Dignity Health
St. Elizabeth Community Hospital

St. Elizabeth Community Hospital
2018 Community Health Needs Assessment

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EXECUTIVE SUMMARY

Rooted in Dignity Health's mission, vision and values, St. Elizabeth Community Hospital (SECH) 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 St. Elizabeth Community Hospital (SECH). 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 years.

SECH is located off of California Interstate 5 in Red Bluff, and serves a core service area population of 86,090 residents. Tehama County is a rural county with the residents being spread out over approximately 2,962 square miles. The majority of individuals served reside in Tehama County. However, there are community health services available to bordering communities in Glenn and Shasta counties. While SECH 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.

SECH is committed to involving residents in the community needs assessment process while being good stewards of limited resources. SECH 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 2018 CHNA was completed through a compilation of primary and secondary data which included a survey, key stakeholder focus groups, and review of established secondary data sources from public health statistics and U.S. Census data. The health needs assessment survey aimed to gain a thorough understanding of the medically underserved, low-income and minority populations living in SECH's primary 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.

After health needs were identified, focus group participants were also asked to help prioritize 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.

The following list of prioritized significant health needs was identified during primary and secondary evaluation at the conclusion of the CHNA process (listed in alphabetical order):

1. Access to Care
    a. Primary Care
    b. Urgent Care
    c. Specialty Care
2. Addiction/Substance Abuse (including Tobacco use)
3. Elderly Population
    a. Aging issues
    b. Alzheimer's/Dementia
    c. Elder Abuse
4. Cancers
5. Child Abuse/Neglect
6. Diabetes
7. Homelessness
8. Mental Health
9. Obesity

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. Tehama 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. SECH will continue to build community capacity by strengthening partnerships among local community-based organizations.

This CHNA report was adopted by the North State Service Area community board in May 2018 (tax year 2017), and follows the previous CHNA report adopted in October 2014 (tax year 2014). 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 St. Elizabeth Community Hospital's Community Health Office. Written comments on this report can be submitted to the St. Elizabeth Community Hospital's Community Health Office, 2550 Sister Mary Columba Drive, Red Bluff, CA 96080 or by e-mail to alexis.ross@dignityhealth.org.

MISSION, VISION AND VALUES

St. Elizabeth Community Hospital (SECH) is a member of Dignity Health, a 40 hospital faith-based organization providing health care services in California, Nevada and Arizona. SECH is a not-for-profit, 76-bed licensed acute care hospital and a sponsored ministry of the Sisters of Mercy of the Americas. 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.

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

Excellence - Exceeding expectations through teamwork and innovation.

ASSESSMENT PURPOSE AND ORGANIZATIONAL COMMITMENT

The purpose of this CHNA is to identify and prioritize significant health needs of the community served by SECH. The priorities identified in this report 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 requirements of the Patient Protection and Affordable Care and California Senate Bill 697 that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

SECH was established in 1907 and offers state-of-the-art medical technology and comprehensive care in providing the following services:

- 24- Hour Emergency Services (Level III Trauma)
- Inpatient Surgery
- Freestanding Outpatient Surgery Center
- Medical/Surgical Units
- Intensive Care Unit (8 beds)
- Maternal-child unit with a water birthing option and certified lactation consultation
- Full Service Outpatient/ Inpatient Imaging Services including MRI and PET/CT
- Respiratory Care Services
- Wound Services
- Social Services
- Spiritual Care Services
- Home Health & Hospice Services
- Physical Therapy & Occupational Therapy
- Laboratory Services & 2 Laboratory Draw Stations outside of the hospital
- Endoscope
- Pediatric Services
- Orthopedics, including minimally invasive and total joint replacement
- Sports Medicine Program
- Diabetic and Congestive Heart Failure (CHF) education and support program
- Chronic Disease Management education and support program
- Pharmacy (Internal)

SECH is committed to providing quality health and wellness services that address the health-related needs of our primary and secondary service areas. In the spirit of the Scriptures and the Sisters of Mercy tradition, we dedicate ourselves to a Christian-oriented response that embraces physiological, psychological, and spiritual healing, as well as the promotion of health. Fundamental to this response is respect for the dignity of all persons, those serving as well as those served, and reverence for life at all ages.

COMMUNITY DEFINITION

The University of Wisconsin Population Health Institute ranked each county in California for health outcomes and health factors. The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

Tehama County is 43rd out of 57 counties for health outcomes and 47th out of 57 for health factors. 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.

SECH serves a core service area population of 86,090 residents. Tehama County is a rural county with the residents being spread out over approximately 2,962 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 majority of individuals served reside in Tehama County. However, there are community health services available to bordering communities in Glenn and Shasta counties. The following zip codes make up the core service area for SECH:

Zip Code	*City*	*County*
95963	Orland	Glenn
96021	Corning	Tehama
96022	Cottonwood	Shasta
96035	Gerber	Tehama
96055	Los Molinos	Tehama
96080	Red Bluff	Tehama

Population Density & Demographics

Tehama County is situated in the northern portion of the Sacramento Valley and is divided in half by the Sacramento River. Red Bluff, the county seat, was established in 1856 and is located on the Interstate 5 corridor. While the majority of individuals served reside in Tehama County there are community health services available to bordering communities in Glenn and Butte counties.

The service area's population remains extremely flat with growth between 2010 and 2018 being less than 1%, while California has grown 6.6% within the same timeframe. Additionally, SECH serves a

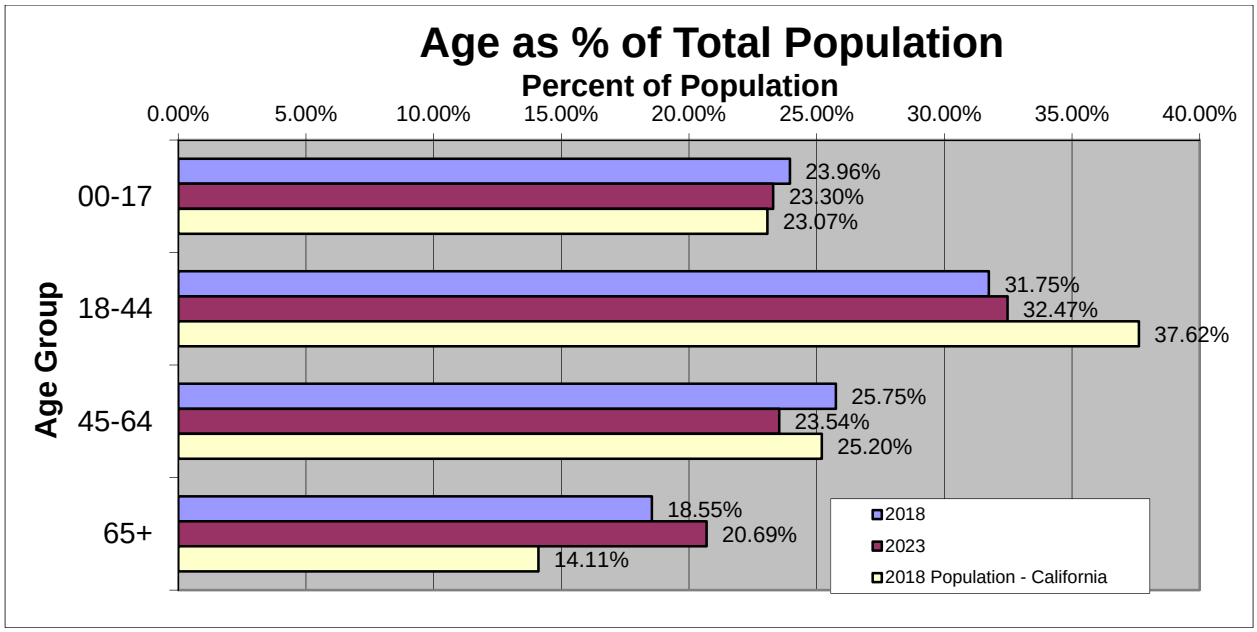
very rural population with approximately 29.1 people per square mile, while California has approximately 254.8 people per square mile.

	Core Service Area	California
2010 Population	85,318	37,253,957
2018 Population	86,090	39,695,753
Change in population	772	2,441,796
Percent Change	0.9%	6.6%
Land in Square Miles	2962	155,779
Population Density	29.1	254.8

Age Distribution

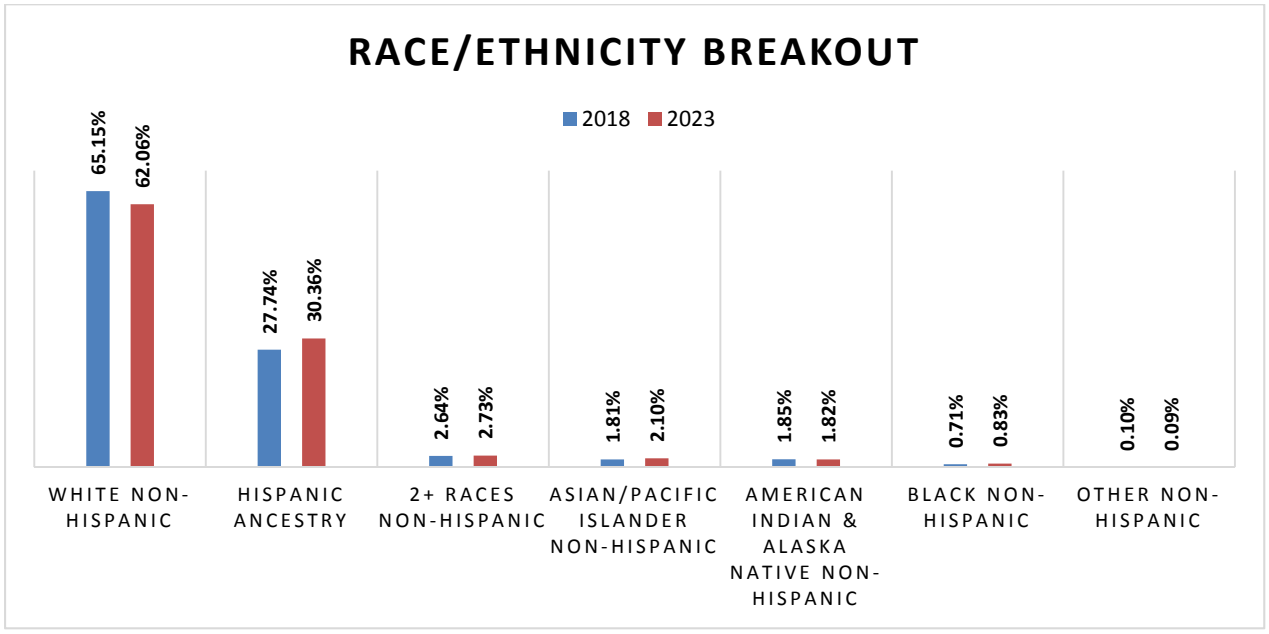
Age and sex distribution within SECH's service area indicates that 50.3% are female and 49.7% are male and that there are more individuals that are 65 and over (18.55%) as compared to California (14.11%) and this age segment is projected to experience an annual growth rate of 2.55%. The largest age segment within SECH's service area are those between the ages of 18 to 44, accounting for 27,330 individuals or 31.75% of the service area population.

	SECH Service Area Population					California Population	
Age Group	***2018***	***% of Total***	***2023***	***% of Total***	***% of Annual Growth***	***2018***	***% of Total***
0-17	20,623	23.96%	20,398	23.3%	**-0.22%**	9,158,873	23.07%
18-44	27,330	31.75%	28,429	32.47%	**0.79**	14,934,130	37.62%
45-64	22,170	25.75%	20,604	23.54%	**-1.45%**	10,003,373	25.20%
65 and Over	15,967	18.55%	18,111	20.69%	**2.55%**	5,599,377	14.11%
Total	**86,090**	**100.0%**	**87,542**	**100.0%**	**0.34%**	**39,695,753**	**100.0%**



Race and Ethnicity

While the majority of the service area population is Caucasian, there is a large Hispanic population that is anticipated to grow 2.62% over the next five years.



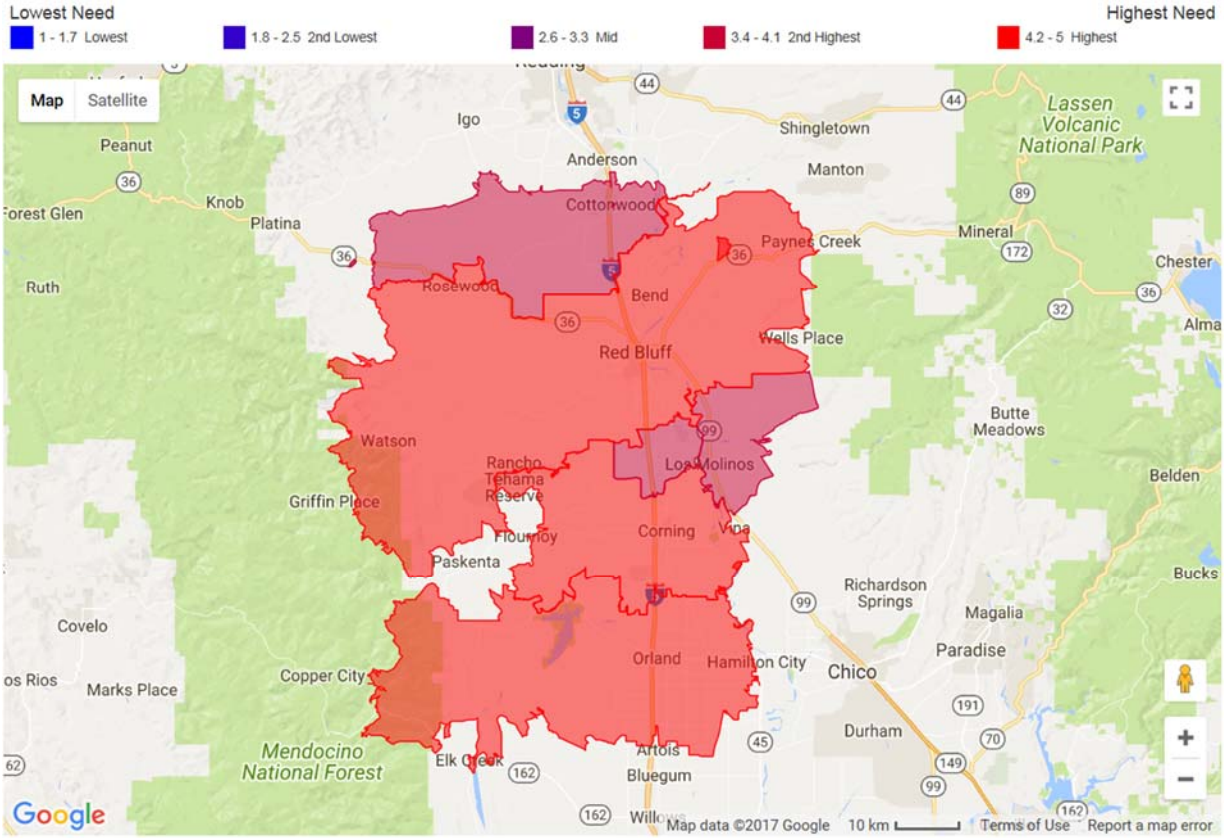
Other pertinent demographics for SECH's service area are listed below:

- Median Income: $45,726
- Uninsured: 10.8%
- Unemployment: 6.9%
- No HS Diploma: 18.6%
- Medicaid Patients: 36.4% - *Does not include individuals dually-eligible for Medicaid and Medicare*

Community Need 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. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are 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 median CNI score of 4.1 for SECH's community places it toward the high end of relative need. The CNI map and ZIP code-specific scores are outlined on the following page.

Community Need Index Map



Mean(zipcode): 4.2 / Mean(person): 4.3 | CNI Score Median: 4.1 | CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
95963	4.6	16684	Orland	Glenn	California
96021	4.8	16400	Corning	Tehama	California
96022	3.6	15922	Cottonwood	Tehama	California
96035	4	3677	Gerber	Tehama	California
96055	3.8	3846	Los Molinos	Tehama	California
96080	4.2	29666	Red Bluff	Tehama	California

ASSESSMENT PROCESS AND METHODS

SECH is committed to involving and informing the residents in the community needs assessment process while being good stewards of limited resources. The CHNA is conducted every three years and identifies the health needs of residents by acknowledging ongoing health concerns within the community. SECH 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 for direct community health programs and services for the community.

SECH 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 2018 CHNA was completed through a compilation of primary and secondary data which included a survey, key stakeholder focus groups, and review of established secondary data sources from public health statistics and U.S. Census data. Each data source and the process utilized for collection and assessment is described in the following subsections.

Primary Data Sources

Primary data can be described as data that is collected or observed directly from first-hand experience. This can be accomplished through the use of focus groups, community surveys, or key stakeholder interviews. The primary data for the SECH 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.

SECH looked to community based organizations to represent their respective clientele in the survey process wherever appropriate to understand the services underrepresented populations are accessing. Focus group meetings were conducted for St. Elizabeth Community Hospital Advisory Council, Tehama County Public Health Department and Board, and Tehama County Elder Services Group. Input from these coalitions was instrumental to the hospital in conducting the needs assessment. Listed below are the community stakeholders from whom input was sought during each focus group meeting:

<u>St. Elizabeth Community Hospital Advisory Council</u>

- Corning retired Police Chief
- Executive Director, Tehama County Public Health Services Agency
- Red Bluff Chamber of Commerce

- Tehama County District Attorney
- Tehama County Sherriff
- Various Community Members – including a retired physician
- Walmart Distribution Center

Tehama County Public Health Department and Board

- Corning Health Center
- California State University Chico
- Dignity Health Connected Living
- Empower Tehama
- Greenville Rancheria
- Rape Crisis Intervention
- Red Bluff Joint Union High School District
- Tehama County Department of Social Services
- Various Community Members

Tehama County Elder Services Group

- Brookdale Senior Living
- Corning Healthcare District
- Dignity Health Connected Living
- Mercy Housing
- Paratransit Services
- Passages Area Agency on Aging
- Public Authority
- Tehama County Adult Services
- Tehama County Department of Social Services and Community Action Agency
- Tehama County Public Guardian
- Tehama Together
- Veterans Resource Center

These groups of 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 June-July, 2017 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. At the end of each focus group session, participants were also asked to complete three brief community health perception surveys. The final survey instrument was previously developed by SECH and Tehama County Public Health and is similar to the surveys used by the hospital for previous CHNA's to keep trending intact.

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 statistical representative sample of the community due to the rural nature of the service area. Content of the focus group conversations and survey results were analyzed by the Service Area Director of Community Health, who holds a graduate degree in data analytics, to find common themes and differences among the results from all participants.

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 2018 CHNA was obtained through CHNA.org, U.S. Census data, and the University of Wisconsin Population Health Institute. CHNA.org and the 2018 County Health Rankings Report were free resources and were used to validate the information obtained from the focus groups and survey results. The data provided through CHNA.org contains aggregated data points available from 7,000 public data sources, including the Centers for Disease Control and Prevention and the National Center for Chronic Disease Prevention and Health promotion. The County Health Rankings Report contains data using a compilation of county-level measures from a variety of national and state data resources and are standardized and combined using scientifically-informed weights (University of Wisconsin Population Health Institute, 2018).

Information gaps were identified through this process that may limit the ability of this CHNA to assess the entirety of the community's health needs. There is limited quantitative data available at the local level for rural areas, as well as, a lack of focus group participation and survey responses from the Hispanic population due to a lack of a translator and a Spanish version of the survey instrument.

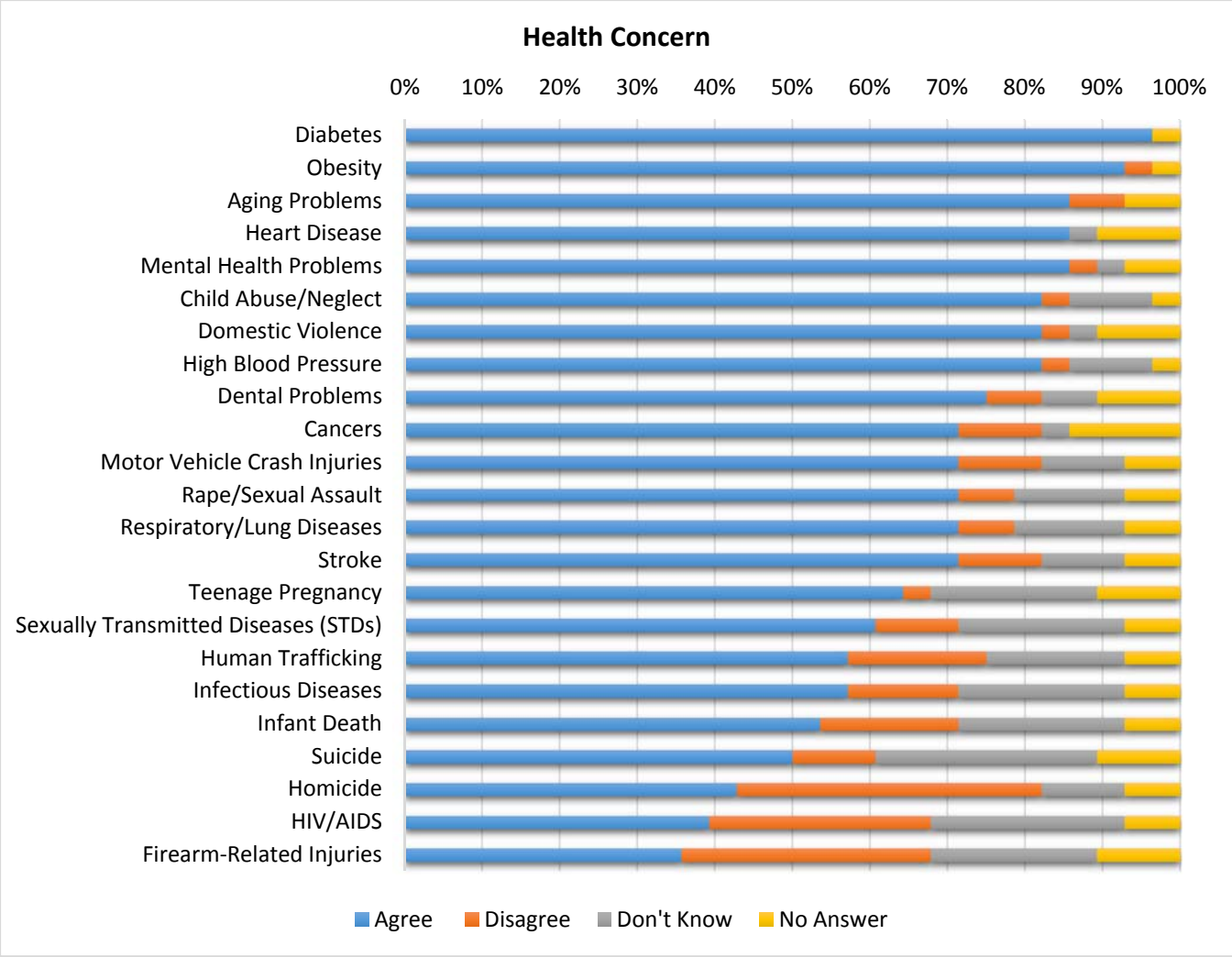
ASSESSMENT DATA AND FINDINGS

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 primary 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 are the health needs that were identified through the focus group discussions. The individual results of the surveys are listed on the following pages.

- Aging Problems
- Cancers
- Child Abuse/Neglect
- Dental Problems
- Diabetes
- Domestic Violence
- Firearm-Related Injuries
- Heart Disease
- High Blood Pressure
- HIV/AIDS
- Homicide
- Human Trafficking
- Infant Death
- Infectious Diseases
- Mental Health Problems
- Motor Vehicle Crash Injuries
- Obesity
- Rape/Sexual Assault
- Respiratory/Lung Diseases
- Sexually Transmitted Diseases (STDs)
- Stroke
- Suicide
- Teenage Pregnancy

Survey: Perceived Health Concerns

The CHNA survey contained the list of pre-populated health concerns that were based on previous assessments. Respondents to the survey were asked to agree or disagree with whether or not they perceive the health issue as a concern for the community. The bar chart on the following page displays the results for each health issue sorted by the percentage of answers that were "agree" it is a significant need. It is also important to note that individuals were only allowed one choice per health concern. Additional health concern categories that respondents identified were captured in the focus group results and will be included in any future CHNA surveys.

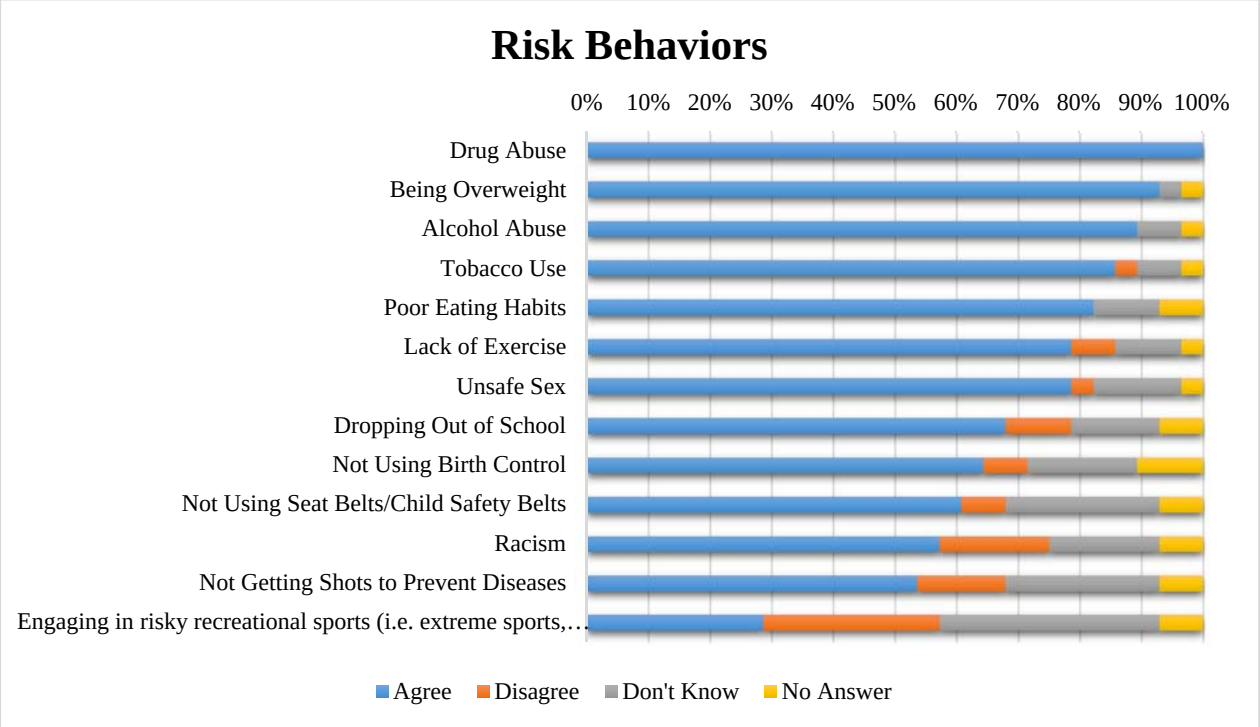


Diabetes and obesity were among the tier one health needs identified by this method receiving more than 90% of the respondents agreeing that they are a significant issues. Tier two health needs identified were: problems associated with aging; heart disease; mental health; child abuse/neglect; domestic violence; and high blood pressure. All of these received between 80 and 89% of respondents agreeing that they are significant issues.

Survey: Perceived Health Risk Behaviors

Still focused on the community as a whole, respondents were then asked to agree or disagree with whether or not certain behaviors were perceived as high risk behavior and an issue for the community. The list of high risk behaviors was pre-populated with behaviors from prior assessments in order to keep trending from previous assessments intact. Respondents to the survey were again asked to agree or disagree with whether or not they perceive the risk behavior as a concern for the community. The following bar chart displays the results for each risk behavior sorted by the percentage of answers that were "agree" based high to low. It is also important to note that individuals were only allowed one choice per risk behavior. As with the health concerns, any

additional risky behavior categories that respondents wanted to see as a choice were captured in the focus group results and will be included in any future CHNA surveys.



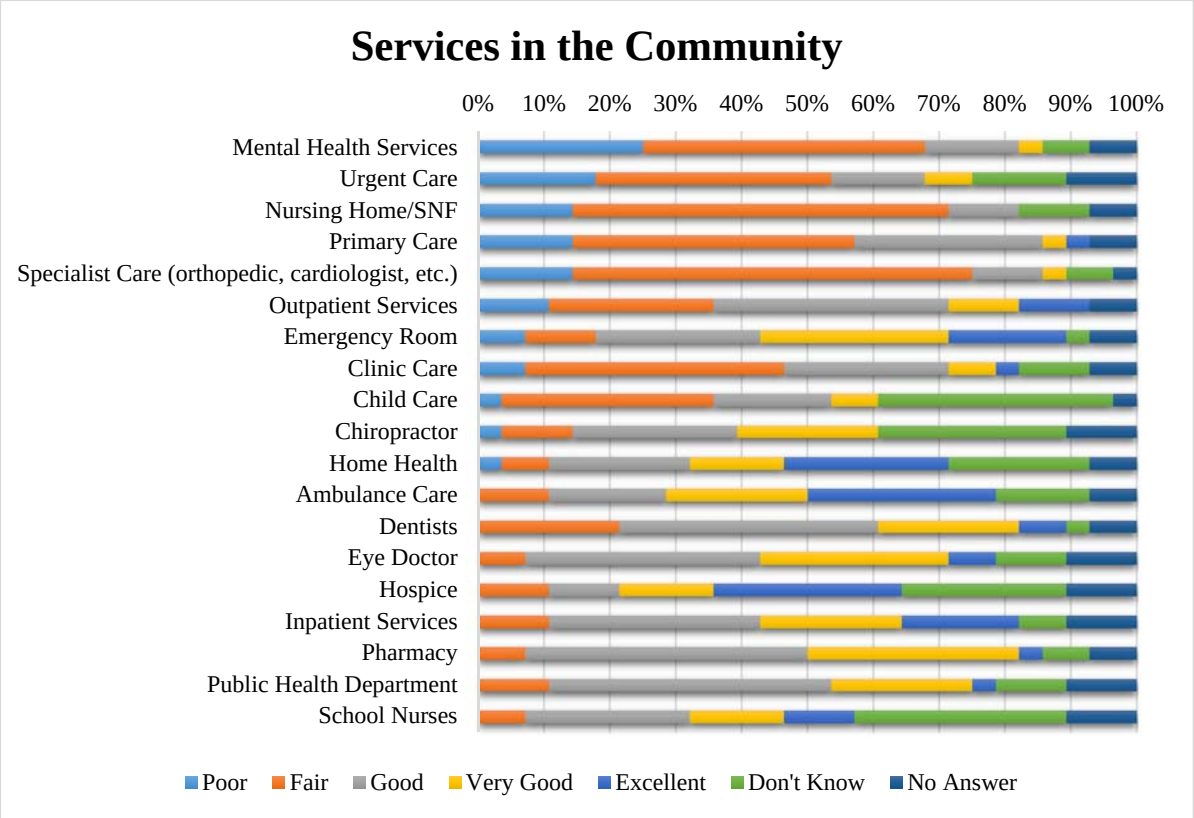
Drug abuse was identified as the highest risk behavior for the community identified by this method with 100% of the respondents agreeing that they perceive drug abuse to be a significant high risk behavior in the community. Other high risk behaviors identified by this method included being overweight, alcohol use, tobacco use, and poor eating habits. These high risk behaviors received between 80 and 89% of respondents agreeing that they are significant issues.

Survey: Community Services

Participants were also asked to rate various services in the community. The intent behind this additional survey was for the Hospital to begin to understand the quality/availability of services available to residents that might impact the capability of accessing certain resources within the context of the social determinants of health framework. Social determinants of health are conditions in the environment that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020, 2018). Resources that enhance quality of life can have a significant influence on population health outcomes.

Respondents to the community services survey were asked to rate availability to various community services from “poor” to “excellent”. The results of the community services perception survey will help the hospital establish and/or support programs and services that positively influence social and economic conditions to improve the health of the community that can be sustained over time. The

following bar chart illustrates the results for the community services survey sorted by the percentage of answers that were "poor" based high to low. It is also important to note that individuals were only allowed one choice per community service. As with the health concerns and risk behavior surveys, any additional community service categories that respondents wanted to see as a choice were captured in the focus group results and will be included in any future CHNA surveys.



Mental health services available in the community were rated poor by 25% of respondents. Availability of urgent care, nursing home/SNF, primary care, and specialist care in in the community were also rated poor receiving between 14-18% of respondents. Conversely, the availability of inpatient services, emergency room services, home health, hospice care, and ambulance services were among those rated as excellent by the greatest percentages of respondents.

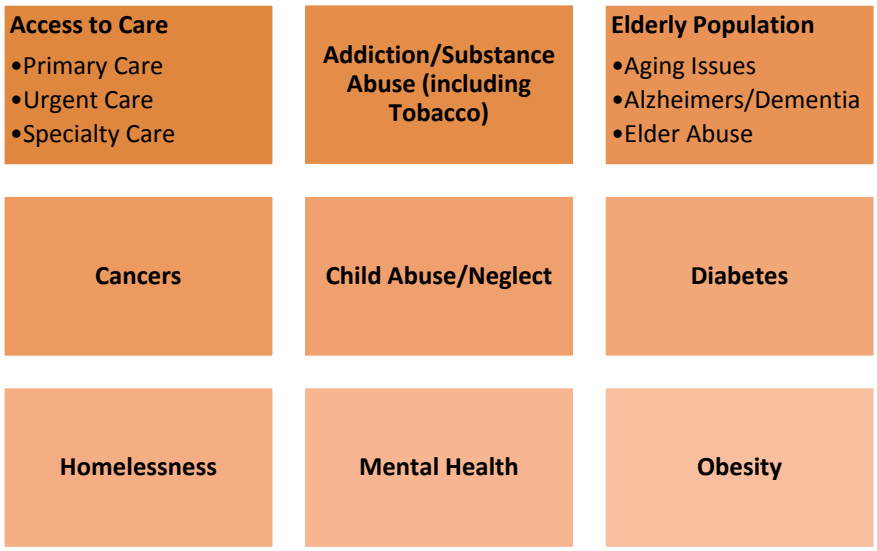
PRIORITIZED DESCRIPTION OF SIGNIFICANT HEALTH NEEDS

After the health needs were identified, focus group participants were also 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 all focus group participants ranked and prioritized the health needs, the following areas were identified as the areas of the most significant need for the community.



The following sections are a review of primary and secondary data available for each prioritized health need that was identified as an output of the overall CHNA process. Statistical data for each identified health need is included in a separate subsection with accompanying focus group comments, where available.

Access to Care - Primary Care; Urgent Care; Specialty 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, disparities in access to health services affect individuals and society. Efforts are continually made to help more people access 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.

Tehama County residents may experience difficulties scheduling appointments to see a physician due to a shortage of primary care physicians in the area. Compared to both California and the United States as a whole, Tehama County has a significantly lower rate of primary care physicians relative to the population.

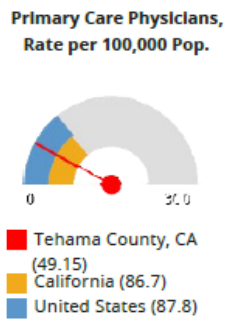
The U.S. Department of Health and Human Services (HHS) designates certain areas as being medically underserved. They are known as Health Professional Shortage Areas (HPSA). There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals),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

Tehama 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 B.

In addition, the CHNA indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues (Community Commons, 2018).

Report Area	Total Population, 2014	Primary Care Physicians, 2014	Primary Care Physicians, Rate per 100,000 Pop.
Tehama County, CA	63,067	31	**49.15**
California	38,802,500	33,638	86.7
United States	318,857,056	279,871	87.8

Note: This indicator is compared with the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014. Source geography: County



Access to Care Focus Group Comments

Strengths

- Opening of Corning clinic
- SECH continuing to recruit physicians and specialists to area
- ED Navigators
- Greenvill Rancheria
- Increase in urgent care clinics

Challenges

- Programs designed to address critical social and health issues are hampered with limited qualified staff and financial resources
- Middle Class Factor - eligibility issues and income eligibility issues
- High deductibles
- Physician shortage
- Length of time to get in to see doctor or specialist
- Lack of Quality caregivers
- Lack of day/time for rehab services
- Urgent cares do not have extended hours/weekends
- Transportation

Opportunities

- Introduce the physicians to the community so individuals/organizations are aware of additional providers

Addiction/Substance Abuse (including Tobacco)

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 (Healthy People 2020, 2018).

Tehama County residents exhibit higher rates of alcohol consumption than the both California and the Unites States. In addition, Tehama County also experiences significantly higher rates of death from drug poisoning and tobacco use by cigarette smoking than both California and the United States overall. Specific data points follow.

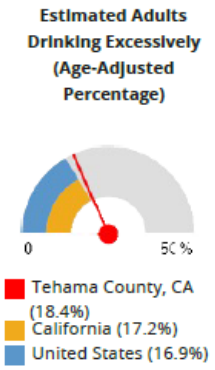
Alcohol Consumption

The CHNA indicator reports the percentage of adults aged 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per

day on average for women). This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

Report Area	Total Population Age 18	Estimated Adults Drinking Excessively	Estimated Adults Drinking Excessively (Crude Percentage)	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)
Tehama County, CA	46,805	8,284	17.7%	**18.4%**
California	27,665,678	4,758,497	17.2%	17.2%
United States	232,556,016	38,248,349	16.4%	16.9%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County

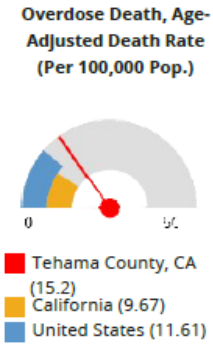


Drug Poisoning

The CHNA indicator report shows the rate of death due to drug overdose per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Report Area	Total Population	Average Annual Deaths, 2010-2014	Crude Death Rate (Per 100,000 Pop.)	Age-Adjusted Death Rate (Per 100,000 Pop.)
Tehama County, CA	63,288	10	15.17	**15.2**
California	131,546,413	12,816	9.74	9.67
United States	1,087,149,278	126,466	11.63	11.61
HP 2020 Target				**<= 10.2**

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2011-15. Source geography: County

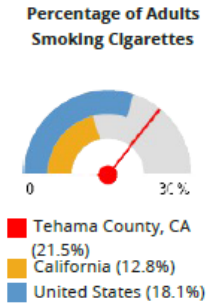


Tobacco Use

In the CHNA report an estimated 9,876, or 21.1% of adults age 18 or older self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

Report Area	Total Population Age 18	Total Adults Regularly Smoking Cigarettes	Percent Population Smoking Cigarettes (Crude)	Percent Population Smoking Cigarettes (Age-Adjusted)
Tehama County, CA	46,805	9,876	21.1%	**21.5%**
California	27,665,678	3,568,872	12.9%	12.8%
United States	232,556,016	41,491,223	17.8%	18.1%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County



Addiction/Substance Abuse/Tobacco Use Focus Group Comments

Strengths

- Community working together to address the opioid concerns
- Agency collaboration

Challenges

- Education Awareness
- Funding
- Staffing

Opportunities

- Interagency collaboration

Elderly Population - Aging Issues; Alzheimer's/Dementia; Elder Abuse

Tehama County demographics indicate that 18.5% of those living in the hospital's service area are aged 65 and over. As Americans live longer, growth in the number of older adults is unprecedented. In 2014, 14.5% (46.3 million) of the US population was aged 65 or older and is projected to reach 23.5% (98 million) by 2060. Aging adults experience higher risk of chronic disease. In 2012, 60% of older adults managed 2 or more chronic conditions. Chronic conditions can lower quality of life for older adults and contribute to the leading causes of death among this population. Common chronic conditions include:

- Heart Disease
- Cancer
- Chronic bronchitis or emphysema
- Stroke
- Diabetes mellitus
- Alzheimer's disease

Cancer screenings and immunizations can prevent disease or help to detect disease early, when treatment is more effective. Unfortunately older adults, especially those from certain racial and ethnic groups, underuse these services. Professionals, paraprofessionals, as well as paid and unpaid caregivers need basic and continuing geriatric education to improve care for older adults (Healthy People 2020, 2018).

Elder Population Focus Group Comments

Strengths

- Nutrition for Seniors
- Community Support for Services
- Caregiver resource program
- Fall prevention programs

Challenges

- Lack of respite care
- Cost of medications for seniors
- Low-income services overtaxed - it can be a 6-month wait for meals on wheels

Opportunities

- Collaboration among community organizations

Cancers

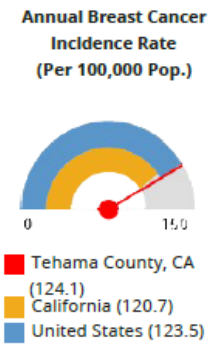
Tehama County residents have higher disease incidence rates than both California and the United States overall for all cancers on which data were collected. In particular, the incidence rates of lung cancer are significantly higher than that state of California and may indicate a correlation with the high rates of tobacco use in Tehama County.

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in 5 years, yet cancer remains a leading cause of death in the United States, second only to heart disease. The Cancer objectives for Healthy People 2020 support monitoring trends in cancer incidence, mortality, and survival to better assess the progress made toward decreasing the burden of cancer in the United States. The objectives reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests. The objectives for 2020 also highlight the importance of monitoring the incidence of invasive cancer (cervical and colorectal) and late-stage breast cancer, which are intermediate markers of cancer screening success (Healthy People 2020, 2018).

Breast Cancer Incidence

Report Area	Estimated Total Population (Female)	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Tehama County, CA	4,190	52	**124.1**
California	2,074,150	25,035	120.7
United States	18,515,303	228,664	123.5

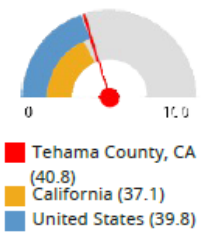
Note: This indicator is compared with the state average.
Data Source: State Cancer Profiles, 2010-14. Source geography: County



Colon and Rectum Cancer Incidence

Report Area	Estimated Total Population	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Tehama County, CA	8,088	33	**40.8**
California	3,882,749	14,405	37.1
United States	34,945,477	139,083	39.8
HP 2020 Target			**<= 38.7**

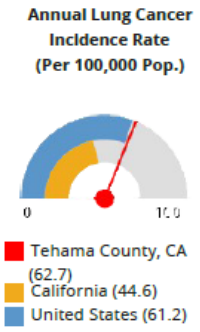
Note: This indicator is compared with the state average.
Data Source: State Cancer Profiles, 2010-14. Source geography: County



Lung Cancer Incidence

Report Area	Estimated Total Population	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Tehama County, CA	8,452	53	**62.7**
California	3,786,547	16,888	44.6
United States	35,229,411	215,604	61.2

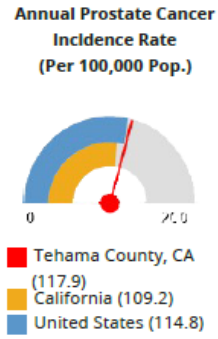
Note: This indicator is compared with the state average.
Data Source: State Cancer Profiles, 2010-14. Source geography: County



Prostate Cancer Incidence

Report Area	Estimated Total Population (Male)	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Tehama County, CA	4,156	49	**117.9**
California	1,842,307	20,118	109.2
United States	16,980,487	194,936	114.8

Note: This indicator is compared with the state average.
Data Source: State Cancer Profiles, 2010-14. Source geography: County



Child Abuse/Neglect

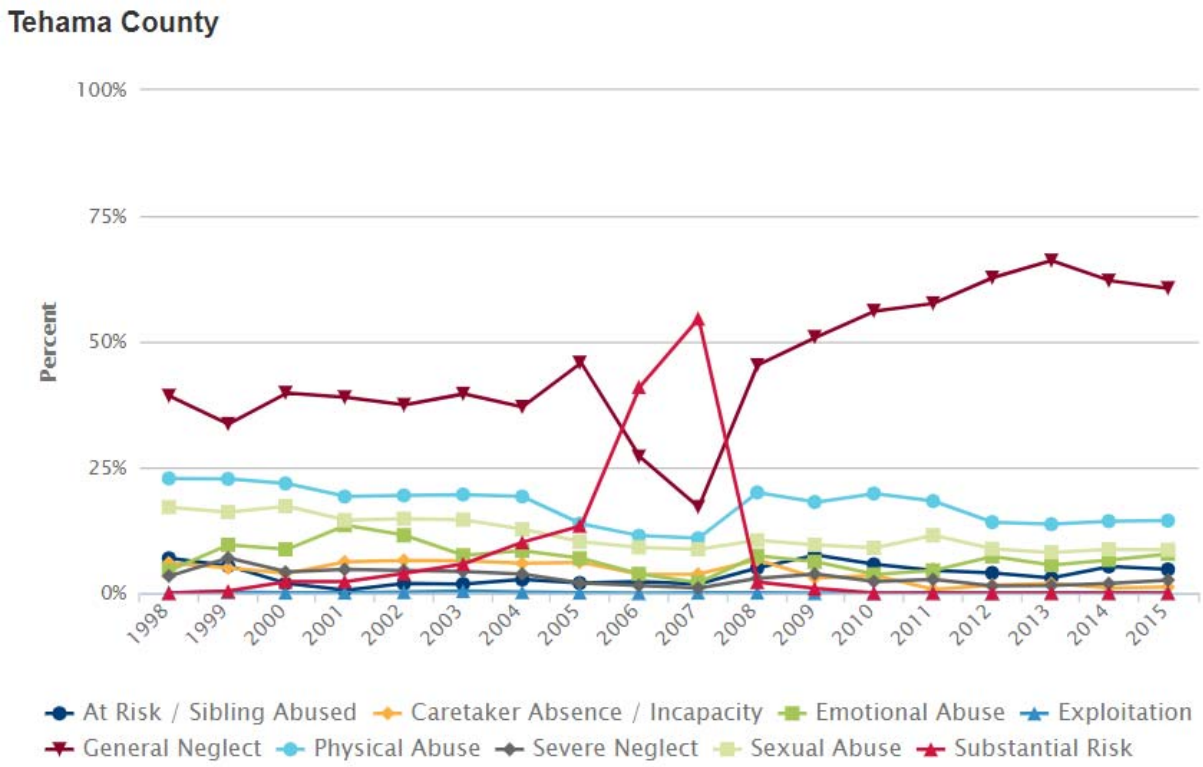
Child abuse and neglect has been a recurring topic in SECH's CHNA since at least 2002. In 2015, there were 1,606 total reports of child abuse in Tehama County. Trending between 1998 and 2015 illustrates the patterns and types of child abuse reports. Anecdotally, a local physician and North State Community Board member have indicated that child abuse is on the rise in SECH's service area.

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, 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 (Lucile Packard Foundation for Children's Health, 2018).

Child Abuse Reports – 2015 Data

Tehama County	Number
At Risk / Sibling Abused	75
Caretaker Absence / Incapacity	19
Emotional Abuse	125
Exploitation	1
General Neglect	974
Physical Abuse	232
Severe Neglect	42
Sexual Abuse	138
Substantial Risk	0

Child Abuse Reports – 1998-2015 Trending



Diabetes

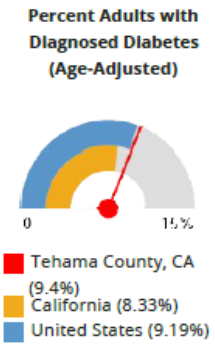
Diabetes is the 7th leading cause of death in the United States. In Tehama County 9.4% of individuals aged 20 and over received a diabetes diagnosis as compared to 8.3% for California and 9.1% for the United States. This indicator is relevant because diabetes puts individuals at risk for further health issues and increased costs of medical care and possibly disability, and premature death. The number of diabetes cases continues to increase both in the United States and due to the steady rise in the number of persons with diabetes, and possibly earlier onset of type 2 diabetes, there is growing concern about the following:

- The possibility of substantial increases in prevalence of diabetes-related complications in part due to the rise in rates of obesity
- The possibility that the increase in the number of persons with diabetes and the complexity of their care might overwhelm existing health care systems
- The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice
- The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing type 2 diabetes

The importance of diabetes and comorbidities will continue to increase as the population ages. Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals. Based on this, new public health approaches are emerging that may deserve monitoring at the national level. For example, the Diabetes Prevention Program research trial demonstrated that lifestyle intervention had its greatest impact in older adults and was effective in all racial and ethnic groups.

Report Area	Total Population Age 20	Population with Diagnosed Diabetes	Population with Diagnosed Diabetes, Crude Rate	Population with Diagnosed Diabetes, Age-Adjusted Rate
Tehama County, CA	46,420	5,199	11.2	**9.4%**
California	28,210,468	2,440,812	8.65	8.33%
United States	236,919,508	23,685,417	10	9.19%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County



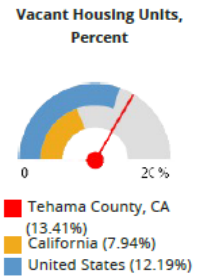
Homelessness

Homelessness data is extremely difficult to obtain, especially for rural communities. A homeless individual is defined as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation (National Health Care for the Homeless Council, 2018).

Without definitive quantitative data regarding homelessness it is important to understand the perception of the issue from the community viewpoint. The focus groups indicated a lack of affordable housing available within the community. Therefore, the CHNA data indicated the number and percentage of housing units that are vacant. A housing unit is considered vacant by the American Community Survey if no one is living in it at the time of interview. Units occupied at the time of interview entirely by persons who are staying two months or less and who have a more permanent residence elsewhere are considered to be temporarily occupied, and are classified as "vacant."

Report Area	Total Housing Units	Vacant Housing Units	Vacant Housing Units, Percent
Tehama County, CA	27,225	3,652	**13.41%**
California	13,911,737	1,104,350	7.94%
United States	134,054,899	16,338,662	12.19%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract



Homelessness Focus Group Comments

Strengths

- Community desire to address the issue of homelessness

Challenges

- Not enough affordable housing available in community for those homeless or at risk of being homeless
- Lack of emergency food/housing resources
- Sustainable Funding

Opportunities

- Collaboration among influencial community organizations for larger impact

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.

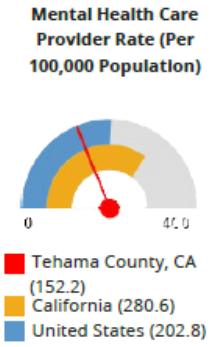
Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders (Healthy People 2020, 2018).

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

There is a severe lack of access to mental health services in SECH's service area due to a lack of providers and ongoing sustainable funding for services. Compared to both California and the United States as a whole, Tehama County has a significantly lower rate of providers relative to the population.

Report Area	Estimated Population	Number of Mental Health Providers	Ratio of Mental Health Providers to Population (1 Provider per x Persons)	Mental Health Care Provider Rate (Per 100,000 Population)
Tehama County, CA	63,067	96	656.9	**152.2**
California	38,802,427	108,908	356.3	280.6
United States	317,105,555	643,219	493	202.8

Note: This indicator is compared with the state average.
Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2018. Source geography: County



Mental Health Focus Group Comments

Strengths

- Opening of new mental health RestPadd facility
- Mental Health Navigator

Challenges

- Lack of mental health providers
- Sustainable Funding
- Youth referral to mental health is not a satisfying situation

Opportunities

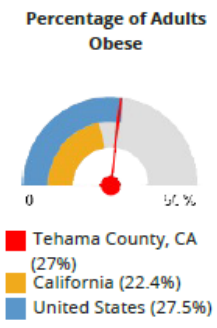
- Interagency collaboration
- Enhance reputation of steady provideers and putting their stamp on mental health services

Obesity

In Tehama County 27% of individuals aged 20 and over have a Body Mass Index greater than 30 and are considered obese as compared to 22.4% for California and 27.5% for the United States. The Nutrition and Weight Status objectives set forth by Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities.

Report Area	Total Population Age 20	Adults with BMI > 30.0 (Obese)	Percent Adults with BMI > 30.0 (Obese)
Tehama County, CA	46,452	12,635	**27%**
California	28,174,046	6,390,985	22.4%
United States	234,188,203	64,884,915	27.5%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County



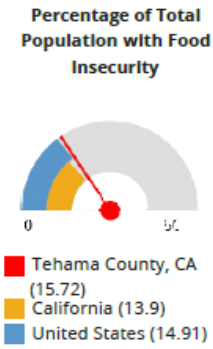
Food Insecurity

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger (Healthy People 2020, 2018).

The CHNA indicator report shows the estimated percentage of the population that experienced food insecurity at some point during the report year. There is a high percentage of food insecurity in Tehama County with 15.7%. The rate is slightly higher than California (13.9%) and similar to the United States (14.9%). Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food

Report Area	Total Population	Food Insecure Population, Total	Food Insecurity Rate
Tehama County, CA	63,284	9,950	**15.72%**
California	38,802,500	5,401,770	13.9%
United States	318,198,163	47,448,890	14.91%

Note: This indicator is compared with the state average.
Data Source: Feeding America. 2014. Source geography: County

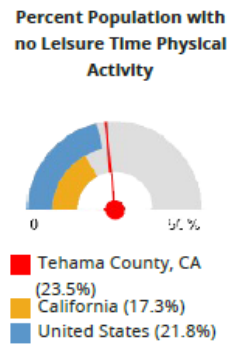


Physical Inactivity

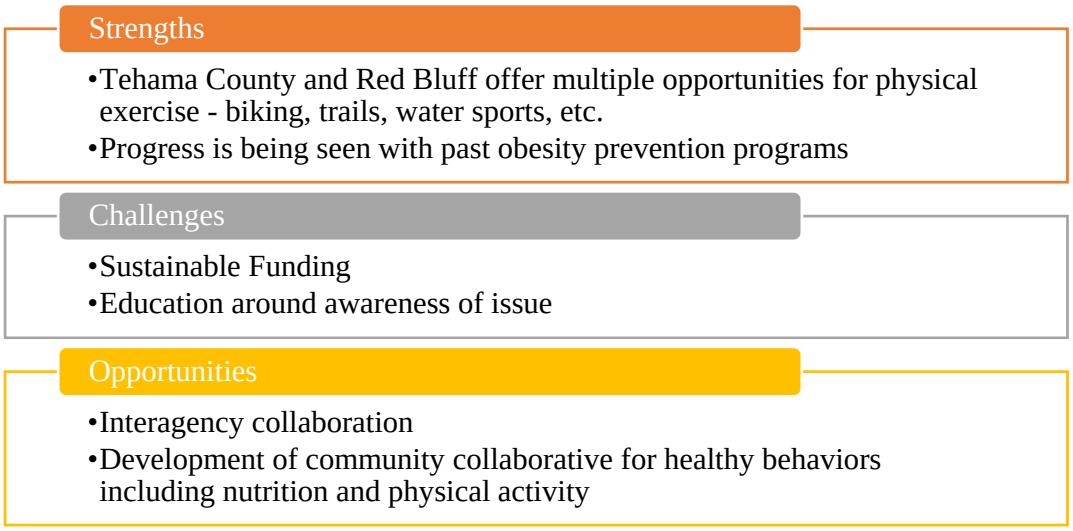
Within the CHNA report, 11,473 or 23.5% of adults aged 20 and older self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

Report Area	Total Population Age 20	Population with no Leisure Time Physical Activity	Percent Population with no Leisure Time Physical Activity
Tehama County, CA	46,449	11,473	**23.5%**
California	28,177,817	4,912,524	17.3%
United States	234,207,619	52,147,893	21.8%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County



Obesity Focus Group Comments



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 Tehama 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.

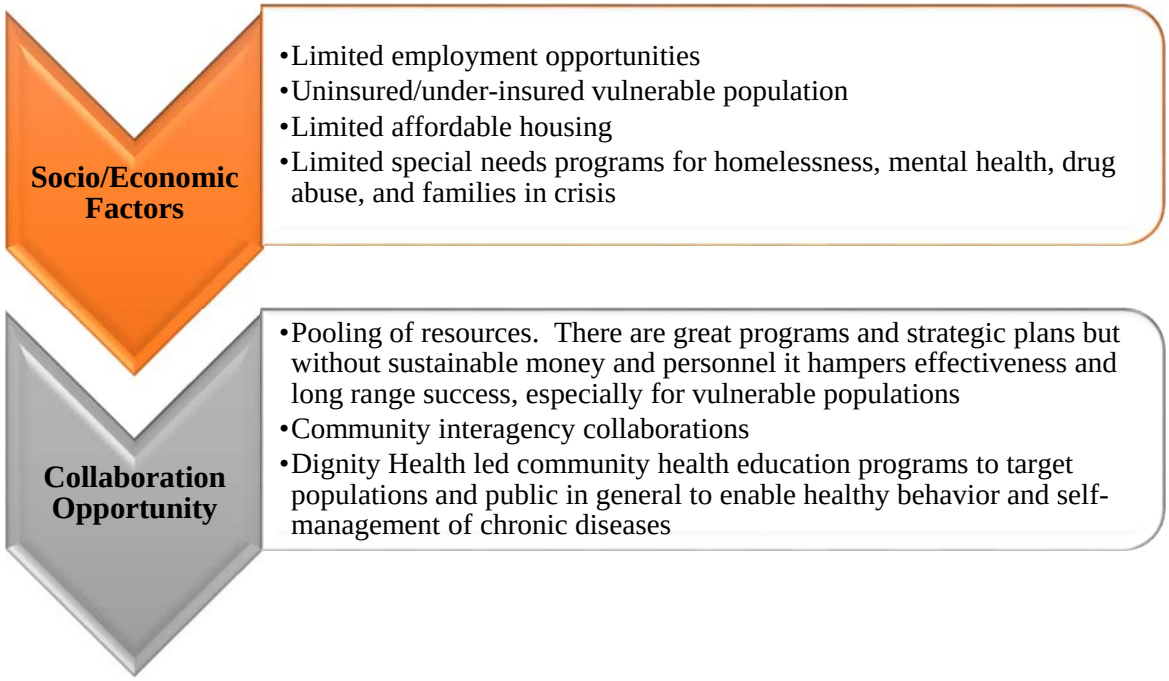
Understanding the Complexity of Health Drivers

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 hard 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:



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. Tehama County is home to a wealth of organizations, businesses, and nonprofits including SECH. The table below illustrates potential resources available f or the significant health needs in Tehama County:

Significant Health Need	Potential Community Resource
Access to Health Services (Primary & Specialty Services)	Lassen Medical Clinic Lassen Medical Clinic Cottonwood Solano Street Clinic Corning Tehama County Public Health Greenville Rancheria Tribal Health Center WIC Tehama First 5
Chronic Disease	SECH Chronic Disease Education Program
Housing	PATH (Poor And The Homeless) a. Transitional housing for Men b. Transitional housing for Women/Children c. Winter overnight shelter Empower Tehama
Injury and Violence Prevention	Empower Tehama Tehama County Social Services
Mental Health and Mental Disorders	Family Counseling Resource Center Northern California Child Development Inc Tehama County Drug/Rehab Wellness Program Tehama County Mental Health Services Restpadd Psychiatric Hospital
Nutrition and Weight Status	Tehama County Gleaners Food From The Heart WIC Vineyard Church, The Lord's Table Tehama First 5
Older Adults	Tehama Co Adult Protective Services Passages-Area Agency On Aging Tehama County Community Action Agency
Substance Abuse, including Tobacco Use	Tehama County Smoking Cessation Program
Transportation	Care A Van Precious Cargo Ride On TRAX

IMPACT OF ACTIONS TAKEN SINCE THE PRECEDING CHNA

Aging issues, cancer, diabetes, heart disease and/or stroke, obesity, substance abuse and tobacco use were identified as significant health needs in the 2014 CHNA. Since the preceding CHNA several improvements in health behaviors, health outcomes, resources and services have been made. In addition, SECH'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.

- Community health fair participation offering glucose testing, cholesterol testing, and nutrition services consultations
- Congestive heart failure readmission initiative
- Diabetes education program
- Diabetes support group program
- LIFT Homeless health services fair: homeless and poor received free flu shots, glucose and cholesterol testing, and breast testing
- Mammography assistance program
- Mental Health Wellness Program
- Sports Medicine nutrition, injury prevention and treatment program
- Tobacco cessation classes

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 – St. Elizabeth Community Hospital
2018 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 St. Elizabeth Community Hospital, 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 2014 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 2014? 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 Tehama 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

NEW RANKING FOR TRENDING PURPOSES (5-10 Minutes):

**Instruction to facilitator(s) Accompanying Stakeholder Survey – These surveys will be printed on separate pieces of paper for ease of handing out to participants to fill out*

In general, how would you rate the overall quality of the healthcare delivered to our community?

	Poor	Fair	Good	Very Good	Excellent	Don't Know
Ambulance Care						
Child Care						
Chiropractor						
Dentists						
Emergency Room						
Eye Doctor						
Home Health						
Hospice						
Inpatient Services						
Mental Health Services						
Nursing Home/SNF						
Outpatient Services						
Pharmacy						
Primary Care						
Specialist Care (orthopedic, cardiologist, etc.)						
Clinic Care						
Urgent Care						
Public Health Department						
School Nurse						

In your opinion, what are the top health concerns in this community?

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Aging Problems					
Cancers					
Child Abuse/Neglect					
Dental Problems					
Diabetes					
Domestic Violence					

Firearm-Related Injuries					
Heart Disease					
High Blood Pressure					
HIV/AIDS					
Homicide					
Human Trafficking					
Infant Death					
Infectious Diseases (Tuberculosis, Hepatitis, etc.)					
Mental Health Problems					
Motor Vehicle Crash Injuries					
Obesity					
Rape/Sexual Assault					
Respiratory/Lung Diseases					
Sexually Transmitted Diseases (STDs)					
Stroke					
Suicide					
Teenage Pregnancy					

In your opinion, what would you say are the top health risk behaviors in this community?

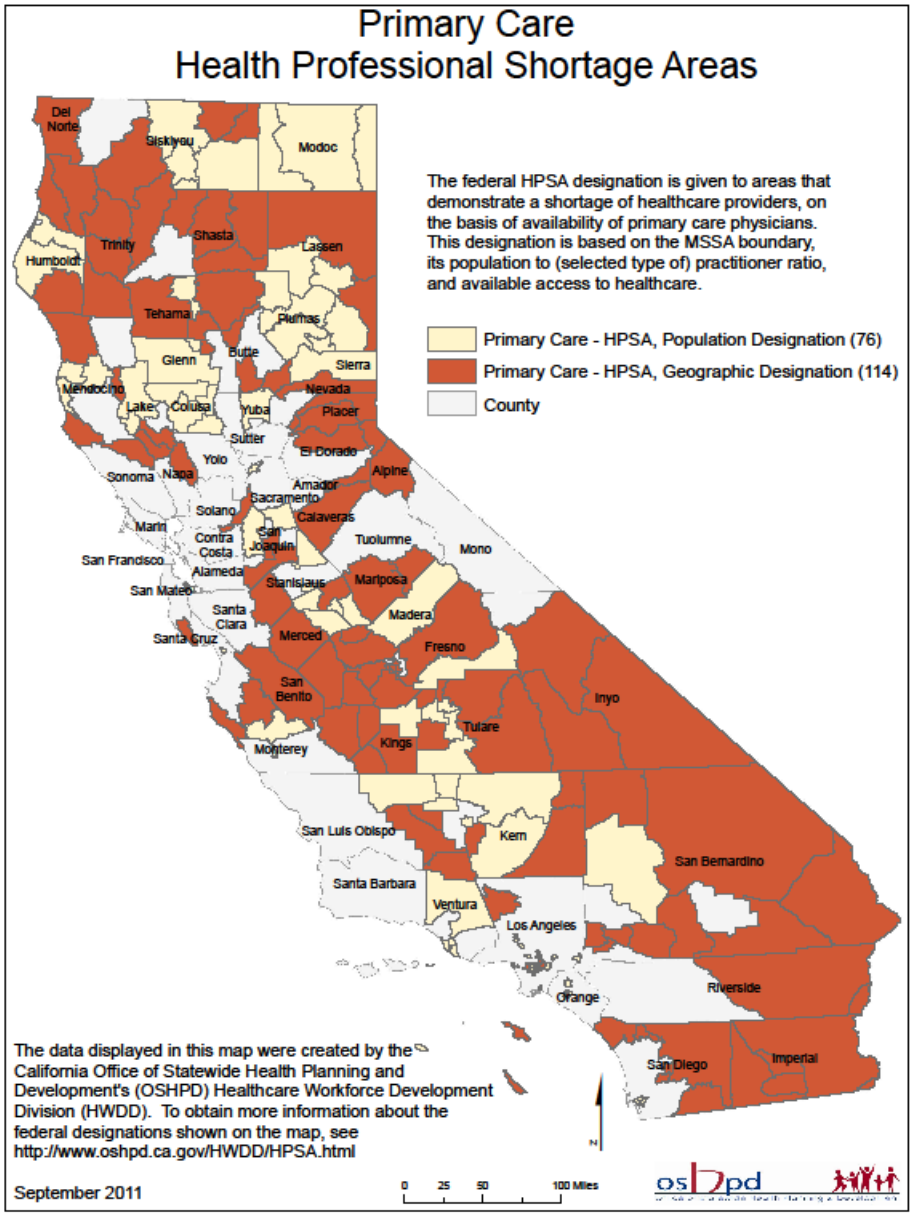
	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Alcohol Abuse					
Being Overweight					
Dropping Out of School					
Drug Abuse					
Engaging in risky recreational sports (i.e. extreme sports, rodeos, etc.) without safety gear (i.e. helmets, elbow/knee pads, etc).					
Lack of Exercise					
Not Getting Shots to Prevent Diseases					
Not Using Birth Control					
Not Using Seat Belts/Child Safety Belts					
Poor Eating Habits					
Racism					
Tobacco Use					
Unsafe Sex					

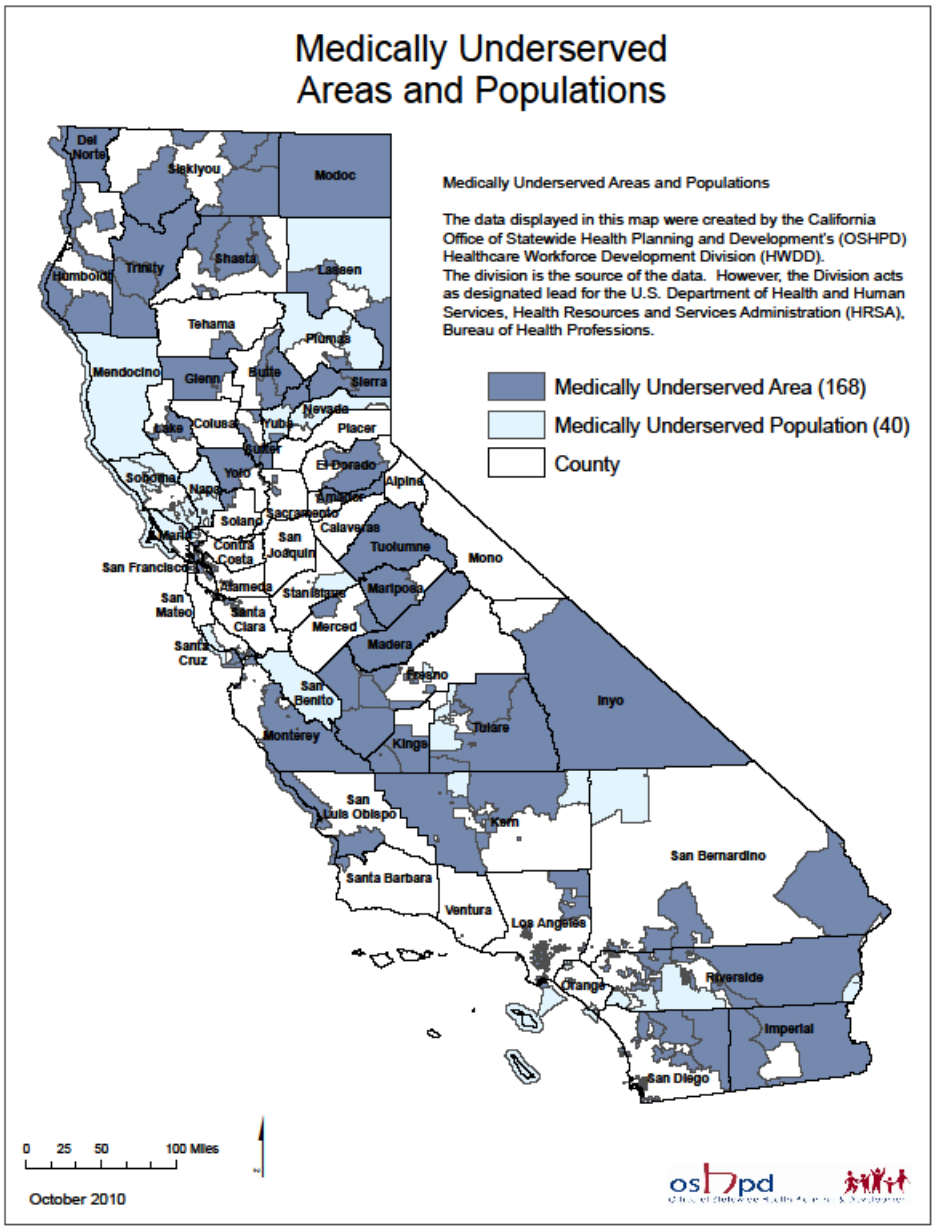
**Instruction to facilitator(s) – Concluding question if time*:*

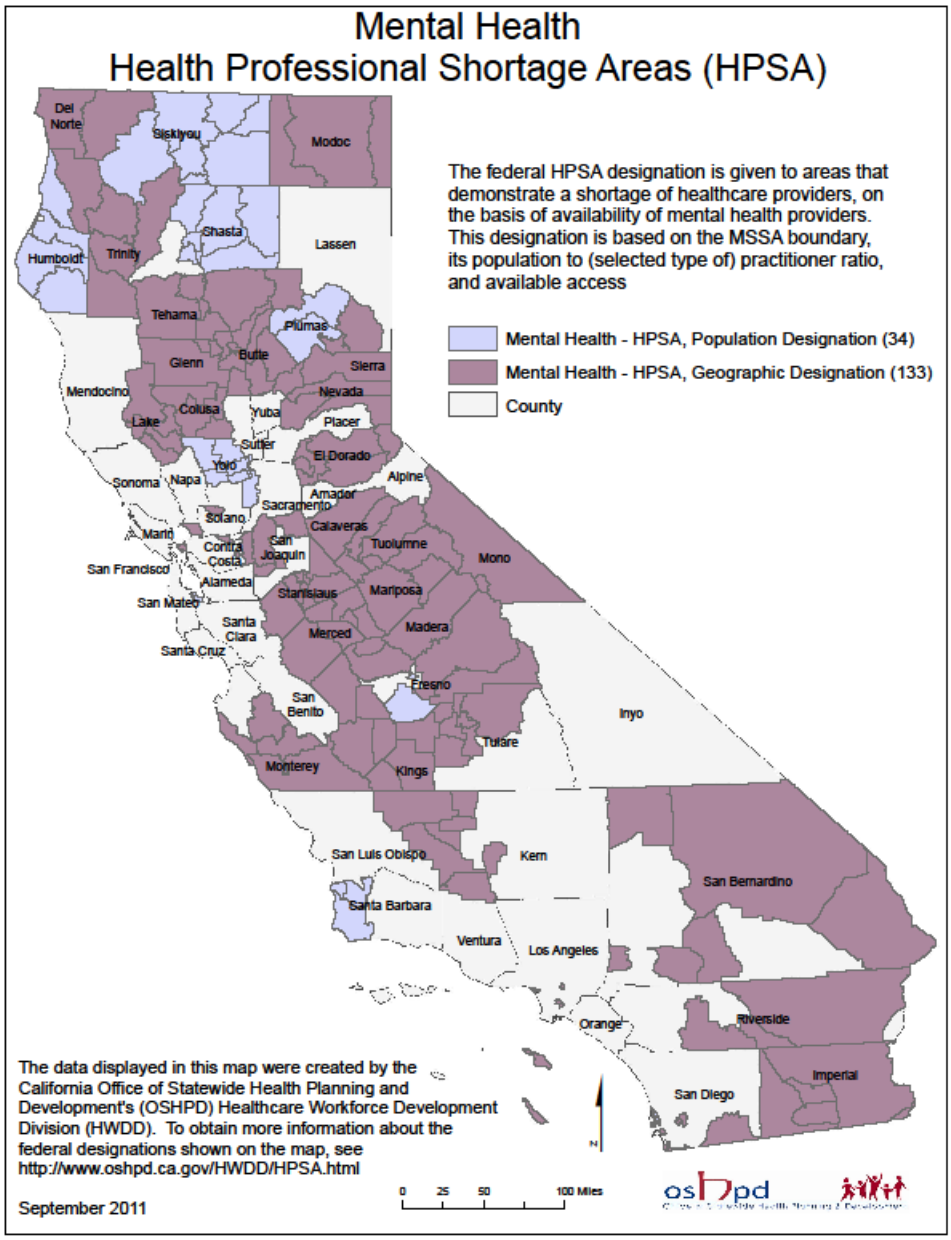
Can you recommend 1 or 2 additional people, groups or organizations you think would be most important to speak to about the health of the community?

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
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Glenn
Butte
Sierra
Mendocino
Lake
Colusa
Yuba
Nevada
Placer
Sutter
El Dorado
Yolo
Sonoma
Napa
Alpine
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
Yolo
El Dorado
Alpine
Amador
Sonoma
Napa
Solano
Sacramento
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
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
Colusa
Yuba
Lake
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
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
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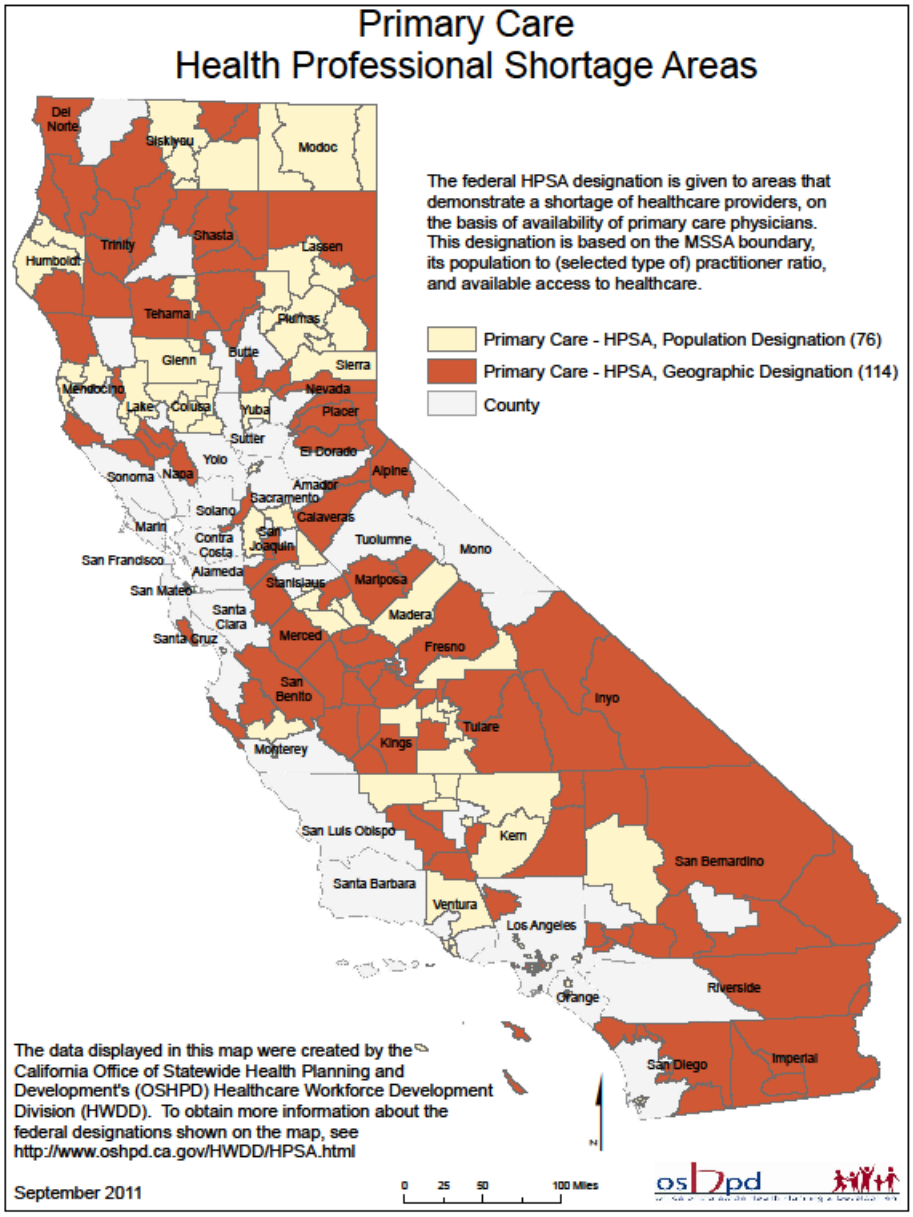
September 2011
0 25 50 100 Miles
oshpd


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
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Glenn
Butte
Sierra
Mendocino
Lake
Colusa
Yuba
Nevada
Placer
Sutter
El Dorado
Yolo
Sonoma
Napa
Alpine
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
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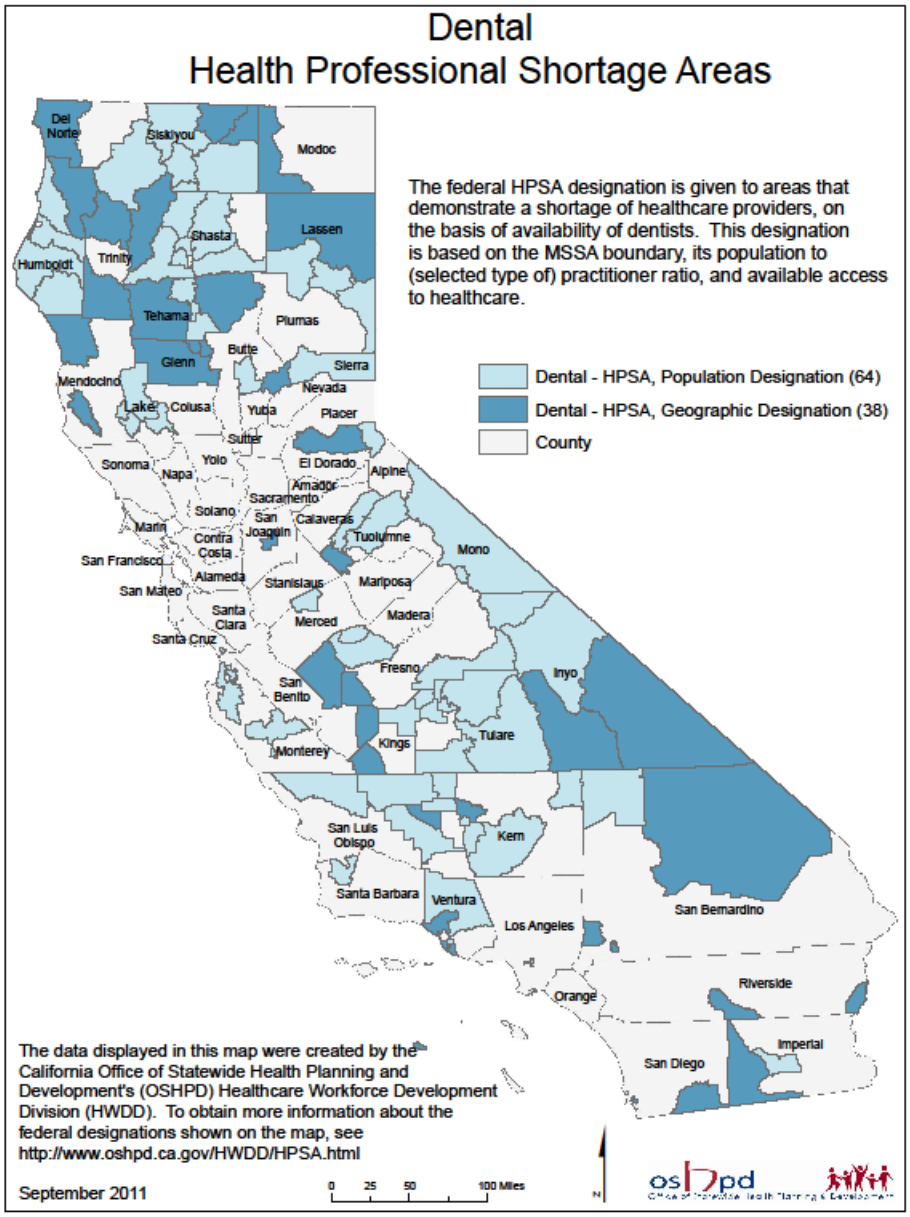
September 2011
0 25 50 100 Miles
N
oshpd


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
Nevada
Mendocino
Lake
Colusa
Yuba
Placer
Sutter
Yolo
El Dorado
Alpine
Sonoma
Napa
Amador
Sacramento
Solano
San Joaquin
Calaveras
Marin
Contra Costa
Tuolumne
Mono
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