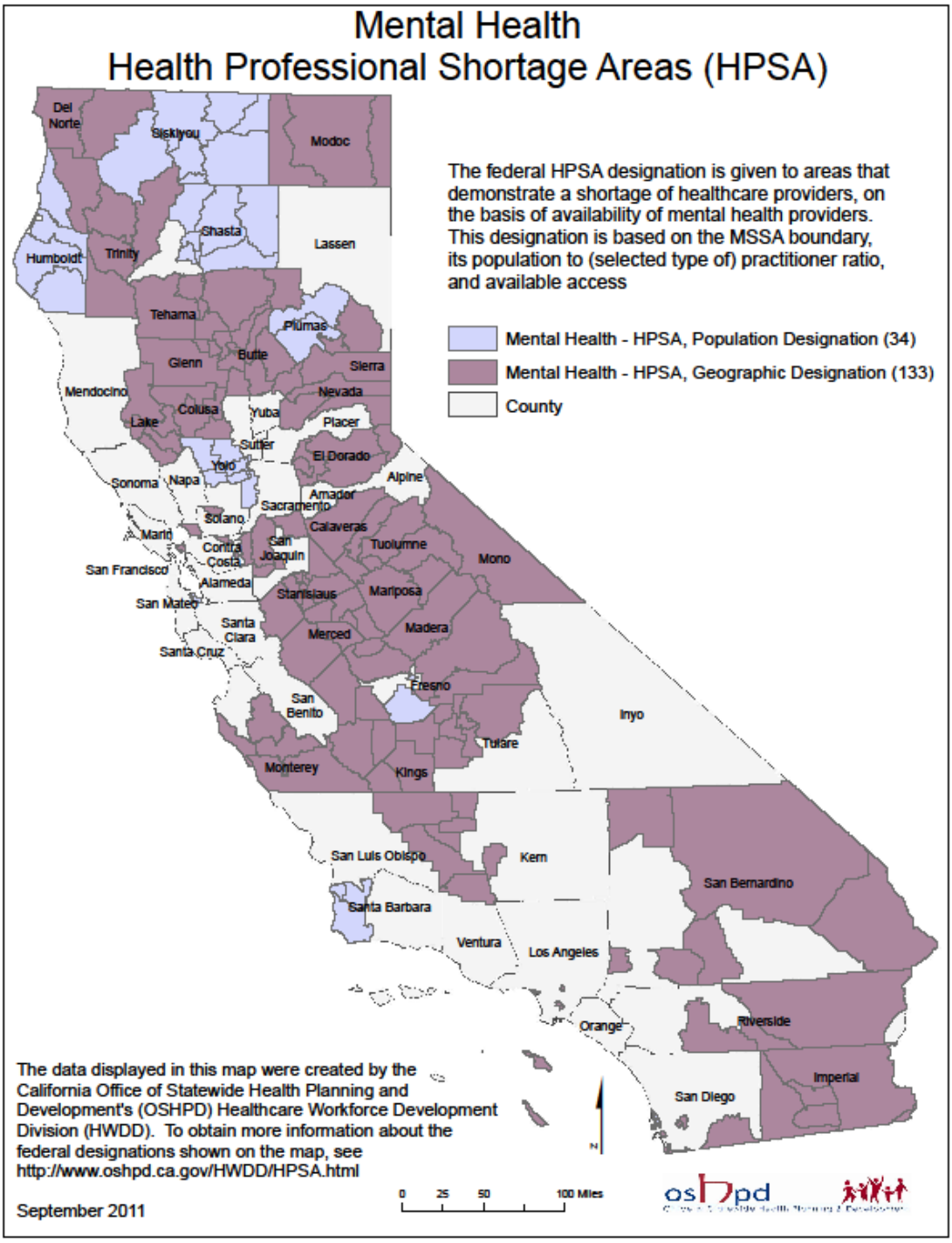
- **Are there any other opportunities for community organizations to partner/collaborate to address the social/economic needs identified?** *Prompts, if they are having trouble thinking of anything:* specific new/expanded programs or services; increase knowledge/understanding; address underlying drivers like poverty, crime, education; infrastructure (transportation, technology, equipment); information/educational materials; funding; collaborations and partnerships expertise.

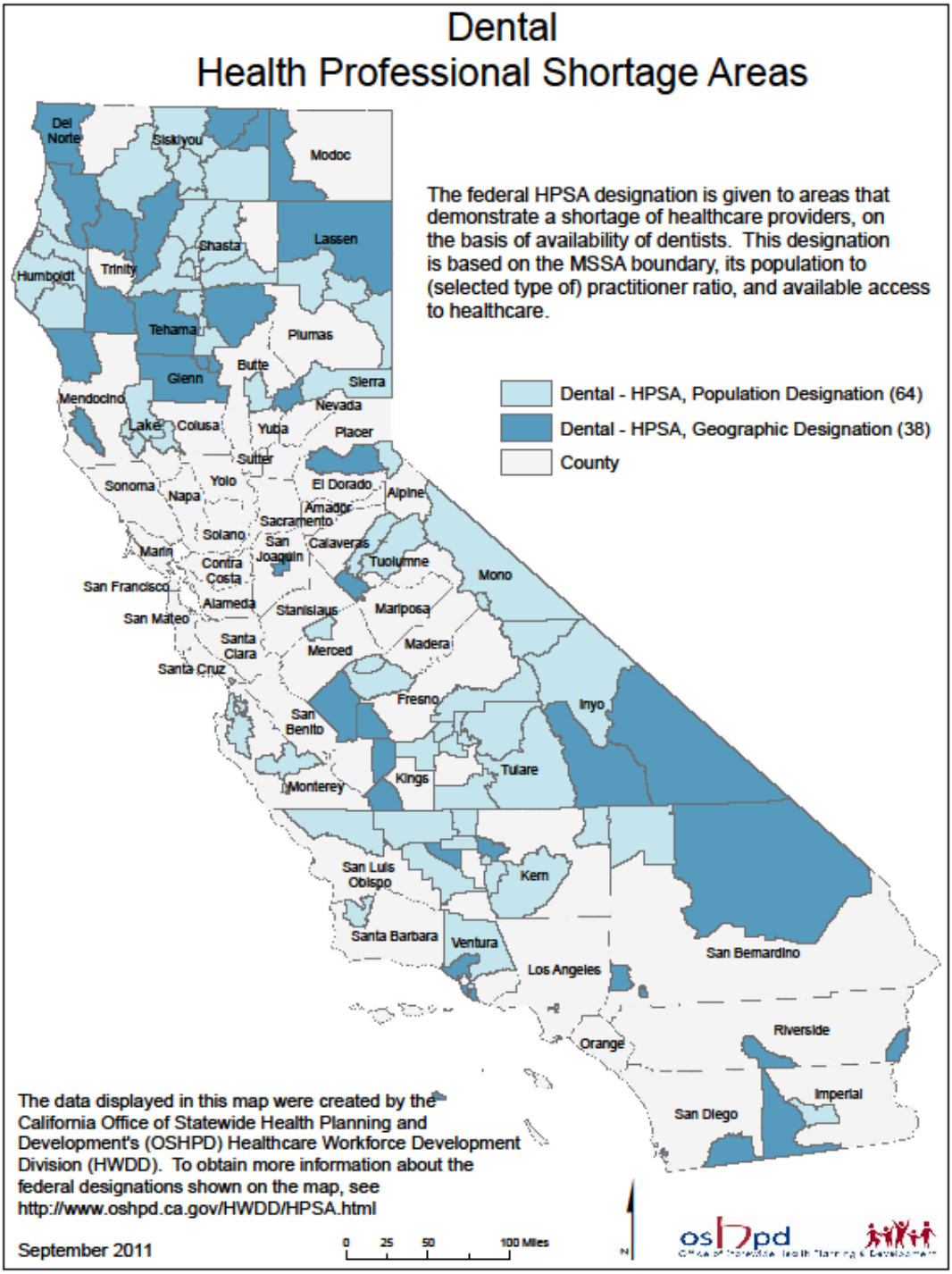
APPENDIX B

CALIFORNIA SHORTAGE AREA MAPS


Primary Care
Health Professional Shortage Areas
The federal HPSA designation is given to areas that demonstrate a shortage of healthcare providers, on the basis of availability of primary care physicians. This designation is based on the MSSA boundary, its population to (selected type of) practitioner ratio, and available access to healthcare.
Primary Care - HPSA, Population Designation (76)
Primary Care - HPSA, Geographic Designation (114)
County
Del Norte
Siskiyou
Modoc
Trinity
Shasta
Lassen
Humboldt
Tehama
Plumas
Glenn
Butte
Sierra
Nevada
Mendocino
Lake
Colusa
Yuba
Placer
Sutter
El Dorado
Yolo
Alpine
Sonoma
Napa
Amador
Sacramento
Solano
Calaveras
Marin
Contra Costa
San Joaquin
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Madera
Santa Cruz
Merced
Fresno
San Benito
Inyo
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Riverside
Orange
San Diego
Imperial
The data displayed in this map were created by the California Office of Statewide Health Planning and Development's (OSHPD) Healthcare Workforce Development Division (HWDD). To obtain more information about the federal designations shown on the map, see http://www.oshpd.ca.gov/HWDD/HPSA.html
September 2011
0 25 50 100 Miles
N
oshpd


Medically Underserved
Areas and Populations
Medically Underserved Areas and Populations
The data displayed in this map were created by the California Office of Statewide Health Planning and Development's (OSHPD) Healthcare Workforce Development Division (HWDD).
The division is the source of the data. However, the Division acts as designated lead for the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Professions.
Medically Underserved Area (168)
Medically Underserved Population (40)
County
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Nevada
Lake
Colusa
Yuba
Placer
Sutter
El Dorado
Sonoma
Yolo
Alpine
Napa
Amador
Solano
Sacramento
Calaveras
Marin
Contra Costa
San Joaquin
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Santa Cruz
Madera
Fresno
San Benito
Inyo
Monterey
Tulare
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
Imperial
San Diego
0 25 50 100 Miles
October 2010
oshpd


Mental Health
Health Professional Shortage Areas (HPSA)
The federal HPSA designation is given to areas that demonstrate a shortage of healthcare providers, on the basis of availability of mental health providers. This designation is based on the MSSA boundary, its population to (selected type of) practitioner ratio, and available access
Mental Health - HPSA, Population Designation (34)
Mental Health - HPSA, Geographic Designation (133)
County
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Glenn
Butte
Sierra
Mendocino
Nevada
Lake
Colusa
Yuba
Placer
Sutter
Yolo
El Dorado
Alpine
Sonoma
Napa
Amador
Sacramento
Solano
Calaveras
Marin
Contra Costa
San Joaquin
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
Fresno
San Benito
Inyo
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
Imperial
San Diego
The data displayed in this map were created by the California Office of Statewide Health Planning and Development's (OSHPD) Healthcare Workforce Development Division (HWDD). To obtain more information about the federal designations shown on the map, see http://www.oshpd.ca.gov/HWDD/HPSA.html
September 2011
0 25 50 100 Miles
N
oshpd


Dental
Health Professional Shortage Areas
The federal HPSA designation is given to areas that demonstrate a shortage of healthcare providers, on the basis of availability of dentists. This designation is based on the MSSA boundary, its population to (selected type of) practitioner ratio, and available access to healthcare.
Dental - HPSA, Population Designation (64)
Dental - HPSA, Geographic Designation (38)
County
Del Norte
Siskiyou
Modoc
Lassen
Shasta
Trinity
Humboldt
Tehama
Plumas
Butte
Glenn
Sierra
Mendocino
Nevada
Lake
Colusa
Yuba
Placer
Sutter
Sonoma
Yolo
El Dorado
Alpine
Napa
Amador
Sacramento
Solano
San Joaquin
Calaveras
Marin
Tuolumne
Mono
Contra Costa
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
Fresno
Inyo
San Benito
Tulare
Kings
Monterey
San Luis Obispo
Kern
Santa Barbara
Ventura
San Bernardino
Los Angeles
Riverside
Orange
Imperial
San Diego
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September 2011
0 25 50 100 Miles
N
oshpd