2022/2023
Community Needs Assessment and Community Action Plan

California Department of
Community Services and Development

Community Services Block Grant

Table of Contents

Checklist

☒ **Cover Page and Certification**
☒ **Public Hearing(s)**

Part I: Community Needs Assessment
☒ **Narrative**
☒ **Results**

Part II: Community Action Plan
☒ **Vision Statement**
☒ **Mission Statement**
☒ **Tripartite Board of Directors**
☒ **Service Delivery System**
☒ **Linkages and Funding Coordination**
☒ **Monitoring**
☒ **Data Analysis and Evaluation**
☒ **Additional Information**
☒ **Federal CSBG Programmatic Assurances and Certification**
☒ **State Assurances and Certification**
☒ **Organizational Standards**
☒ **Appendices**

Cover Page and Certification

Agency Name	**North Coast Opportunities, Inc. (NCO)**
Name of CAP Contact	**Patty Bruder**
Title	**Executive Director**
Phone	**707-462-1956**
Email	**pbruder@ncoinc.org**

CNA Completed MM/DD/YYYY:
(Organizational Standard 3.1)

2/28/2021

Board and Agency Certification

The undersigned hereby certifies that this agency complies with the Federal CSBG Programmatic and State Assurances as outlined in the CSBG Act and California Government Code, respectively for services provided under the Federal Fiscal Year 2022/2023 Community Action Plan. The undersigned further certifies the information in this Community Needs Assessment and the Community Action Plan is correct and has been authorized by the governing body of this organization. (Organizational Standard 3.5)

Tami Bartolomei	Tami Bartolomei	6-28-21
Board Chair (printed name)	**Board Chair (signature)**	**Date**
Patty Bruder	Patty Bruder	6.28.21
Executive Director (printed name)	**Executive Director (signature)**	**Date**

Certification of ROMA Trainer/Implementer *(If applicable)*

The undersigned hereby certifies that this agency's Community Action Plan and strategic plan documents the continuous use of the Results Oriented Management and Accountability (ROMA) system (assessment, planning, implementation, achievement of results, and evaluation).

NCO does not have a certified ROMA trainer at this time.		
NCRT/NCRI (printed name)	**NCRT/NCRI (signature)**	**Date**

CSD Use Only

Dates CAP (Parts I & II)		Accepted By
Received	Accepted	
6/20/2021	8/12/2021	Sandra Fletcher

Public Hearing

State Statute Requirements

As required by California Government Code Section 12747(b)-(d), agencies are required to conduct a public hearing for the purpose of reviewing the draft CAP. All testimony presented by low-income individuals and families during the public hearing shall be identified in the final CAP. Agencies shall indicate whether or not the concerns expressed by low-income individuals and families have been addressed. If an agency determines that any of the concerns have not been addressed in the CAP, the agency shall include in its response document, information about the concerns and comment as to their validity.

Public Hearing Report

Date(s) of Public Hearing(s)	23 June 2021
Location(s) of Public Hearing(s)	Public Hearing was held via Zoom
Dates of the Comment Period(s)	25 May – 23 June 2021
Where was the Notice of Public Hearing published? (agency website, newspaper, social media channels)	NCO website NCO Facebook Page Lake County News
Date the Notice(s) of Public Hearing(s) was published	NCO Website: 25 May 2021 NCO Facebook Page: June 8 and 21, 2021 Lake County News: 25 May 2021
Number of Attendees at the Public Hearing(s) (Approximately)	10

Part I: Community Needs Assessment

Community Needs Assessment Narrative

CSBG Act Sections 676(b)(3)(C), 676(b)(9)

Organizational Standards 1.1, 1.2, 2.2, 3.2, 3.3, 3.4 State Plan

1. How did the agency share the CAP, including the CNA, with the community, stakeholders, partner organizations? (Check all that apply.)

☒ The agency's website	☒ Posted on the agency's Facebook page
☒ Electronic reports were sent on request	☐ Printed copies were distributed
☐ Social media channels	☐ Other

2. Describe how your agency collected and included current data specific to poverty and its prevalence related to gender, age, and race/ethnicity for your service area. (Organizational Standard 3.2, State Plan)

NCO worked in collaboration with community partners to complete Community Health Needs Assessments using the following strategies:

Focus Groups. In Lake County, five focus groups were held with a total of 31 low-income participants. Each focus group was recorded, transcribed to capture the verbatim conversation, and analyzed using a qualitative analysis program. In Mendocino County, NCO also identified needs through its disaster case management process, which served hundreds of fire survivors and families experiencing hardships as a result of the COVID-19 pandemic.

Surveys. Healthy Mendocino worked with community partners to collect 1,324 surveys (1,276 in English and 48 in Spanish). In Lake County, 674 individuals responded to community surveys, which were also available in both Spanish and English.

Community Forums. Five community forums were held in communities throughout Lake County as part of the assessment process, while Healthy Mendocino held 23 listening tours with agencies and groups in Mendocino County to inform the assessment process. At each site, participants were asked to describe major barriers to health and wellness, gaps in care and prevention, and support needed to address the barriers, as well as questions about resources and programs that are working well. In 2020, virtual forums organized by Healthy Mendocino were convened to assess needs related to specific topics, including: Social Services and Vulnerable Populations (June 2020, 43 participants); Workforce and Economy (June 2020, 40 participants); Community Connection and Resiliency (July 2020, 48 participants); and Diversity, Equity, and

Inclusion (December 2020, 64 participants). In addition, the Healthy Mendocino Roundtable met three times (September 2020, December 2020, and March 2021), with discussions focused on social determinants of health, structural racism, shelter-in-place burnout, and recovery from the pandemic.

Community Conversations. NCO's Leadership Mendocino hosted 16 informal conversations with a range of community sectors (e.g., first responders, local business, local government, youth, social support, employment development, hospitality, education). This assessment effort was initiated in response to the COVID-19 pandemic, which precluded NCO from carrying out the 2020 in-person Leadership Program. In all, 65 individuals participated in the conversations, which were streamed live on Facebook and rebroadcast on local public radio station KZYX&Z.

Interviews. Lake County conducted 10 interviews with key stakeholders with expertise in public health or special knowledge of community health needs. In Mendocino County, interviews were conducted with 90 key stakeholders representing community-based organizations, nonprofits, local government, tribal entities, education, health care, law enforcement, private business, agriculture, health and human services, and community members.

People Helping People Case Management. Throughout 2020, NCO case managers provided assessment and support to families experiencing economic and other challenges as a result of the COVID-19 pandemic. The case management process enabled NCO to identify emerging needs and develop responsive programming. For example, NCO's MendoLake Food Hub contracted with USDA and other entities to pack and distribute food boxes to families who were going hungry and/or feared going grocery shopping because of their at-risk status.

Public Records. Data on a wide range of topics were extracted from public databases, reports, and other records, as detailed in the response to Question 4 below.

3. Describe the geographic location(s) that your agency is funded to serve. If applicable, include a description of the various pockets, high-need areas, or neighborhoods of poverty that are being served by your agency.

North Coast Opportunities (NCO) is the Community Action Agency for Lake and Mendocino Counties in rural Northern California. The two-county area is home to 151,135[1] people and covers 4,763 square miles of

[1] US Census, American Community Survey One-Year Estimates 2019.

mostly mountainous terrain. In terms of geographical size, the area is nearly as large as the state of Connecticut, although in population density it is closer to the state of Nevada. The California Department of Finance projects minimal growth over the next twenty years, with an anticipated population of 153,503 in 2041.[2]

Lake County's 64,386 residents occupy an area of 1,257 square miles, with a population density of 51 persons per square mile. Approximately 30% of Lake County residents live in the cities of Clearlake and Lakeport, while the remainder live in unincorporated communities and other parts of the county. The county is about 100 miles long by about 50 miles wide, with Clear Lake, the largest natural freshwater lake in California, at its center. The county is surrounded by mountain ranges and bordered by Mendocino, Sonoma, Napa, and Colusa counties. Lake County's rugged rural geography, winding two-lane roads, and widely-separated towns limit access to services, including health care, social support, employment, and recreation.

Mendocino County lies on the Pacific coast 100 miles north of San Francisco. Humboldt, Trinity, Tehama, Glenn, Lake, and Sonoma Counties encircle the county to the north, east, and south. Mendocino County's vineyard-covered hillsides, towering redwoods, deep fertile valleys, and rugged mountains cover 3,506 square miles, only 3% of which is flat. Although Mendocino County is the 15th largest of California's 58 counties, its 86,749 residents represent less than one-quarter of one percent of the state population. Mendocino County is equal in size to the states of Delaware and Rhode Island combined but has a population density of only 25 persons/square mile, compared with the statewide population density of 249 persons per square mile.

The area continues to grow increasingly diverse. While both counties are primarily white/non-Hispanic, Hispanics represent 20.6% of the Lake County population and 25.8% of Mendocino County residents. Both counties also have significant American Indian populations—5.6% in Lake County and 7.7% in Mendocino County.[3] The area's increasing diversity is reflected in local kindergarten classes, where 41.5% of 2020-2021 Lake County and 45.8% of Mendocino County students were Hispanic.[4] Lake County's Hispanic population is

[2] California Department of Finance, Demographic Research Unit Estimates, Table P2A.
[3] US Census, American Community Survey Five-Year Estimates 2015-2019.
[4] California Department of Education (http://data1.cde.ca.gov/dataquest).

projected to reach 15,781 (24%) by 2041; in Mendocino County, the Hispanic population is projected to rise to 26,091 (29%) by 2040.[5]

In Lake County, 22.3% of residents are age 65 or older and 21.2% of Mendocino County residents are in the senior age group, compared with 14.8% statewide. The California Department of Finance has projected that the older age population will increase slightly over the next 20 years—by 2041, seniors age 65 and up will number 35,247, almost one-quarter of the population.[6]

The scenic beauty of the area belies the realities of life faced by many residents. According to the US Census, the 2019 poverty rate was 18.3% in Lake County and 14.0% in Mendocino County, compared with 11.8% statewide. Among Lake County's female-headed families with children of any age, the poverty rate is 43.1% and it is 42.8% in female-headed families where the children are under the age of 5 (compared with 35.6% statewide). In Mendocino County, the rates are 33.5% for female-headed families with children of any age and 37.6% for female-headed families with children under the age of 5. Lake County's median household income in 2019 was $47,040 (62.5% of the statewide median of $75,235) and Mendocino County's median is $51,416 (68.3%).[7]

On the Robert Wood Johnson Foundation Health Rankings website for 2021,[8] Lake County is ranked among the least healthy counties in California, placing in the lowest quartile in terms of both health outcomes and health factors. In Mendocino County, health rankings are higher but far from stellar, placing the county in the second from the bottom quartile.

Lake and Mendocino County have experienced changes over decades that have impacted local poverty, including devastating wildfires that have occurred over the past five years. Since the summer of 2015, ten major wildfires have devastated more than half of Lake County's 1,256 square miles as well as significant portions of Mendocino County, destroying some 3,000 homes and other structures and wreaking havoc on individuals, families, businesses, and communities. Since 2015, more than half of Lake County's land area has been scorched by wildfires.

[5] California Department of Finance, Demographic Research Unit Projections, Table P2A and P2D.
[6] California Dept. of Finance, Demographic Research Unit Projections, Table P2B.
[7] US Census, American Community Survey Five-Year Estimates 2015-2019.
[8] Robert Wood Johnson Foundation, County Health Rankings, 2021 (www.countyhealthrankings.org).

Since the beginning of the COVID-19 pandemic early last year, Lake County has reported 3,580 positive COVID-19 cases of which 1,298 (40.8%) were Hispanic and 168 (5.3%) were Native American. The ethnicity of an additional 11.1% of positive cases is unknown. It has been well documented statewide and nationally that COVID-19 testing methodologies have failed to accurately capture data that would accurately identify tribal affiliations for Native Americans. To date, Mendocino County has reported 4,363 positive COVID-19 cases of which 2,076 (52.6%) of those with reported race or ethnicity were Hispanic and 298 (7.6%) were Native American. The ethnicity of an additional 9.6% of positive cases is unknown. Beyond the impact experienced by those infected with the disease, the pandemic has impacted low-income families economically and socially, with many experiencing job losses, food shortages, and other losses.

4. Indicate from which sources your agency collected and analyzed quantitative data for the CNA. (Check all that apply.) (Organizational Standard 3.3)

Federal Government/National Data Sets
☒ Census Bureau
☒ Bureau of Labor Statistics
☒ Department of Housing & Urban Development
☒ Department of Health & Human Services
☒ National Low-Income Housing Coalition
☒ National Center for Education Statistics
☒ Other online data resources
☐ Other

California State Data Sets
☒ Employment Development Department
☒ Department of Education
☒ Department of Public Health
☐ Attorney General
☒ Department of Finance
☒ State Covid-19 Data
☐ Other

Surveys
☒ Clients
☒ Partners and other service providers
☒ General public
☐ Staff
☐ Board members

Local Data Sets
☒ Local crime statistics
☒ High school graduation rate
☒ School district school readiness
☒ Local employers
☒ Local labor market
☒ Childcare providers
☒ Public benefits usage
☒ County Public Health Department
☐ Other

Agency Data Sets
☒ Client demographics
☒ Service data
☒ CSBG Annual Report
☒ Client satisfaction data
☐ Other

☐ Private sector
☐ Public sector
☐ Educational institutions

5. If you selected "Other" in any of the data sets in Question 4, list the additional sources.

NOT APPLICABLE

6. Indicate the approaches your agency took to gather qualitative data for the CNA. (Check all that apply.) (Organizational Standard 3.3)

Surveys
- ☒ Clients
- ☒ Partners and other service providers
- ☒ General public
- ☐ Staff
- ☐ Board members
- ☐ Private sector
- ☐ Public sector
- ☐ Educational institutions

Interviews
- ☒ Local leaders
- ☒ Elected officials
- ☒ Partner organizations' leadership
- ☐ Board members
- ☐ New and potential partners
- ☐ Clients

Focus Groups
- ☒ Local leaders
- ☒ Elected officials
- ☒ Partner organizations' leadership
- ☐ Board members
- ☐ New and potential partners
- ☐ Clients
- ☐ Staff

☒ **Community Forums**

☐ **Asset Mapping**

☐ **Other**

7. If you selected "Other" in Question 6, please list the additional approaches your agency took to gather qualitative data.

NOT APPLICABLE

8. Describe your agency's analysis of the quantitative and qualitative data collected from low-income individuals and families. Include a description of the data collected. (Organizational Standards 1.1, 1.2, 3.3; State Plan)

Each NCO program develops its own systems and processes to ensure that programs are informed by customer input. For example, some programs conduct annual customer satisfaction surveys, while others gather input from a consumer advisory board. Data collected from low-income individuals are not managed

differently from data collected from the general public. For example, community surveys are collected from the broadest possible audience, including low-income individuals, and low-income individuals participated in all CNA data collection activities (e.g., surveys, focus groups, community forums, interviews). Efforts to ensure the participation of low-income individuals in these processes include broad outreach through newspaper and radio PSAs, email blasts, social media posts, and direct outreach by partners to their constituents. On the community surveys, respondents were asked for their income levels, which enabled data disaggregation. However, the data analysis did not find significant differences in the needs identified by low-income people compared to needs identified by the general population.

9. Summarize the data gathered from each sector of the community listed below and detail how your agency used the information to assess needs and resources in your agency's service area(s). Your agency must demonstrate that each sector was included in the needs assessment; A response for each sector is required. (CSBG Act Sections 676(b)(3)(C), 676(b)(9); Organizational Standard 2.2; State Plan)

ALL SECTORS:

NCO worked with partners to conduct the community assessment process through a variety of strategies. While the assessment strategies reached all sectors of the community, partners did not seek to collect data separately by sector. For example, assessments did not isolate data from the public sector from data collected from faith-based organizations, although both were included in the process. The assessment used as large a net as possible, so that information was gathered from all sectors, and specific sectors were not targeted. Representatives of each sector assisted by distributing and collecting surveys from members of their sector, and members of each sector also participated in key informant interviews, community forums, and focus groups.

Examples include the community surveys conducted in each county, and the community forums held as part of the community needs assessment process. Partners representing specific sectors of the community were tasked with reaching out to their clients and constituents to ensure that their input was included in the process. The collaborative groups in which NCO participates have been cultivated to include broad community representation.

10. "Causes of poverty" are the negative factors that create or foster barriers to self-sufficiency and/or reduce access to resources in communities in which low-income individuals live. After review and analysis of the data, describe the causes of poverty in your agency's service area(s). (Organizational Standard 3.4, State Plan)

In general, causes of poverty in Lake and Mendocino Counties are similar to conditions associated with poverty in other communities (e.g., multi-generational drug and alcohol use, unemployment, housing instability and homelessness, inadequate access to health services, domestic abuse, mental illness, inadequate access to nutritious food, inadequate availability of early education, youth development, and higher education opportunities). NCO works tirelessly to address and alleviate poverty, but does not anticipate that its efforts will resolve structural causes of poverty during the coming years. Please see attached Lake and Mendocino Community Health Needs Assessments (CHNA) for further discussion (Appendix D and Appendix E).

From the beginning of the pandemic through May 20, 2021, Lake and Mendocino Counties have reported 7,943 positive COVID cases and 95 deaths from the disease. Mendocino County reported 4,363 positive COVID-19 cases of which 2,076 (52.6%) of those with reported race or ethnicity were Hispanic and 298 (7.6%) were Native American. The ethnicity of an additional 9.6% of positive cases are unknown. Lake County has reported 3,580 positive COVID-19 cases of which 1,298 (40.8%) were Hispanic and 168 (5.3%) were Native American. The ethnicity of an additional 11.1% are unknown. It has been well documented statewide and nationally that COVID-19 testing methodologies have failed to accurately capture data that would accurately identify tribal affiliations for Native Americans. See Appendix C, Additional Assessment Data for COVID-Related Needs, for qualitative data related to COVID needs.

11. "Conditions of poverty" are the negative environmental, safety, health and/or economic conditions that may reduce investment or growth in communities where low-income individuals live. After review and analysis of the data, describe the conditions of poverty in your agency's service area(s). (Organizational Standard 3.4, State Plan)

Conditions of poverty in Lake and Mendocino Counties are similar to conditions associated with poverty in other communities (e.g., systemic inequality, institutional racism, globalization, economic downturns, rising healthcare costs, climate change, housing shortages). Conditions especially relevant to Lake and Mendocino County in recent years include a series of devastating wildfires and, more recently, the COVID-19 pandemic.

Since the summer of 2015, ten major wildfires have devastated more than half of Lake County's 1,256 square miles as well as significant portions of Mendocino County, destroying some 3,000 homes and other structures and wreaking havoc on individuals, families, businesses, communities, and the environment. In the summer of 2018, the Mendocino Complex Fire blazed through both counties to become the largest fire in California history, burning 459,000 acres.

The county CHNAs are framed around the social determinants of health and highlight many of the disparities that local Latinx and Native American populations face in terms of education, income, and related conditions that contribute to disproportionate harm from COVID-19.

12. Describe your agency's approach or system for collecting, analyzing, and reporting customer satisfaction data to the governing board. (Organizational Standard 6.4, State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

Each NCO program has developed its own systems and processes to ensure that programs are informed by customer input. For example, some programs conduct annual customer satisfaction surveys, while others gather input from a consumer advisory board. Data collected through these processes are compiled by program staff and presented to Board members during their regularly scheduled meetings.

Community Needs Assessment Results

CSBG Act Section 676(b)(11)
California Government Code Section 12747(a)

Table 1: Needs Table

Needs Identified	Level	Integral to Agency Mission (Y/N)	Currently Addressing (Y/N)	Agency Priority (Y/N)
Collaboration and alignment of services	Community	YES	YES	YES
Health and nutrition	Family and individual	YES	YES	YES
Community engagement	Community, family, and individual	YES	YES	YES
Housing and homelessness	Family and community	YES	YES	YES
Economic	Community, family, and individual	YES	YES	YES
Employment	Community, family, and individual	YES	YES	YES
Mental health and substance use	Family and individual	YES	YES	YES

Needs Identified: List the needs identified in your most recent CNA.

Level: List the need level, i.e. community or family. Community Level: Does the issue impact the community, not just clients or potential clients of the agency? For example, a community level employment need is: There is a lack of good paying jobs in our community. Family Level: Does the need concern individuals/families who have identified things in their own life that are lacking? An example of a family level employment need would be: Individuals do not have good paying jobs.

Integral to Agency Mission: Indicate if the identified need aligns with your agency's mission.

Currently Addressing: Indicate if your agency is already addressing the identified need.

Agency Priority: Indicate if the identified need will be addressed either directly or indirectly.

Table 2: Priority Ranking Table

Agency Priorities	Description of programs, services, activities	Indicator(s)/Service(s) Category (CNPI, FNPI, SRV)
1. Collaboration and alignment of services	• Hope Rising • Healthy Mendocino • Continuums of Care	• Capacity Building: Module 2, Section B5 • Allocated Resources: Module 2, Section C3
2. Housing and homelessness	• New Digs case management and financial support for rapid rehousing • Building Homes, Building Lives Workforce Accelerator Program to renovate and build affordable housing to increase rental housing stock	• Housing: Module 4, Section A: FNPI4a-4e and Section B: SRV 4c, 4d, 4f, 4g, 4h, 4k, 4m, 4n, 4o, 4p (Housing Indicators)
3. Community engagement	• EPIC program, providing emergency preparedness information and trainings • Volunteer Network • COVID outreach and education • Caring Kitchen • Leadership Mendocino	• Civic Engagement: Module 4, Section A FNPI 6a, 6a1 and 6a3 for all 5 programs. • Volunteers Trained: Module 4, Section B SRV 6f • Health: COVID Outreach: SRV 5a and Incentives distributed 5hh • Health: Volunteers trained by Caring Kitchen: Module 4, Section A FNPI 5a • Leadership Training: Leadership Mendocino Module 4, Section B SRV6b
4. Health and nutrition	• Gardens Project for community gardens, food production workshops • Caring Kitchen • Walk and Bike Mendocino • Food Hub and COVID box distribution • Lakeport Community Kitchen	• Health: Module 4, Section A FNPI 5a-5f • Health: Gardens Project gardening activities and skills classes: Module 4 Section B: SRV 5ff and 5gg • Walk and Bike: Module 4, Section B SRV 5p (Wellness Classes) and Section A FNPI 5b and 5c • Health: Food Hub and COVID Box (Food Distribution) Module 4 Section B: SRV 5jj • Health: Lakeport Community Kitchen Module 4 Section B: SRV 5ii (Prepared Meals)
5. Economic issues	• Food Hub, to support farmers in building capacity to access local markets • VITA tax preparation assistance	• Income: Module 4, Section A FNPI 3h, 3e, 3z for Food Hub • VITA tax preparation assistance: Module 4, Section A FNPI 3d and 3h and Module 4 Section B: SRV 3o

Agency Priorities	Description of programs, services, activities	Indicator(s)/Service(s) Category (CNPI, FNPI, SRV)
	• People Helping People Project case management to provide COVID economic crisis relief	• People Helping People: Mod 4, Section A FNPI 4c-4e (Housing) and Section B: SRV 4c, 4d, 4k (Rent Payments, Mortgage Payments, Utility Payments)
6. Employment	• Caring Kitchen, training at-risk youth to prepare meals for cancer patients • Building Homes, Building Lives Workforce Accelerator program to provide construction training and employment options • Head Start and Rural Communities Child Care: explore opportunities to build agency capacity through improved outreach and recruitment	• Employment: Module 4, Section A FNPI 1a and SRV 1a • Employment: Module 4, Section A FNPI 1b, 1c, 1d Section B: SRV 1a (Employment Indicators) • Employment: Module 2, Section B4d: Number of staff with a child development certification
7. Mental health and substance use	• Life skills training for homeless families • ACEs training for childcare providers and Head Start staff	• Module 4, Section A FNPI 5C and 5f (seniors) SRV 5II Life skills coaching sessions • Staff Training: Module 2, Section B2b

Agency Priorities: Rank your agency priorities.

Description of programs, services, activities: Briefly describe the program, services or activities that your agency will provide to address the need. Identify the number of clients to be served or the number of units offered, including timeframes for each.

Indicator/Service Category (CNPI, FNPI, SRV): List the indicator(s) or service(s) that will be reported in annual report.

Part II: Community Action Plan

CSBG Act Section 676(b)(11)
California Government Code Sections 12745(e), 12747(a)
California Code of Regulations, Title 22, Division 11, Chapter 1, Sections 100651 and 100655

Vision and Mission Statement

1. Provide your agency's Vision Statement.
At NCO, we envision healthy, vibrant, compassionate, and strong communities.
2. Provide your agency's Mission Statement.
NCO strengthens our communities through responsive advocacy, engagement, and services. **NCO VALUES** *Focus our energy for greatest impact:* We collaborate to make a difference in the lives of the people we serve. *Learn from challenge and change:* We look for opportunities to work differently and forge new paths. *Demonstrate respect and integrity:* We treat individuals, their ideas and expressions, with dignity, honesty, and fairness. *Embrace excellence:* We provide high quality service through the dedicated efforts of our team. *Honor diversity:* We welcome every opportunity to enrich our organization and our work with the experiences and perspectives that are expressed through each person's race, culture, religion, mental or physical abilities, heritage, age, sexual orientation, and gender identity.

Tripartite Board of Directors

CSBG Act Sections 676B(a); 676(b)(10)
California Code of Regulations, Title 22, Division 11, Chapter 1, Section 100605
State Plan

1. Describe how your Advisory or Governing Board is involved in the decision-making process and participates in the development, planning, implementation and evaluation of programs to serve low-income communities. (CSBG Act Section 676B(a))
☒ No change to the response in your agency's 2020-2021 CAP. ☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.
NCO Board members are fully involved in the organization's decision-making processes throughout program design, planning, implementation, and evaluation phases. Through a scheduled rotation, NCO Program Directors make regular presentations at monthly Board meetings and submit monthly reports on the status of their programs as well as challenges, future plans, and evaluation data demonstrating progress and accomplishments. Board members respond to the presentations with questions and suggestions that may then be incorporated for program improvement. The Board Finance Committee reviews monthly financial statements and reports back to the full Board.
2. Describe your agency's procedures under which a low-income individual, community organization, religious organization, or representative of low-income individuals that considers its organization or low-income individuals to be inadequately represented on your agency's board to petition for adequate representation. (CSBG Act Section 676(b)(10), State Plan)
☒ No change to the response in your agency's 2020-2021 CAP. ☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.
NCO embraces the tripartite Board requirement. When a member vacancy occurs, the Board Membership Committee encourages members to personally recruit individuals meeting the vacancy criteria. Board policies provide a process for organizations or individuals to petition if they feel their group or community is not adequately represented on the Board.

3. Describe your Advisory or Governing Board's policy for filling board vacancies in accordance with established bylaws. Include the recruiting process, democratic selections process for low-income board members, and the timeframe established by your agency to fill vacancies. (State Plan)
☒ No change to the response in your agency's 2020-2021 CAP. ☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.
When a member vacancy occurs, the Board Membership Committee encourages members to personally recruit individuals meeting the vacancy criteria; notifications of the vacancy are also sent to eligible government officials, NCO staff members, community organizations, and newspapers and Facebook. If no applicants meet the criteria for the vacant membership slot, an applicant is required to present 20 signatures as evidence that they are working with or affiliated with a group or community that meets the criteria. Vacancies are normally filled within three to six months.

Service Delivery System

CSBG Act Section 676(b)(3)(A)
State Plan

1. Describe your agency's service delivery system. Include a description of your client intake process or system and specify whether services are delivered via direct services or subcontractors, or a combination of both. (CSBG Act Section 676(b)(3)(A), State Plan)
Direct services provided by NCO with CSBG funds include disaster case management, rapid rehousing support, Head Start programming, youth development and food distribution, food production training and nutrition education, tax preparation assistance, and volunteer coordination. In addition to direct services, CSBG funding supports NCO's collaborative efforts. For example, in each county NCO plays a leading role in collaborative groups that seek to identify needs and determine the best ways in which they can be addressed and coordinated while minimizing duplication of services. Most of the direct service programs operated by NCO are delivered directly by agency staff, rather than through subcontracts. When a client intake process has been completed, staff enter the information into CAP60, the database used to track numbers served and client demographics, quantity and type of services delivered, and client needs and outcomes.
2. List your agency's proposed programs/services/activities that will be funded by CSBG. Include a brief explanation as to why these were chosen and how they relate to the CNA. (CSBG Act Section 676(b)(3)(A), State Plan)
For the following programs, CSBG funds will be used for leveraging resources; program planning, development, and administration; securing funding; and staffing and occupancy costs. **COLLABORATION AND ALIGNMENT OF SERVICES** **Hope Rising, Healthy Mendocino, Continuums of Care for the Homeless.** Development of collaborative partnerships to build community capacity to address issues related to poverty is a primary focus of NCO activities and of these collaborative bodies. **HOUSING AND HOMELESSNESS** **New Digs.** NCO has developed a broad portfolio of housing-related services, ranging from case management for fire survivors, to financial support to prevent homelessness, to rebuilding homes for fire

survivors and development of permanent supportive housing. A Housing Navigator works with landlords and local jurisdictions to develop housing resources, and Case Managers work with clients to address social and medical barriers to securing and retaining housing. Strategies focused on this result include relationship restoration, tenancy care, and landlord support, including covering home repair costs (in order to make a home suitable for renting), security deposits, or reimbursement for damages.

Building Homes, Building Lives Workforce Accelerator Program. Through this program NCO works with community partners to renovate and/or build new housing that is designated for the homeless and other low-income families.

COMMUNITY ENGAGEMENT

Emergency Preparedness In Communities. NCO is partnering with County Offices of Emergency Services and community-based organizations to deliver emergency preparedness information and training to a wide range of residents using the CalOES English/Spanish curricula, and to offer CERT trainings.

Volunteer Network. Through the Volunteer Network, NCO builds community capacity by working with a wide range of community partners to promote volunteer opportunities, recruit and place volunteers, and provide general volunteer trainings to people who would like to become volunteers.

COVID Outreach and Education. NCO works with community partners to bring COVID prevention information to low-income families and other vulnerable groups.

Caring Kitchen. Volunteers contribute their time to help with cooking, meal delivery, and follow-up to support healthy nutrition for persons with chronic diseases.

Leadership Mendocino. Founded in 1992, Leadership Mendocino was created to prepare community members from diverse occupations and backgrounds for leadership roles. The program informs current and emerging leaders on county issues, opportunities, and challenges and provides a forum for each participant to create a project that gives back to the community. Each year, 30 individuals from diverse professions, nationalities, ages, and regions of the county participate in the program, and the program now has more than 700 alumni.

HEALTH AND NUTRITION

Gardens Project. The NCO Gardens Project works with schools, communities, and neighborhoods to develop community and school gardens; the project also offers workshops on a wide range of food production topics.

Caring Kitchen. The Caring Kitchen provides weekly delivery of meals for people who are undergoing treatment for cancer or experiencing other chronic diseases and for their family members. Nutrient-dense meals are primarily plant-based and families receive enough prepared food for 3-5 meals per week.

Walk and Bike Mendocino. Walk and Bike Mendocino promotes walking and biking as primary transportation choices and advocates for economic equity and improved safety in transportation infrastructure. This program also provides traffic safety education to children and adults at events such as bike rodeos.

MendoLake Food Hub. The Food Hub uses a web-based ordering portal to aggregate and distribute foods produced by local farmers and ranchers. To better respond to the pandemic, NCO developed strategies that increased access to healthy food for low-income people who were struggling with economic and social losses.

Lakeport Community Kitchen. NCO is working with the City of Lakeport and other community partners to develop a new project, the Lakeport Community Kitchen, to prepare meals for those experiencing homelessness and other low-income people.

ECONOMIC ISSUES

MendoLake Food Hub. NCO provides extensive support and technical assistance to farmers to ensure their ability to participate in the Food Hub and access local markets.

VITA Tax Assistance. This program supports low-income families by providing no-cost assistance with preparing and filing tax returns.

People Helping People Project. NCO initially developed People Helping People to provide disaster case management for people who had lost their homes in wildfires. In 2020, the program expanded to support community members struggling through the COVID-19 shelter-in-place order, including those who had lost

jobs and income. The program supports community residents by helping to fill gaps for those who do not qualify for unemployment or federal stimulus packages, have been laid off and are not able to produce income, or are otherwise experiencing food or housing crises as a direct result of COVID-19.

EMPLOYMENT

Caring Kitchen. NCO recruits and trains at-risk youth to assist with food preparation, giving them the opportunity to learn soft and hard job skills.

Building Homes, Building Lives Workforce Accelerator Program. This construction program recruits homeless people and those nearing the end of temporary housing stays and trains them in construction skills. Upon completion of the training program, participants receive a certificate and assistance with job placement.

Head Start and Rural Communities Child Care. The COVID-19 pandemic has exacerbated the need to develop more effective recruitment strategies to fill openings in child care and Head Start programs.

MENTAL HEALTH AND SUBSTANCE USE

Life Skills Trainings. NCO works with its partners to offer life skills trainings to homeless clients and to people who are experiencing challenges related to mental health and/or substance use.

ACEs Trainings and Trauma-Informed Services. NCO programs such as Head Start and Rural Communities Child Care ensure that teachers, staff, and child care providers are informed about Adverse Childhood Experiences (ACEs), understand how ACEs can affect the children in their care, and are able to provide trauma-informed services and support.

Linkages and Funding Coordination

CSBG Act Sections 676(b)(1)(B) and (C), (3)(C) and (D), 676(b)(4), (5), (6), and (9)
California Government Code Sections 12747, 12760
Organizational Standards 2.1, 2.4
State Plan

1. Describe how your agency coordinates funding with other providers in your service area. If there is a formalized coalition of social service providers in your service area, list the coalition(s) by name and methods used to coordinate services/funding. (CSBG Act Sections 676(b)(1)(C), 676(b)(3)(C); Organizational Standard 2.1; State Plan)

NCO plans and coordinates programs with a wide number of organizations, community groups, businesses, and governmental agencies that deal with the reduction of poverty. Community linkages are developed through a continuum of collaboration and referral efforts with partner agencies who work together to identify and address gaps in services and coordinate service delivery. Two of the collaboratives with which NCO works are described below.

Hope Rising is an Accountable Community for Health collaborative focused on improving the health and wellness of Lake County. The organization's Governing Board and Leadership Team consist of CEO-level executives and program directors and coordinators from health systems, Medicaid payer organizations, behavioral health organizations, criminal justice, education, elected officials, housing, long term care, payers, public health department, providers, philanthropy, county agencies, non-profit organizations, elected officials, workforce development, and community members. Hope Rising operates through four program areas, identified through the Community Health Needs Assessment: health and prevention, community engagement, housing and homelessness, and alcohol and drug misuse.

Healthy Mendocino works to improve quality of life in Mendocino County by encouraging informed dialogue about the actions local residents and organizations can take to improve community health. The Healthy Mendocino initiative was launched in 2013, bringing together a coalition of 20 founding partners to create and fund the project. Healthy Mendocino develops and maintains HealthyMendocino.org, a data source providing current information on a broad range of factors that affect health and well-being—from air quality, to student achievement, to poverty. Healthy Mendocino is an NCO program as well as a collaborative body.

2. Provide information on any memorandums of understanding and/or service agreements your agency has with other entities regarding coordination of services/funding. (Organizational Standard 2.1, State Plan)

NCO and its programs enter into MOUs with a wide range of organizations and other entities. For example, NCO's Head Start program alone has MOUs with 44 entities in Mendocino County, ranging from tribal agencies, to school districts, to volunteer organizations such as Foster Grandparents. Also in Mendocino County, Healthy Mendocino partners have demonstrated their commitment to supporting informed dialogue about the actions local residents and organizations can take to improve community health in their MOU. In Lake County, the members of the Hope Rising Collaborative have entered into an MOU demonstrating their commitment to working together to address local needs.

3. Describe how services are targeted to low-income individuals and families and indicate how staff is involved, i.e. attend community meetings, provide information, make referrals, etc. Include how you ensure that funds are not used to duplicate services. (CSBG Act Section 676(b)(9), California Government Code Section 12760, State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

All NCO programs and services are developed in alignment with the organization's mission of serving low-income individuals, families, and communities. Programs are designed in response to needs observed in the community and those revealed through the community assessment process. NCO staff participate in a wide range of groups that include other organizations and agencies whose work is focused on low-income communities, ensuring that NCO is informed about other efforts and opportunities for collaboration to avoid duplication of services. NCO communicates its activities, progress, challenges, and accomplishments to the community through a variety of media and outreach strategies and has created a Director of Communications and Administration position to coordinate these activities. Strategies include: social media posts, radio PSAs and newspaper articles; reports to partners through collaborative groups; and tabling at community events.

4. Describe how your agency will leverage other funding sources and increase programmatic and/or organizational capacity. (California Government Code Section 12747, State Plan)

NCO is currently administering a $563,388 Community Service Block Grant (CSBG), which has been supplemented with $32,000 in Discretionary Funds for website update, client database upgrade, and technology training for staff. Selected current grants listed below demonstrate NCO's ability to use CSBG funds to leverage other resources.

Building Homes, Building Lives ($212,260) Funding from the State of California's Workforce Accelerator Program supports a workforce development program that trains and employs people experiencing homelessness. Under the direction of a licensed contractor and NCO staff, new homes are built and dilapidated homes are remodeled and made available as affordable rentals through NCO's New Digs Program. The program is increasing the affordable housing pool while helping homeless people earn skills and a wage as they work toward achieving permanent housing and stable employment.

CalFresh ($50,000). Provides funding for CalFresh outreach and enrollment assistance.

Emergency Preparedness In Communities ($1,023,694)**.** Funding from the California Office of Emergency Services (CalOES) enables NCO to deliver emergency preparedness training to vulnerable groups in Lake and Mendocino Counties. NCO anticipates that this funding will be renewed in the coming year.

California for All CERT/LISTOS Target County Support ($50,000). Funding from California Volunteers supports the training of Community Emergency Response Teams, as well as providing Spanish-language LISTOS emergency preparedness trainings.

COVID Awareness and Education ($150,000). Funding from the County of Mendocino supports targeted outreach and education efforts to combat the COVID-19 pandemic.

Farm to School ($250,000). NCO's Farm to School programming supports a range of activities focused on increasing the use of local foods in school meals and increasing access to local markets for local farmers.

New Digs Rapid ReHousing Project ($1,431,731). NCO is providing a range of support and services to homeless people throughout Lake County with funding from the California Department of Housing and Community Development's Emergency Solution Grants (ESG) Program, California Emergency Solutions and Housing (CESH) Program, and the Lake County Department of Social Services. Program goals are to help

people who are homeless or at risk of homelessness to quickly move into and/or retain stable housing by providing assistance ranging from help with utility payments to six months of rental assistance and 12 months of intensive case management.

Redwood Credit Union ($25,000). This funding provides partial support for three NCO programs: Gardens Project, MendoLake Food Hub, and Lakeport Community Kitchen.

USDA Food Insecurity Nutrition Incentive Project ($60,000). NCO partners with the Ecology Center California Market Match Program to expand food stamp match at farmers markets.

COVID Volunteer Recruitment ($50,000). NCO received $50,000 from the County of Mendocino to expand volunteer outreach and recruitment efforts in response to the pandemic.

People Helping People Program ($70,000). NCO received funding from the Community Foundation of Mendocino County to continue providing case management and direct assistance for people who have lost income as a result of the pandemic and/or are unable to return to their previous jobs.

Emergency Rental Assistance Program ($105,600). This program complements NCO's case management support services by connecting eligible clients to emergency rental assistance. NCO also receives state funding for outreach and promotion of rental support available through the State of California.

Disaster Case Management Program ($1,000,000). Catholic Charities provided funding for case management for survivors of Mendocino and Lake County fires in 2021.

5. Describe your agency's contingency plan for potential funding reductions. (California Government Code Section 12747, State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

During the project period, NCO will continue to use CSBG dollars to leverage major grants from federal, state, and foundation funders. NCO's contingency plan for potential funding reductions includes a tighter focus on priority issues, and the development of stronger collaborative partnerships. NCO emphasizes using federal funds to support indirect services to community-based collaborative projects and programs. To the extent that NCO funnels its CSBG funding into indirect services and capacity building, it enables beneficiary agencies to secure funds to operate services. Should CSBG funds be reduced, NCO will convene to review all

affected projects and programs. Other appropriate groups (e.g., agency advisory boards and community focus groups) will be invited to assist in this process, with NCO's Governing Board making final decisions.

6. Describe how your agency documents the number of volunteers and hours mobilized to support your activities. (Organizational Standard 2.4)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

NCO's Volunteer Network uses the Volgistics database to track volunteers and the time they contribute to NCO programs and other programs throughout the community. During 2020, almost 1,450 volunteers contributed their time through NCO programs: Caring Kitchen (2,093 hours); Gardens Project (37,920 hours); Head Start (28,771 hours); Healthy Mendocino (512 hours); MendoLake Food Hub (792 hours); Walk & Bike Mendocino (232 hours); and Volunteer Network (75,550 hours). In all, volunteers contributed 145,870 hours in 2020. Calculated at the 2020 hourly rate for California of $33.61, the hours donated by volunteers represent a contribution valued at $4,902,690 (https://independentsector.org).

7. Describe how your agency will address the needs of youth in low-income communities through youth development programs and promote increased community coordination and collaboration in meeting the needs of youth. (CSBG Act Section 676(b)(1)(B), State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

NCO involves youth in violence-free, positive alternative activities through programs that teach life skills and develop youth assets and resiliency. Such programming includes teen cooking and nutrition classes delivered through the Caring Kitchen Project. Through NCO's Rural Communities Child Care program, NCO supports parents in need of child care and provides training to child care providers.

8. Describe how your agency will promote increased community coordination and collaboration in meeting the needs of youth, and support development and expansion of innovative community-based youth development programs such as the establishment of violence-free zones, youth mediation, youth mentoring, life skills training, job creation, entrepreneurship programs, after after-school child care. (CSBG Act Section 676(b)(1)(B), State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

NCO will work with partner agencies to develop and enhance after school programs that incorporate nutrition, gardening, and cooking skills. Through partnerships with other youth-serving agencies, youth will have access to recreation, sports, homework help, computer access, cultural enrichment, and mentoring during after school hours.

9. If your agency uses CSBG funding to provide employment and training services, describe the coordination of employment and training activities as defined in Section 3 of the Workforce and Innovation and Opportunity Act [29 U.S.C. 3102]. (CSBG Act Section 676(b)(5), State Plan)

NCO is working with Hope Rising to identify opportunities to strengthen workforce development for disenfranchised groups. To develop workforce skills among clients served through the New Digs Rapid Rehousing Program, NCO operates the Building Homes, Building Lives Workforce Accelerator Project that provides construction training and creates affordable housing options for the unhoused. Youth working with Caring Kitchen gain hands-on experience in the kitchen, an opportunity to make a difference, and opportunities to learn healthy eating, leadership, and job-readiness skills.

10. Describe how your agency will provide emergency supplies and services, nutritious foods, and related services, as may be necessary, to counteract conditions of starvation and malnutrition among low-income individuals. (CSBG Act Section 676(b)(4), State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

NCO collaborates with agencies that provide emergency support services and coordinates with food policy councils, food advocacy groups, and community gleaner groups that provide food to low-income people. NCO has established multiple community gardens and has also been a key player in making CalFresh purchases possible at local farmers markets and offering dollar-for-dollar match. NCO's Caring Kitchen project brings nutritious, organic meals and a community of caring to low-income people with cancer or other chronic diseases, while at-risk youth gain hands-on experience and develop new skills as they work to prepare the meals that are then delivered to their clients. Through the CalOES Emergency Preparedness Campaign grants, NCO provides mini-grants to community-based organizations, who then conduct outreach and trainings for the vulnerable groups that they serve. NCO also coordinates CERT and LISTOS trainings to strengthen community emergency response capacity. The Lakeport Community Kitchen will serve up to 200

meals per week to homeless and other low-income community residents as well as preparing ready-made meals for partner organizations offering transitional housing to those experiencing homelessness.

11. Describe how your agency coordinates with other antipoverty programs in your area, including the emergency energy crisis intervention programs under title XVI (relating to low-income home energy assistance) that are conducted in the community. (CSBG Act Section 676(b)(6), State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

NCO coordinates with other communities through its participation in the statewide California Community Action Partnership Association and other statewide and regional bodies, such as the Partnership HealthPlan of California. NCO also coordinates with and refers clients to North Coast Energy Services, which is the Low Income Home Energy Assistance Program (LIHEAP) agency for seven northern California counties (Lake, Marin, Mendocino, Napa, Solano, Sonoma, and Yolo). NCO continues to be an active member of the Lake County Continuum of Care, which provides resources and creates policy to support the unhoused population.

12. Describe how your agency will use funds to support innovative community and neighborhood-based initiatives, which may include fatherhood and other initiatives, with the goal of strengthening families and encouraging effective parenting. (CSBG Act Section 676(b)(3)(D), State Plan)

☒ No change to the response in your agency's 2020-2021 CAP.

☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.

CSBG funds will be used to support projects that have the greatest potential to maximize impact and leverage resources. Family strengthening is broadly defined to include programs that support family economy and build family self-reliance. Programs meeting this description that will be supported through CSBG funding trainings provided to parents and child care providers through NCO's Head Start and Rural Communities Child Care programs.

Monitoring

CSBG Act Section 678D(a)(1)(A) and (B)

1. Describe how your agency's monitoring activities are related to establishing and maintaining the integrity of the CSBG program. Include your process for maintaining high standards of program and fiscal performance.
NCO conducts program evaluations, including periodic client surveys, partner surveys, and surveys of other community members, to inform program planning and development. NCO's Director of Communications and Administration works with NCO Program Directors to develop monitoring and data collection processes and collect data to document all work supported by CSBG dollars, including participant numbers and demographics, services provided and units of service, and client satisfaction. Data collected by each project or program is compiled by the Project Director or Coordinator, summarized for comparison with target goals and objectives, and shared with appropriate staff, as well as entered in the CAP60 database. This process provides staff with data for completion of required reports to CSD and other funders and enables them to understand and address any barriers.
2. If your agency utilizes subcontractors, please describe your process for monitoring the subcontractors. Include the frequency, type of monitoring, i.e., onsite, desk review, or both, follow-up on corrective action, and issuance of formal monitoring reports.
NCO does not use CSBG funds for subcontracting.

Data Analysis and Evaluation

CSBG Act Section 676(b)(12)
Organizational Standards 4.2, 4.3

1. Describe your agency's method for evaluating the effectiveness of programs and services. Include information about the types of measurement tools, the data sources and collection procedures, and the frequency of data collection and reporting. (Organizational Standard 4.3)
Evaluation methods vary from project to project, depending on funder requirements and project needs. Data collection methods may include: pre/post surveys for assessment of changes in knowledge and behavior; workshop and training assessments; client satisfaction surveys; and/or staff surveys. Evaluation strategies include trend analysis of changes in data indicators over time; counts of activities, units of service, and number of people served; demographics; etc. Evaluation reporting varies from project to project, depending on funder requirements and project needs, but customarily includes an annual report of evaluation activities and findings.
2. Applying the Results Oriented Management and Accountability (ROMA) cycle of assessment, planning, implementation, achievement of results, and evaluation, describe one change your agency made to improve low-income individuals' and families' capacity for self-sufficiency. (CSBG Act Section 676(b)(12), Organizational Standard 4.2)
☒ No change to the response in your agency's 2020-2021 CAP. ☐ Adaptations to the response in your agency's 2020-2021 CAP are described below.
Examples of NCO's use of program data to plan and guide program improvement are provided below. As NCO struggled to establish and implement case management protocols in the midst of responding to the wildfire disasters of the past five years, it became clear that a better data collection system would be essential to understanding what was working and what needed to be changed to ensure high quality program services. As a result, NCO has developed and standardized data collection and reporting systems. A review and evaluation of data collected from fire survivors through the People Helping People Program made it clear that while many families did have some resources, most were uninsured or underinsured and many were not eligible for single programs that would be sufficient to fund their rebuilding processes. Accordingly, NCO has worked to identify and access additional sources of funding that can be combined in

resource packages to meet family needs. This process also resulted in requesting and receiving permission to raise the ceiling amount that families could receive through specific funding programs.

3. Applying the full ROMA cycle, describe one change your agency facilitated to help revitalize the low-income communities in your agency's service area(s). (CSBG Act Section 676(b)(12), Organizational Standard 4.2) (Optional)

Review and evaluation of data collected during implementation of NCO's MendoLake Food Hub made it clear that the program could only reach the stage of self-sufficiency if it expanded its operations to include a wider range of products and services. During the past year, the program demonstrated its flexibility by securing USDA and other contracts to distribute food boxes to low-income families impacted by the pandemic.

Additional Information (Optional)

Disaster Preparedness

1. Does your agency have a disaster plan in place that includes strategies on how to remain operational and continue providing services to low-income individuals and families during and following a disaster?
☐ Yes ☒ No
2. If so, when was the disaster plan last updated?
NCO has completed several components of a comprehensive disaster plan, but is still working to finalize and compile a consolidated Agency Emergency Plan for Continuity of Operations.
3. Briefly describe your agency's main strategies to remain operational during and after a disaster.
NCO's offices are configured to provide permanent, centrally-located homes for NCO's disaster preparedness and response work in each county, including a Disaster Recovery Room where NCO staff and partners can work together on disaster readiness and disaster response efforts, survivors can access services and support, and staff can carry out case management and other activities focused on housing and homelessness. In both counties, NCO works closely with the Office of Emergency Services and Red Cross on prevention advocacy, and NCO staff are available for deployment during disasters to support emergency services. In addition, NCO is in the process of implementing an automated Alert Media system to notify appropriate staff when they are needed to work in person or from home.

Agency Capacity Building

1. Although the CNA focused on Community and Family Level needs, if your agency identified Agency Level need(s) during the CNA process, list them here.
NCO has identified three capacity-building needs: development of an agency-wide Disaster Plan, increased training in and focus on equity issues, and development of more effective recruitment strategies for Head Start and Rural Communities Child Care providers.

2. Describe the steps your agency is planning to take to address the Agency Level need(s).
NCO will work with appropriate staff and/or external consultants to develop the Disaster Plan. The Board of Directors has already established an ad hoc committee to focus on equity issues, and the agency will be embarking on an organizational assessment of diversity, equity, and inclusion. This will be a year-long assessment process intended to support and foster organizational learning and changes that strengthen equity-centered practices. NCO will work with state and federal agencies to develop solutions to the shortage of applicants for jobs in child care and Head Start classrooms.

Federal CSBG Programmatic Assurances and Certification

CSBG Act 676(b)

Use of CSBG Funds Supporting Local Activities

676(b)(1)(A): The state will assure "that funds made available through grant or allotment will be used – (A) to support activities that are designed to assist low-income families and individuals, including families and individuals receiving assistance under title IV of the Social Security Act, homeless families and individuals, migrant or seasonal farmworkers, and elderly low-income individuals and families, and a description of how such activities will enable the families and individuals--

i. to remove obstacles and solve problems that block the achievement of self-sufficiency (particularly for families and individuals who are attempting to transition off a State program carried out underpart A of title IV of the Social Security Act);
ii. to secure and retain meaningful employment;
iii. to attain an adequate education with particular attention toward improving literacy skills of the low-income families in the community, which may include family literacy initiatives;
iv. to make better use of available income;
v. to obtain and maintain adequate housing and a suitable living environment;
vi. to obtain emergency assistance through loans, grants, or other means to meet immediate and urgent individual and family needs;
vii. to achieve greater participation in the affairs of the communities involved, including the development of public and private grassroots
viii. partnerships with local law enforcement agencies, local housing authorities, private foundations, and other public and private partners to

–

I. document best practices based on successful grassroots intervention in urban areas, to develop methodologies for wide-spread replication; and
II. strengthen and improve relationships with local law enforcement agencies, which may include participation in activities such as neighborhood or community policing efforts;

Needs of Youth

676(b)(1)(B) The state will assure "that funds made available through grant or allotment will be used – (B) to address the needs of youth in low-income communities through youth development programs that support the primary role of the family, give priority to the prevention of youth problems and crime, and promote increased community coordination and collaboration in meeting the needs of youth, and support development and expansion of innovative community-based youth development programs that have demonstrated success in preventing or reducing youth crime, such as--

I. programs for the establishment of violence-free zones that would involve youth development and intervention models (such as models involving youth mediation, youth mentoring, life skills training, job creation, and entrepreneurship programs); and
II. after-school childcare programs.

Coordination of Other Programs

676(b)(1)(C) The state will assure "that funds made available through grant or allotment will be used – (C) to make more effective use of, and to coordinate with, other programs related to the purposes of this subtitle (including state welfare reform efforts)

Eligible Entity Service Delivery System

676(b)(3)(A) Eligible entities will describe "the service delivery system, for services provided or coordinated with funds made available through grants made under 675C(a), targeted to low-income individuals and families in communities within the state;

Eligible Entity Linkages – Approach to Filling Service Gaps

676(b)(3)(B) Eligible entities will describe "how linkages will be developed to fill identified gaps in the services, through the provision of information, referrals, case management, and follow-up consultations."

Coordination of Eligible Entity Allocation 90 Percent Funds with Public/Private Resources

676(b)(3)(C) Eligible entities will describe how funds made available throughgrants made under 675C(a) will be coordinated with other public and private resources."

Eligible Entity Innovative Community and Neighborhood Initiatives, Including Fatherhood/Parental Responsibility

676(b)(3)(D) Eligible entities will describe "how the local entity will use the funds [made available under 675C(a)] to support innovative community and neighborhood-based initiatives related to the purposes of this subtitle, which may include fatherhood initiatives and other initiatives with the goal of strengthening families and encouraging parenting."

Eligible Entity Emergency Food and Nutrition Services

676(b)(4) An assurance "that eligible entities in the state will provide, on an emergency basis, for the provision of such supplies and services, nutritious foods, and related services, as may be necessary to counteract conditions of starvation and malnutrition among low-income individuals."

State and Eligible Entity Coordination/linkages and Workforce Innovation and Opportunity Act Employment and Training Activities

676(b)(5) An assurance "that the State and eligible entities in the State will coordinate, and establish linkages between, governmental and other social services programs to assure the effective delivery of such services, and [describe] how the State and the eligible entities will coordinate the provision of employment and training activities, as defined in section 3 of the Workforce Innovation and Opportunity Act, in the State and in communities with entities providing activities through statewide and local workforce development systems under such Act."

State Coordination/Linkages and Low-income Home Energy Assistance

676(b)(6) "[A]n assurance that the State will ensure coordination between antipoverty programs in each community in the State, and ensure, where appropriate, that emergency energy crisis intervention programs under title XXVI (relating to low-income home energy assistance) are conducted in such community."

Community Organizations

676(b)(9) An assurance "that the State and eligible entities in the state will, to the maximum extent possible, coordinate programs with and form partnerships with other organizations serving low-income residents of the communities and members of the groups served by the State, including religious organizations, charitable groups, and community organizations."

Eligible Entity Tripartite Board Representation

676(b)(10) "[T]he State will require each eligible entity in the State to establish procedures under which a low-income individual, community organization, or religious organization, or representative of low-income individuals that considers its organization, or low-income individuals, to be inadequately represented on the board (or other mechanism) of the eligible entity to petition for adequate representation."

Eligible Entity Community Action Plans and Community Needs Assessments

676(b)(11) "[A]n assurance that the State will secure from each eligible entity in the State, as a condition to receipt of funding by the entity through a community service block grant made under this subtitle for a program, a community action plan (which shall be submitted to the Secretary, at the request of the Secretary, with the State Plan) that includes a community needs assessment for the community serviced, which may be coordinated with the community needs assessment conducted for other programs."

State and Eligible Entity Performance Measurement: ROMA or Alternate System

676(b)(12) "[A]n assurance that the State and all eligible entities in the State will, not later than fiscal year 2001, participate in the Results Oriented Management and Accountability System, another performance measure system for which the Secretary facilitated development pursuant to section 678E(b), or an alternative system for measuring performance and results that meets the requirements of that section, and [describe] outcome measures to be used to measure eligible entity performance in promoting self-sufficiency, family stability, and community revitalization."

Fiscal Controls, Audits, and Withholding

678D(a)(1)(B) An assurance that cost and accounting standards of the Office of Management and Budget (OMB) are maintained.

☒ **By checking this box and signing the Cover Page and Certification, the agency's Executive Director and Board Chair are certifying that the agency meets the assurances set out above.**

State Assurances and Certification

California Government Code Sections 12747(a), 12760, 12768

California Government Code § 12747(a): Community action plans shall provide for the contingency of reduced federal funding.

California Government Code § 12760: CSBG agencies funded under this article shall coordinate their plans and activities with other agencies funded under Articles 7 (commencing with Section 12765) and 8 (commencing with Section 12770) that serve any part of their communities, so that funds are not used to duplicate particular services to the same beneficiaries and plans and policies affecting all grantees under this chapter are shaped, to the extent possible, so as to be equitable and beneficial to all community agencies and the populations they serve.

For MSFW Agencies Only

California Government Code § 12768: Migrant and Seasonal Farmworker (MSFW) entities funded by the department shall coordinate their plans and activities with other agencies funded by the department to avoid duplication of services and to maximize services for all eligible beneficiaries.

☒ **By checking this box and signing the Cover Page and Certification, the agency's Executive Director and Board Chair are certifying the agency meets assurances set outabove.**

Organizational Standards

MAXIMUM FEASIBLE PARTICIPATION

Category One: Consumer Input and Involvement

Standard 1.1 The organization/department demonstrates low-income individuals' participation in its activities.

Standard 1.2 The organization/department analyzes information collected directly from low-income individuals as part of the community assessment.

Category Two: Community Engagement

Standard 2.1 The organization/department has documented or demonstrated partnerships across the community, for specifically identified purposes; partnerships include other anti-poverty organizations in the area.

Standard 2.2 The organization/department utilizes information gathered from key sectors of the community in assessing needs and resources, during the community assessment process or other times. These sectors would include at minimum: community-based organizations, faith-based organizations, private sector, public sector, and educational institutions.

Standard 2.4 The organization/department documents the number of volunteers and hours mobilized in support of its activities.

Category Three: Community Assessment

Private Agency - Standard 3.1 Organization conducted a community assessment and issued a report within the past 3 years.

Public Agency - Standard 3.1 The department conducted or was engaged in a community assessment and issued a report within the past 3-year period, if no other report exists.

Standard 3.2 As part of the community assessment, the organization/department collects and includes current data specific to poverty and its prevalence related to gender, age, and race/ethnicity for their service area(s).

Standard 3.3 The organization/department collects and analyzes both qualitative and quantitative data on its geographic service area(s) in the community assessment.

Standard 3.4 The community assessment includes key findings on the causes and conditions of poverty and the needs of the communities assessed.

Standard 3.5 The governing board or tripartite board/advisory body formally accepts the completed community assessment.

VISION AND DIRECTION

Category Four: Organizational Leadership

Private Agency - Standard 4.1 The governing board has reviewed the organization's mission statement within the past 5 years and assured that:

1. The mission addresses poverty; and
2. The organization's programs and services are in alignment with the mission.

Public Agency - Standard 4.1 The tripartite board/advisory body has reviewed the department's mission statement within the past 5 years and assured that:

1. The mission addresses poverty; and
2. The CSBG programs and services are in alignment with the mission.

Standard 4.2 The organization's/department's Community Action Plan is outcome-based, anti-poverty focused, and ties directly to the community assessment.

Standard 4.3 The organization's/department's Community Action Plan and strategic plan document the continuous use of the full Results Oriented Management and Accountability (ROMA) cycle or comparable system (assessment, planning, implementation, achievement of results, and evaluation). In addition, the organization documents having used the services of a ROMA-certified trainer (or equivalent) to assist in implementation.

Category Six: Strategic Planning

Standard 6.4 Customer satisfaction data and customer input, collected as part of the community assessment, is included in the strategic planning process, or comparable planning process.

Appendices

Please complete the table below by entering the title of the document and its assigned appendix letter. Agencies must provide a copy of the Notice(s) of Public Hearing and the Low-Income Testimony and the Agency's Response document as appendices A and B, respectively. Other appendices such as need assessment surveys, maps, graphs, executive summaries, analytical summaries are encouraged. All appendices should be labeled as an appendix (e.g., Appendix A: Copy of the Notice of Public Hearing) and submitted with the CAP.

Document Title	Appendix Location
Appendix A. Notices of Public Hearing	Page 44
Appendix B. Low-Income Testimony and Agency Response	Page 46
Appendix C. Additional Assessment Data for COVID-Related Needs	Page 50
Appendix D. Lake County Community Health Needs Assessment	Page 51 (1-161)
Appendix E. Mendocino County Community Health Needs Assessment	Page 52 (1-162)

Appendix A. Notices of Public Hearing

NORTH COAST OPPORTUNITIES
50th ANNIVERSARY
Celebrating 50 years of Community Action • 1968-2018

We invest in people through Community Action.

Our Programs | About Us | Give | News | Jobs | Fiscal Sponsorships | Disaster Response | Volunteer

News • Public Hearing Announcement

https://www.ncoinc.org/about-us/news/public-hearing-announcement/

Click here to view NCO's DRAFT Community Action Plan 2022/2023 (05/15/2021). If you'd a copy of the Draft CAP please contact Bianca at bnieto@ncoinc.org or call (707) 467-3227.

Haga un clic aquí para ver el Plan de Acción Comunitario 2022/2023 provisional. (15/5/21) (Actualmente, solo tenemos el PAC en inglés.)

Public Hearing Announcement

Tuesday, May 25, 2021

Public Announcement
North Coast Opportunities, Inc. (NCO) will hold a Public Hearing on Wednesday, June 23rd, 2021. Members of the Lake and Mendocino community are invited to attend and to make recommendations to NCO's Board of Directors regarding ideas about the 2022/2023 Community Action Plan. The Community Action Plan (CAP) serves as a two-year roadmap demonstrating how NCO plans to deliver Community Services Block Grant (CSBG) eligible Services. Public comments on identified unmet needs will be incorporated into the Agency's biennial Community Action plan for the period of 2022 and 2023.

Click here to view NCO's 2022/2023 Draft Community Action Plan.

Written recommendations are welcome and may be mailed to Attn: CAP PLAN, NCO, 413 North State Street, Ukiah CA 95482 or sent via email to Bianca Nieto bnieto@ncoinc.org between June 8th - 23rd. For more information contact Bianca at (707) 467-3227.

Public comment will be accepted during NCO's Board meeting on **Wednesday, June 23rd, 2021 at 2:00 pm**. Due to social distancing directives, we ask that you participate via Zoom.

NCO hearing on 2022/2023 Community Action Plan

Calendar Agencies & NGOs
Date
06.23.2021 2:00 pm - 3:00 pm
Author Editor

Description

North Coast Opportunities Inc. is holding a public hearing on Wednesday, June 23, 2021, to accept comments about the 2022/2023 Community Action Plan.

The Community Action Plan (CAP) serves as a two-year roadmap demonstrating how NCO plans to deliver CSBG services.

Public comment will be accepted during NCO's Board meeting on Wednesday, June 23, from 2 to 3 p.m.

Due to social distancing directives, NCO asks that the public participates via Zoom. Zoom meeting details may be found at www.ncoinc.org .

For more information or to receive a copy of the draft plan visit www.ncoinc.org or contact Bianca Nieto at 707-467-3227 or email bnieto@ncoinc.org .

North Coast Opportunities, Inc. organizara una audiencia pública el miércoles 23 de junio 2021 para aceptar recomendacions y comentarios sobre el Plan de Acción Comunitario 2022/2023 (PAC).

El PAC demuestra cómo NCO planea utilizar los fondos de CSBG a través de los próximos dos años.

Se invita a los miembros de la comunidad a asistir y a hacer recomendaciones durante la Junta Directiva de NCO de 2:00 pm - 3:00 pm con respecto a las ideas incluidas en el PAC. Debido a las directivas de distanciamiento social le pedimos que participe a través de Zoom. Los detalles de la reunión estarán disponibles en www.ncoinc.org.

Para más información o para recibir una copia del PAC, visite www.ncoinc.org o comuníquese con Bianca Nieto, 707-467-3227 o bnieto@ncoinc.org .

Appendix B. Low-Income Testimony and Agency Response

NOTE: NCO received the following questions from Betsy Cawn, a community member who attended the Public Hearing, and provided her with the responses shown below for each question. Because these questions are not comments about the plans articulated in the CAP, they are not addressed in the CAP document itself.

1. Who are the legal representatives to the Community Action Agency Board of Directors appointed or delegated by the Lake County Board of Supervisors?

RESPONSE:

NCO is a private nonprofit public benefit corporation governed by a tripartite board composed of representatives of local government, low-income individuals, and interested community organizations. One-third of Board members must be elected officials, holding office at their time of selection, or their representatives. If a sufficient number of elected officials or their representatives are not available to serve, appointed public officials or their representatives may take the place of elected officials. However, representatives of local governments are recruited by the NCO Board, rather than being appointed or delegated by County Boards of Supervisors. NCO By-laws require the Board to include two representatives of local government in each county. Currently, these positions are filled for Mendocino County, and NCO is in the process of recruiting local government representatives to serve as NCO board members for Lake County.

2. Why does NCO "not have a certified ROMA trainer," and for how long has this position been unfilled?

RESPONSE:

NCO staff members who completed the ROMA training and certification process in the past are no longer working with the organization. NCO is in the process of selecting a staff member to become a certified ROMA trainer and fill this role in the future.

3. Are you actively recruiting for the "ROMA trainer," and to whom would that individual report?

RESPONSE:

The certified ROMA trainer role will be filled by an NCO staff member that has completed the ROMA training and certification process. This individual will also continue to fulfill their current job within the organization and will report to their current supervisor. Currently, two staff members are participating in ROMA trainings and working toward certification, and a third staff member has expressed interest in pursuing the certification. All leadership staff have been briefed on ROMA and have a basic understanding of the ROMA process.

4. What agencies are listed on the recipients of the draft of the plan, whose participation was solicited in its review and approval for today's hearing?

RESPONSE:

The draft CAP was made available on the NCO website from 25 May – 23 June 2021, and also posted on social media. It was not distributed to individuals or organizations separately.

5. Who reviewed this document in the Lake County Department of Social Services, Office of Emergency Services, Administration, and other offices related to continuing the long-term recovery from recent years' wildfires (including but not limited to the 2015 Rocky and Valley Fires)?

RESPONSE:

NCO accepts and addresses all comments received as part of the CAP review process, but does not track the identity of individuals or organizations that download and/or review the CAP.

6. Is the "Community Health Needs Assessments" survey accessible through your website or other online media?

RESPONSE:

NCO partnered with Hope Rising and more than ten other organizations and groups, including Hope Rising and Lake County Public Health, in conducting the 2019 Lake County Community Health Needs Assessment. The full reports can be found on the Hope Rising website (http://www.hoperisinglc.org/tiles/index/display?id=200426747104935311) and the Healthy Mendocino website (https://www.healthymendocino.org/).

7. Was the "Community Health Needs Assessments" associated with the survey of the same name distributed in 2019 by the Lake County Public Health Department, in association with the entity titled "Hope Rising"? See Table 2: Priority Ranking Table (Page 16) which lists "Hope Rising" as one of three "programs, services, activities" responding to the first query entry ("Collaboration and alignment of services").

Has the Lake County Public Health Department been working with NCO and the Community Action Agency in partnership with Hope Rising organizations currently organized separately as a registered charitable trust by the Secretary of State as "Hope Is Rising" (D.B.A. "Hope Rising") to develop this proposed Community Action Plan?

On Page 6, this statement is found that leads me to believe that the Lake County surveys were those produced by our PH Department:

"Healthy Mendocino worked with community partners to collect 1,324 surveys (1,276 in English and 48 in Spanish). In Lake County, 674 individuals responded to community surveys, which were also available in both Spanish and English." The "data" extracted from these surveys was — at one time — available as the results of the survey that were intended to inform the creation of a "Lake County Long-Term Health Improvement Plan." Will the Community Action Plan support that development, in collaboration with the Lake County Public Health Department, "Hope Rising" and its multi-disciplinary governing board, and the population in need?

RESPONSE:

Both Mendocino and Lake Counties conducted an intentional collaborative assessment process to focus energy, reduce duplication of effort, and produce a comprehensive assessment document. NCO's 2022-2023 Community Action Plan was developed in response to the findings of the County Community Health Needs Assessments and is designed to address selected needs identified through those assessments and through information collected through NCO programs, including case management programs. See also response to Question 6 above.

8. Why is there such a disproporationate effort made in Mendocino County than in Lake County, as exemplified by these excerpts from Page 6:

"In Lake County, five focus groups were held with a total of 31 low-income participants. Each focus group was recorded, transcribed to capture the verbatim conversation, and analyzed using a qualitative analysis program. In Mendocino County, NCO also identified needs through its disaster case management process, which served hundreds of fire survivors and families experiencing hardships as a result of the COVID-19 pandemic."

"Five community forums were held throughout Lake County as part of the assessment process, while Healthy Mendocino held 23 listening tours with agencies and groups in Mendocino County to inform the assessment process."

"In 2020, virtual forums organized by Healthy Mendocino were convened to assess needs related to specific topics, including: Social Services and Vulnerable Populations (June 2020, 43 participants); Workforce and Economy (June 2020, 40 participants); Community Connection and Resiliency (July 2020, 48 participants); and Diversity, Equity, and Inclusion (December 2020, 64 participants). In addition, the Healthy Mendocino Roundtable met three times (September 2020, December 2020, and March 2021), with discussions focused on social determinants of health, structural racism, shelter-in-place burnout, and recovery from the pandemic."

Without belaboring this point, also see the statements on Page 7, describing "Community Conversations" (which mention public radio broadcasts in Mendocino County, but not Lake) and "Interviews":

"Lake County [the county itself?] conducted 10 interviews with key stakeholders with expertise in public health or special knowledge of community needs. In Mendocino County, interviews were conducted with 90 key stakeholders representing community-based organizations, nonprofits, local government, tribal entities, education, health care, law enforcement, private business, agriculture, health and human services, and community members."

RESPONSE:

NCO is a member of the Hope Rising Collaborative. As stated in previous responses, NCO worked with a range of partners in each county to develop the CAP, drawing from assessment work completed by these partners. Lead agencies in each county work with their partners to determine the types and quantities of strategies they will use in conducting their assessments.

9. What is the organization chart of the NCO "programs, activities, and services" staffing, what are the "programs, activities, and services" that are planned for emergency management, disaster preparedness, and assistance for "Access & Functional Needs" in disasters by NCO planners.

RESPONSE:

NCO's emergency preparedness and emergency response programs and activities are wide ranging and are described in various places throughout the draft CAP document, including in the response to Question 2 on page 21 of the draft document. These programs include People Helping People (disaster case management); EPIC (Emergency Preparedness in Communities); the Volunteer Network; Caring Kitchen; MendoLake Food Hub; Building Homes, Building Lives in Lake County, the construction and remodeling project that provides construction training and creates housing; and the Community Emergency Response Training (CERT) program.

10. One NCO staff person has been involved with delivery of LISTOS and EPIC projects here in Lake County, and that individual is currently in the process of being hired by the County of Lake. Will NCO hire a replacement for that individual and provide support for delivery of critical services in our now-shuttered senior centers? On Page 23, there is reference to the "Lakeport Community Kitchen. NCO is working with the City of Lakeport and other community partners to develop a new project, the Lakeport Community Kitchen, to prepare meals for those experiencing homelessness and otehr low-income people." What department of the City of Lakeport is involved in this project? Who are the "other community partners"?

RESPONSE:

NCO provides services for seniors within the ambit of most of its programs. For example, seniors are served through People Helping People, New Digs, EPIC, Foster Grandparents, and more. Although NCO does not normally deliver services directly at senior centers, during the pandemic NCO staff did provide emergency support at the senior center in Clearlake by delivering groceries to homebound seniors, making phone calls to check on seniors' wellbeing, and linking senior to services.

NCO will continue to implement the LISTOS and EPIC programs as funding is secured for these programs. Staffing changes for these programs will be made as appropriate. The anticipated contract with the County of Lake will help strengthen and develop additional emergency services in Lake County, but this effort will constitute only a small percentage of the referenced staff member's job.

In development of the Lakeport Community Kitchen, NCO is working closely with community partners including Hope Rising's Hope Center Project and Yuba College Culinary Arts Program, among others.

11. On Page 25: "Hope Rising is an Accountable Community for Health collaborative focussed on improving the health and wellness of Lake County. The organization's Governing Board and Leadership Team consist of CEO-level executives and program directors and coordinators from health systems, Medicaid payer organizations, behavioral health organizations, criminal justice, education, elected officials, non-profit organizations, elected officials [sic - listed twice], workforce development, and community members. Hope Rising operates through four program areas, identified in the Community Health Needs Assessment: health and prevention, community engagement, housing and homelessness, and alcohol and drug misuse." This statement provides additional confirmation to the guess described in Item 7, above. However, please note that (as referred to in that item) the legal entity registered in the state of California as a "private non-profit public-benefit California corporation" is "Hope Is Rising, d.b.a. Hope Rising," which does not have a physical location or fiscal work products available to the community via their only collective manifestation, the "Hope Rising" website. Where does the definition "Accountable Community for Health" come from and what are the criteria for claiming that the "organization" is "accountable"?

RESPONSE:

Please see more information about Accountable Communities for Health on this website: www.preventioninstitute.org/projects/accountable-communities-health-ach.

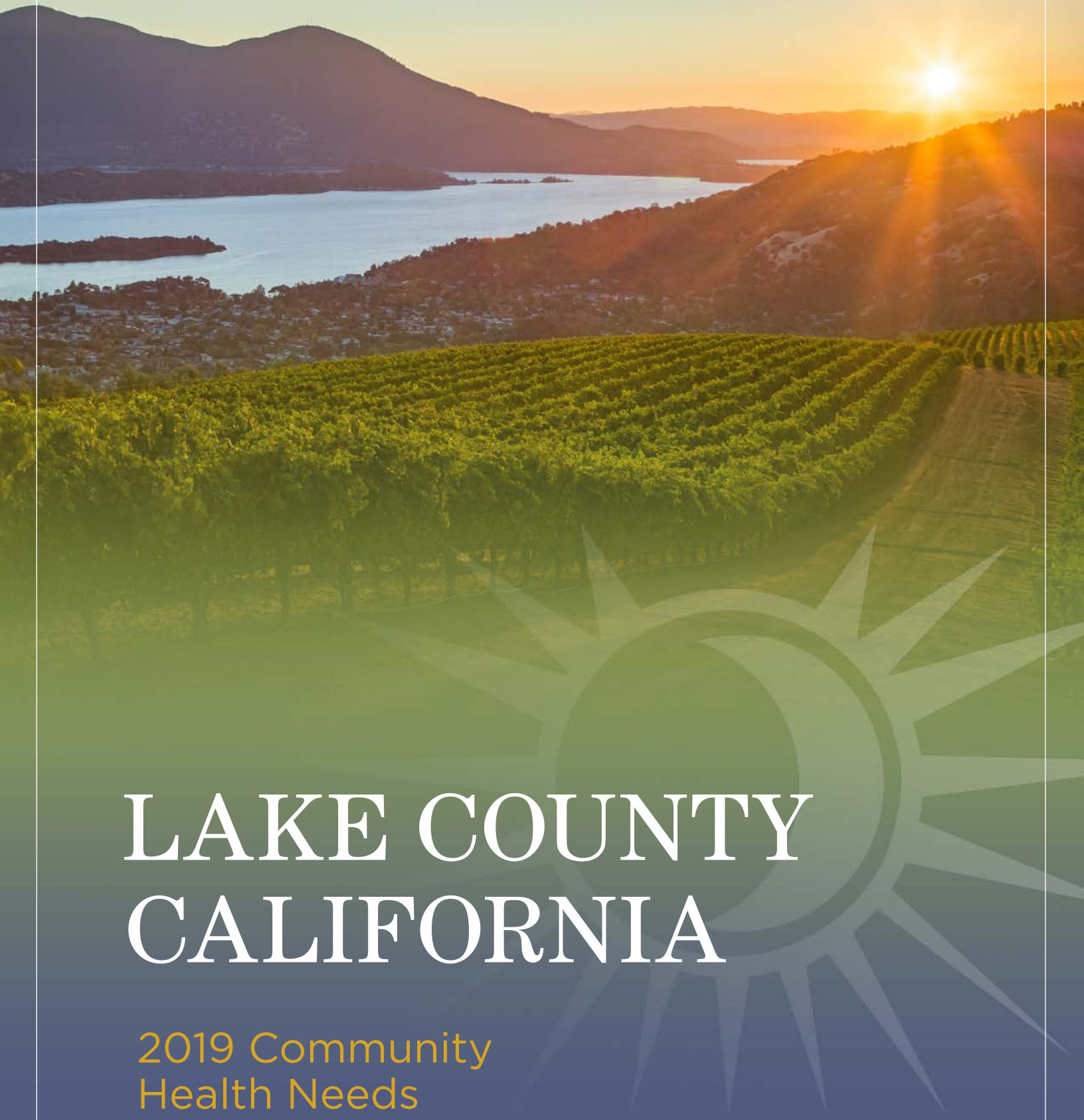
Appendix C. Additional Assessment Data for COVID-Related Needs

In addition to the comprehensive assessments and data compilations conducted for each county (Attachments C and D), NCO staff compiled the following listing of needs identified through their work with vulnerable families and individuals during the COVID-19 pandemic:

- Many families are not eligible for government assistance or are unwilling to apply for eligible family members (e.g., children born in the U.S.) due to fears surrounding their immigration status. Many were concerned that receiving funding support would be considered a public charge and affect their immigration status.
- Clients have lost jobs, experienced reduced working hours, or missed work without pay due to quarantine or isolation orders (in some cases for up to 3 months).
- Mothers particularly have been unable to work due to childcare responsibilities.
- Families who rely on childcare help from elderly grandparents or other relatives are unable to do so because of the risk of COVID-19 transmission.
- People have behind with rent and utility payments, with some owing up to $5,000 on utility bills. Some are paying bills with credit cards or have taken out loans to pay landlords. Others are relying on help from friends or family members.
- Some landlords do not want to participate (e.g., refuse to provide W9s) with programs that can provide rental assistance, meaning their tenants cannot take full advantage of resources provided by the community or state.
- The unemployment application process is difficult and confusing, and people who experience difficulties with the process were often unable to reach anyone at the EDD office for assistance. People receiving disability insurance and some clients receiving social security have similar difficulties getting any issues sorted out.
- Clients who receive unemployment note that the payments aren't sufficient and are often irregular amounts or unreliable.
- Many clients are homeless and rental or utility assistance can't help them. Organizations that help find affordable housing have long waiting lists.
- Homeless families with children don't have a shelter to go to.

Federal and state assistance, whether through unemployment, stimulus payments, or otherwise, is usually insufficient to cover the financial needs of those who lost employment during the pandemic. Moreover, a significant portion of people in Mendocino County are ineligible for government assistance.

Appendix D. Lake County Community Health Needs Assessment



LAKE COUNTY CALIFORNIA

2019 Community Health Needs Assessment

TABLE OF CONTENTS

SECTION 1

EXECUTIVE SUMMARY

1.1 INTRODUCTION

Hope Rising Lake County — the Lake County, California Collaborative of hospitals, provider groups, community-based organizations and County of Lake Government — is pleased to present its 2019 Community Health Needs Assessment (CHNA). As federally required by the Affordable Care Act, this report provides an overview of the methods and process used to systematically identify and prioritize significant health needs in Lake County, California — Hope Rising Lake County's service area. Hope Rising Lake County partnered with Conduent Healthy Communities Institute (Conduent HCI) to conduct the CHNA.

The goal of this report is to offer a meaningful understanding of the most pressing health needs across Hope Rising Lake County's service area, as well as to guide planning efforts to address those needs. Hope Rising Lake County realizes that there are health inequities and unequal opportunities for health in the county. Special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services, and input from the communities that have a high burden of poor health factors. The assessment makes an effort to implement a transparent and collaborative approach to understanding the needs and assets in the communities with an intention to render the highest level of accountability to all partners — present and potential. Findings from this report will be used to identify, develop, and target Hope Rising Lake County's strategies for the next three years to provide and connect residents with resources to improve health outcomes and the quality of life of residents in Lake County. Hope Rising Lake County would like to thank all those that contributed to this assessment.

1.2 SUMMARY OF FINDINGS

The CHNA findings in this report result from the extensive analysis of primary and secondary data sources; over 204 indicators from national and state data sources were included in the secondary analysis and primary data was collected from community leaders, non-health professionals, community based organizations, community members and populations with unmet health needs and/or populations experiencing health disparities. The main source for the secondary data, or data that has been previously collected by the government and other health agencies to inform health planning, is the Hope Rising Lake County platform, a publicly available data platform. That platform can be found here: http://www.hoperisinglc.org

The identified community health needs for Lake County had strong social and economic root causes. The community health needs assessment also describes barriers to experiencing health and wellness in the community and provides information necessary to all levels of stakeholders to build upon each other's work in a coordinated, collaborative manner.

Through an examination of the primary and secondary data, the following top health needs were identified:

LAKE COUNTY'S SIGNIFICANT HEALTH NEEDS	
• Access to Health Services	• Mental Health
• Alcoholism	• Poverty
• Drug Use	• Unemployment
• Housing Stability and Homelessness	

1.3 PRIORITIZED AREAS

To thrive, everyone in the community needs to be given the opportunity to live a long, healthy life, regardless of his or her background or socioeconomic status. The conditions of the physical environment where people live, learn, work and play present a wide range of health risks and outcomes. Hope Rising Lake County is committed to supporting environments that protect and promote the health and well-being of residents equitably.

In April 2019, stakeholders of the Hope Rising Lake County from 15 organizations completed an online survey to select prioritization criteria and attended an in-person session to prioritize the significant health issues, based on previously selected criteria that contributed to the Hope Rising Lake County's strategic focus. The significant health topics that offered the broadest platform for collaboration across the county and subpopulations were chosen. The following four encompassing topics were identified as priorities to address:

LAKE COUNTY'S 2019 CHNA PRIORITIES
• **PRIORITY** Address substance/drug abuse within the community
• **PRIORITY** Increase housing stability and target homelessness
• **PRIORITY** Provide community outreach and engagement for all high burden and/or disenfranchised communities
• **PRIORITY** Increase opportunities for cancer prevention and screenings

Specifically, the primary motivation for choosing the priorities mentioned below were the economic burden of cancer on families already struggling with financial burdens; the disruption of good quality of life for all residents due to substance abuse and the loss of academic, social, and health opportunities for addicts; and, the broad opportunities to intervene at multiple levels (policy, community, individual) and settings (schools, faith centers, clinics, worksites) to educate and inform communities about the health issues of the county and the solutions. The priorities were also based upon the capacity and resources of the stakeholders to make decisive impacts and on priorities that would improve quality of life for the entire community.

Hope Rising Lake County has established clear priorities based on the results of this CHNA to improve the health status of the residents of Lake County. In collaboration with community stakeholders and residents, Hope Rising Lake County wants to realize the vision of increasing its standing in County Health Rankings and Roadmaps by 2022, by improving the county's current status in terms of its population's health factors (i.e. educational attainment and access to care) and health outcomes (i.e. disease and death). Hope Rising Lake County will develop initiatives to address these priorities, through implementation strategy and community health improvement planning, beginning in 2019.

SECTION 2

INTRODUCTION

2.1 HOPE RISING LAKE COUNTY

Hope Rising Lake County is an Accountable Community for Health Collaborative that was established in 2015. Hope Rising Lake County's vision is to ensure that Lake County is a healthy place for every person to live, learn, engage and thrive. A formal partnership of fourteen health agencies - health systems, county leaders, non-profit organizations and other relevant organizations of Lake County - the purpose of Hope Rising Lake County is to mobilize and inspire community partnerships and actions that support individual, collective and community health. As the lead organization, Hope Rising Lake County undertakes joint effort, leveraging the resources and influence of the collective to improve the overall health and wellness of Lake County. Hope Rising Lake County serves as a neutral convener to bring together leaders in the county to identify issues, develop innovative solutions, and implement agreed-upon actions with accountability and measurable outcomes. Hope Rising Lake County acts to raise, manage and disburse funds. Additionally, Hope Rising Lake County provides facilitation and project management support to drive the work forward and keep projects on track, ensuring active engagement of stakeholders and a focus on outcomes.

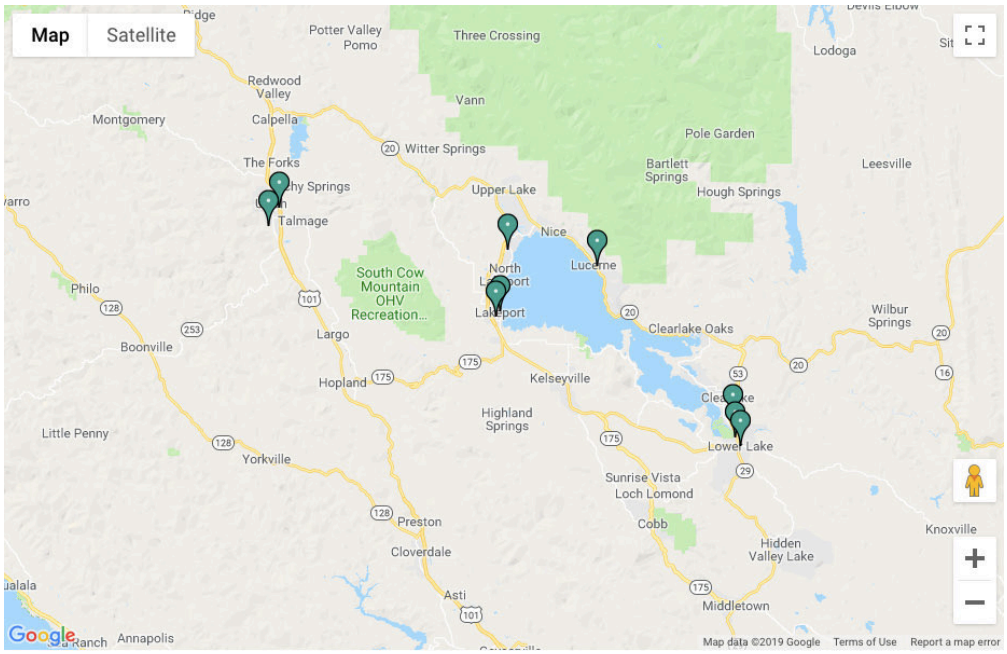
The partner health agencies that constitute Hope Rising Lake County are given below:

Partnering Organizations in Hope Rising Lake County

- Adventist Health Clear Lake
- County of Lake Board of Supervisors
- Lake County Health Department
- Lake County Office of Education
- Lakeview Health Center
- North Coast Opportunities
- Redwood Community Services
- The Way to Wellville
- County of Lake Behavioral Health
- Department of Social Services
- Mendocino County Health Clinic
- Partnership Health Plan of California
- Sutter Lakeside Hospital
- Woodland Community College

The partner agencies of Hope Rising Lake County have participated in a collaborative community health needs assessment that is documented in this report and will be published every three years or according to Internal Revenue Service (IRS), the Health Resources and Services Administration's (HRSA) Health Center Compliance Manual, Section 330 of the Public Health Service Act, and Public Health Accreditation Board (PHAB) requirements. The Collaborative will work to develop implementation strategies, to be included in each member organization's individual Community Health Improvement Plans (CHIP)/Implementation Strategies (IS), that align with CHNA identified health priorities and focus on achieving health equity. Together, these agencies will support health advocacy, education, prevention, and partnerships that extend the care continuum for medically underserved and vulnerable populations.

FIGURE 1: LOCATION OF HOPE RISING LAKE COUNTY PARTNER ORGANIZATIONS

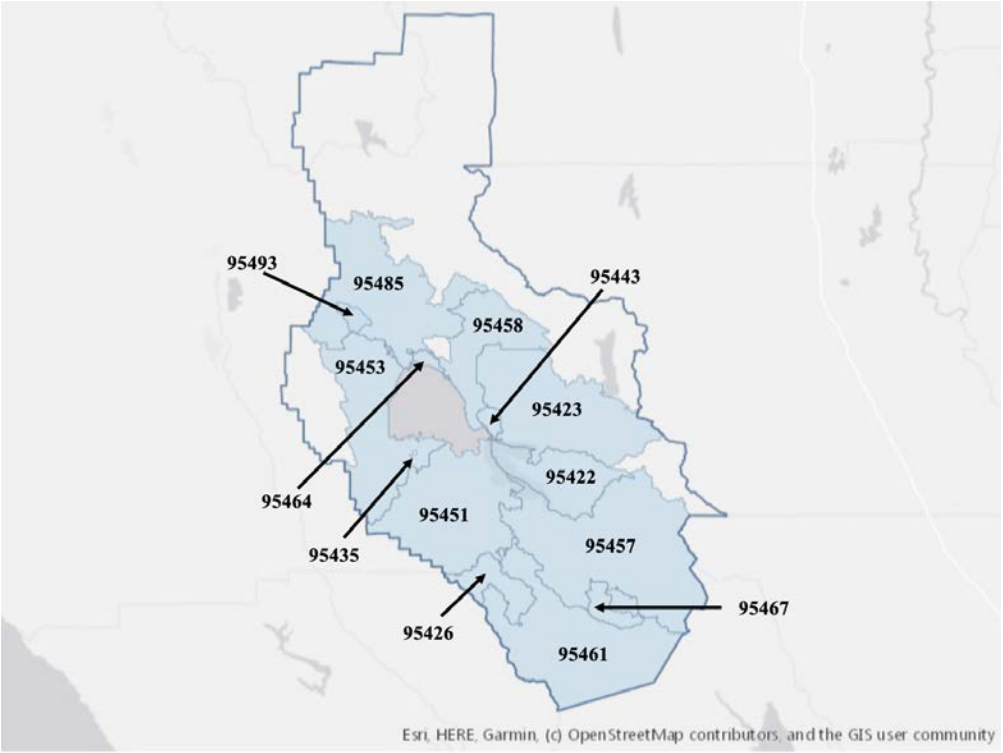


Source: Google Maps, Hope Rising Lake County Website, 2019

2.2 SERVICE AREA

With the purpose of jointly addressing health challenges of residents and serving communities with impactful solutions that leverage shared resources and coordinate care, the twelve health agencies that make up the Hope Rising Lake County Collaborative have come together in defining their service area as entire County of Lake. This area includes the following residential ZIP Codes: 95422 (Clearlake), 95423 (Clearlake Oaks), 95426 (Cobb), 95435 (Finley), 95443 (Glenhaven), 95451 (Kelseyville), 95453 (Lakeport), 95457 (Lower Lake), 95458 (Lucerne), 95461 (Middletown), 95464 (Nice), 95467 (Hidden Valley Lake), 95485 (Upper Lake), and 95493 (Witter Springs).

FIGURE 2: ZIP CODE TABULATED AREAS, LAKE COUNTY



Source: Hope Rising Lake County Website, 2019

2.3 COLLABORATIVE STRUCTURE

Health Assessments have been conducted by health agencies — hospitals, local health departments, and Federally Qualified Health Centers (FQHCs) — for many years individually to guide their work in communities. The *Patient Protection and Affordable Care Act* (PPACA) requires tax-exempt 501 (c)(3) hospitals to conduct a Community Health Needs Assessment (CHNA) every three years with input from public health experts and community members, and develop and adopt an implementation strategy. At the same time, local health departments that are preparing for the Public Health Accreditation Board (PHAB) process are required to conduct strategic planning, including a Community Health Assessment conducted every five years, and a corresponding Community Health Improvement Plan (CHIP). Section 330 of the Public Health Service Act (42 U.S.C. §254b), the authorizing legislation of the Health Resources & Services Administration's (HRSA) Health Center Program, requires health centers to perform a similar exercise to demonstrate the need for health services, a shortage of personal health services, and commitment to operate where the greatest number of individuals residing in the service area can be reached. These coinciding requirements of health agencies offer an ideal opportunity for hospitals, health centers and health departments to work together in defining priorities and addressing health challenges within the community they share. That opportunity to align goals and combine resources and efforts is what led to the development of the Hope Rising Lake County, which together commissioned the assessment defined in this report.

The Hope Rising Lake County Collaborative is the decision-making entity for the 2019 Community Health Needs Assessment and is chaired by the Executive Director of Hope Rising Lake County. A core group of representatives from the partner organizations mediated on every aspect of the process design and implementation of the CHNA and are as follows:

- Allison Panella - **Hope Rising Lake County**, *Executive Director*
- Dan Peterson - **Sutter Lakeside Hospital**, *Chief Administrative Officer*
- Denise Pomeroy - **Lake County Health Department**, *Director of Health Services*
- Elise Jones - **Lake County Health Department**, *Health Programs Accreditation Coordinator*
- Kate Gitchell – **Hope Rising**, *Project Manager*
- Kim Tangermann - **Mendocino Community Health Clinic**, *Lakeview Health Center Clinic Director*
- Marvin Avilez – **Wellville**, *Chief Operating Officer*
- Russell Perdock - **Adventist Health**, *Director of Community Integration*

Other representatives of the partner organizations that constitute Hope Rising Lake County are given below:

- Lynn Scuri - **Partnership Health Plan**, *Regional Director*
- Marshall Kubota - **Partnership Health Plan**, *Regional Medical Director*
- Nellie Gottlieb – **Hope Rising Safe Rx Lake County**, *AmeriCorps VISTA*
- Paige Hotchkiss - **Sutter Lakeside Hospital**, *Community Benefit Specialist*
- Patty Bruder - **North Coast Opportunities**, *Executive Director*
- Todd Metcalf- **Lake County Behavioral Health**, *Administrator/Director*

2.4 DISTRIBUTION OF CHNA REPORT

To meet the requirements of the IRS regulations 501(r) for charitable hospitals, hospitals are required to make the Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) available publicly through print copies and on the internet. Public comment is also solicited and documented. In keeping with these regulations, the two hospitals — Adventist Health Clear Lake and Sutter Lake Hospital — that are members of Hope Rising Lake County Collaborative made available their hospitals' previous CHNA and IS to the public via the following websites:

- Adventist Health Clear Lake 2016 CHNA
  - Adventist Health Clear Lake Implementation Strategy
- Sutter Lake Hospital 2016 CHNA
  - Sutter Lake Implementation Strategy

Each website allows for members of the community to submit comments via e-mail. Paper copies were also made available at the main entrances to the hospital. Community members were invited to read the report and provide comments. No comments or feedback were received on the preceding CHNA at the time this report was written.

2.5 PRIORITY HEALTH NEEDS AND IMPACT FROM PRIOR CHNA

Given below is a synopsis of the priorities that were earmarked for action by the different health agencies that constitute Hope Rising Lake County and recommended strategies.

PAST PRIORITIZED HEALTH TOPICS	RECOMMENDATIONS IN 2016 CHNA
Mental Health	• Emotion regulation in schools • Early Intervention counseling in PTSDs (e.g. fires) • Social support to elderly, LGBT, Single parents • Substance abuse and de-addiction services (AA, tobacco cessation, residential treatment) • Promoting volunteerism • Caregiver respite • Home-visitation to ill and isolated • Social media campaign to reduce stigma
Substance Abuse	• School-Based health promotion and substance abuse prevention • After school activities • Safe Rx • Inhibitive policy initiatives and enforcement programs • Outdoor recreation ordinances and tobacco tax • Increased availability of physical activities
Access to Programs and Services	• County-wide resource guide to programs and services • In- and out-county transportation assistance for medical and social services • Recruitment and retention of specialists and non-traditional healthcare providers • Recruitment to medical homes through healthcare navigators • Care coordination • Healthy eating training for vulnerable populations • Alignment of activities between public, behavioral and health systems
Housing and Homelessness	• Year round sheltering • Care coordination and social needs connection for homeless • Housing locator services • Financial and other support • Low demand housing

All the health topics prioritized in the previous reports coincide with the significant health needs identified in this assessment (detailed below). A detailed table describing the strategies/action steps and indicators of success for each of the preceding priority health topics can be found in Appendix A. Evaluation since Prior CHNA.

2.6 EVALUATION OF PROGRESS SINCE PRIOR CHNA

The CHNA process should be viewed as a three-year cycle (Figure 3). An important part of that cycle is revisiting the progress made on priority topics from previous CHNAs. By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can better focus and target its efforts during the next CHNA cycle.

2.7 CONSULTANTS

The Hope Rising Lake County Collaborative commissioned Conduent Healthy Communities Institute (Conduent HCI) to conduct its 2019 Community Health Needs Assessment. Conduent HCI works with clients across most states in the U.S. to drive improved community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing progress monitoring systems, and implementing performance evaluation processes. Working with diverse clients nationwide has contributed to Conduent HCI's national knowledge base of population health solutions. In addition, by engaging directly with clients and communities through the primary data collection process and final workshops, Conduent HCI works on behalf of clients to build trust between and among organizations and their communities.

To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/community-population-health/

SECTION 3

METHODOLOGY

Two types of data were used in this assessment: primary and secondary data. Primary data are data that have been collected for the purposes of this community assessment. Primary data were obtained through a community survey, focus groups, and key informant interviews. Secondary data are health indicator data that have already been collected by public sources such as government health departments. Each type of data was analyzed using a unique methodology. Findings were organized by health topics and then synthesized for a comprehensive overview of the health needs in the Hope Rising Lake County Community Health Needs Assessment (CHNA) Collaborative service area.

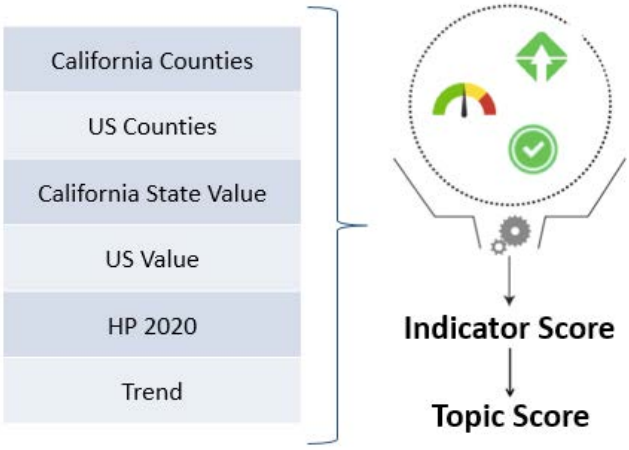
3.2 SECONDARY DATA SOURCES & ANALYSIS

Secondary data used for this assessment were collected and analyzed from Conduent HCI's community indicator database. This database, maintained by researchers and analysts at Conduent HCI, includes over 204 community indicators from at least 21 state and national data sources. Conduent HCI carefully evaluates sources based on the following three criteria: the source has a validated methodology for data collection and analysis; the source has scheduled, regular publication of findings; and the source has data values for small geographic areas or populations.

3.2.1 SECONDARY DATA SCORING

Conduent HCI's Data Scoring Tool® (Figure 4) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of California and US counties, state and national values, Healthy People 2020, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. See Appendix C. Secondary Data Methodology for further details on the quantitative data scoring methodology as well as secondary data scoring results.

FIGURE 4: SUMMARY OF TOPIC SCORING ANALYSIS



3.2.2 INDEX OF DISPARITY

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations, and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined in the Lake County Service Area. For secondary data health indicators, Conduent HCI's Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for the county, and the indicators with the highest race/ethnicity index value were found, with their associated subgroup with the negative disparity listed below in SECTION 5: Disparities.

3.2.3 DATA CONSIDERATIONS

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators.

Data scores represent the relative community health need according to the secondary data for each topic and should not be considered to be a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole, and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

3.2.4 RACE/ETHNIC GROUPINGS

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

3.2.5 ZIP CODES AND ZIP CODE TABULATION AREAS

This report presents both ZIP Code and ZIP Code Tabulation Area (ZCTA) data. ZIP Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or ZIP Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of ZIP Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference ZIP Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

3.3 PRIMARY DATA METHODS & ANALYSIS

Community input for Hope Rising Lake County's CHNA was collected to expand upon the information gathered from the secondary data. The process was undertaken by Conduent HCI team and Hope Rising Lake County members. Primary data used in this assessment consisted of a community survey in English and Spanish, focus groups and key informant interviews. See Appendix D. Primary Data Methodology for the survey and interview questions.

3.3.1 COMMUNITY SURVEY

Since one of the most valuable ways to learn about the health of a community is by reaching out to the different constituents in the community, including residents, Hope Rising Lake County prioritized local participation for this community needs assessment and community health improvement planning cycle. A community health survey was designed and inputs from residents was collected online. This survey consisted of 24 questions related to top health needs in the community, factors which most improve life in a community, and behaviors which have the greatest impact on overall community health besides some personal health and demographic questions. The community survey was distributed online through SurveyMonkey® from January 29th through April 7th of 2019. The survey was made available in both English and Spanish. Paper surveys were also made available and answers to the paper survey were entered into the SurveyMonkey tool.

3.3.2 KEY INFORMANT INTERVIEWS

To expand upon the information gathered from the secondary data, key informant interviews were conducted to collect community input. Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs and/or represented the broad interest

of the community served by the hospital and health department, and/ or could speak to the needs of medically underserved or vulnerable populations. Eleven Key Informant Interviews with stakeholders and five group discussions with community members were conducted from February 5th through March 5th, 2019.

The key informant interviews were conducted by telephone, each ranging from 30 – 60 minutes in length with stakeholders from a range of sectors such as government, healthcare, Tribal Health, law enforcement and community service organizations. Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs and/or represented the broad interest of the community served by the hospital, and/or could speak to the needs of medically underserved or vulnerable populations. Community leaders with specific experience working with priority populations, such as women, children, tribal communities, the disabled, and more were interviewed. During the interviews, questions were asked to learn about the interviewee's background and organization, biggest health needs and barriers of concern in the community, as well as the impact of health issues on vulnerable populations. A list of the questions asked during the interviews can be found in Appendix D. Primary Data Methodology.

Each interview was transcribed by the interviewer and then analyzed qualitatively so as to code the transcripts according to a list of major health and quality of life topics. Interviews were transcribed and analyzed using the qualitative analytic tool, Dedoose . Interview excerpts were coded by relevant topic areas and key health themes. Input from key informants is included in each relevant health need topic area detailed in SECTION 6: Primary Data Collection and SECTION 7: Data Synthesis and Prioritization of this report.

Organizations of Key Informant Interview Participants

- Adventist Health Clear Lake
- Adventist Health Live Well Program, Clear Lake
- First 5 Lake County
- Lake County Behavioral Health, Substance Abuse Program
- Lake County Department of Health Services, Division of Public Health
- Lake County Office of Education, Healthy Start Program
- Lake County Sheriff's Office
- Lake County Tribal Health Consortium
- Lake County Tribal Health Consortium Board of Directors, Big Valley Rancheria, and
- Sutter Lakeside Hospital

3.3.3 FOCUS GROUPS AND FOCUS GROUP PROFILES

Five focus groups, including 31 participants, took place between March 5th and March 21st 2019. The groups were organized and facilitated by the Health Programs Coordinator of the Lake County Health Department. Participants were recruited from zip codes with a high burden according to Conduent HCI's SocioNeeds Index using multiple modes: direct recruitment by partner community based organizations, email invitations, flyers, and social media postings. Each focus group was recorded and the audio recordings were transcribed to capture the verbatim conversation. A list of the questions asked during the focus groups can be found in Appendix D. Primary Data Methodology. The focus group transcripts were analyzed

qualitatively using the qualitative analytic tool, Dedoose[1] by relevant topic areas and key health themes. Input from focus group participants is included in each relevant health need topic area detailed in SECTION 6: Primary Data Collection for Community Input and SECTION 7: Data Synthesis and Prioritization of this report.

1 Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com

TABLE 1: FOCUS GROUP DISCUSSION PROFILE

NUMBER	GENDER	AGE	RACE/ ETHNICITY	INCOME GROUP (BELOW $45,000 FOR HOUSEHOLD)	ZIP CODE TABULATED AREA/ CITY	NUMBER OF PARTICIPANTS
Group 1	Male	18-24	White	x	Zip 95422	5
Group 2	Female, Male	25-54	Tribal	x	Zip 95453	11
Group 3	Male	25-54	White	x	Zip 95422	5
Group 4	Female	55-70	White	x	Zip 95458	7
Group 5	Male	55-70	White	x	Zip 95458	3
TOTAL-5						**31**

SECTION 4

PROFILE OF LAKE COUNTY, CALIFORNIA

Located in north central California, Lake County has a land area of 1,256.46 square miles, about 100 miles long by 50 miles wide, which encompasses 2 cities and 13 census-designated places. The county is predominantly rural and includes Clear Lake, California's largest natural freshwater lake, known as "The Bass Capital of the West". The county economy is based largely on tourism and recreation. Lake County is mostly agricultural, with tourist facilities and some light industry. Major crops include pears, walnuts and wine grapes. Dotted with vineyards and wineries, orchards and farm stands, and small towns, the county is also home to Mt. Konocti, which towers over Clear Lake. Many roads are unpaved, unmarked, and unlit, even within blocks of main streets and schools in Clearlake and Lakeport. In addition, few market and store are available which make transportation a necessity for this population (California Department of Public Health, 2017-2018).

In 2018, Lake County's population had a median age of 45.8 years and a median household income of $40,446 (United States Census Bureau, 2019). In Lake County, 50.2% of the population are female, 5.7% are below 5 years of age, 20.7% are below 18 years and 22.4% are 65 years and above. Among county residents, 10.7% have veteran status. About 15.3% of the people in Lake County speak a non-English language, and 8.7% are foreign born. The median value of owner occupied houses in Lake County is $182,000 and the homeownership rate is 65.9%. The percent of households with a computer is 81.3% and with a broadband internet subscription is 70.6% (United States Census Bureau, 2019). According to data from the National Vital Statistics System (NVSS), the life expectancy in Lake County is 74.5 years on an average, 74.2 for White and 80.2 for Hispanic residents (County Health Rankings and Roadmaps, 2015-2017).

4.1 DEMOGRAPHIC PROFILE

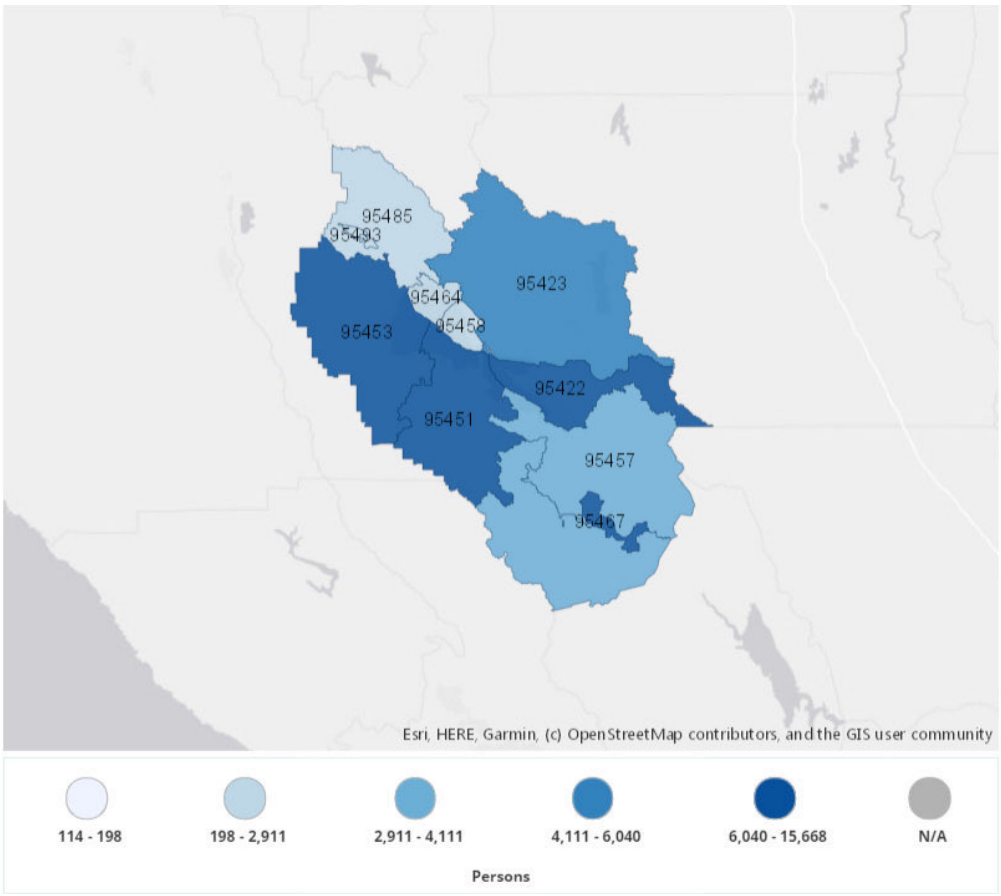
The following section explores the demographic profile of Lake County. Demographics are an integral part of describing the community and its population, and critical to forming further insights into the health needs of the community in order to best plan for improvement. Different race/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

All demographic estimates are sourced from the U.S. Census Bureau's (a) 2017 population estimates or (b) 2013-2017 American Community Survey, or (c) 2019 Claritas Pop-Facts®, unless otherwise indicated. Please note that demographics and data sourced from Claritas Pop-Facts derive from the Claritas Pop-Facts data set which provides demographics data based on Census and American Community Survey (ACS) data. This data set provides current year (2019) estimates using the 2010 Census and the incorporation of newly available ACS data. Periods of measurement and sources for the data discussed are given in these sections if they are not mentioned elsewhere in the tables and figures enclosed within the report.

4.1.1 POPULATION

According to 2019 Claritas Pop-Facts population estimates, Lake County has a population of 64,562 persons. Figure 5 illustrates the population size in Lake County by zip code. The most populated zip codes are 95422 (Clearlake), 95451 (Kelseyville), and 95453 (Lakeport) with population totals of 15,668, 11,277, and 10,876.

FIGURE 5: POPULATION BY ZIP CODE, 2019



Source: Claritas Pop-Facts Population Estimates, 2019

Table 2 presents the population estimates in Lake County by year for 2014, 2015, 2016, and 2017. Lake County has had a stable population between 2014 and 2017, with a percent change of 0.2%. This is less than the California and US growth rate of 2.2%.

TABLE 2: TOTAL POPULATION: PAST FOUR YEARS, 2014-2017

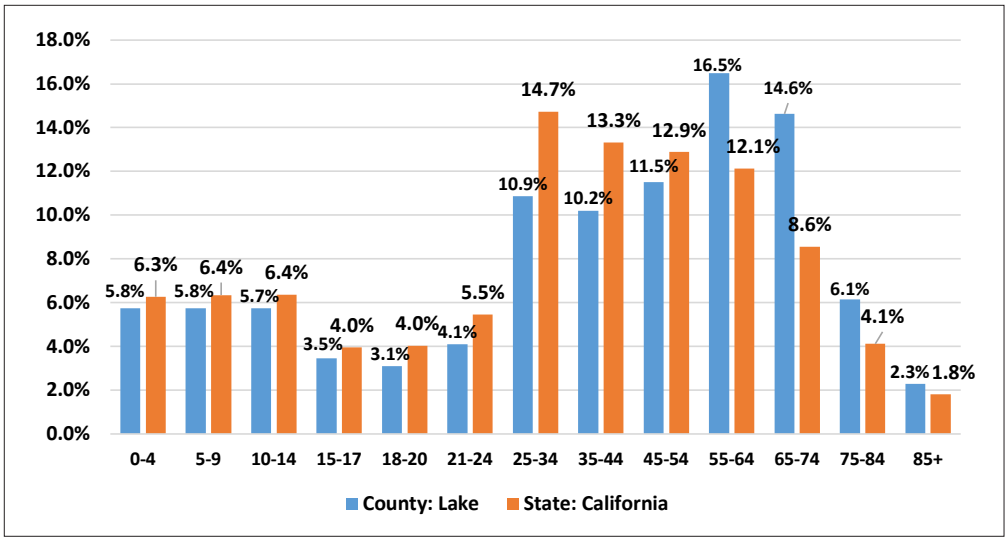
TOTAL POPULATION					
County	2014	2015	2016	2017	Percent Change 2014-2017
Lake County	64,113	64,310	63,950	64,246	0.2%
California	38,701,278	39,032,444	39,296,476	39,536,653	2.2%
United States	318,622,525	321,039,839	323,405,935	325,719,178	2.2%

Source: American Consumer Survey

4.1.2 AGE

Distribution of age impacts the healthcare needs of a population. Economic means, work status, and entitlement program eligibility are based on age, which can affect an individual's ability to access preventive health care services (Figure 6).

FIGURE 6: POPULATION BY AGE, 2019

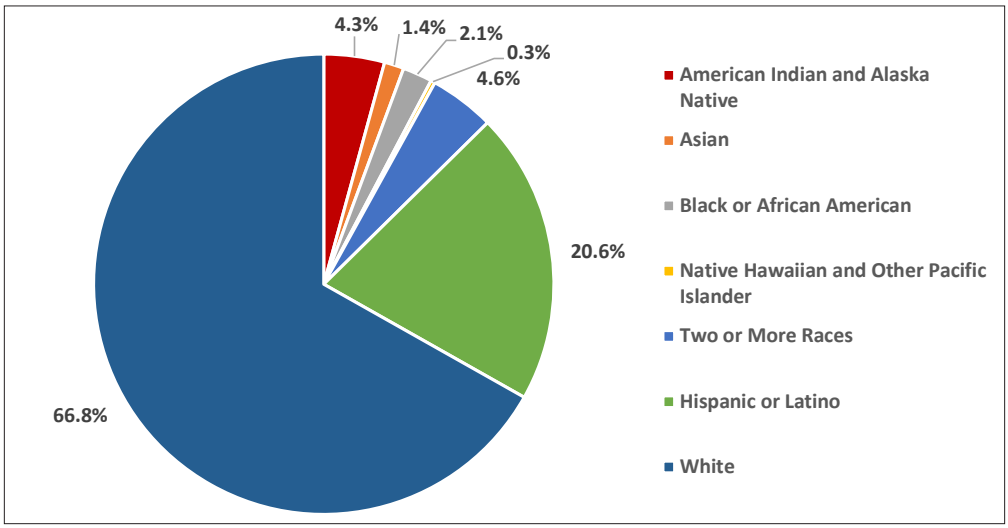


Source: Claritas Pop-Facts Population Estimates, 2019

4.1.3 RACE/ETHNICITY

Figure 7 shows the racial and ethnic distribution of Lake County. The majority of the population is comprised of White (Non-Hispanic) individuals, with 66.8% of the population and Hispanics with 20.6% of the population. The Asian population accounts for 1.4% of the population, followed by two or more races with 4.6% of the population, Black or African American with 2.1% of the population, American Indian and Alaska Native with 4.3% of the population, and lastly Native Hawaiian and Other Pacific Islander with 0.3% of the population.

FIGURE 7: LAKE COUNTY POPULATION BY RACE/ETHNICITY, 2017



Source: U.S. Census Bureau, 2017

Table 3 presents a closer examination of population trends over a span of four years. Overall, Lake County has experienced a slight decrease in the population from 2010 to 2019 (-0.16%). The share of residents identifying as Hispanic or Latino from 2014 to 2017 increased from 18.8% in 2014 to 20.6% in 2017. The White population experienced a slight decrease, from 69% in 2014 to 66.8% in 2017 with the number of American Indian or Alaskan Native population remaining stable.

TABLE 3: POPULATION BY RACE/ETHNICITY: PAST FOUR YEARS, 2014-2017

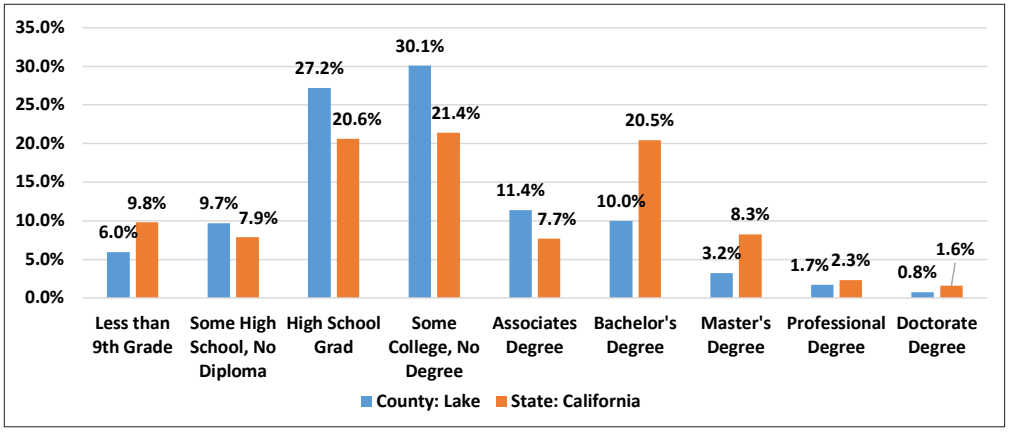
LAKE COUNTY				
	2014	2015	2016	2017
American Indian and Alaska Native	4.1%	4.1%	4.2%	4.3%
Asian	1.3%	1.3%	1.3%	1.4%
Black or African American	2.0%	2.0%	2.0%	2.1%
Native Hawaiian and Other Pacific Islander	0.3%	0.3%	0.3%	0.3%
Two or More Races	4.5%	4.5%	4.5%	4.6%
Hispanic or Latino	18.8%	19.3%	20.0%	20.6%
White	69.0%	68.4%	67.6%	66.8%

Source: U.S Census Bureau, 2014-2017

4.1.4 EDUCATION

Educational attainment is one of the key factors that affects the health status of a community. It can influence employment and income, influence health behavior and health seeking, and determine the ease with which a person can access and navigate the health system. Figure 8 displays the educational attainment for population age 25+ in Lake County. Over half of the population in Lake County has a high school degree or some college with no degree. However, high school degree attainment, some college education and associates degree attainment are slightly higher in Lake County compared to the California state values (20.6%, 21.4% and 7.7%). Notably, there is a large difference between the proportion of the population with a bachelor's degree in Lake County (10%) compared to the California state value (20.5%).

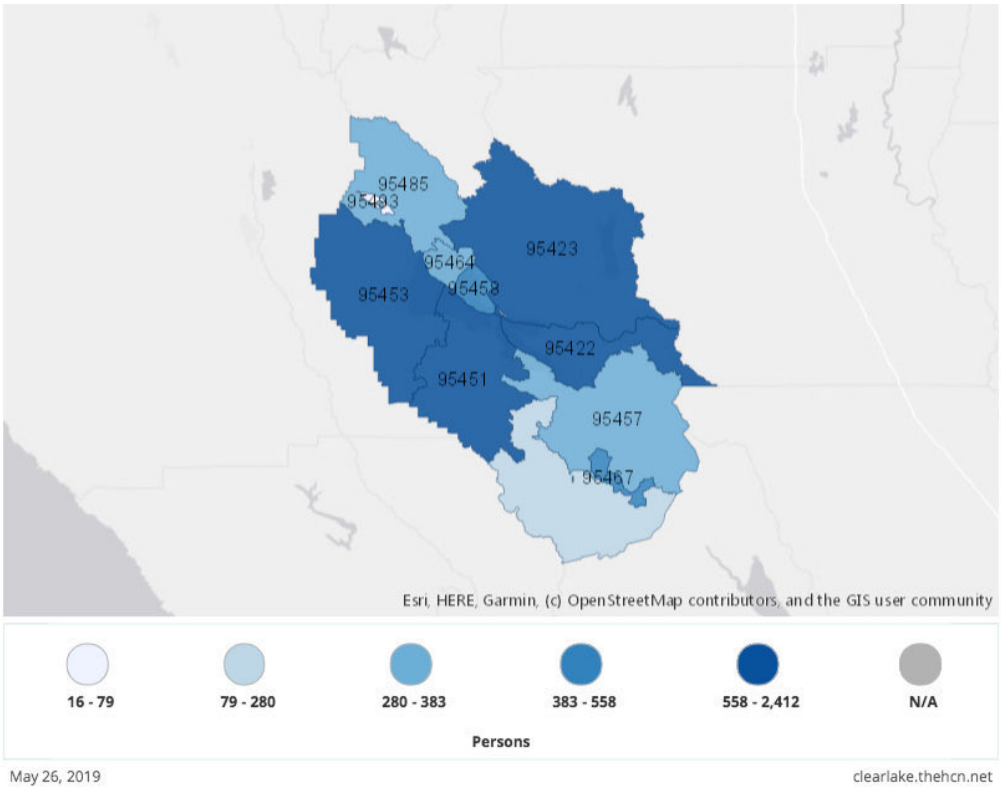
FIGURE 8: EDUCATIONAL ATTAINMENT FOR 25+, 2019



Source: Claritas Pop-Facts Population Estimates, 2019

Figure 9 depicts the population age 25+ with less than a high school graduation at the granular level, with darker blue regions indicating a greater percentage of individuals with less than a high school graduation. From this map, the areas with the highest number of individuals without a high school degree are 95422 (2,412), 95453 (1,133), and 95451 (1,008).

FIGURE 9: POPULATION AGE 25+ WITH LESS THAN HIGH SCHOOL GRADUATION, 2019



Source: Claritas Pop-Facts Population Estimates, 2019

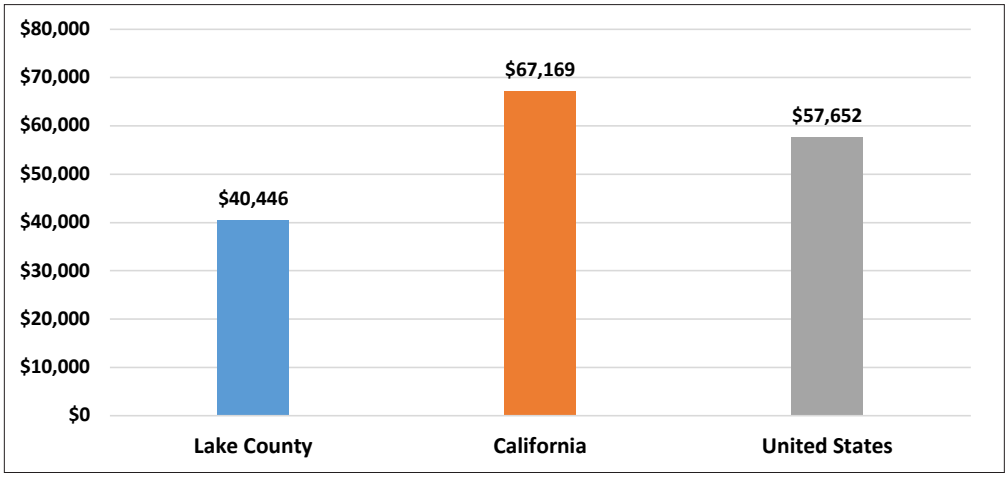
4.1.5 INCOME

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have a greater share of educated residents and lower unemployment rates. The Gini index, which measures income distribution among the residents of a specified geography, indicates the extent to which the distribution of income among individuals or households within a community differs from a perfectly equal distribution. A value of zero indicates perfect equality of income (all households having equal income) and a value of one indicates perfect inequality (one household having all the income). A value of 0.5 indicates an even distribution of incomes. The Gini index for Lake County is 0.4691; the difference of Lake County's score from an even distribution of incomes points to a very small size population that has higher incomes than the rest of the county residents (United States Census Bureau, 2013-2017). However, as the section below will illustrate, Lake County has low median income than the state and the country.

Figure 10 compares the median household income values for Lake County to the median household income value for California and the United States. The median household income is below the state value and the national value. Lake County has an estimated median household income of approximately $40,446, which is about

$27,000 less than the median household income of California and about $17,000 less than the national value of $57,652. Approximately 38% of the 12,888 households in Lake County have median household incomes below $49,999 in 2017 inflation adjusted dollars. Upon examining the median household income in the past 12 months (in 2017 inflation-adjusted dollars) by household size, 1-person households had a median income of $20,515, 2-person households of $51,754, 4-person households of $52,228, and 6-person households had a median household income of $58,571 (United States Census Bureau, 2019).

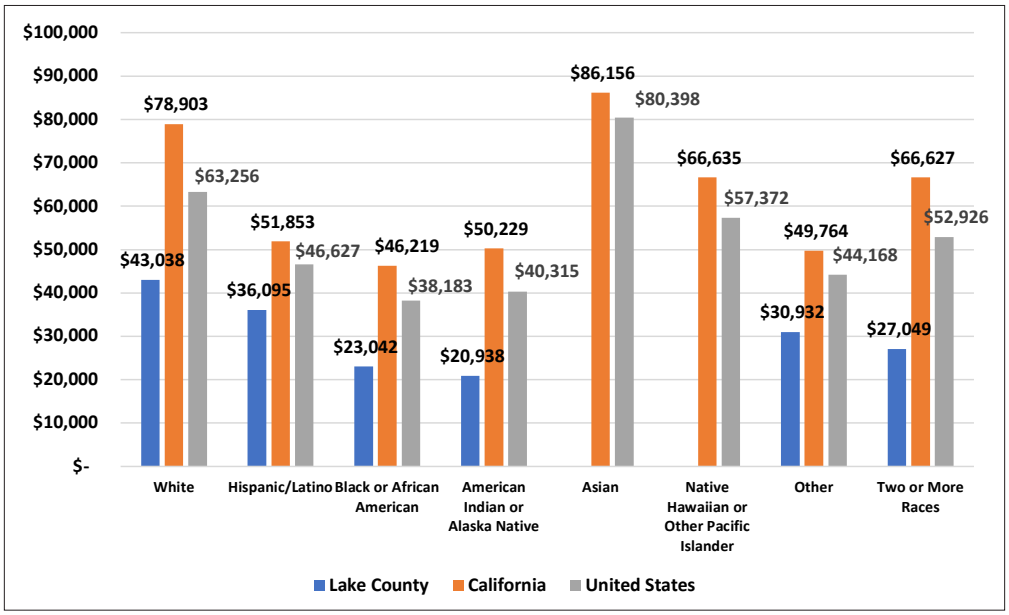
FIGURE 10: MEDIAN HOUSEHOLD INCOME, 2013-2017



Source: U.S Census Bureau, 2013-2017

Figure 11 shows the percentage of people living below the poverty level by race and ethnicity. All race/ethnic groups in Lake County have lower median household incomes in comparison to California state values. The median household income for Native American population is less than half the median household income for Native Americans in California. Black/African American population in Lake County earns approximately half what the Black/African American population earn on an average in the state while the White population have a median household income of $43,038 in Lake County and $78,903 in California. Hispanic/Latino populations have the smallest difference among all of the race/ethnic groups, with the median household income of $36,095 in Lake County compared to $51,853 in California. There is no comparison county data for Asians or Native American or Other Pacific Islanders.

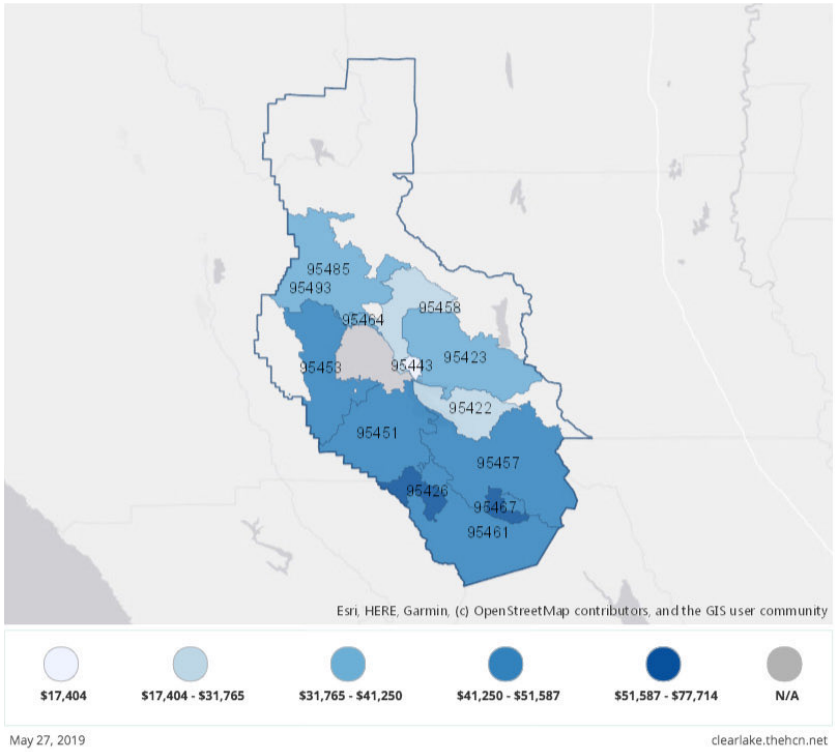
FIGURE 11: MEDIAN HOUSEHOLD INCOME BY RACE/ETHNICITY, 2013-2017



Source: Source: U.S Census Bureau, 2013-2017

Looking at Figure 12, the regions with the darker shades of blue indicate zip codes with high median household incomes, while the lighter shades indicate low median household incomes. The zip code with the highest median household income in Lake County is 95426 ($77,714), while the zip code with the lowest median household income is 95443 ($17,404).

FIGURE 12: MEDIAN HOUSEHOLD INCOME BY ZIP CODE, 2013-2017



Source: American Community Survey, 2013-2017

In Lake County, single parent families have the lowest median household incomes. Male householders, no wife present with children under 18 years had a median household income of $19,306 while female households, with no husband and own children under 18 years had a median household income of $20,403. Household median income for householders above 65 years was $39,332 while it was $42,229 and $44,079 for householders in the age group 45 to 64 years and 25 to 44 years respectively (United States Census Bureau, 2013-2017).

4.1.6 EMPLOYMENT

A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.

In Lake County, 48.6% of the population above the age of 16 years is employed, as compared to 63.5% in California and 63% in the United States. Private wage and salary owners make up the largest proportion of the employed (68.3% in Lake County in comparison to 78.2% in California), while Government workers (20.0% in Lake County as compared to 13.5% in the state), self-employed in own businesses (11.4% in the county in comparison to 8.1% in California) and unpaid family workers (.3% in Lake County versus .2% in California) constitute the remaining proportions.

Table 4 lists the industries that employ civilian population 16 years and over in Lake County. Approximately 22.2% of civilians are employed by educational services, and health care and social assistance and 9.2% professional, scientific, and management, and administrative and waste management services. Additionally, 16.1% of civilians are employed by the agriculture (including forestry, fishing and hunting, and mining) and construction sectors together, while 10.3% work in the retail trade and 9.4% in the arts, entertainment, and recreation, and accommodation and food services sector.

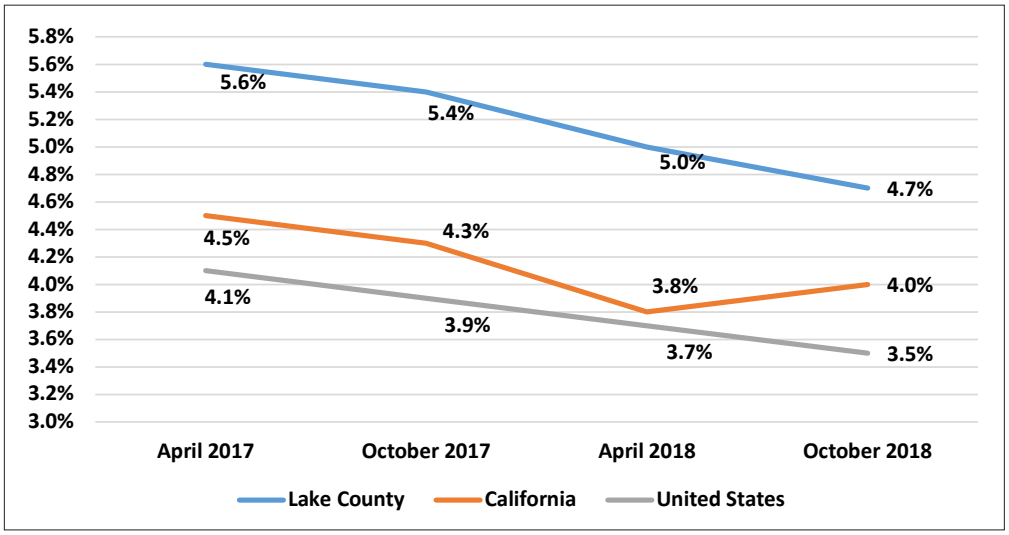
TABLE 4: INDUSTRY OF WORK FOR THE CIVILIAN EMPLOYED POPULATION 16 YEARS AND OVER

OCCUPATION	NUMBER	PERCENT
Agriculture, forestry, fishing and hunting, and mining	1,523	6.7%
Construction	2,151	9.4%
Manufacturing	1,132	4.9%
Wholesale trade	425	1.8%
Retail trade	2,353	10.3%
Transportation and warehousing, and utilities	1,210	5.3%
Information	334	1.4%
Finance and insurance, and real estate and rental and leasing	865	3.8%
Professional, scientific, and management, and administrative and waste management services	2,095	9.2%
Educational services, and health care and social assistance	5,501	22.2%
Arts, entertainment, and recreation, and accommodation and food services	2,141	9.4%
Other services, except public administration	1,289	5.6%
Public administration	1,672	7.3%
Total:	**22,691**	

Source: American Community Survey, 2013-2017

Figure 13 depicts the percent of civilians, 16 years of age and older, who are unemployed as a percent of the civilian labor force. Overall, Lake County's unemployment rate decreased between April 2017 and October 2018. In April 2017, the unemployment rate was 5.6% and it decreased by .9% to 4.7% in October 2018. An examination of the data for youth 16+ not employed shows that the highest percentages are in zip codes 95422 (19.8%), 95457 (18.9%), 95426 (18.37%) and 95458 (17.67%).

FIGURE 13: UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE, APRIL 2017–OCTOBER 2018



Source: U.S. Bureau of Labor Statistics

4.2 SOCIAL DETERMINANTS OF HEALTH

Health conditions are determined by the neighborhoods, schools, communities and workplaces of individuals. Healthy People 2020 defines social determinants of health as conditions in which people are born, grow, live, work, and age that affect a wide range of health outcomes and risks. The social determinants of health partly explain why some people are healthier than others, and generally why some people are not as healthy as they could be. Resources that address the social determinants of health and improve quality of life can have a significant impact on population health outcomes. Examples of these resources include access to education, public safety, affordable housing, availability of healthy foods, and local emergency and health services.

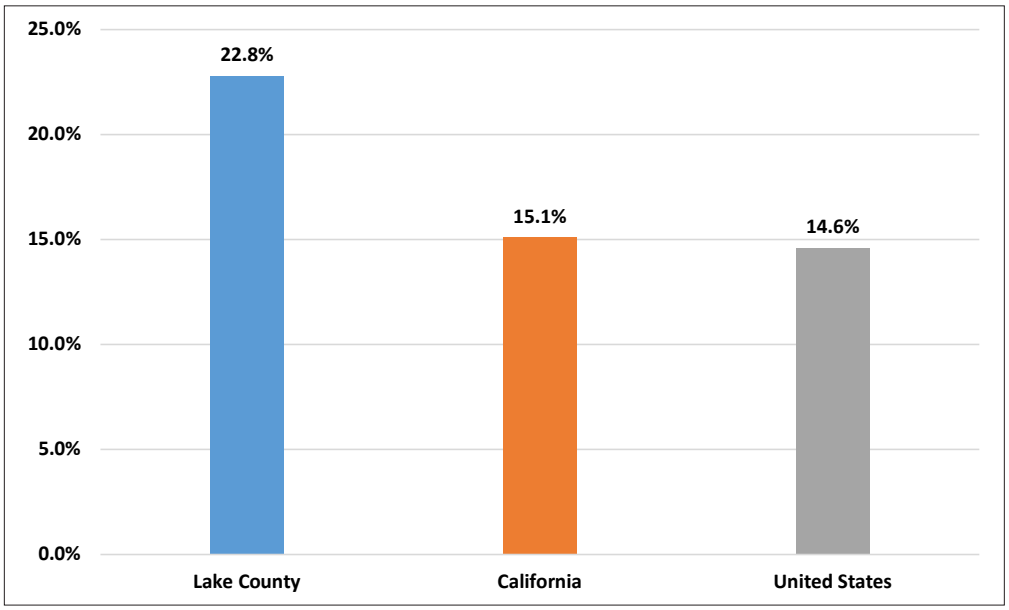
Understanding the different social determinants in a service area can lead to identification of drivers or 'root cause' of health conditions and potential services that work to improve disparities within that community. Programs that address the social determinants such as targeted outreach to people living alone, translation services for people with limited English proficiency, and financial counseling for people living in poverty, can help to improve the overall health of the community. This section explores the social and economic determinants of health in Lake County. These social determinants and other factors help build the context of the service area to allow for better understanding of the results of both primary and secondary data.

4.2.1 POVERTY

In 2019, the federal poverty guideline was $25,750 for a family of four (U.S. Department of Health and Human Services, 2019). Federal assistance programs use the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility for Head Start, the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program.

As shown in Figure 14, Lake County has a higher rate of poverty compared to the state and national poverty rates. Lake County has a poverty rate of 22.8%, while state and national rates of poverty are 15.1% and 14.6% respectively.

FIGURE 14: PEOPLE LIVING BELOW POVERTY LEVEL, 2013-2017

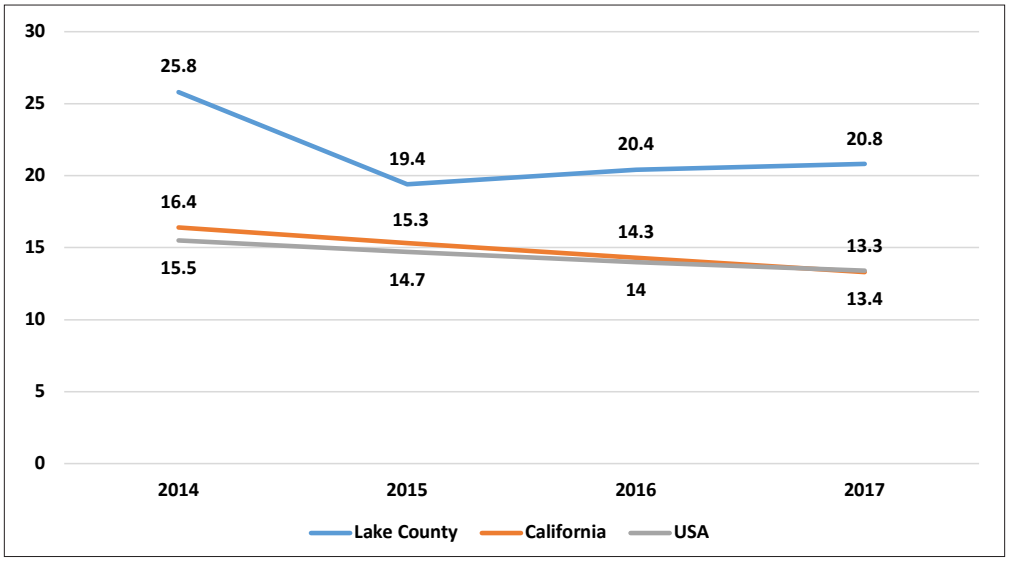


Source: American Community Survey, 2013-2017

United Ways of California has arrived at an estimate of the amount of income required to meet basic needs (the "Real Cost Budget") for a given household type in a specific community. The Real Cost Measure builds a bare-bones budget that reflects constrained yet reasonable choices for essential expenses: housing, food, transportation, health care, taxes and child care. United Ways estimates that an income of at least $64,401 was required to meet the basic needs (housing, food, transportation, health care, taxes, and child care) for a family of four, with two adults and two children, in Lake County. This is more than two and a half times the federal poverty level for a family of four. This threshold of affordability is referred to as the Real Cost Measure (RCM). In Lake County, 79% of residents with education levels below high school, 81% of households headed by single females and 32% headed by seniors, 67% of Latino households and 71% of foreign born, non-citizen households are below the RCM. By the same estimates, a family of four (two adults, one infant, one school age child) would need to hold more than three full time, minimum-wage jobs to achieve economic security (United Way of California, 2018).

According to Figure 15, the rate of people living below the federal poverty level in Lake County has a downward trend, similar to the state and national trends. However, the overall percentages of Lake County's population living below poverty across all four years are higher than the state and national values. In 2014, Lake County had a poverty rate of 25.8%, which dropped in 2015 to 19.4% and has remained stable from 2015 to 2017, with a slight increase in 2017 to 20.8%. In comparison, the poverty rate in California was 13.3% and national value was 13.4% in 2017.

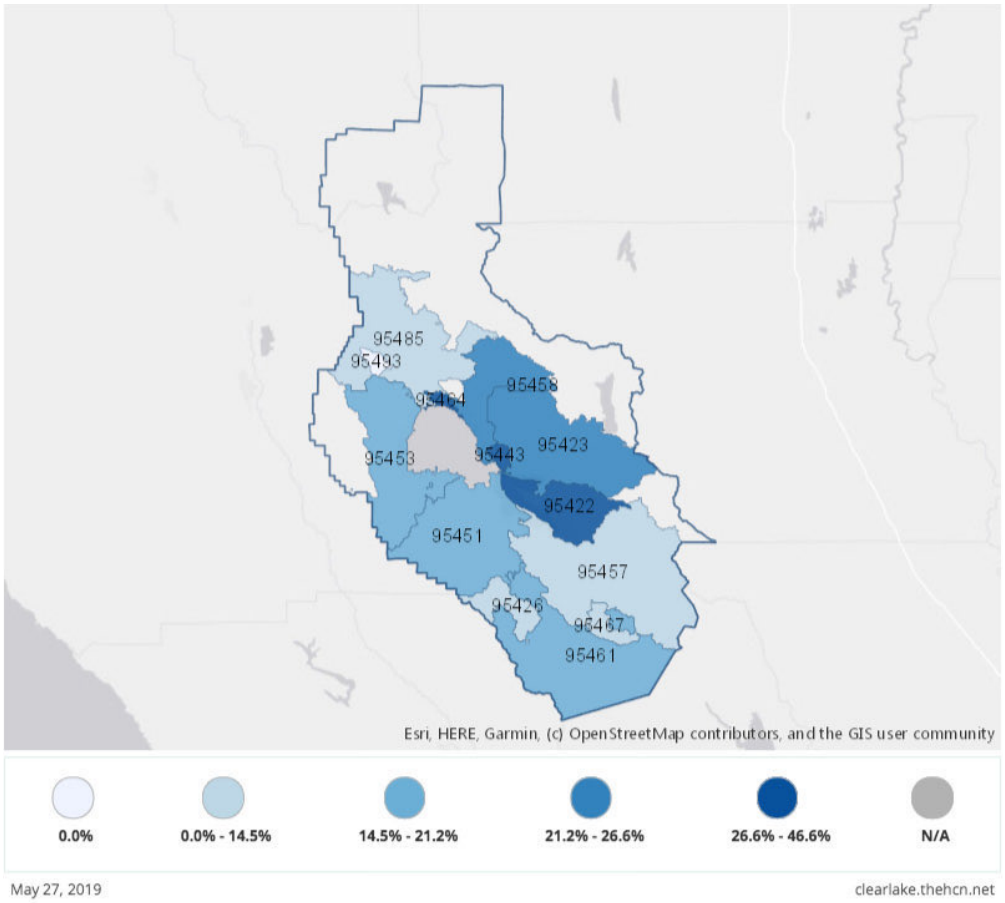
FIGURE 15: PEOPLE LIVING BELOW POVERTY LEVEL, 2014-2017



Source: American Community Survey

Figure 16 depicts the percentage of individuals living below poverty broken up by sub-county geographies. The dark blue regions indicate zip codes with the highest levels of poverty in the county while lighter shades represent lower rates of poverty. The Lake County zip code with the largest proportion of its population living below poverty is 95443 (46.6%), followed by 95422 (35.4%) and 95464 (34.5%).

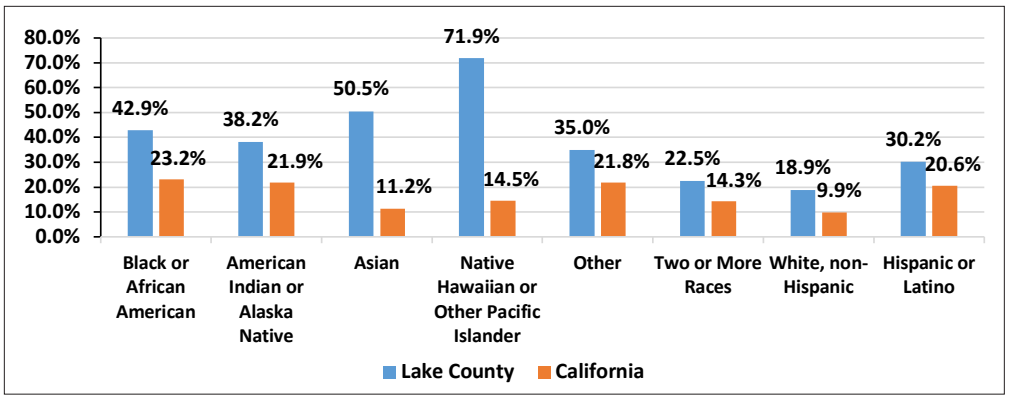
FIGURE 16: PEOPLE LIVING BELOW POVERTY LEVEL, 2013-2017



Source: American Community Survey, 2013-2017

Figure 17 shows the percentage of people living below 100% poverty level by race and ethnicity in comparison to state and national values. The race/ethnicity group with the greatest percentage of its population living in poverty is the Native Hawaiian or Other Pacific Islander population, with 71.9%. A little more than half the Asian population (50.5%), 42.9% of the Black or African American population and 18.9% of White persons live below the 100% poverty level mark in Lake County. All race and ethnicity groups are higher than state levels.

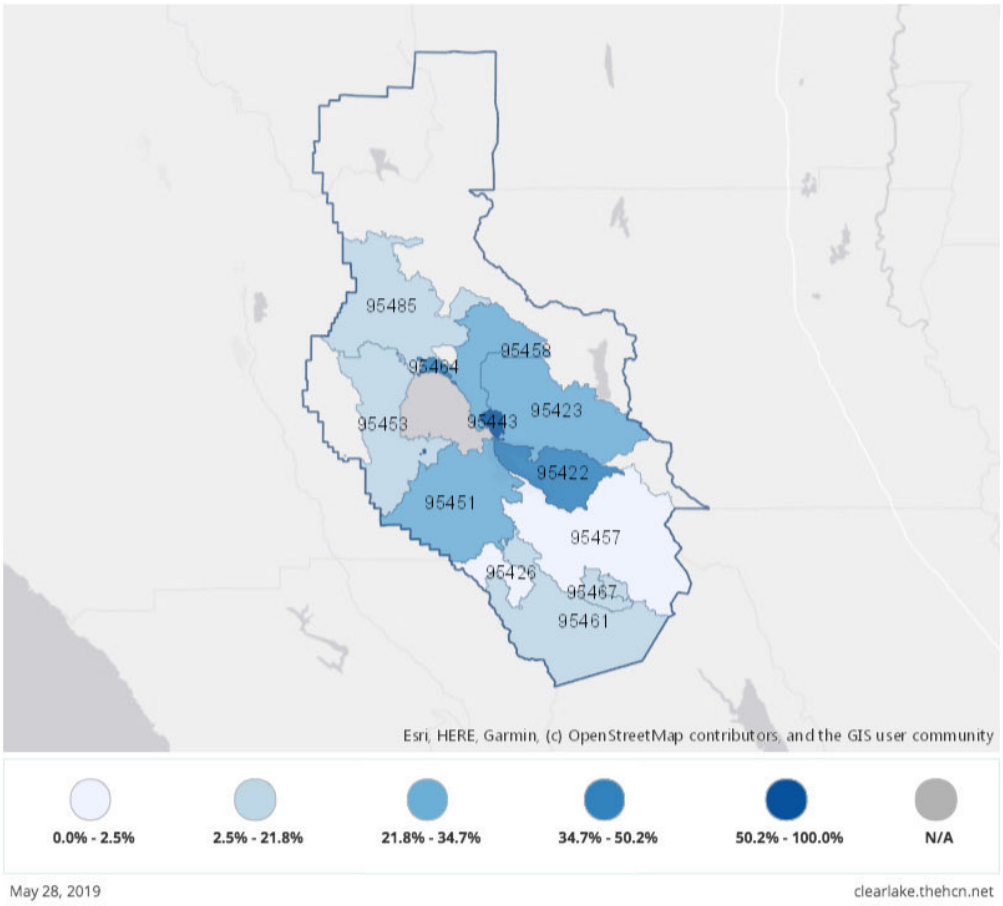
FIGURE 17: PEOPLE LIVING BELOW POVERTY LEVEL BY RACE/ETHNICITY, 2013-2017



Source: American Community Survey, 2013-2017

According to the American Community Survey, in 2013-2017, 31.6% of children below 18 years in Lake County were living below the 100% federal poverty level. This is higher than the proportion of children living below poverty level in California (20.8%) and the US (20.3%). Examining this by race, American Indian or Alaska Native children and other race/ethnicity had the highest disparity, with 63.1% of American Indian or Alaska Native children living under poverty and 45.1% of children from other race/ethnicities living below poverty. At the granular level, 95443 and 95435 had the greatest percentage of people under the age of 18 living below the 100% federal poverty level (Figure 18).

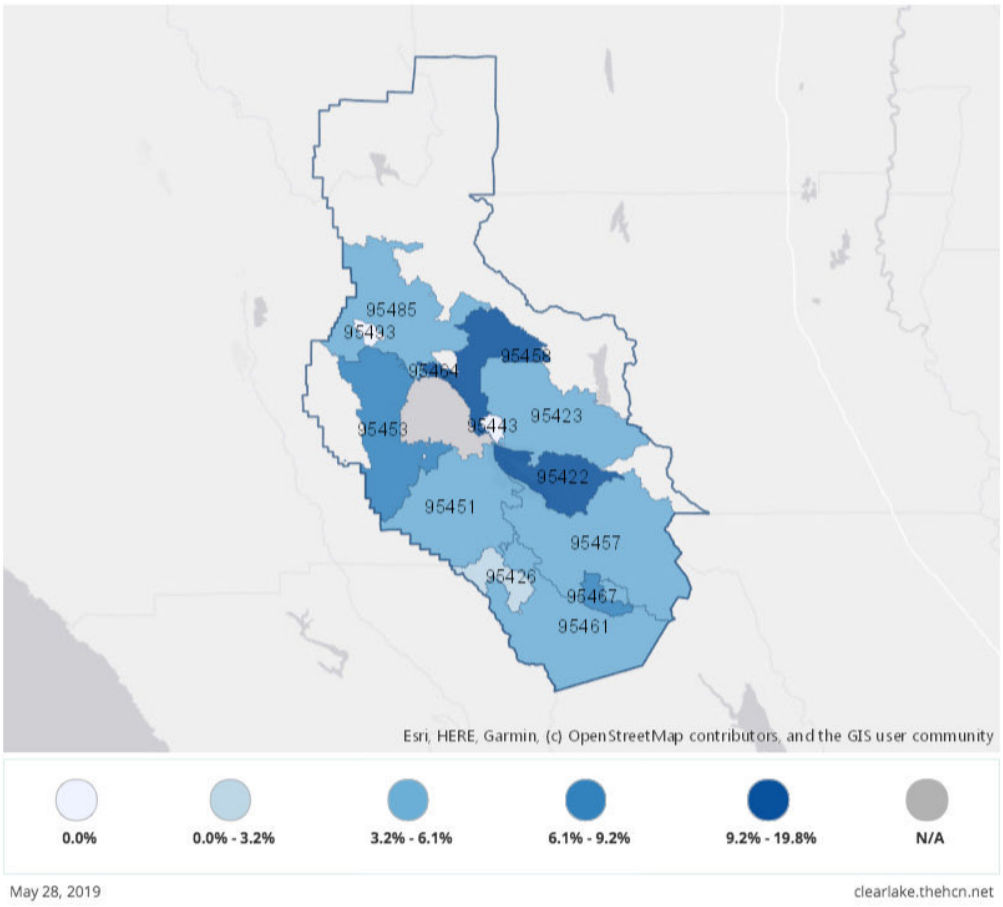
FIGURE 18: CHILDREN LIVING BELOW POVERTY, 2013-2017



Source: American Community Survey, 2013-2017

In 2013-2017, 8.6% of individuals aged 65 and over were living below the federal poverty level in Lake County. This is lower than the California value (10.2%) and the US value (9.3%). Examining poverty rates broken up by zip code, the highest proportion of individuals aged 65 and over living below poverty was in 95464 at 19.8% followed by 95422 (13.9%) and 95458 (11.8%).

FIGURE 19: PEOPLE 65+ LIVING BELOW POVERTY LEVEL, 2013-2017



Source: American Community Survey, 2013-2017

Among female headed households, 35.9% fell below the 100% poverty line as did 35% of households headed by a person with less than a high school education. Almost a quarter of households where the head was disabled (23.8%) or foreign born (26.0%) were also below the 100% poverty mark.

Low income affects housing stability, food access, healthcare spending, healthcare access, and health status of residents. These disparities, as illustrated within Section 4, correspond with race/ethnicity, languages spoken, foreign-born status and women headed households among other factors. However, as seen from the median household incomes of the county and the higher than state averages of percent living under poverty, the community has lower median household income on an average and fewer financial buffers against factors that contribute to poorer health outcomes in the county.

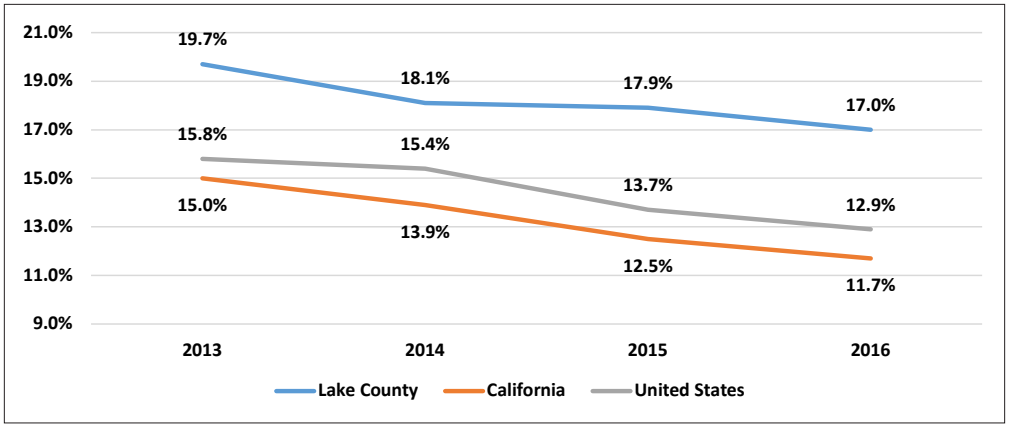
4.2.2 FOOD INSECURITY

Food insecurity is defined as the disruption of food intake or eating patterns because of lack of money and other resources. The U.S. Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Food insecurity, and the resulting hunger, is associated with disability, lack of adequate employment and racial and ethnic disparities. It leads to intake of

nutritionally deficient but high calorie foods that cause obesity, diabetes, heart disease, high blood pressure, and hyperlipidemia. Food assistance programs, such as the National School Lunch Program (NSLP), the Women, Infants, and Children (WIC) program, and the Supplemental Nutrition Assistance Program (SNAP) address food insecurity in vulnerable populations by delivering food benefits.

Figure 20 describes the percent of the population in Lake County that has experienced food insecurity, compared to state and national rates. Overall, there is a downward trend in food insecurity rate across all three geographies. Lake County has higher food insecurity in comparison to the state and the nation. In 2016, Lake County had a food Insecurity rate of 17%, about 4% greater than the state value and 5% greater than the national value. Between 2013 and 2016, the food insecurity rate in Lake County has dropped 2.7%, from 19.7% in 2013 to 17% in 2016.

FIGURE 20: FOOD INSECURITY RATE, 2013-2016



Source: Feeding America (2013-2016)

Per the 2013-2017 American Community Survey 5-Year Estimates, 11.4% or 3,007 of all households in Lake County and 53.6% or 5,529 households with children less than 18 years receive food stamps or SNAP benefits. Of the households receiving SNAP benefits, 47.9% had one worker in the 12 months; 73% of these households is White alone, 17.2% are Hispanic or Latino, 4.4% are American Indian and Alaska Native alone, and 3.4% are Black or African American alone.

Children exposed to food insecurity are of particular concern given the implications scarce food resources pose to a child's health and development. Children who are food insecure are more likely to be hospitalized and may be at higher risk for developing chronic diseases such as obesity as a result in lower quality diet, anemia and asthma. In addition, food-insecure children may also be at higher risk for behavioral and social issues including fighting, hyperactivity, anxiety, and bullying. In Lake County, 18% of the children who are food insecure are likely to be ineligible for assistance; this is the percentage of food insecure children in households with incomes above 185% of the federal poverty level who are likely not income-eligible for federal nutrition assistance.

The maximum income level of a family of 4 to qualify for Cal-Fresh is $4,184 gross monthly income (that is, before taxes) or $2,092 net monthy income (CAFoodbanks.org, 2019). Paradoxically, earning even marginally more money than the CalFresh eligibility limit disqualifies families from receiving benefits though the marginal income increase will not make healthy food options more affordable. Yet,

the Real Cost Measure (RCM) — which estimates the amount of income required to meet basic needs of food, housing, transportation, healthcare, child care etc. (the "Real Cost Budget") for a given household type in a specific community — estimates that a family of 4 needs an annual income of $64,401 per year in Lake County (United Ways of California, 2018). By these estimates, one in 2.5 households in Lake County are below the Real Cost Measure in 2018.

4.2.3 TRANSPORTATION

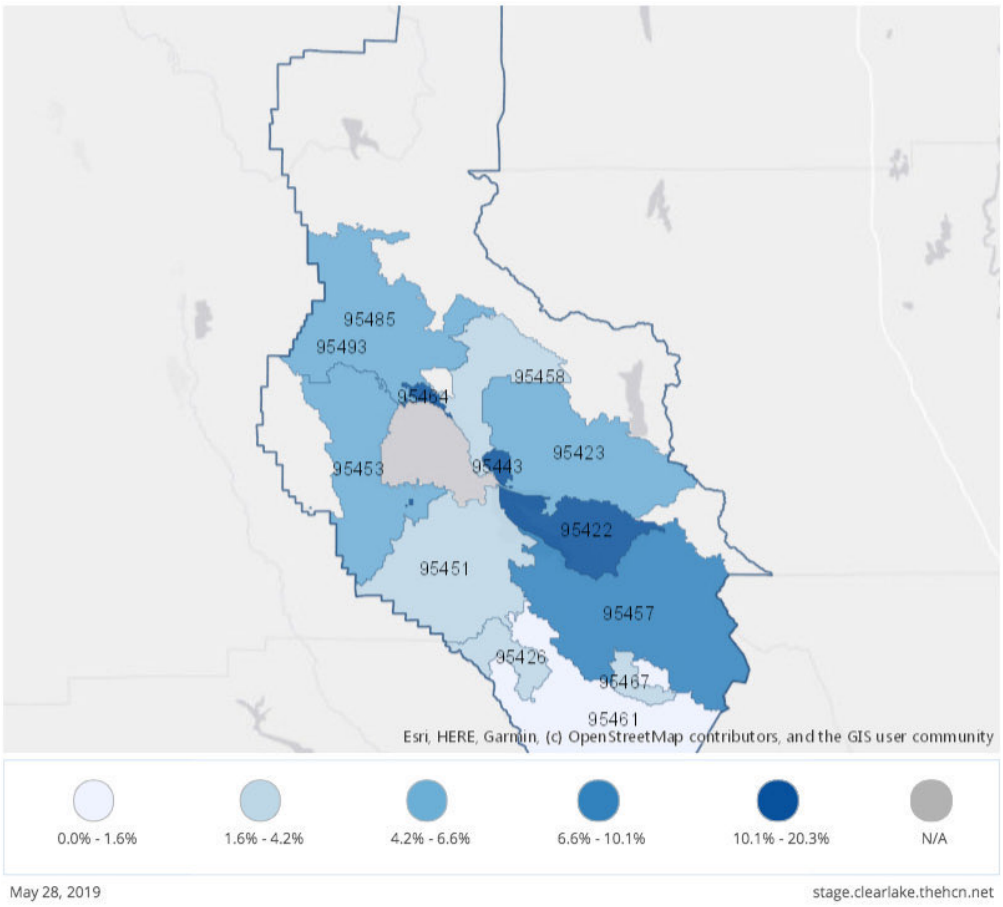
Public transportation offers mobility, particularly to people without cars. Transportation is interrelated with other social determinants of health such as poverty, social isolation, access to education and racial discrimination. Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public transportation also reduces fuel consumption, minimizes air pollution, and relieves traffic congestion.

Maintaining private vehicles imposes a burden on the household budget. According to the Real Cost Measure estimates of United Ways, yearly transportation costs for one person in Lake County is $4,854 while it is $9,714 for a family with two adults; this constitutes almost 25% of the budget for most households given that the median household income is $40,446. Lake County has an average of 1.8 vehicles per household.

Among workers 16 years and over for whom poverty status is determined (17,854 persons), 68.4% (12,228) drove to work alone while only 1.08% (194 persons) used public transportation in Lake County and 3.31% (591) walked to work (United States Census Bureau, 2019).

With regards to households without a vehicle, 7.3 % of households in Lake County overall do not have a car. The map (Figure 21) below depicts regions in the county that do not have a vehicle. Areas shaded in dark blue indicate zip codes in the highest quartile, while the regions with light blue shading represent lower quartiles. The zip code with the highest proportion of households without a car is 95435 (20.3%) and 95443 (13.1%), followed by 95464 (12.5%), and 95422 (12.2%). Residents in these locations may be more likely to experience difficulties accessing services in Lake County.

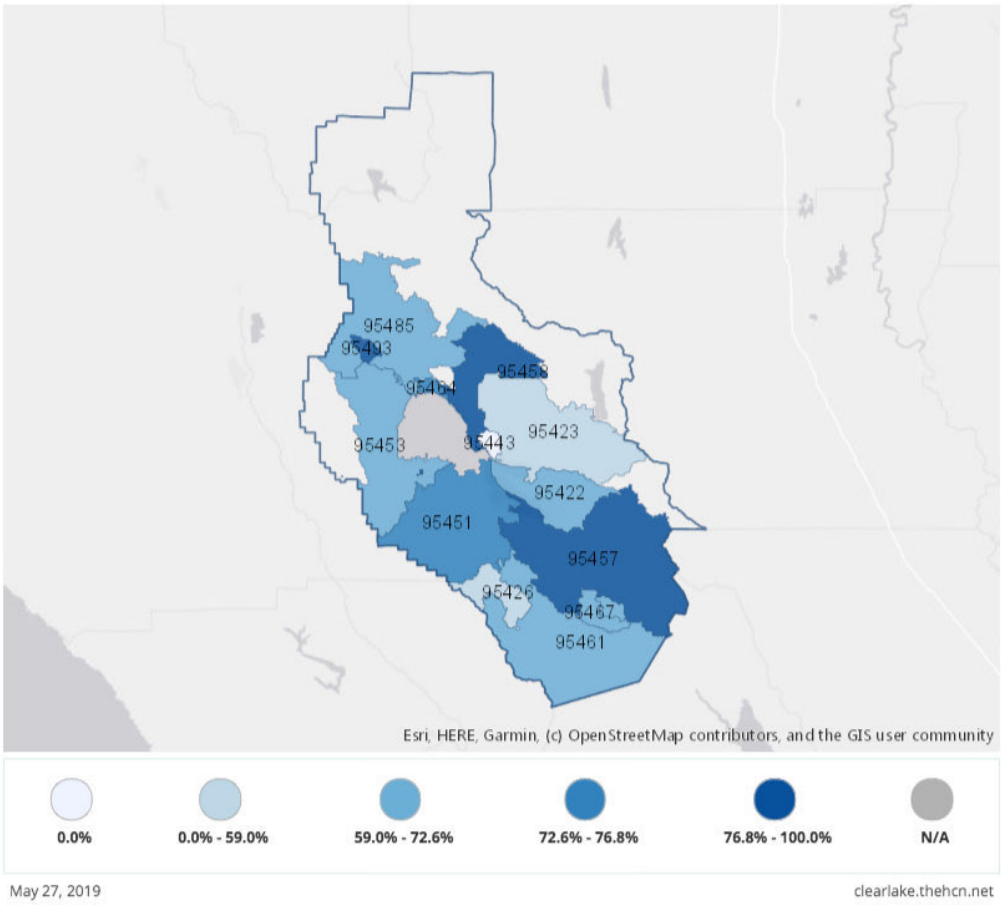
FIGURE 21: HOUSEHOLDS WITHOUT A VEHICLE, 2013-2017



Source: American Community Survey, 2013-2017

Figure 22 shows the percent of workers who drive alone to work by zip code. The darkest shaded regions on the map indicate zip codes with the highest proportion of workers who drive alone to work. Within Lake County, the area with the largest percentage of individuals that drove alone to work is zip code 95435 at 100%. Other regions in the upper quartile are 95457 (82.2%), 95493 (81.8%), and 95458 (81.1%). Driving alone to work can have long lasting impacts on health, affecting aspects such as active living, pollution, and accidents due to vehicle collisions.

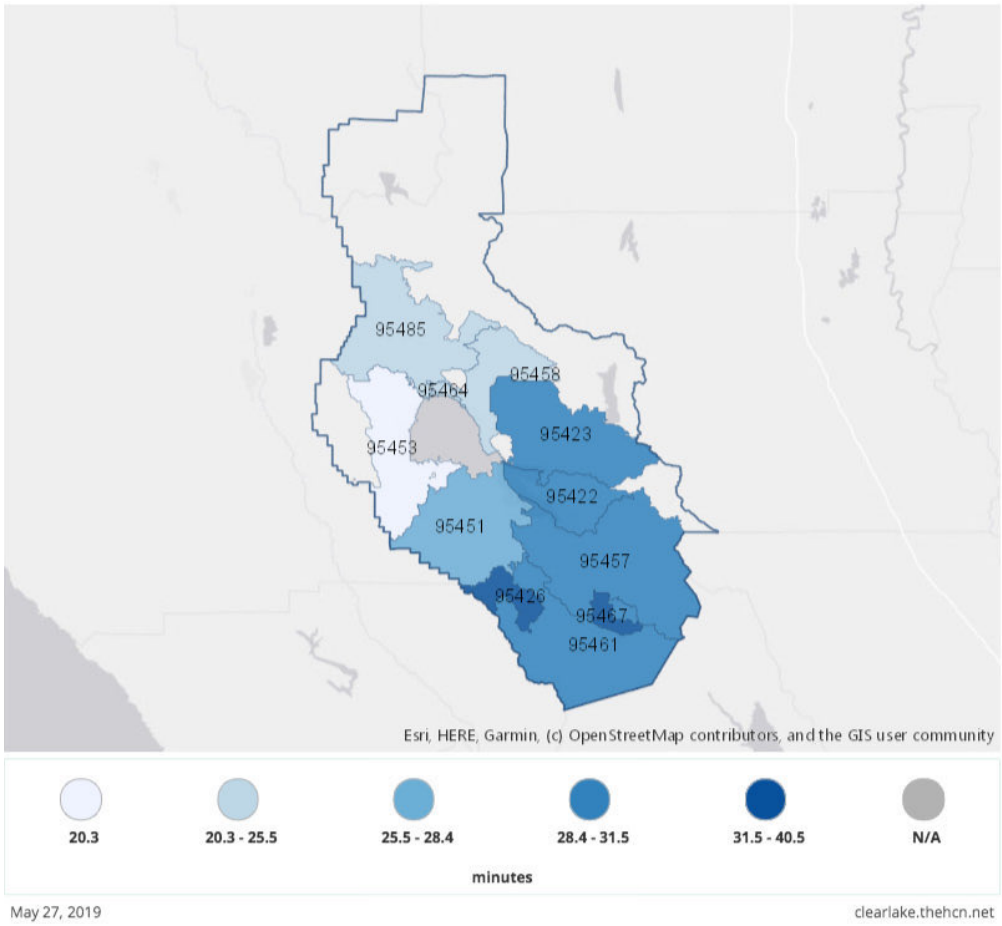
FIGURE 22: WORKERS WHO DRIVE ALONE TO WORK, 2013-2017



Source: American Community Survey, 2013-2017

The mean travel time to work for the Lake County population is 28.9 minutes. Longer commutes cut into worker's free time and can contribute to health problems such as anxiety and increased blood pressure. The zip code with the highest proportion of households without a car is 95467 (40.5%) and 95426 (36.5%). The map below (Figure 23) depicts travel time for regions within the county. Areas shaded in dark blue indicate zip codes in the highest quartile, while the regions with light blue shading represent lower quartiles.

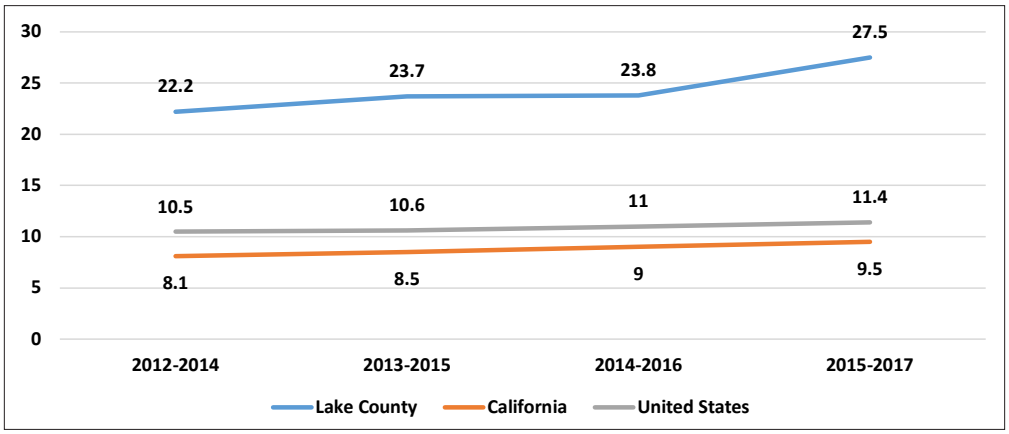
FIGURE 23: MEAN TRAVEL TIME TO WORK, 2013-2017



Source: American Community Survey, 2013-2017

Figure 24 depicts the rate of age-adjusted deaths due to motor vehicle collisions in Lake County. Overall, rates are higher than state and national values, with 27.5 deaths per 100,000 population between 2015 -2017 compared to 9.5 deaths per 100,000 population and 11.4 per 100,000 population for the state and for the nation. Overtime, the death rate due to motor vehicle collisions is rising within Lake County, with an increase from 23.8 deaths due to motor vehicle traffic collision to 27.5 deaths between 2014-2016 and 2015-2017. In children, there are 18.3 motor vehicle injury hospitalizations per 100,000 children (California Department of Public Health, 2017-2018).

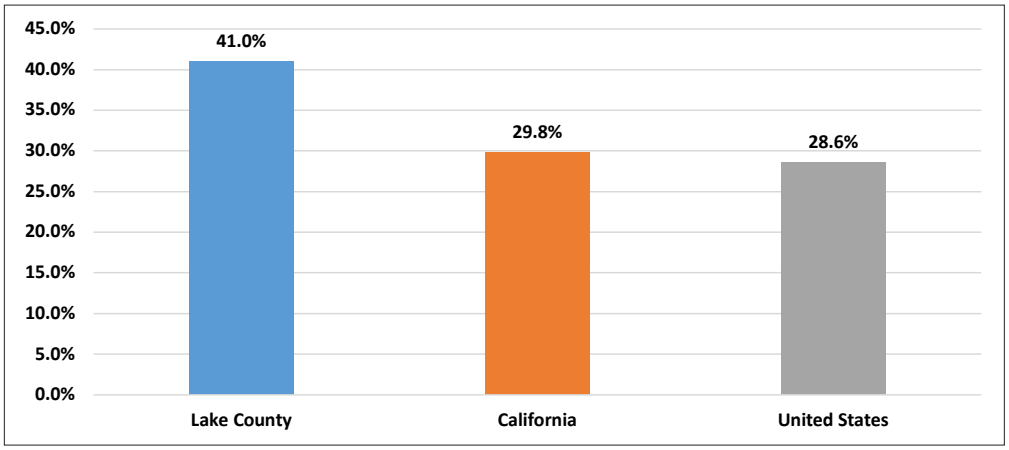
FIGURE 24: AGE-ADJUSTED DEATH RATE DUE TO MOTOR VEHICLE TRAFFIC COLLISIONS, 2012-2017



Source: Centers for Disease Control, 2015-2017

Figure 25 depicts the percentage of alcohol impaired driving deaths in Lake County compared to California and the US. Lake County has a higher rate of alcohol impaired driving deaths, with 41% of motor vehicle deaths due to alcohol involvement. This rate is higher than the California rate of 29.8% and the United States rate of 28.6%.

FIGURE 25: ALCOHOL IMPAIRED DRIVING DEATHS, 2013-2017



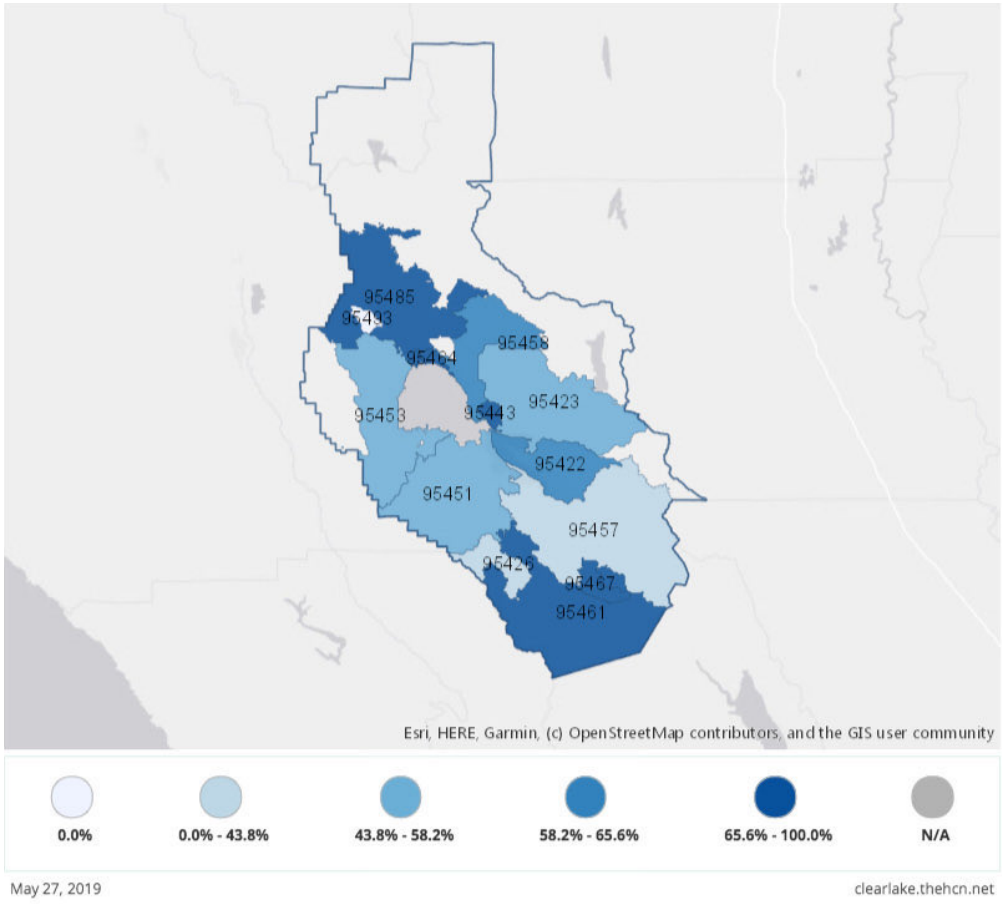
Source: County Health Rankings, 2013-2017

4.2.4 HOUSING

With a limited income, paying a high rent may not leave enough money for other expenses such as food, transportation, and medical. The five year average between 2013-2017 data shows that the median gross rent was $914 (United States Census Bureau, 2019). Moreover, high rent reduces the proportion of income a household can allocate to savings each month. The Real Cost Measure (RCM) estimates of United Ways for housing are $9,090 for 2 adults and $12,168 for a family of four which constitutes more than 30% of the median family income in Lake County.

Figure 26 shows renters spending 30% or more of household income on rent in Lake County. Overall, 62.6% of individuals in Lake County spend 30% or more of their household income on rent. This is greater than the California value of 56.0% and the US value of 50.6%. The percent of 15-24 year old renters in Lake County who spend more than 30% of their income on housing is 74.9%, while this percent in 25-34, 35 to 64 and 65+ years is 58.6%, 63% and 60.3% respectively. Looking at the map below, the largest proportion of individuals in Lake County comes from the zip code 95433 where 100% of the population spends 30% or more of their household income on rent. Additional zip codes that fall in the upper quartile are 95467 (79.9%), 95461 (73.3%), 95485 (72.6%), and 95464 (71.3%).

FIGURE 26: RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT, 2012-2016



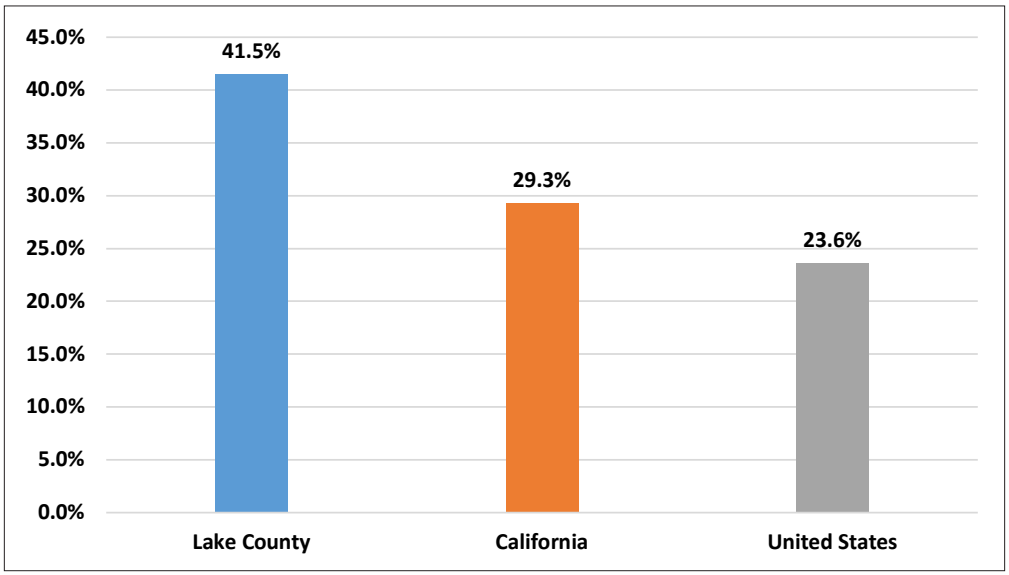
Source: American Community Survey, 2013-2017

4.2.5 ACCESS TO HEALTH

Access to health is the most important factor in determining health outcomes and includes coverage, physical access, health literacy and relationships of trust with physicians (Office of Disease Prevention and Health Promotion, 2019).

In 2017, 41.5% of people had only public health insurance in Lake County (Figure 27). This rate is higher than the California average (29.3%) and the U.S. average (23.6%).

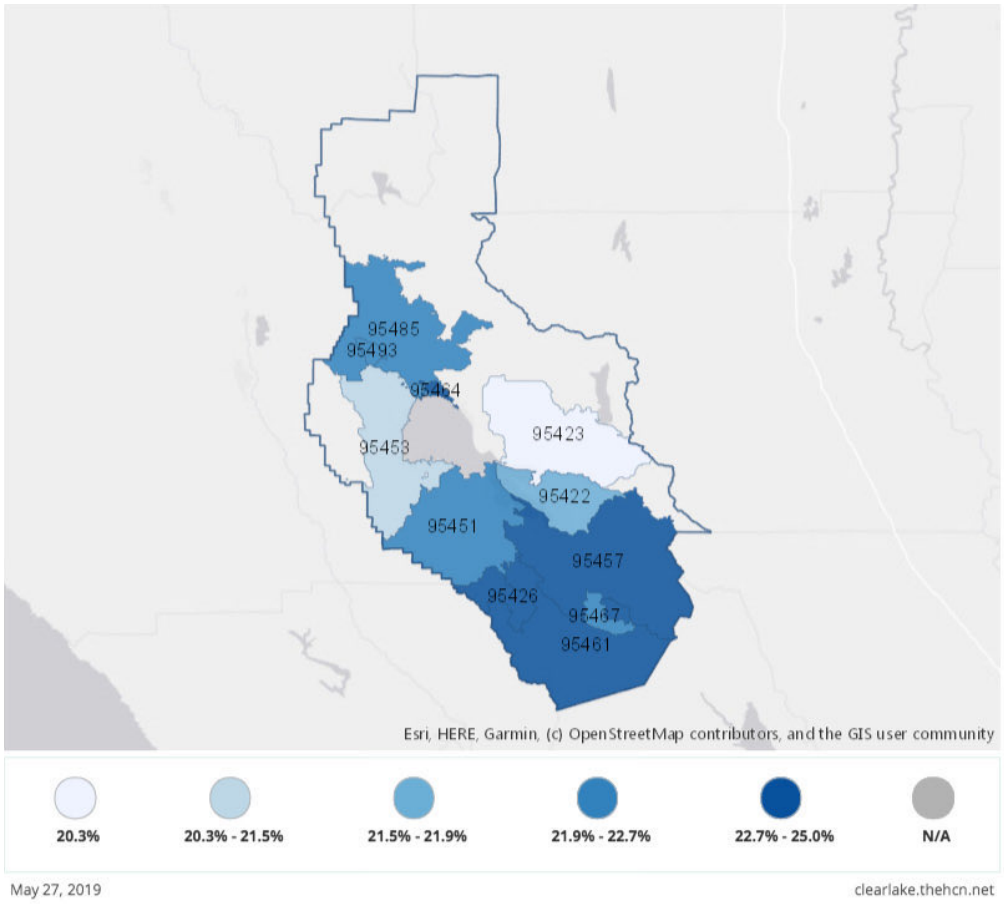
FIGURE 27: PERSONS WITH PUBLIC HEALTH INSURANCE ONLY, 2017



Source: American Community Survey, 2017

With regards to delays or difficulty receiving needed care, 22.2% of adults over the age of 18 in Lake County reported having to delay or not receive care they felt they needed. This is due to a variety of reasons, including cost, availability of services, difficulty with appointments, lack of transportation, inability to access care, and numerous other barriers. Within Lake County, zip code 95426 had the highest percentage of adults who delayed or had difficulty obtaining care, at 25.0% (Figure 28). Zip code 95457 (23.6%), 95461 (23.4%), and 95464 (23.2%) also had high rates for this measure.

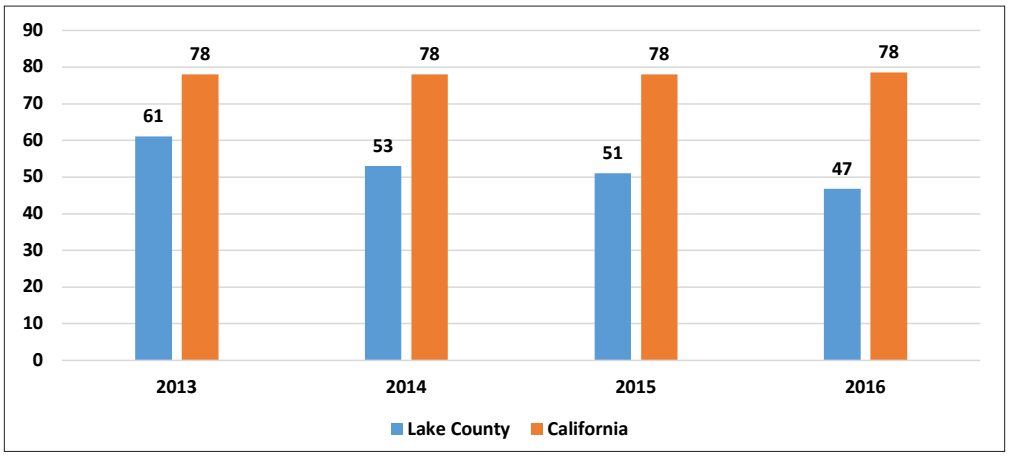
FIGURE 28: ADULTS DELAYED OR HAD DIFFICULTY OBTAINING CARE, 2013-2014



Source: California Health Interview Survey, 2013-2014

Access to primary care providers increases the likelihood that community members will have routine checkups and screenings. Moreover, those with access to primary care are more likely to know where to go for treatment in acute situations. Communities that lack a sufficient number of primary care providers typically have members who delay necessary care when sick and conditions can become more severe and complicated. Access to primary care shown in Figure 29 describes the primary care provider rate in Lake County compared to the state average. Across all 4 time periods, Lake County has a lower primary care provider rate than California. However, there is a statistically significant downward trend, with 61 providers per 100,000 population in 2013 to 47 providers per 100,000 population in 2016. Other professionals can serve as usual sources of routine, preventive care, including nurse practitioners (NP), physician assistants PA), and clinical nurse specialists. The ratio of Other Primary Care Providers in Lake County is better (1,311 patients: 1 provider) than the state average (1,770 patients: 1 provider).

FIGURE 29: PRIMARY CARE PROVIDER RATE, 2013-2016



Source: County Health Rankings, 2013-2016

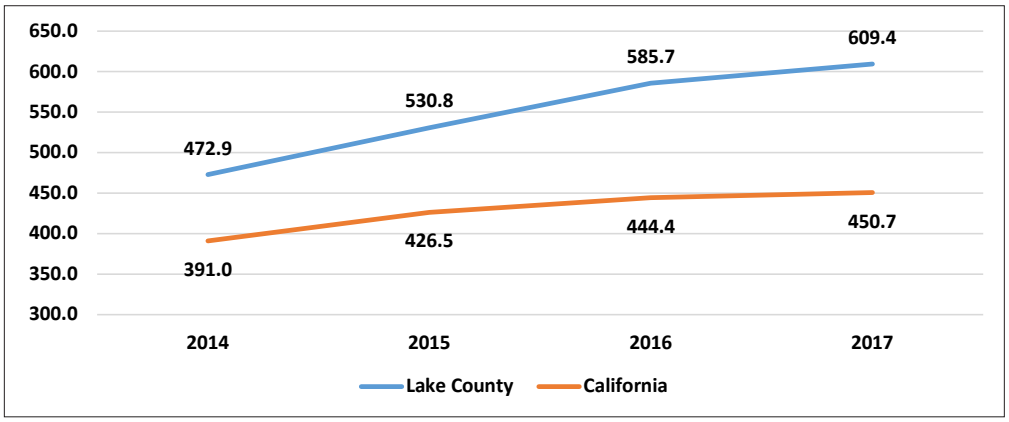
4.3 CRIME AND SAFETY PROFILE

Violence impacts the health of individuals, families, and communities; safe communities that provide opportunities to be active and eat well support people in making healthy choices. Crime ridden communities increase incidence of childhood trauma, impacting lifelong health. Safe neighborhoods that are free of crime help to create opportunities for healthy eating and active living. Creating these opportunities in all neighborhoods will help to reduce health disparities within Lake County.

Based on data from Uniform Crime Reporting (UCR) Program provided by County Health Rankings, Lake County reported 535 violent crime offenses per 100,000 population between 2014 and 2016. Figure 30 looks at violent crime rate in Lake County compared to the state of California. There is a rising trend of violent crimes, with 472.9 crimes per 100,000 population in 2014, rising to 609.4 violent crimes per 100,000 population in 2017. California has a lower violent crime rate in comparison, however both rates are moving in the upward direction.

The rate of homicides in Lake County was 11 per 100,000 population between 2011 and 2017. In 2017. The California Department of Justice reported 221 violent crimes in Lake County. Of those crimes, 6 were attributed to homicides, 26 were rapes and 180 crimes were due to aggravated assault, which includes the use of weapons, such as firearms (Lake Co. Sheriff's Department, 2017). There is also a rising, significant trend for substantiated child abuse in Lake County. Based on the Child Welfare Dynamic Report System, in 2017, there were 9.9 cases per 1,000 children, which is higher than the California average of 7.5 and the national average of 9.1. This incorporates several types of child abuse, including physical, sexual, and emotional abuse. There are 12.2 children in Foster Care per 1,000 children in Lake County (California Department of Public Health, 2017-2018).

FIGURE 30: VIOLENT CRIME RATE PER 100,000 POPULATION, 2014-2017



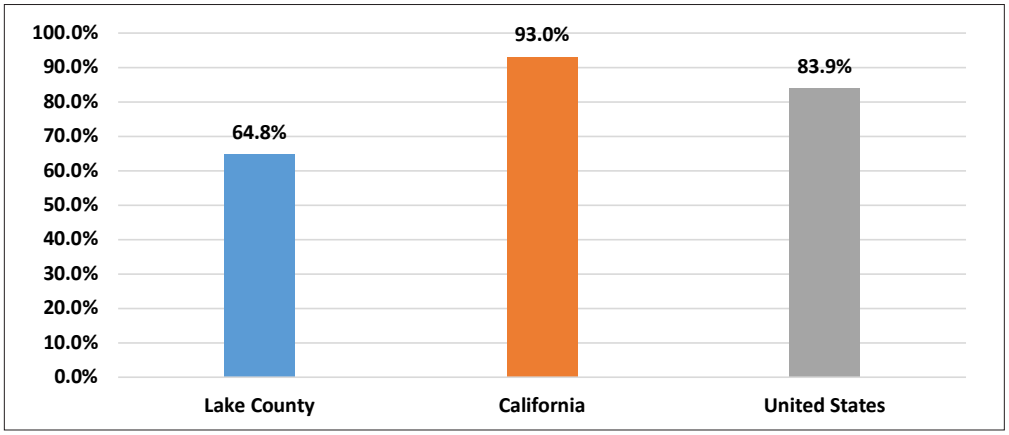
Source: California Department of Justice, 2014-2017

4.4 BUILT ENVIRONMENT PROFILE

Communities that are designed to be walkable provide health, social and economic benefits. Safe neighborhoods and workplaces make communities healthier because residents are more likely to walk and bike to work and school to improve their fitness and overall health. Healthy communities are marked with adequate public places to play and be active, access to affordable healthy foods, and streetscapes designed to prevent injury. Proximity to exercise opportunities, such as parks and recreation facilities, has been linked to an increase in physical activity among residents, which is important for enhancing quality of life and improve life expectancy. Moreover, it reduces the risk of cardiovascular disease, diabetes, and some cancers.

Figure 31 depicts the percentage of individuals who live reasonably close to a park or a recreational facility in Lake County compared to the state and national values. In 2015, only 45% percent of Lake County population lived within a half mile of a park (Centers for Disease Control and Prevention, 2015). In 2019, 64.8% of residents in Lake County reported having access to exercise opportunities. This proportion is less than the state and national values of 93% and 83.9%.

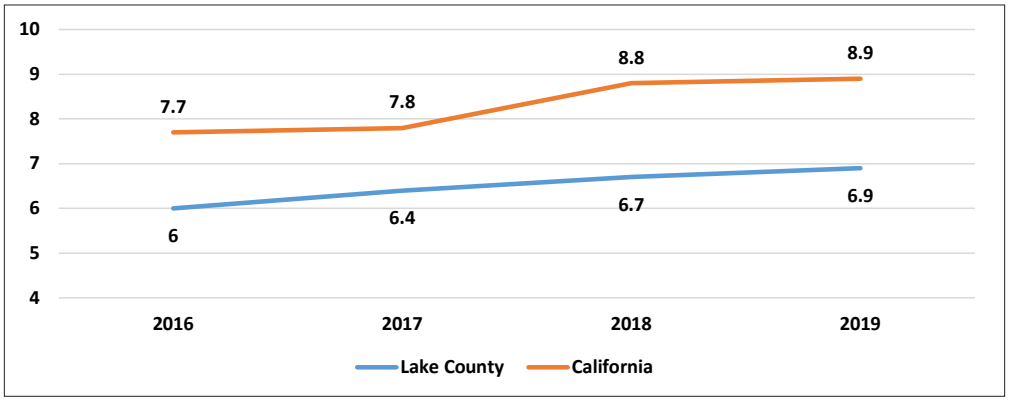
FIGURE 31: ACCESS TO EXERCISE OPPORTUNITIES, 2019



Source: County Health Rankings, 2019

Figure 32 shows the trend over four years of Food Environment Index values in Lake County and California. The Food Environment Index combines two measures of food access – the percentage of the population that is low income and has low access to a grocery store and the percentage of the population that does not have access to a reliable source of food. Index scores range from 0 to 10, with 0 being the worst and 10 being the best. Looking at the graph below, Lake County, overall, has a lower Food Environment Index than the state. However, the Index score trend is rising, with a score of 6 in 2016 and a score of 6.9 in 2019. In comparison, California has a score of 7.7 in 2016 and 8.9 in 2019.

FIGURE 32: FOOD ENVIRONMENT INDEX, 2016-2019



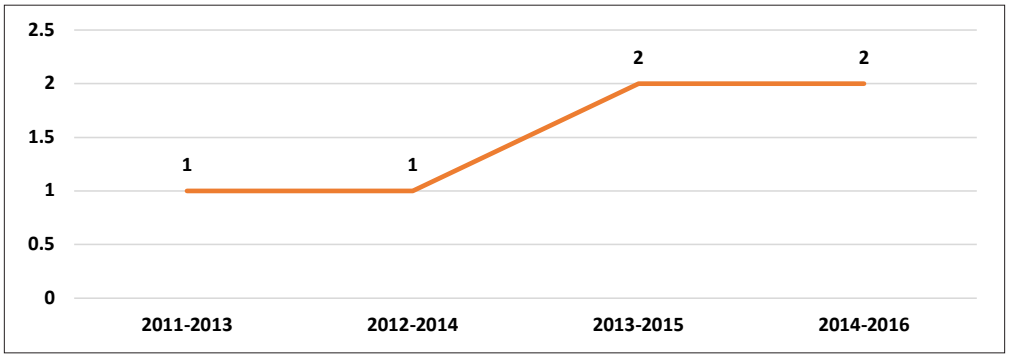
Source: County Health Rankings, 2019

4.5 ENVIRONMENTAL PROFILE

Health also requires that all environments, including homes, schools, communities and worksites, have clean air and water and are free from toxins and physical hazards. A healthy environment gives people the opportunity to make healthy choices and decrease their risk for heart disease, cancer, low birth weight and premature deaths and respiratory diseases such as asthma.

Figure 33 shows the trend of particle pollution in Lake County from 2011-2013 to 2014-2016. The Air Quality Index scores on a scale of 1 to 5, with 1 denoted as good air quality and 5 as poor air quality. Overall, the Lake County value is increasing with an upward trend from 1 to 2 between 2012-2014 and 2013-2015.

FIGURE 33: ANNUAL PARTICLE POLLUTION, 2011-2016



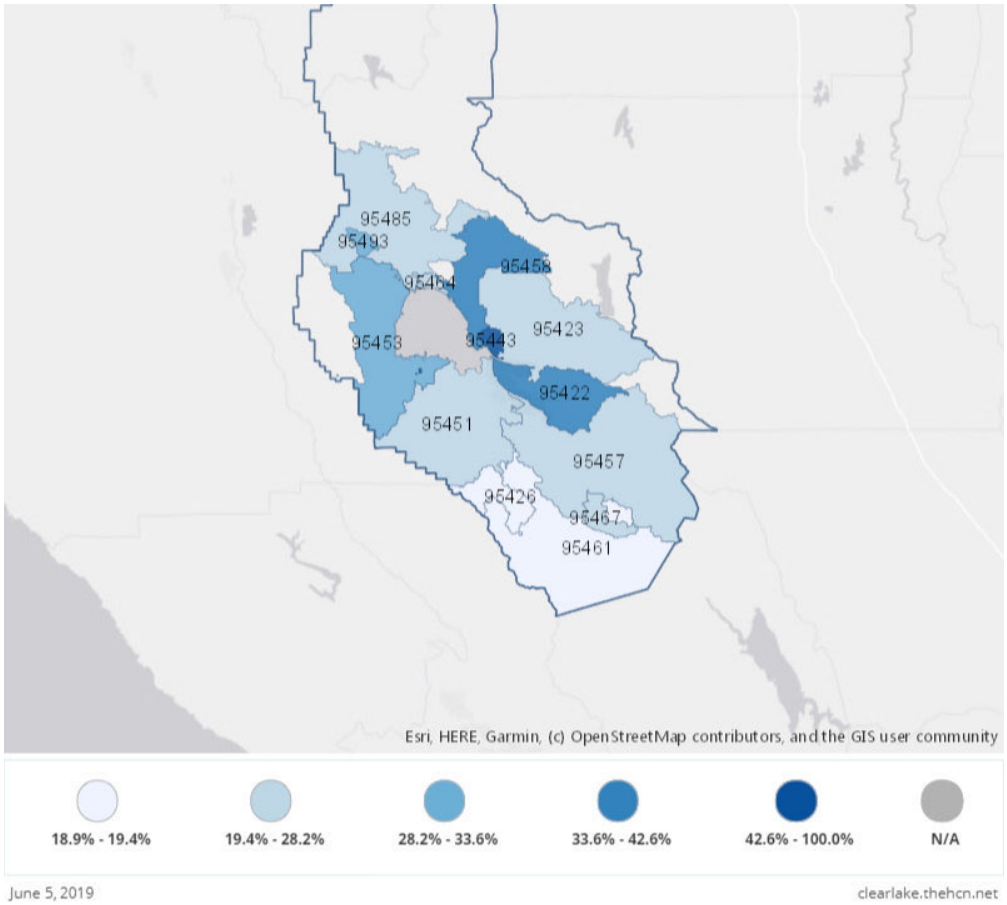
Source: American Lung Association, 2014-2016

Particulate Matter 2.5 levels (very small particles from vehicle tailpipes, tires and brakes, power plants, factories, burning wood, construction dust, and many other sources) above 12.0µg/m3 are considered dangerous to human health. In 2016, the annual level of PM2.5 in Lake County was 3 µg/m3 (Centers for Disease Prevention and Control, 2019).

4.6 SOCIAL PROFILE

People over age 65 who live alone may be at risk for social isolation, limited access to support, or inadequate assistance in emergency situations. Many older people who live alone are vulnerable due to social isolation, poverty, disabilities, lack of access to care, or inadequate housing. The proportion of the population 65 and over that live alone in Lake County is 30.3%. This is higher than the California value (22.8%) and the US Value (26.2%). By zip code, the region with the highest number of individuals 65 and over living alone is 95435 (100%). 95443 also falls into the upper quartile at 49.5% (Figure 34).

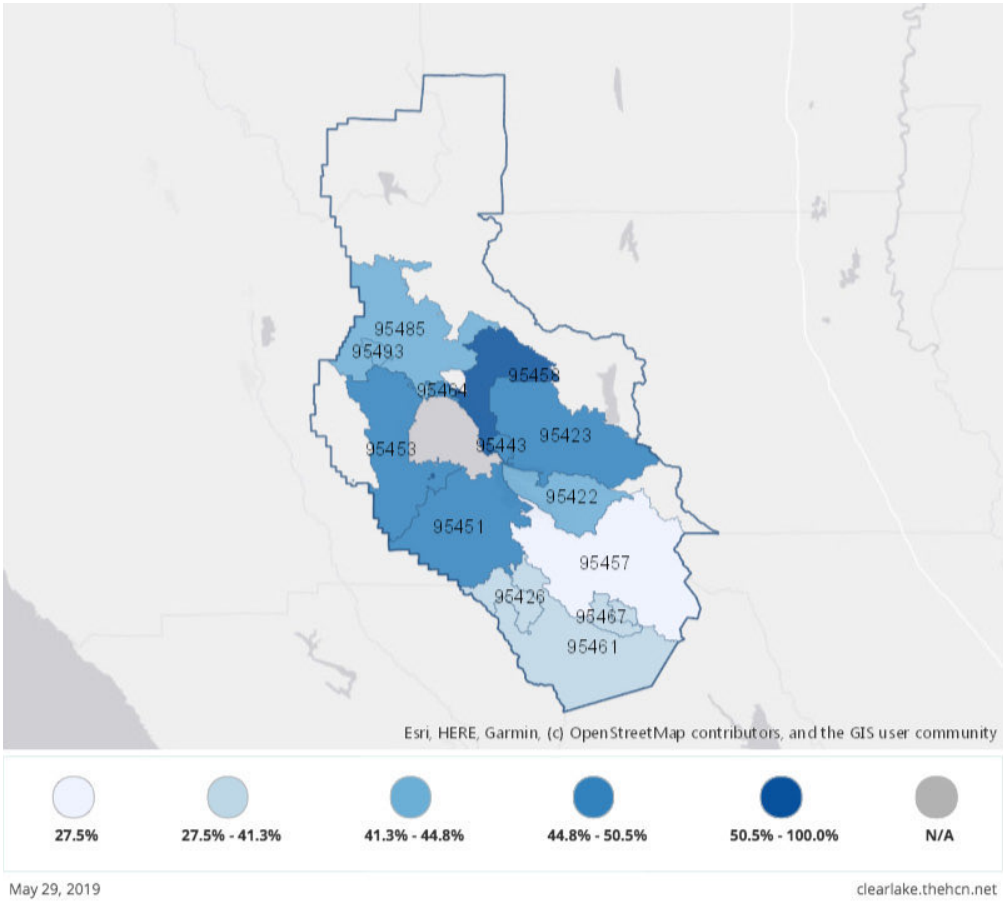
FIGURE 34: PEOPLE 65+ LIVING ALONE



Source: American Community Survey, 2013-2017

In 2013-2017, 45.3% of individuals aged 65 and over were living with a disability in Lake County. This is higher than the California value (35.6%) and the US value (35.5 %). Examining poverty rates broken up by zip code, the highest proportion of individuals aged 65 and over with a disability was in 95435 at 100%. 95458 also falls in the upper quartile at 55.6% (Figure 35).

FIGURE 35: ADULTS 65+ WITH DISABILITY

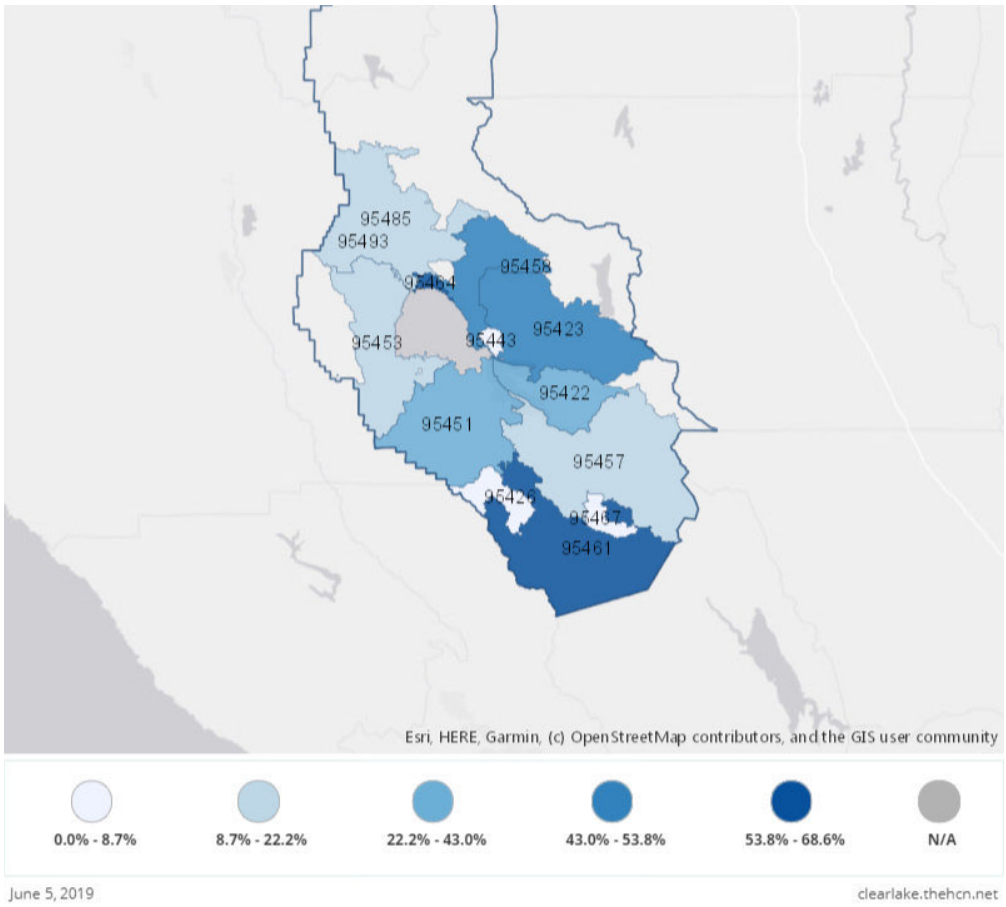


Source: American Community Survey, 2013-2017

In 2013-2016, according to the California Health Interview Survey, 49.1% of adults were living with a disability in Lake County. This is higher than the California value (29.7%) and the US value (20.6%). The trend steadily rose from 2013 to 2015, up to 53.4% with a small drop in 2016.

People with a disability are more likely to live in poverty, as compared to the rest of the population. Without adequate income, individuals with disabilities may not be able to afford necessary expenses, such as rent or mortgage, utility bills, medical and dental care, and food. The percent of the population living in poverty with a disability in Lake County was 37.1 which is greater than the California value 25.5 and US value 27.1. By zip code, the region with the greatest proportion of the population living in poverty with a disability is 95464 at 68.6%. Closely after is 95461 at 65.7% (Figure 36).

FIGURE 36: PERSONS WITH DISABILITY LIVING IN POVERTY, 2013-2017



Source: American Community Survey, 2013-2017

4.7 CLINICAL PROFILE: HOSPITALIZATION AND EMERGENCY ROOM UTILIZATION RATES

Collected through the California Office of Statewide Health Planning and Development, the tables below identify Hospitalization and Emergency Room (ER) Utilization rates for 2013-2015 in Lake County. Table 5 shows the preventable emergency room visits and hospitalizations for clinical outcomes which are potentially preventable diseases through access to high-quality outpatient care. The table provides the Lake County value as well as the zip code with the highest ER visit rate or hospitalization rate for each indicator. Age-Adjusted ER Rate (ER visit per 10,000 population) due to Mental Health (202.7), Urinary Tract Infections (167.7), Dental Problems (154.4), Adolescent Suicide and Intentional Self-inflicted Injury (91.3), COPD (78.7) and Pediatric Asthma (72.5) are the highest for Lake County.

Table 5 displays the total number of hospitalization and emergency room utilization indicators by zip code. Based on the tables below, Clearlake (95422) is the most heavily impacted, with 17 indicators displaying high rates in this zip code. The topics include indicators related to mental health, substance abuse, heart disease, and respiratory diseases. Following 95422 is Clearlake Oaks (95423) and Upper Lake (95485) with 5 indicators each.

TABLE 5: HOSPITALIZATION AND EMERGENCY ROOM UTILIZATION INDICATORS BY ZIP CODE, CALIFORNIA OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, 2013-2015

HOSPITALIZATION AND EMERGENCY ROOM UTILIZATION INDICATORS BY ZIP CODE				
Health Indicator	Units	Lake County Value	Zip Code	Value
Age-Adjusted ER Rate due to Mental Health	ER visits/ 10,000 population 18+ years	202.7	95422	316.3
Age-Adjusted ER Rate due to Urinary Tract Infections	ER visits/ 10,000 population 18+ years	167.7	95423	236.5
Age-Adjusted ER Rate due to Dental Problems	ER visits/ 10,000 population	154.4	95458	232.1
Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population aged 12-17	91.3	95422	157.9
Age-Adjusted ER Rate due to COPD	ER visits/ 10,000 population 18+ years	78.7	95422	136.7
Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	72.5	95464	147.8
Age-Adjusted ER Rate due to Community Acquired Pneumonia	ER visits/ 10,000 population 18+ years	69.8	95422	115.1
Age-Adjusted ER Rate due to Pediatric Mental Health	ER visits/ 10,000 population under 18 years	69.4	95423	164.8
Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	66.9	95422	104.3
Age-Adjusted Hospitalization Rate due to Mental Health	hospitalizations/ 10,000 population 18+ years	66	95458	110.8
Age-Adjusted ER Rate due to Adult Asthma	ER visits/ 10,000 population 18+ years	65	95422	109.4
Age-Adjusted ER Rate due to Alcohol Use	ER visits/ 10,000 population 18+ years	56.6	95464	97.5
Age-Adjusted ER Rate due to Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population 18+ years	52.6	95422	87.3
Age-Adjusted ER Rate due to Diabetes	ER visits/ 10,000 population 18+ years	51.3	95485	111.6
Age-Adjusted ER Rate due to Substance Use	ER visits/ 10,000 population 18+ years	41.2	95422	64.4
Age-Adjusted ER Rate due to Dehydration	ER visits/ 10,000 population 18+ years	39.6	95422	61.2
Age-Adjusted ER Rate due to Heart Failure	ER visits/ 10,000 population 18+ years	34	95422	52
Age-Adjusted Hospitalization Rate due to Heart Failure	hospitalizations/ 10,000 population 18+ years	31.8	95458	49.9
Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	hospitalizations/ 10,000 population under 18 years	31.1	95423	130.7
Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia	hospitalizations/ 10,000 population 18+ years	30.6	95422	49.8
Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	29.8	95457	42.9
Age-Adjusted Hospitalization Rate due to Diabetes	hospitalizations/ 10,000 population 18+ years	29.4	95485	73.1

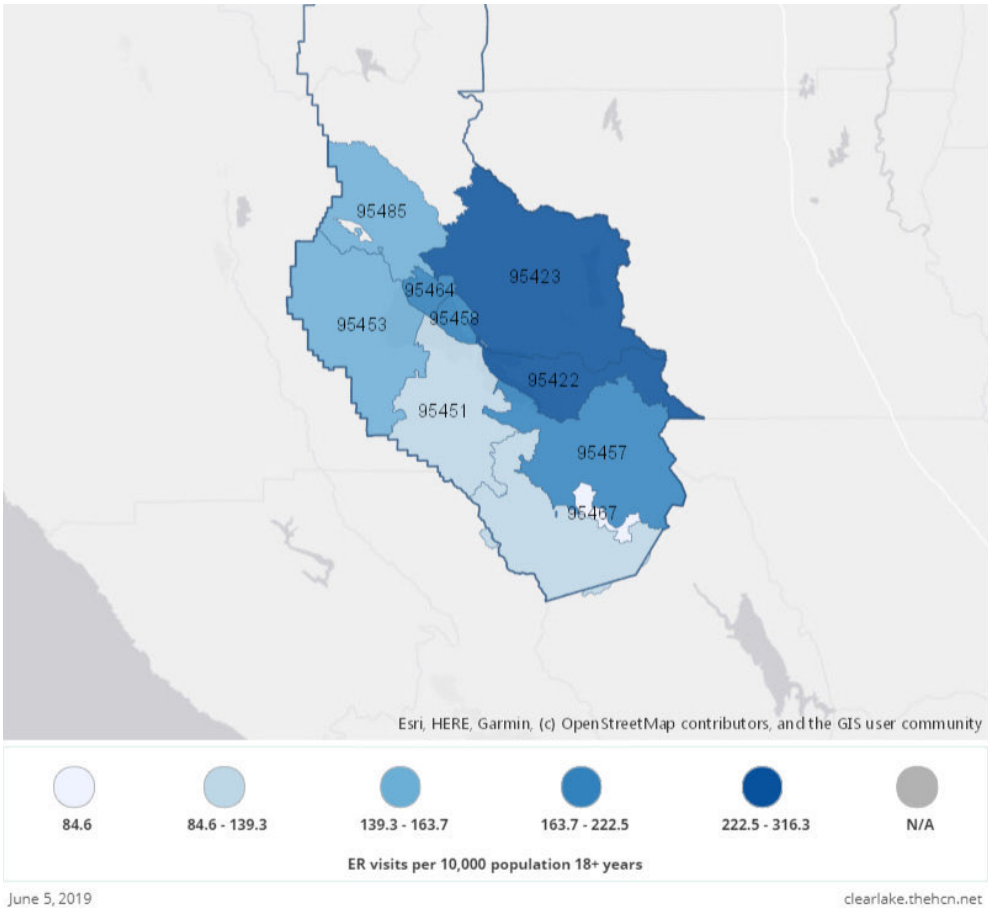
Health Indicator	Units	Lake County Value	Zip Code	Value
Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population aged 12-17	22.1	N/A	N/A
Age-Adjusted Hospitalization Rate due to COPD	hospitalizations/ 10,000 population 18+ years	20.1	95422	34.3
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes	ER visits/ 10,000 population 18+ years	18.6	95485	39.9
Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population 18+ years	17.3	95423	40.6
Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes	hospitalizations/ 10,000 population 18+ years	16	95485	46.7
Age-Adjusted Hospitalization Rate due to Alcohol Use	hospitalizations/ 10,000 population 18+ years	13.4	95426	29
Age-Adjusted Hospitalization Rate due to Dehydration	hospitalizations/ 10,000 population 18+ years	13	95422	20.6
Age-Adjusted Hospitalization Rate due to Urinary Tract Infections	hospitalizations/ 10,000 population 18+ years	12.9	95422	18.7
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	hospitalizations/ 10,000 population 18+ years	12.3	95485	26.5
Age-Adjusted ER Rate due to Short-Term Complications of Diabetes	ER visits/ 10,000 population 18+ years	10.2	N/A	N/A
Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza	ER visits/ 10,000 population 18+ years	9.6	95453	11.3
Age-Adjusted Hospitalization Rate due to Substance Use	hospitalizations/ 10,000 population 18+ years	9.5	95422	15.1
Age-Adjusted Hospitalization Rate due to Adult Asthma	hospitalizations/ 10,000 population 18+ years	9.1	95457	50.5
Age-Adjusted Hospitalization Rate due to Asthma	hospitalizations/ 10,000 population	8.5	95457	39.2
Age-Adjusted ER Rate due to Uncontrolled Diabetes	ER visits/ 10,000 population 18+ years	6.3	95423	13.6
Age-Adjusted Hospitalization Rate due to Hepatitis	hospitalizations/ 10,000 population 18+ years	4	N/A	N/A
Age-Adjusted ER Rate due to Hepatitis	ER visits/ 10,000 population 18+ years	2.7	N/A	N/A
Age-Adjusted Hospitalization Rate due to Hypertension	hospitalizations/ 10,000 population 18+ years	2.4	95422	4.6
Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	hospitalizations/ 10,000 population 18+ years	1.4	N/A	N/A
Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes	hospitalizations/ 10,000 population 18+ years	0.8	N/A	N/A
Age-Adjusted Hospitalization Rate due to Pediatric Asthma	hospitalizations/ 10,000 population under 18 years	6.9	95422	12.9

TABLE 6: NUMBER OF HOSPITALIZATION INDICATORS BY ZIP CODE WITH HIGHEST RATE, CALIFORNIA OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, 2013-2015

ZIP CODE	HOSPITALIZATION INDICATOR COUNT
95426	1
95453	1
95464	2
95458	3
95457	3
95485	5
95423	5
95422	17

Figure 37 shows the Age-Adjusted ER Rate due to Mental Health in Lake County, by zip code. The overall rate in Lake County is 202.7 ER visits per 10,000 population. In comparison, 95422 has the highest rate in Lake County with 316.3 ER visits due to Mental Health per 10,000 population. This indicator had the highest county and zip code rates among all the hospitalization indicators and it had one of the greatest differences — of 113.6 ER visits per 10,000 population — between the overall county value and the highest zip code value. Other zip codes in the upper quartile include 95423 (268.9 ER visits per 10,000 population).

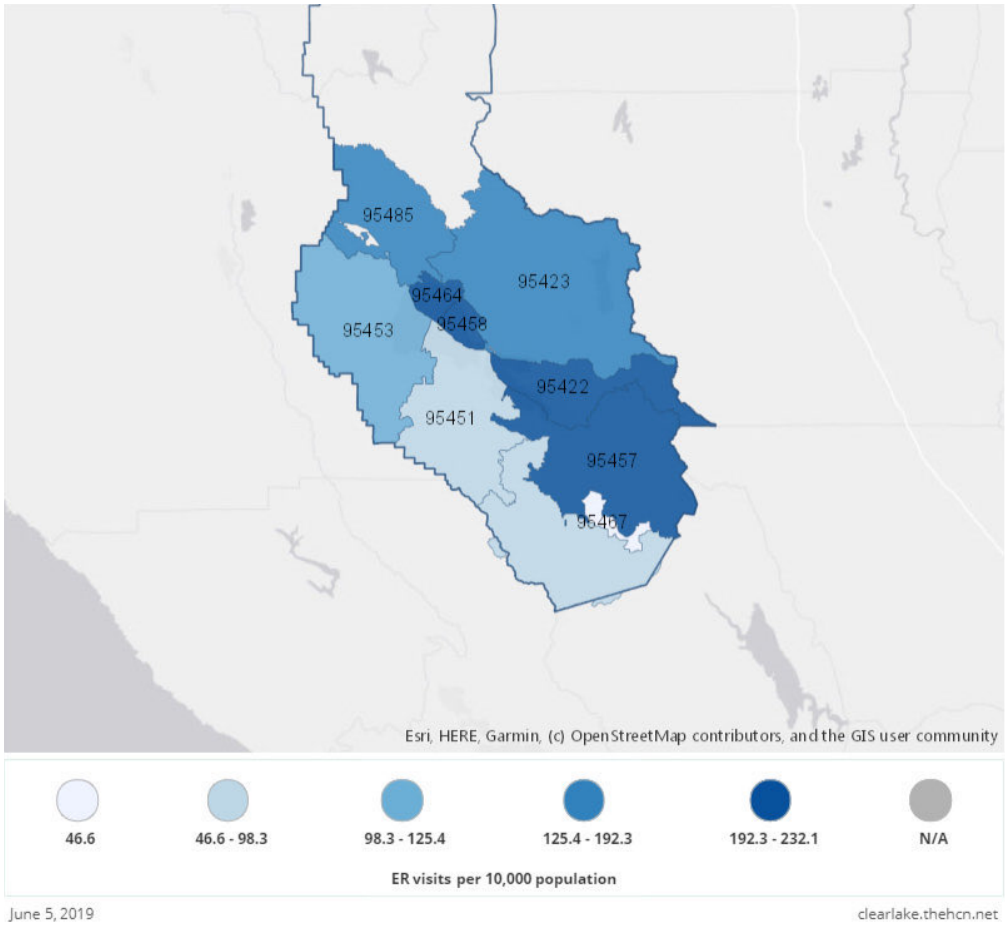
FIGURE 37: AGE-ADJUSTED ER RATE DUE TO MENTAL HEALTH, 2013-2015



Source: California Office of Statewide Health Planning and Development, 2013-2015

Figure 38 shows the Age-Adjusted ER Rate due to Dental Problems in Lake County, by zip code. The overall rate in Lake County is 154.4 ER visits per 10,000 population. In comparison, 95458 has the highest rate in Lake County with 232.1 ER visits due to Dental Problems per 10,000 population. This indicator had one of the largest differences between the overall county value and the highest zip code value of 77.7 ER visits per 10,000 population. Other zip codes in the upper quartile include 93033 (31.7 ER visits per 10,000 population) and 93036 (27.8 ER visits per 10,000 population).

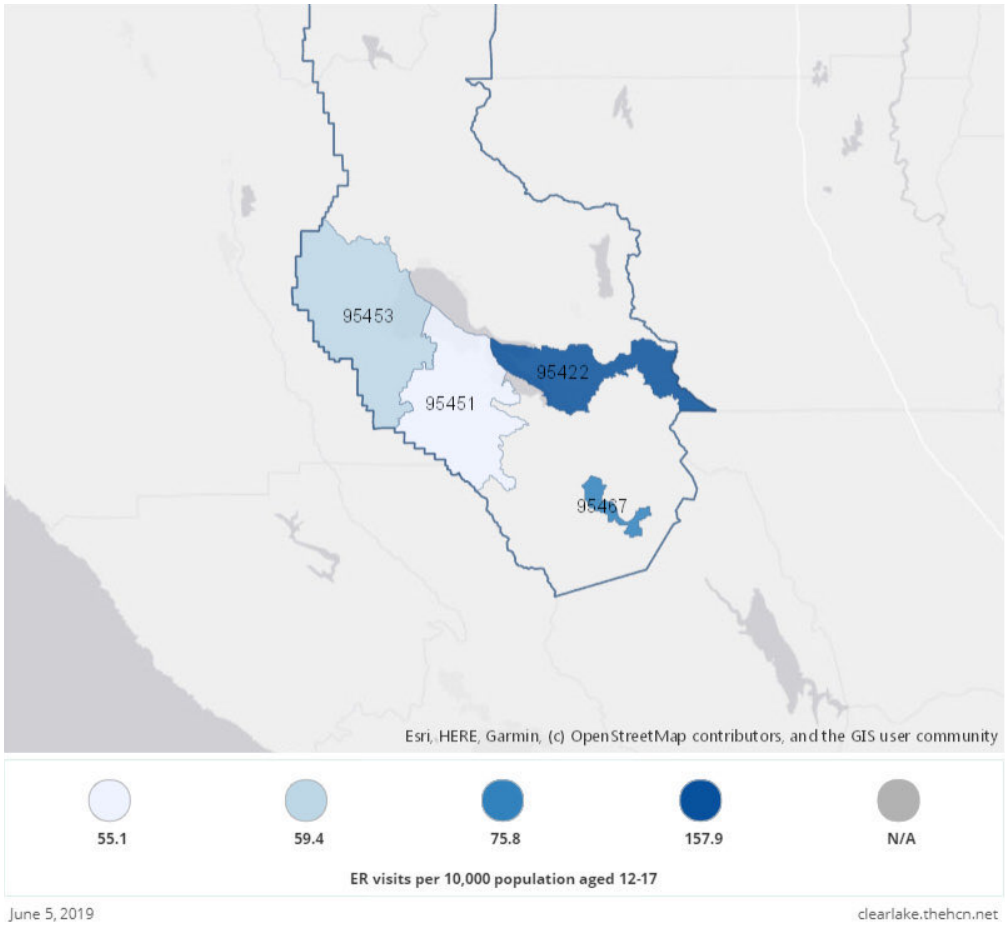
FIGURE 38: AGE-ADJUSTED ER RATE DUE TO DENTAL PROBLEMS, 2013-2015



Source: California Office of Statewide Health Planning and Development, 2013-2015

Figure 39 shows the Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-Inflicted Injury in Lake County, by zip code. The overall rate in Lake County is 91.37 ER visits per 10,000 population in the age group 12-17 years. In comparison, 95422 has the highest rate in Lake County with 157.9 ER visits. This indicator had the highest county and zip code rates among all the hospitalization indicators and it had one of the largest differences between the overall county value and the highest zip code value which is 66.6 ER visits per 10,000 population. Other zip codes in the second quartile include 95467 (75.8 ER visits).

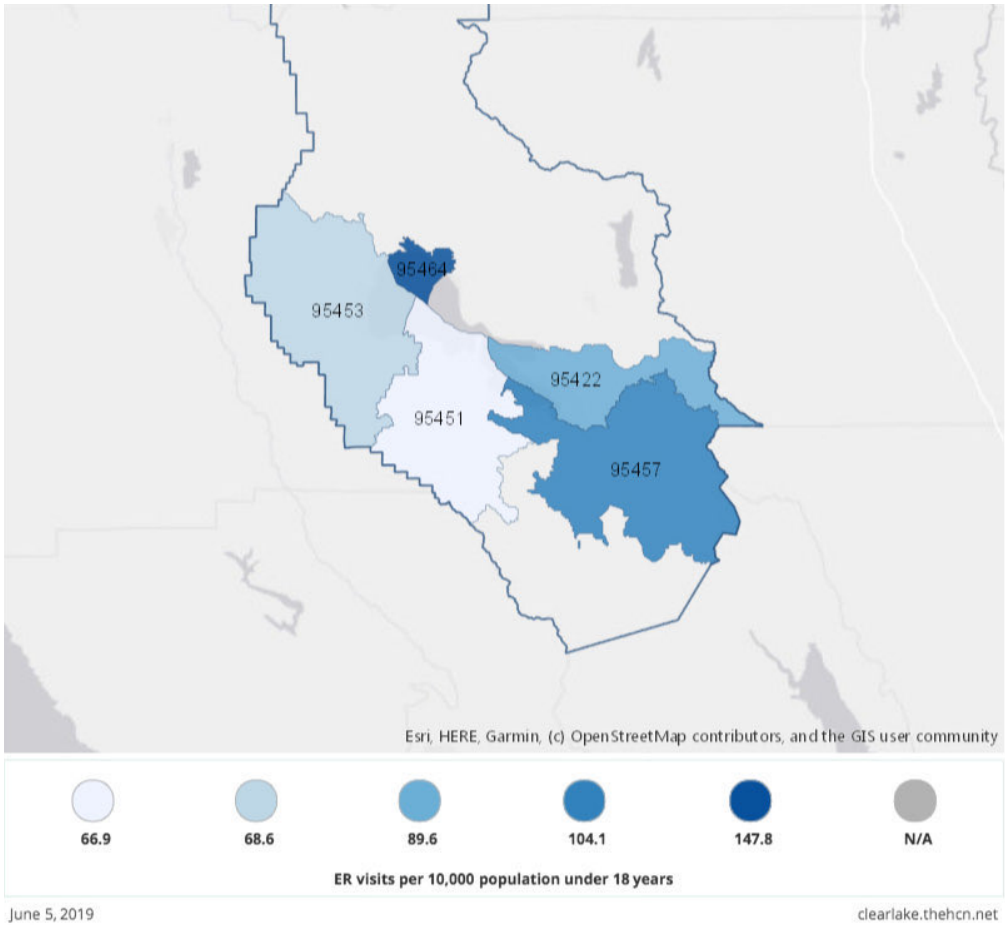
FIGURE 39: AGE-ADJUSTED ER RATE DUE TO ADOLESCENT SUICIDE AND INTENTIONAL SELF-INFLICTED INJURY, 2013-2015



Source: California Office of Statewide Health Planning and Development, 2013-2015

Figure 40 depicts age-adjusted ER rates due to Pediatric Asthma. Reducing exposure to poor housing conditions, traffic pollution, secondhand smoke and other factors impacting air quality can help prevent asthma and asthma attacks. Asthma is a manageable chronic disease for most with proper education, household allergen mitigation and self-management of treatment through inhalers. The overall county value for this indicator is 72.5 ER visits per 10,000 population. The region with the highest ER rate due to asthma is 95464, with a rate of 147.8 ER visits per 10,000 population. Zip codes in the upper quartile also include 93022, (26.7 ER visits per 10,000 population) and 93030 (25.1 ER visits per 10,000 population). In comparison to other indicators, ER rates due to Adult Asthma has the greatest disparity between the overall county value and the highest zip code value. This is indicative of strong disparities in prevalence related to race, access to treatment and mitigation techniques.

FIGURE 40: AGE-ADJUSTED ER RATE DUE TO PEDIATRIC ASTHMA, 2013-2015



Source: California Office of Statewide Health Planning and Development, 2013-2015

4.8 HEALTH PROFILE

Life expectancy is a measure of population's longevity and overall health. Americans born today can expect to live 78.6 years (Kochanek, Murphy, Xu, & Tejada-Vera, 2016); Californians live on an average for 81.5 years. Lake County residents born today can expect to live 74.5 years, 4.1 fewer years than the United States average and 7 fewer years than the state average. The life expectancy in Lake County is the lowest in the state. The life expectancy for Hispanics in Lake County is 80.2 and for Whites is 74.2 years. Life Expectancy takes into account the number of deaths in a given time period and the average number of people at risk of dying during that period, allowing a comparison of data across counties with different population sizes (County Health Rankings and Roadmaps, 2015-2017).

Mortality trends help to drive public health priorities. The 10 leading causes of age-adjusted death in Lake County from 2015-2017 were coronary heart disease, accidents (unintentional injuries), chronic lower respiratory disease, lung cancer, drug induced deaths, cerebrovascular disease chronic liver disease and cirrhosis, Alzheimer's disease, colorectal cancer, and female breast cancer.

Table 7 & Figure 41 compares the leading causes of death in Lake County to those in California and in the United States. It also compares the most recent data to the previous count.

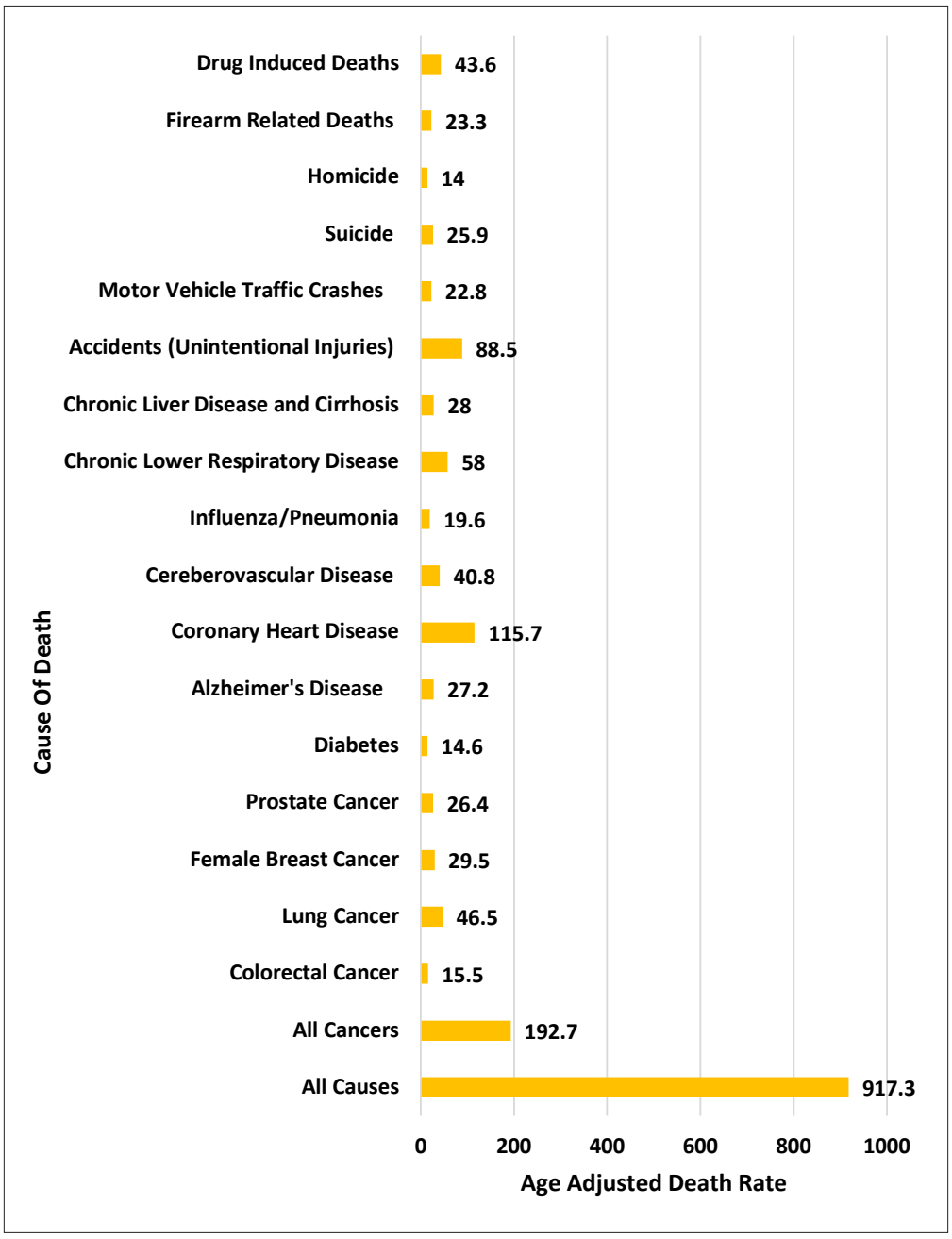
Cancer (combined) is the leading cause of death in both Lake County and California, but heart disease is the leading individual cause of death in the county. Per the National Center for Health Statistics, deaths due to heart disease have been declining since 1985, while deaths due to cancer have been on the rise; cancer is already the leading cause of death in 22 states in America including California. As the population is living longer, more people will be diagnosed with cancer; this is driving some of the shift in the mortality statistics. In Lake County, accidental death due to unintentional injuries is the 3rd leading cause of death. Chronic Liver Disease and Cirrhosis and colorectal cancer at the only two causes of death that have increased over the previous measuring period.

TABLE 7: CAUSE OF DEATHS, LAKE COUNTY, 2014-2016

RANK ORDER	HEALTH STATUS INDICATOR	AGE ADJUSTED DEATH RATE	2014-2016 DEATHS (AVERAGE)	CRUDE DEATH RATE	NATIONAL OBJECTIVE	AGE ADJUSTED CALIFORNIA CURRENT	COUNTY DEATH RATE PREVIOUS
58	All Causes	917.3	843.3	1,293.90	-	608.5	938.4
57	All Cancers	192.7	190.7	292.5	161.4	140.2	195.1
50	Coronary Heart Disease	115.7	109.7	168.3	103.4	89.1	131.6
57	Accidents (Unintentional Injuries)	88.5	65.3	100.2	36.4	30.3	86.8
52	Chronic Lower Respiratory Disease	58	59.7	91.5	a	32.1	71
55	Lung Cancer	46.5	47.7	73.1	45.5	28.9	53.1
58	Drug Induced Deaths	43.6	30.3	46.5	11.3	12.2	41.3
42	Cerebrovascular Disease	40.8	38.7	59.3	34.8	35.3	48.4
57	Chronic Liver Disease and Cirrhosis	28	24	36.8	8.2	12.2	21.5
23	Alzheimer's Disease	27.2	26.7	40.9	a	34.2	30.4
53	Colorectal Cancer	15.5 *	15.7	24.0 *	14.5	12.8	15
56	Female Breast Cancer	29.5 *	14	43.0 *	20.7	19.1	19.9 *
50	Prostate Cancer	26.4 *	12	36.8 *	21.8	19.6	23.2 *
15	Diabetes	14.6 *	14.7	22.5 *	b	20.7	18.6 *
54	Influenza/ Pneumonia	19.6 *	19	29.2 *	a	14.3	20.9 *
54	Motor Vehicle Traffic Crashes	22.8 *	15	23.0 *	12.4	8.8	25.8
53	Suicide	25.9 *	18.7	28.6 *	10.2	10.4	25.7 *
55	Homicide	14.0 *	8.3	12.8 *	5.5	5	9.4 *
54	Firearm Related Deaths	23.3 *	15.7	24.0 *	9.3	7.6	15.3 *

*Source: California Department of Public Health; *some of the rates presented are deemed unreliable based on fewer than 20 data elements*

FIGURE 41: AGE-ADJUSTED DEATH RATE, LAKE COUNTY



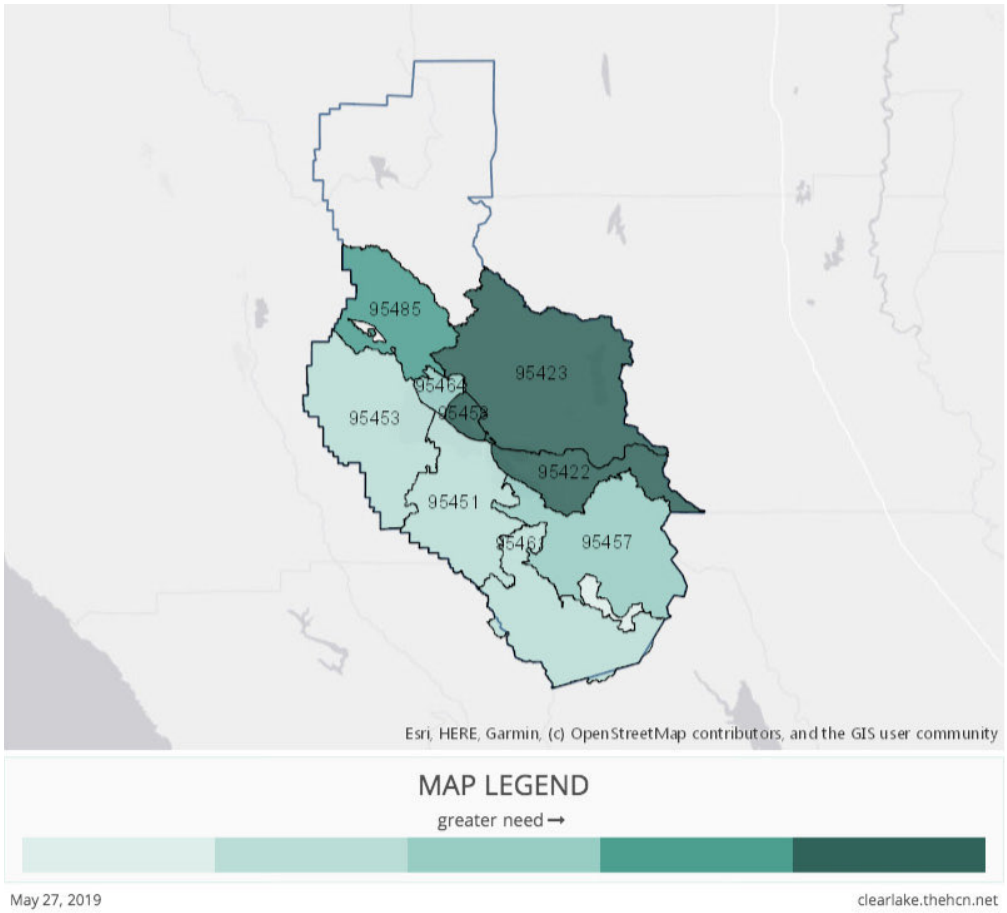
SECTION 5

DISPARITIES

5.1 SOCIONEEDS INDEX®

All communities can be described by various social and economic factors that are well known to be strong determinants of health outcomes, as discussed previously. Healthy Communities Institute developed the SocioNeeds Index® to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for six different social and economic determinants of health — income, poverty, unemployment, occupation, educational attainment, and linguistic barriers — that are associated with poor health outcomes including preventable hospitalizations and premature death. Within Lake County, zip codes are ranked based on their index value to identify the relative levels of need. Those geographic areas with the highest values (from 0-100) are estimated to have the highest socioeconomic need which can be correlated with preventable hospitalizations and premature death (Conduent HCI, 2019). Figure 42 shows that Clearlake (95422), Lucerne (95458), and Clearlake Oaks (95423) are the areas within the county that have the highest socioeconomic needs.

FIGURE 42: SOCIONEEDS INDEX, LAKE COUNTY, 2019



Source: Conduent Healthy Communities Institute, 2019

5.2 INDEX OF DISPARITY

Critical components in assessing the needs of a community are identifying barriers and disparities in health care. Additionally, the identification of barriers and disparities will help inform and focus strategies for addressing the prioritized health needs for Lake County. Healthy Communities Institute developed the Index of Disparity, a tool used to summarize disparities across groups within a population across all indicators.

The tables below identify secondary data health indicators with racial or ethnic disparities in Lake County. Table 8 lists the indicators with the greatest, statistically significant race/ethnicity disparities and highlights the groups that were impacted.

Table 9 displays the number of significant health indicators for each race/ethnic group. Black and African American populations are most negatively impacted in Lake County, with disparities in 14 indicators. This is followed by the American Indian / Alaska Native, which has disparities in 10 indicators, and the Hispanic/ Latino population, with disparities in 7 indicators.

Upon further examination, the Black and African American population is predominately affected in topics related to poverty, diabetes, asthma, heart disease and nutrition. Among the significant health indicators, Age-Adjusted ER Rate due

to Adult Asthma has the highest disparity in Black or African American individuals, with 207.6 ER visits per 10,000 population. This is in comparison to the Lake County rate of 65 ER visits per 10,000 population. The American Indian or Alaska Native population is affected in topic areas such as poverty, diabetes, asthma, heart disease. Among the significant health indicators, Age-Adjusted ER rate due to Adult Asthma had the greatest disparity, with 65.9 ER visits per 10,000 population in the American Indian or Alaska Native Population. This is compared to the overall Lake County value of 65 ER visits per 10,000 population. The Hispanic or Latino population is affected in topic areas such as poverty, diabetes, asthma and nutrition. This population had the greatest disparity in the health indicator Adult Fast Food Consumption. 82.7% of Hispanic or Latino teens reported eating fast food in Lake County, compared to the overall county value of 48.5%.

TABLE 8: INDICATORS WITH SIGNIFICANT RACE/ETHNIC DISPARITIES, 2013-2015

SUBGROUP WITH MOST DISPARITIES	
Health Indicator	**Groups with Disparities**
Families Living Below Poverty Level	Black, Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, Multiple Races, Other Race, Hispanic or Latino
People Living Below Poverty Level	Black, Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, Other Race, Hispanic or Latino
Substantiated Child Abuse Rate	Black, American Indian or Alaska Native, Asian or Pacific Islander
Adults with Diabetes	Hispanic or Latino
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes	Black, American Indian / Alaska Native, Hispanic / Latino
Age-Adjusted Hospitalization Rate due to Diabetes	Black, White, American Indian / Alaska Native
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	Black, American Indian / Alaska Native
Age-Adjusted Hospitalization Rate due to Asthma	Black, Hispanic / Latino
Age-Adjusted ER Rate due to Asthma	Black, White, American Indian / Alaska Native, Asian / Pacific Islander
Age-Adjusted ER Rate due to Adult Asthma	Black, White, American Indian / Alaska Native
Age-Adjusted Hospitalization Rate due to Adult Asthma	Black, Hispanic / Latino
Adult Fast Food Consumption	Black, Multiple Races, Hispanic / Latino
Adults Who Are Obese	Black
Age-Adjusted ER Rate due to Heart Failure	Black, American Indian / Alaska Native
Age-Adjusted ER Rate due to Hypertension	Black, American Indian / Alaska Native
Adults Who Ever Thought Seriously About Committing Suicide	White, Multiple Races

TABLE 9: COUNT OF DISPARITIES PER POPULATION SUBGROUP, 2013-2015

SUBGROUP WITH MOST DISPARITIES	
Race/Ethnicity Group	Health Indicator Count
Black	14
American Indian / Alaska Native	10
Hispanic / Latino	7
White	4
Native Hawaiian / Pacific Islander	2
Multiple Races	3
Other Races	2
Asian	2

SECTION 6

PRIMARY DATA COLLECTION FOR COMMUNITY INPUT

6.1 COMMUNITY SURVEY

The source of all the figures included in this section is the Lake County Community Health Assessment Survey (2019), designed by Conduent HCI and disseminated by the partner members of the Hope Rising Lake County Community Health Needs Assessment Collaborative. A total of 708 responses were collected. The sample size met the conditions of 95% confidence interval and had a margin of error of 3.7%. This was a convenience sample, which means results may be vulnerable to selection bias. The results are generalizable to the population of Lake County.

According to key findings of the community input survey conducted, drug abuse was a county-wide health priority reported by populations across gender, age, and income groups. Mental health, alcohol misuse, and housing were pervasive in their impact and remained important priorities as well. Almost 56% of survey participants reported being sad or worried or finding day to day life difficult and were unable to function. Approximately one third of participants said lack of specialists prevented them from seeking healthcare. Costs of care and unavailability of appointments were also barriers. Connections to organizations that provide social needs and social support was a high demand from hospitals. Easy-to-follow instructions and having staff that could communicate in their language were areas of suggested improvements. Support and rehabilitation services for people who were re-entering communities after de-addiction, prison, or mental health treatment was the most needed service in the county. Almost 83% stated programs that provided job training to young people were very important; 73% stated programs for youth like Big Brothers, Big Sisters were strongly needed.

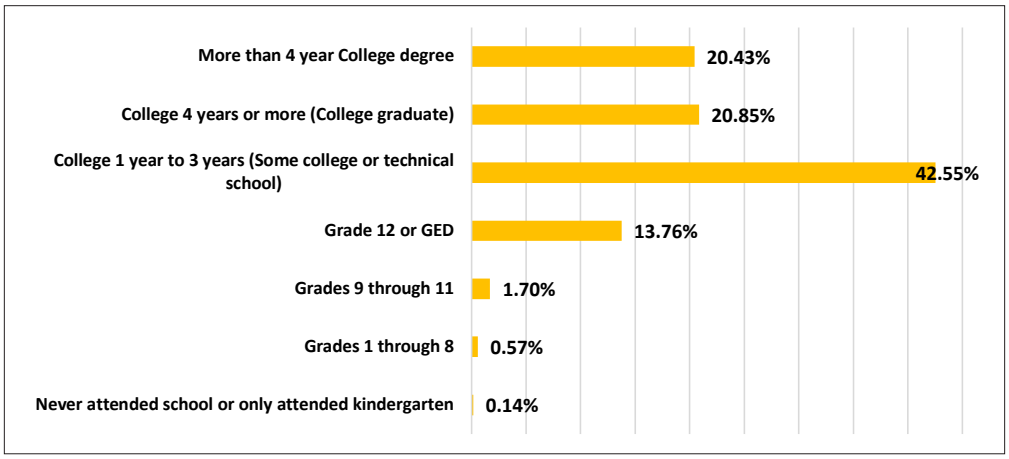
Profile of Survey Participants

Of the total survey participants, 98.8% (696) spoke in English at home and 8.1% (57) were Spanish speakers. Survey participants were more likely to be female than male (78.4% female versus 20.4% male), have annual household incomes above $50,000 (59.5%) and have 1-3 years of education (42.5%). The bulk of the survey participants were of White/Caucasian (79.6%) while the remainder were of Hispanic or Latino, American Indian or Alaskan Native, and Black or African American race/ethnicity (10.8%, 2.2%, and 0.57% respectively). The survey was able to reach most of the age-groups equally. Four different age groups (25-34, 35-44, 45-54, and 55-64) had nearly 20% representation in this survey with the highest group being 55-64 year olds at 22.2%. This is in keeping with the age profile of the community which has an older median age than the state average. The two age groups — 18-24 year olds (4%) and 75+ year olds (2.4%) — constituted the rest of the participants. Regarding regular healthcare, 73.3% of the survey participants have a regular physician; 12.26%

do not receive routine healthcare or use urgent care or Emergency Rooms (ER). Most of the participants have insurance coverage; 93.9% pay for health care with their insurance, 19.7% have Medi-Cal or Medicare and 6.61% pay with cash or other methods.

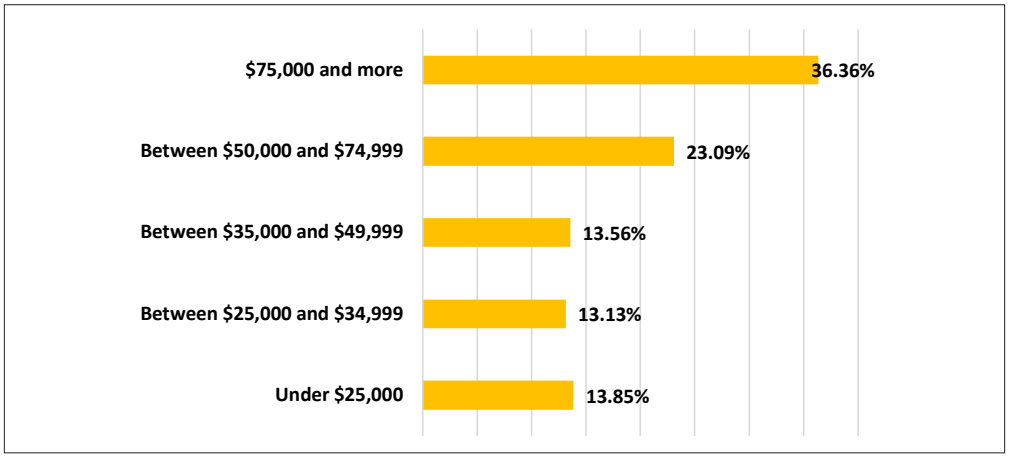
Figure 43 below shows the breakdown of survey participants by education attainment. Over 80% of the participants had achieved an education level higher than 1-3 years at college. The most had attended some college or technical school in the past (42.6%), followed by graduation with a college degree (at 20.9%), or an advanced degree (at 20.4%). The remaining participants included those who only had a high school diploma or GED (at 13.8%), and those who had less than a high school education, which was less than 3%.

FIGURE 43: EDUCATION ATTAINMENT OF SURVEY PARTICIPANTS



Nearly 60% of participants had total household income levels of greater than $50,000 (Figure 44). Those earning $75,000 or more had the greatest representation in this survey (36.4%), followed by those earning between $50,000 and $74,999 (23.1%). The following three income groups (those earning under $25,000, those earning between $25,000 and $34,999, and those earning between $35,000 and $49,999) each represented roughly 13% of all survey participants.

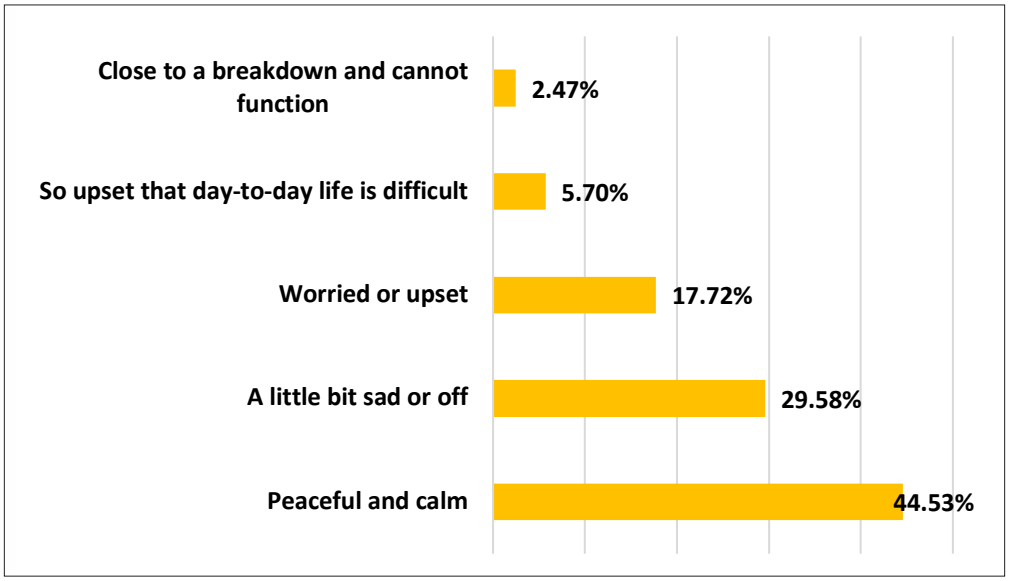
FIGURE 44: TOTAL HOUSEHOLD INCOME OF SURVEY PARTICIPANTS



The survey participants were asked to self-report on their physical and mental health. Perception of personal health is indicative of the quality of life in the community. About 75% of survey participants stated their physical health as either good (at 34.1%), very good (at 31%), or excellent (at 11.8%) in the past 30 days. Only 6% of participants stated their health to be poor, while 17.2% stated their health to be fair in the past 30 days.

However, the percentage of participants that reported poor mental health was higher (55.47%) than those that reported no mental health problems. Nearly 45% of survey participants felt mostly peaceful or calm in the past 30 days, encompassing the largest proportion of survey participants. However, 30% of participants mostly felt a little bit sad or off, while 17.7% of survey participants felt mostly worried or upset in the past 30 days. Approximately 2.5% of survey participants felt close to a breakdown or could not function in the past 30 days (Figure 45).

FIGURE 45: MENTAL HEALTH OF SURVEY PARTICIPANTS IN LAST 30 DAYS



Key Findings

To understand the priority the survey participants placed on health in comparison to other issues that govern their life, they were asked what they worried about in the past 12 months. Nearly half of survey participants selected cost of utilities at 46.9%. In addition, roughly a third of survey participants selected the following issues as those that worried them in the past 12 months — cost of health care (35.6%), illegal and prescription drugs in the community (33.7%), and crime/violence (30.9%). Moreover, nearly a quarter survey participants also selected housing (27.4%) and employment availability (23.3%) as worrisome issues. Only 2.2% of survey participants selected lack of assistance with completing daily activities as an issue that worried them in the past 12 months.

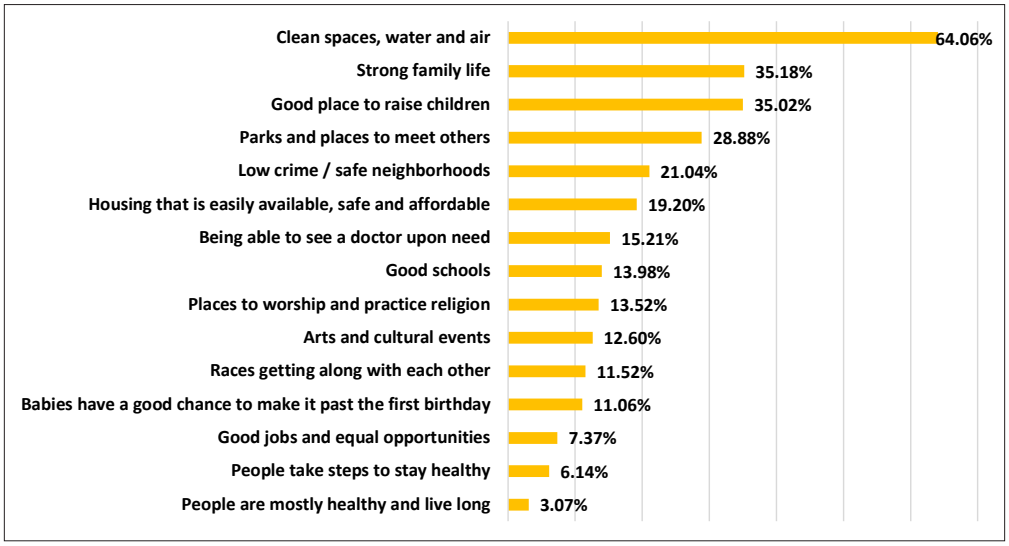
When asked to select three services that were needed more in Lake County, support for people re-entering communities after addiction, prison or mental health treatment was selected the most, by 43.9% of survey participants. The next three services that were selected by roughly a third of survey participants included job training or employment camps (36.2%), housing aid (35.7%), and crises and

counseling centers (33.9%). Survey participants also selected from several given examples of free resources as those that were needed in Lake County; these included free classes that teach people how to manage diseases (19.2%), free community exercise classes (18.4%), and free screenings and vaccinations (11.8%). Services of need that were selected the least by survey participants included programs to help stop smoking (8.4%) and meal assistance (8.2%).

Survey participants were asked to choose the three most important factors that make Lake County a good place to live. Figure 46 below show the top responses. Clean spaces, water and air received the most selections (at 64.1%), followed by a strong family life and being a good place to raise children (at roughly 35% each). Two other issues that were selected frequently by survey participants were parks and places to meet others (28.9%) and low crime/ safe neighborhoods (at 21%).

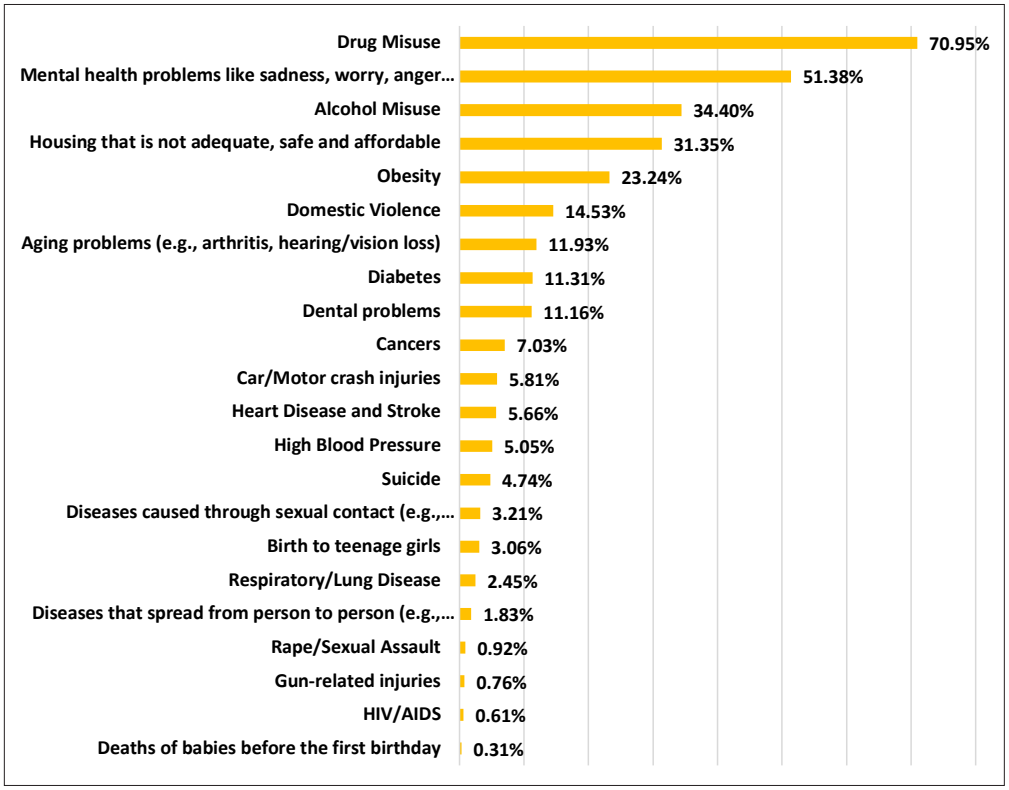
Issues that were clearly not salient features of the county were selected by only 10-16% of survey participants including being able to see a doctor upon need, good schools, places to worship and practice religion, arts and cultural events, races getting along with each other, and babies having a good chance to make it past their first birthday. Notably, the two issues that received the fewest selections were directly health-related - people take steps to stay healthy (at 6.1%) and life expectancy in Lake County, which is people are mostly healthy and live long (at 3.1%).

FIGURE 46: THE FACTORS THAT MAKE LAKE COUNTY A GOOD COMMUNITY ACCORDING TO SURVEY PARTICIPANTS



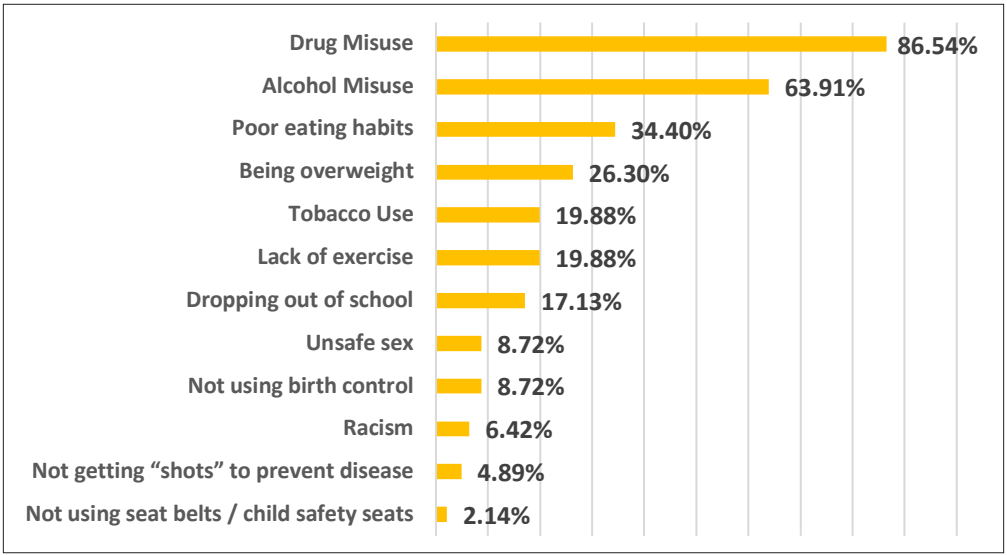
Survey participants were asked to choose the three most important health problems facing residents in Lake County (Figure 47). By far, drug misuse was selected the most participants (71%). Mental health was chosen by nearly half of the survey participants, while alcohol misuse and inadequate housing were selected by nearly a third of survey participants at 34% and 31%. Other issues that were selected frequently included — obesity (23.2%) and domestic violence (14.5%). Aging, diabetes, and dental problems were each selected by roughly 11% of survey participants. Conversely, less than 1% of survey participants selected rape/ sexual assault, gun-related injuries, HIV/ AIDS, or deaths of babies before their first birthday as the most important health problems in Lake County.

FIGURE 47: MOST IMPORTANT HEALTH PROBLEMS IN LAKE COUNTY ACCORDING TO SURVEY PARTICIPANTS



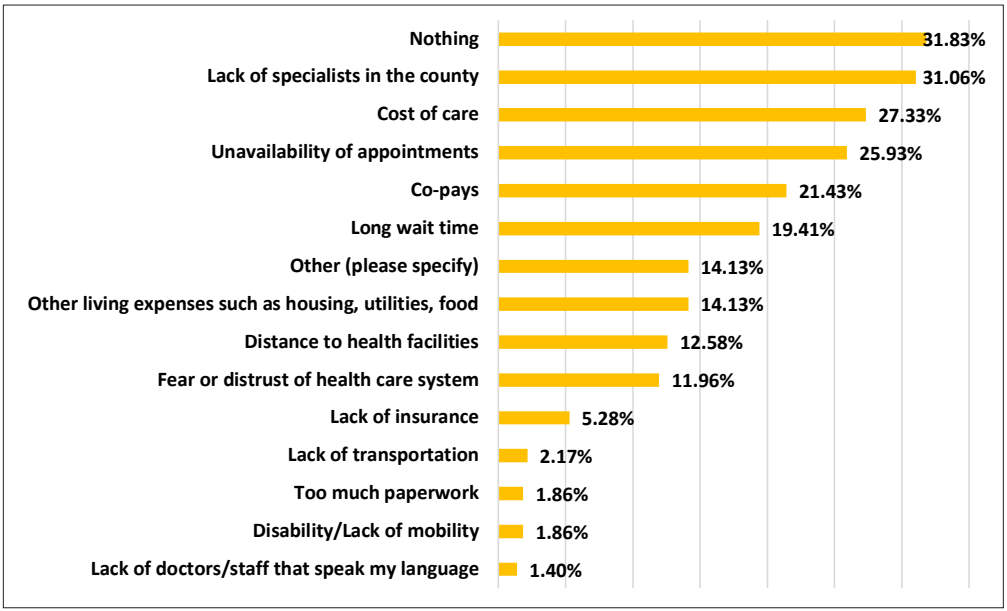
Participants were asked to select the three most important risky behaviors that have the greatest impact on the overall health of Lake County (Figure 48). Like in the previous question, drug misuse was selected by the vast majority of survey participants (86.5%), followed by alcohol misuse (63.9%). The next three issues receiving the most selections were obesity-related and included poor eating habits (34.4%), being overweight (26.3%), and lack of exercise (19.9%). Tobacco use was reported by 19.9% survey participants along with dropping out of school (17.1%). Conversely, less than 7% of survey participants selected racism, not getting shots to prevent disease, or not using seat belts as the most important risky behaviors in Lake County.

FIGURE 48: IMPORTANT RISKY BEHAVIORS THAT IMPACT HEALTH IN THE COUNTY ACCORDING TO SURVEY PARTICIPANTS



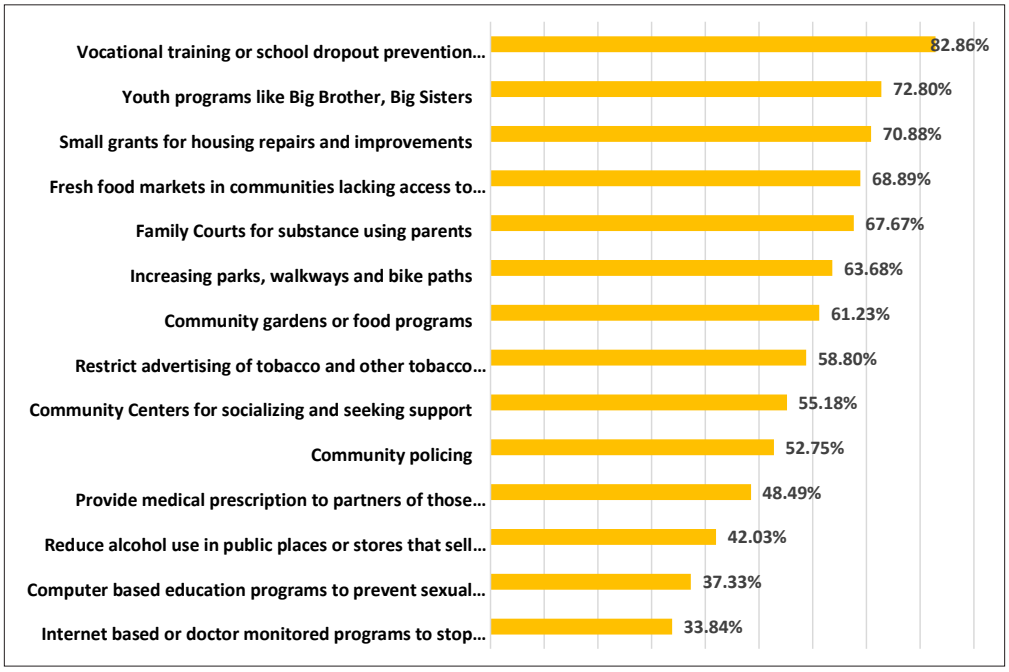
Survey participants were asked about their barriers to seeking health care (Figure 49). "Nothing" was selected most frequently by 31.8% but a lack of specialists in the county (31.1%) was selected by almost the same percentage. Other reasons that received selections from greater than 20% of survey participants were cost of care (27.3%), appointment unavailability (25.9%), and co-pays (21.4%). Long wait times (19.4%) and having a fear or distrust of the health care system (12%) were the other important barriers to healthcare reported by survey participants. Issues that received the fewest responses were— lack of transportation (at 2.2%), disability (at 1.9%), too much paperwork (at 1.9%), and lack of doctors/staff who speak in their language (at 1.4%).

FIGURE 49: REASONS FOR NOT SEEKING HEALTHCARE ACCORDING TO SURVEY PARTICIPANTS



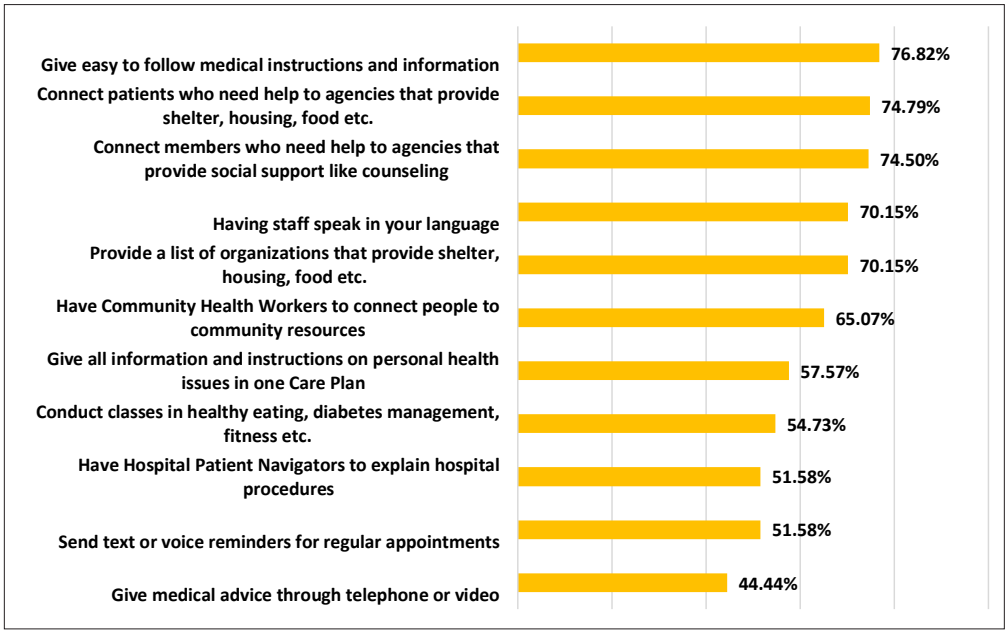
Survey participants were asked to rate the importance of programs that could tackle some of the health challenges of Lake County. Of all the programs, vocational training or dropout prevention programs for high risk students was 'very important' (82.9%), followed by youth programs like Big Brothers, Big Sisters (72.8%). Several programs were rated as 'very important' by 60-71% survey participants including—small grants for housing repairs (70.9%), fresh food markets (68.9%), family courts for substance using parents (67.7%), increasing parks, walkways and bike paths (63.7%), and community gardens or food programs (61.2%). Programs that were seen as 'very important' by the least percent were computer based education programs to prevent diseases passed through sexual contact (37.3%) and Internet based or doctor monitored programs to stop smoking with medicines or counseling (33.8%).

FIGURE 50: 'VERY IMPORTANT' PROGRAMS NEEDED TO ADDRESS CURRENT HEALTH CHALLENGES ACCORDING TO SURVEY PARTICIPANTS



Survey participants were asked to rate the many strategies or activities that local hospitals could implement to improve their quality of service to people of Lake County (Figure 51). After weighting the scores, the following three strategies had the highest weighted scores of 1.7 — giving easy to follow instructions and information, connecting patients who need help to agencies that provide shelter, housing, and food, and connecting members who need help to agencies that provide social support like counseling. The issues receiving the lowest weighted scores of 1.2 were having hospital patient navigators to explain hospital procedures, and giving medical advice through telephone or video.

FIGURE 51:'VERY IMPORTANT' SERVICES THAT AREA HOSPITALS COULD DELIVER TO IMPROVE ACCORDING TO SURVEY PARTICIPANTS



6.2 KEY INFORMANT AND FOCUS GROUP DISCUSSION FINDINGS

One of the key objectives of this assessment was to engage the community, including vulnerable populations, physicians, and other service providers to share their perceptions on health needs for Lake County residents. Key informant interviews and focus group discussions helped to develop a deeper understanding for the reasons behind the health data seen in the previous sections. It served also to identify the high priorities for Lake County stakeholders. In the case of the key informants, the interviews touched upon many issues that were specific to their area of work, especially with vulnerable populations, whereas the focus group discussions with community members focused on age, race and/or gender issues related to accessing healthcare and barriers to access. Any findings, arising from the interviews and group discussion that pertain to prioritized health needs are discussed in SECTION 7: Data Synthesis and Prioritization.

Though Lake County was known widely to rank at the bottom of state county health rankings, key informants and community members expressed the sentiment that the county was changing for the better. The county was acknowledged to be close-knit, with a sense of pride and resilience that had seen the community through multiple fires and other natural disasters. One of the positive forces of change in recent times was the increased awareness of the county's poor health status and the increased attention by agencies like Wellville that brought fresh perspectives and resources to the county. Most people were hopeful that with new leadership and cross-sectional collaboration among agencies, the county outcomes were going to improve in the near future.

Among all key informants and group discussion members that issue that was high concern, cross-cutting and with the widest reaching implications was Barriers to Healthcare. It is discussed below in detail.

6.2.1 BARRIERS TO UTILIZING HEALTH CARE

Focus group participants and key informants reported many instances of county residents being unable to access healthcare in a timely manner, get the full range of services that they needed within the county, and get quality service which included an understanding of their cultural beliefs. Barriers mentioned by the participants are discussed below:

Lack of Specialists and Appointments

By far, the barrier to access that was mentioned with the highest frequency and the greatest intensity by all participants was the lack of specialists in the county. Because the county has fewer number of specialists and other providers, the long wait time for appointments either dissuaded patients from following up, forced them to access emergency rooms in case of acute health needs, or had them travel out of the county. To quote a focus group participant:

All these factors caused emotional and financial distress for patients and their families. The unavailability of providers and lack of timely care was mentioned by focus group participants and key informants as an issue that affected all county residents equally; it had less to do with income or coverage related disparities and more to do with the dearth of physicians. The lack of nephrologists and psychiatrists in the county was mentioned repeatedly and felt most acutely.

"We can't get referrals for anything but the big cities"
—Older Woman group participant

"You need three months to get into the clinic because it's so back-logged"
—Physician

"There are wealthy people that need mental health and indigent people who need mental help here and they both have problems accessing it"
—Hospital Physician

Quality of Care

Low face time with the doctor per patient, on top of prolonged wait times, had an effect of adding to patient dissatisfaction with the quality of care being received. Even when an appointment was made, the time spent by physicians on delivering care was not perceived to be sufficient, leaving the patient feeling as if they had not been heard and had passed through a revolving door at the physician office. Providers had their own compulsions because of the press of patients that they had to see to meet the demand.

"Quality of it is challeng-ing once you get in the door because of the (few) number of providers"
—Hospital Physician

Lack of Services

The capacity of the health care system in Lake County to provide services for all the needs of the county was cited to be insufficient; this was most true for dialysis and mental health related services. While acknowledging an improvement over the past few years, gaps in services and a lack of coordination between providers was still reported.

"If you want a specialist, the county is not there yet"
—Older Woman group participant

"You reach out for services and they don't send you help. I know people are calling but no one is calling back, so it's hard"
—Tribal Member

Transportation

Travel in Lake County was acknowledged by all to be challenging because of the terrain, the road conditions, and the Lake in the middle dividing the county into disconnected areas. Lake County Transit offers service on 6 routes within the county, but due to the distances and the frequency of service, transportation was one of the greatest challenges reported by County residents.

Given that most healthcare providers were located near Clearlake or Lakeport, this made physical access to healthcare providers difficult for residents of zip codes that were further away. The distance was felt acutely by certain minority communities and by the elderly and disabled as it was compounded by factors such as not having reliable personal vehicles or an ability to drive long distances. Often families are able to access gas funds but don't have a vehicle. Many participants mentioned that the low frequency of public transportation modes as well as lack of ride-share services (like Uber or Lyft) in the county were additional barriers. Local transportation in Lake County were reported to be underfunded and fluctuate in availability. Access to primary care was not mentioned as much in this regard as specialty care was.

"We keep bad things out, but don't get a lot of good things in because of the inaccessibility to Clear Lake"
—Hospital Physician

"When people have no transportation and they need to go two counties over for an appointment, they stay undiagnosed"
—Tribal Council Member

Cost of Healthcare

There were several ways in which health coverage and accessing healthcare imposed financial stress on community members. While most participants had health coverage, either private or public, the high cost of health was felt through co-pays for procedures and treatments, cost of medication, cost of travel to provider, not having paid leave and loss of pay due to the time it took to be seen by a physician. This was especially true for those populations that were indigent or vulnerable and that had the least ability to absorb the financial burden.

The implications of not accessing care regularly due to cost of care — that there was a likelihood of poor health status or being diagnosed later — were known to group participants but not feared. There was a degree of optimism that whatever was in store would still be treatable at a later stage.

"People are not making enough money to be able to use their healthcare insurance"
—Practice Manager

Limited Clinic Hours

A common refrain among group discussion participants was that they wanted clinic to have extended hours of service beyond normal office hours.

The assessment revealed that there had been instances of hospital systems and providers offering extended clinic hours in Lake County, only to close them again because of under-utilization. This does not imply that the practice was unsuccessful; rather that it was likely abandoned before the extended hours became known widely to the patient population.

"We need a facility to offer services that is going to be open after hours and on weekends for families"
—County Government Official

Lack of Urgent Care Facilities and Trauma Care

One of the service gaps in the county was the absence of urgent care facilities and trauma care. As a result any treatment outside minor injuries, for accidents or major injuries, required patients to be flown by helicopter service to other counties. Similarly, the lack of urgent care meant that when county residents required ambulatory care for minor illnesses that needed immediate treatment but were not able to get a same-day appointment from their regular physician or needed care after hours, they were forced to go to the emergency room of hospitals.

Lack of Information regarding Coverage

Both low literacy and low health literacy were stated as barriers in the utilization of health benefits by county residents. Key informants reported that though the Medicaid expansion had resulted in the enrollment of many hitherto uninsured individuals in the county, there was no education of enrollees that had ensued, leaving them unaware and unable to use the benefits conferred to them. This resulted in clients losing out on free preventive care such as annual check-ups, screenings and vaccinations. Further, undocumented immigrant children became eligible for Medi-Cal in 2016, but this was not a widely known provision.

"New inductees into Medi-Cal have no knowledge that they are covered or of coverage"

—Practice Manager

Lack of Culturally Sensitivity

According to minority leaders and community members, Lake County's cultural diversity has gone unrecognized or been ignored by healthcare. Western medicine practices were said to be at odds sometimes with traditional medicines, beliefs and practices of minorities like Native tribes and immigrants from south of the border. Unless these differences are taken into account, these interviewees claimed that healthcare did not have a good chance of positively affecting health outcomes for these groups. Physicians were reported to perceive minorities as unhealthy and/or unable to follow medical instructions without understanding that these populations were governed by generations-old traditions. For instance, tribal community stated having fried bread as a staple and Hispanics subsist on rice and beans. They found it difficult to change their food habits even upon receiving a diagnosis of diabetes. Having physicians display cognizance of the patients' cultural beliefs before giving treatment was felt to be a necessary first step in influencing patient behavior.

"Because elders in the tribe did not want to go on insulin, they waited until it got worse, then went on insulin and died because they waited too long. So now people think that insulin and death are connected"

—Tribal Member

"Doctors have to do a lot of one on one work to gain trust of the people and then take small steps to help with diabetes and obesity. Can't just do everything at once"

—Hispanic Consortium Member

Lack of Culturally Competent Care

Another aspect of diversity was the language in which healthcare was delivered; language provided significant challenges to providers as well as patients. According to a Hispanic key informant, language was a major barrier to accessing healthcare because the patients did not felt as though they were heard or understood in their interactions with doctors that did not speak their language.

"Because we have had a lot of doctors coming in, it might just be that they are not 'bought-in' to our community. When doctors can speak their language, patients feel safe"

—Hispanic Consortium Member

Lack of Insurance

Some of the most indigent populations in the county were reported to be the undocumented immigrants that worked as agricultural workers and other low paying professions in the county. California has coverage for pregnant women and children who are undocumented but had no provision to cover men or elderly till very recently. Many undocumented workers in Lake County, who might otherwise have qualified for Medi-Cal based on their income, were thus ineligible for health insurance due to immigration status. Among undocumented workers there is also the fear of utilizing government services or enrolling for coverage for fear of deportation. Difficulty navigating enrollment processes and procedures was an additional barrier.

Another large group of people that was cited as not being covered by health insurance in Lake County were young adults whose parents were unemployed, on public assistance or had no coverage themselves. While these young adults were eligible to purchase coverage, they did not either qualify for federal Affordable Care Act (ACA) subsidies to bring down the cost of their premiums or could not afford the cost of deductibles. Cost is the biggest barrier cited by health providers to this group obtaining coverage. Other factors that were reported to contribute for lack of coverage were the high rate of unemployment in this age group, employment in low paying jobs, inter-generational poverty and a family tradition of reliance on public assistance.

"They need to stop looking at people like anybody who is an immigrant is costing us something. We need sliding fee scale for them"

—Hispanic Consortium Member

Lack of Health Plan Options

Individuals covered by health insurance in Lake County reported dissatisfaction with their coverage. One of the problems was lack of options offered by employer so that competitive rates could not be obtained and premiums were claimed to be higher than other counties. Another associated problem was the lack of in-network providers in the county so that members were forced to travel to neighboring counties for regular care.

"Our insurance does not allow us to see any dentists in the area so we have to travel to outside the county to get preventive care. Even people who are highly motivated to get care are discouraged because we have to leave the county to access the care"

—Government Service Provider

Misclassification of Disease

Due to the lack of services and specialty care in the county, focus groups and key informants reported a force-fitting of diagnoses that sometimes took place and that resulted in inaccurate treatment. Not receiving the right treatment for the right diagnosis prolonged the condition and suffering of the patient as well as their caregivers or family. For instance, there were reports of patients that were kept in prison for drug abuse for days where the root cause for the drug abuse was reported to be mental health problems.

"Any mental health issues — they say it is methamphetamine abuse related"

—Tribal Member

"The new partnership between the sheriff and mental health department means they do not put someone who is affected by mental health, and acting out, in prison but they bring them to the hospital and sit there for hours waiting to be evaluated, clogging up the ED"

—Hospital Physician

6.2.2 CHALLENGES FACED BY HEALTHCARE AND GOVERNMENT SERVICE PROVIDERS

While patients experience problems accessing healthcare, at the other end of the spectrum are physicians that face barriers delivering optimal healthcare. Many of the barriers reported by physicians relate to regulatory compulsions and profitability, whereas the factors affecting government service providers were political and administrative in nature.

Recruitment of Specialists

Because of the geographical isolation of Lake County, rural classification and lack of regional economic development, county health providers were quoted as being unable to attract and retain physicians. Multiple study participants said that doctors, especially specialists, had the options of working in other counties and earning substantially more and that usually the only professionals who chose to live long-term in the area were those with root in the community such as family ties or near retirement age. Per a hospital affiliated physician, it was not just a matter of recruitment but also of providing space according to state regulations and investing in growing their practice that were constraints.

> **"We've got to grow our own (physicians and other providers. You've got to forgive loans, or make sure their salaries are going to be above what they are being paid in the big cities"**
> —Hospital Physician

Low Revenue of Rural Hospitals

According to hospital based physicians, medical services at the hospitals were constrained due to the fact that rural hospitals have workforce shortages, low patient volumes and low profitability to be able to host a complete range of services. The low population density especially did not justify specialty healthcare with adequate returns.

Though rural hospitals often had to find innovative methods of giving care — like tele-health — to overcome their multiple challenges, the physicians were not reimbursed at the same rate as seeing a patient in their office despite spending the same amount of time. The area hospitals were thus challenged to provide quality of care to its populations and dependent on mission based values of the health system to keep them solvent. The new rules for reimbursement for tele-health was seen as a welcome change in delivery of quality of care.

> **"We lose money on almost everything that we do. We really have to pick and choose what we are able to support"**
> —Hospital Physician

> **"Our populations are not big enough to support a specialist in many areas. It's been dwindling. A nephrol-ogist will need at least 25 dialysis patients to make money but we don't have enough"**
> —Hospital Physician

Lack of Care Coordination

According to the key informants interviewed, most of who worked in senior, decision making capacities within organizations that service the population of Lake County, some of the problems — like poverty, substance abuse, mental health or lack of stable housing — were too big for any one organization to make an impact. They acknowledged that problems would alleviate only if addressed from different directions and with joint efforts of many organizations. The key informants also said that more care coordination was needed between health agencies across county to prevent patients from falling through the cracks and getting lost in the system, especially the homeless, mentally ill and substance users. This would require more deliberate cooperation from all organizations involved in the care of such individuals, as well as formal systems of tracking and monitoring.

Among health centers within the county, coordination had improved but key informants stated there was a lot of scope for more collaboration. For instance, Tribal Health was grant funded by Substance Abuse and Mental Health Services Administration (SAMSHA) to conduct mental health activities for youth. They would like to open these programs to all in the county, but stated that there was no mechanisms of collaboration that allowed them to do this.

"I think what's happened is that different groups have tried to do the best that they can with the patients that they serve"

—Government Program Manager

"We have discovered that collaboration is the key for us to improving these issues"

—Non-Profit Leader

"We need a referral system, an increased capacity for continuum of care across the closed loop referral system"

—Government Program Manager

Underfunding or Lack of Funding

Among the government employees interviewed, the lack of committed funding for needed programs, services, and for positions was a huge concern. In Lake County, grants were stated to be short termed resulting in lack of trust in such programs and services. Further, salaries were not competitive to attract or retain talent leading to unfilled positions and loss of institutional knowledge. This was stated to have resulted in a large turnover in County Government staff, especially in behavioral health.

6.2.3 RECOMMENDATIONS BASED ON KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS

The interviews and group discussions served to generate some key suggestions for Lake County and Hope Rising Lake County Collaborative.

- More collaboration that generates county-wide accessibility of services; less 'siloes' especially between tribal and other health care centers

  "We need relationships between organizations that will last. Ongoing increased collaboration, not just person to person relationships"
  —Tribal Council Member

  "It is important to find out what is being duplicated" —Non-Profit Leader

- Increase ease of working with Government with emphasis on responsiveness, transparency and accountability; address perceptions of 'Old Boy Network'

  "We want to see support from those who are in authority positions"
  —Community Member

- Work co-jointly to attract more funding for much needed services and programs given high need and inter-connectedness of issues

  "We need more grant funding. We have the numbers (outcomes)"
  —Health Program Manager

  "There are agencies that come out here and do the survey and then that is the last time we ever hear of them. They take our worst case scenario data and then they get funding and we get left out" —Tribal Members

- Develop a central database/resource for all programs, facilities and services to facilitate care coordination

- Pursue policies/programs that invite representation from all communities for equitable decision making

  "They (the government) are making decisions for us without having us at the table" —Tribal Council Member

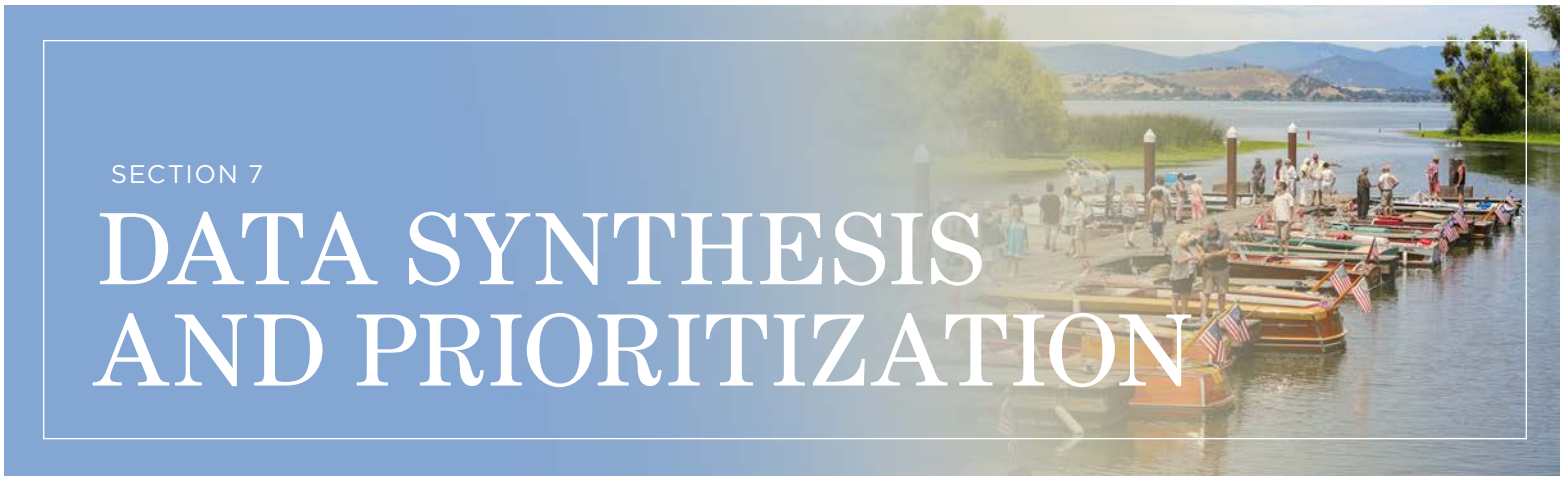
- Need for a Backbone Organization that leads a Collaborative of inclusive, multi-sectoral organizations with formal partnerships and infrastructure, including roles and responsibilities and greater stakeholder engagement

  "People don't want to get together because no one is bringing them together. We need leadership" —Government Program Manager

  "We need to string the schools, hospitals, NGOs, senior centers, churches that will coming together (with Hope Rising Lake County)" —Hospital Physician

- Expand Collaborative to include Education and Chamber of Commerce/Local Businesses, possibly faith-based communities and tap their areas of expertise

- Have rigorous performance management of care coordination and case management activities of Collaborative; continuous quality improvement through evaluation and monitoring



SECTION 7

DATA SYNTHESIS AND PRIORITIZATION

7.1 DATA SYNTHESIS

Data synthesis is a method that pools data obtained from various sources and combines results to obtain a clear answer to the overall effect of the combined sources. For this project, primary and secondary data were collected, analyzed, and synthesized. Given that all forms of data have strengths and limitations the findings from the primary data and the secondary data were compared and studied separately and then together, to gain a comprehensive understanding of the significant health needs for Lake County.

As a first step, secondary data, key informant interviews and community survey were treated as three separate sources of data. In primary data, topic areas demonstrating strong evidence of need were the health needs discussed with greatest intensity and frequency during key informant interviews and focus groups, as well as the highest ranked health needs and quality of life conditions in the community survey. The analysis of key informant interviews occurred using the qualitative software: Dedoose[1]. For the community survey, Conduent HCI performed a descriptive statistical analysis to identify top health needs. Overall, each method produced individual results that represent the community input in this report. These results have been described in SECTION 6: Primary Data Collection for Community Input.

Secondary data were analyzed using Conduent HCI's data scoring which identified health areas of need based on the values of indicators for each topic area to yield a list of priorities (see Appendix C. Secondary Data Methodology for a detailed explanation). The data scoring process of Conduent HCI categorized over 204 indicators for Lake County under 29 topic scores. Comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Data scoring then ranks and lists the health needs as determined by the highest weighted data scoring results from across the entire county Service Area. The health needs that rise to the top using data scoring from the secondary data are those which demonstrate strong evidence of need for the entire county Service Area.

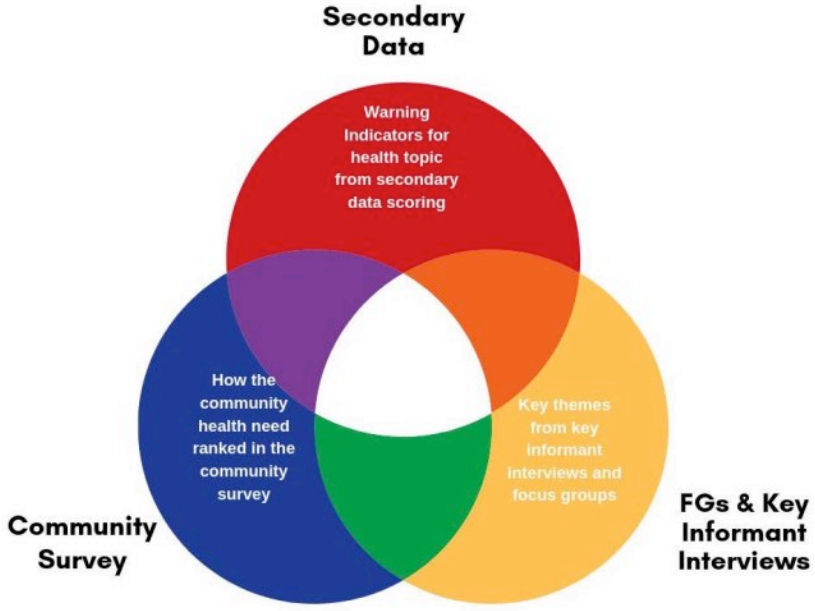
Table 10 displays the data scores for Health and Quality of Life Topics for Lake County.

TABLE 10: RANKED HEALTH AND QUALITY OF LIFE TOPICS

HEALTH AND QUALITY OF LIFE TOPICS	SCORE
Prevention & Safety	2.47
Social Environment	2.27
Economy	2.15
Public Safety	2.14
Mortality Data	2.12
Oral Health	2.09
Education	1.94
Mental Health & Mental Disorders	1.94
Medicine, Drugs, & Medical Technology	1.92
Substance Abuse	1.91
Teen & Adolescent Health	1.91
Respiratory Diseases	1.90
Women's Health	1.89
Other Conditions	1.88
Environmental & Occupational Health	1.84
Wellness & Lifestyle	1.82
Cancer	1.79
Access to Health Services	1.79
Transportation	1.71
Diabetes	1.69
Immunizations & Infectious Diseases	1.64
Exercise, Nutrition, & Weight	1.61
Men's Health	1.58
Children's Health	1.51
Maternal, Fetal & Infant Health	1.51
Environment	1.47
Heart Disease & Stroke	1.43
Older Adults & Aging	1.32
Other Chronic Diseases	0.80

As a second step, the high needs from each source of data were then put through the data synthesis process to identify the significant community health needs in the Lake County Service Area. The data synthesis process conducted by Conduent HCI is illustrated in Figure 52.

FIGURE 52: VISUAL OF DATA SYNTHESIS APPROACH



The results of the three sources of data were consolidated using a triangulated approach, shown in Figures 53 and 54. This consolidated input, shown in the area where all three circles intersect in the middle of the figure, lead to the list of significant health needs, given below.

FIGURE 53: DATA SYNTHESIS RESULTS

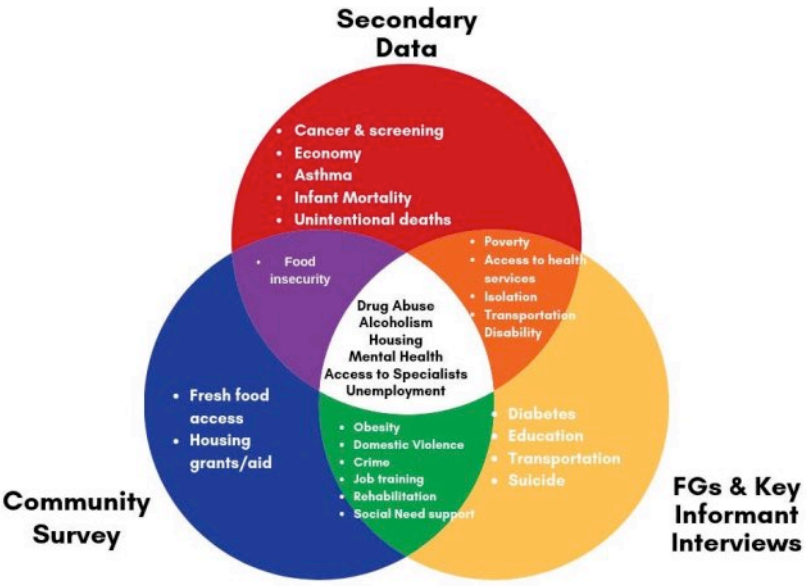


FIGURE 54: LIST OF SIGNIFICANT HEALTH NEEDS

LAKE COUNTY'S SIGNIFICANT HEALTH NEEDS

- Access to Health Services
- Alcoholism
- Drug Use
- Housing Stability and Homelessness
- Mental Health
- Poverty
- Unemployment

7.2 PRIORITIZED SIGNIFICANT HEALTH NEEDS

Prioritization of significant needs is a necessary step that must be carried out systematically to identify top priority health problems that can be tackled when time and resources are limited. A two-step process for prioritization of significant needs was followed; it is explained in detail in SECTION 7: Data Synthesis and Prioritization.

An online survey taken by 15 of Hope Rising Lake County's core stakeholders in April 2019 led to the finalization of criteria that would be used to prioritize health problems. These criteria were:

- Availability and commitment from leadership in the involved organizations
- Expertise and resources within the county to address this health problem
- Opportunities for partnerships that will allow leveraging of shared resources
- Opportunities to address the health problem before it gets exacerbated
- Alignment of problem with your organization's strengths, priorities, mission

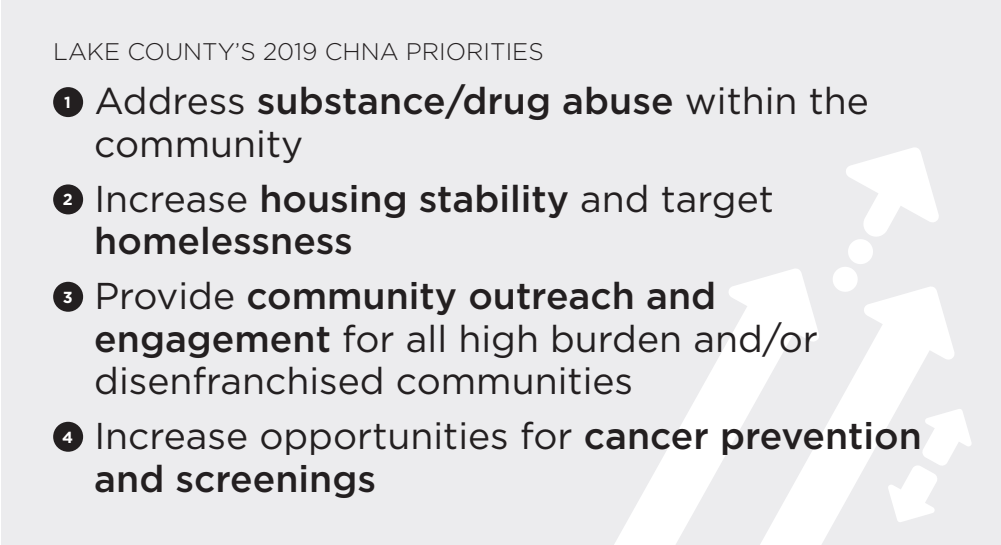
On April 19th, 2019 the stakeholders convened at Clear Lake to review and discuss the results of Conduent HCI's primary and secondary data analysis leading to the preliminary top six significant health needs shown in Figures 53 and 54. The following is the list of participants in the in-person prioritization exercise conducted:

- Allison Panella - **Hope Rising Lake County**, *Executive Director*
- Ana Santana – **Lake County Office of Education Head Start**, *Program Director*
- Brad Chatten – *Activist and Community Leader*
- Brock Falkenberg - **Lake County Office of Education**, *Superintendent of Schools*
- Carla Ritz – **First 5 Lake**, *Executive Director*
- Dan Peterson - **Sutter Lakeside Hospital**, *Chief Administrative Officer*
- Elise Jones - **Lake County Health Department**, *Health Programs Accreditation Coordinator*
- Erin Gustafson – **County of Lake**, *Public Health Officer*
- Gina Lyle – Griffin - **Lake County Tobacco Education Program,** *Project Director*
- Kate Gitchell - **Hope Rising**, *Project Manager*
- Kim Tangermann - **Mendocino Community Health Clinic**, *Lakeview Health Center Clinic Director*
- Lisa Morrow – **Lake Family Resource Center**, *Executive Director*
- Nellie Gottlieb – **Hope Rising Safe Rx Lake County**, *AmeriCorps VISTA*
- Paige Hotchkiss - **Sutter Lakeside Hospital**, *Community Benefit Specialist*
- Patty Bruder - **North Coast Opportunities**, *Executive Director*
- Russell Perdock - **Adventist Health**, *Director of Community Integration*
- Todd Metcalf- **Lake County Behavioral Health**, *Administrator/Director*

From there, participants utilized a prioritization toolkit (Appendix E. Prioritization Process) to examine how well each of the six significant health needs met the criteria set forth by Hope Rising Lake County stakeholders. They scored each need for each criteria on a scale from 1-3 with 1 meaning it did not meet the criteria to 3 meaning it strongly meets the criteria. Completion of the prioritization toolkit in Appendix E. allowed participants to arrive at numerical scores for each health need that correlated to how well each health need met the criteria for prioritization. Participants then ranked the top six health needs according to their topic scores, with the highest scoring health needs receiving the highest priority ranking.

Participants were encouraged to use their own knowledge of their community while scoring. After completing their individual ranking of the ten health needs, participants' rankings were manually collated, resulting in an aggregate ranking of the health topics. The aggregate ranking can be seen below. After reviewing the below results, participants engaged in a group discussion to narrow the most pressing health needs down to four health needs to consider for subsequent implementation planning. The four top health priorities, presented in no particular order and with equal weightage, chosen by Hope Rising Lake County are:

FIGURE 55: PRIORITIZED HEALTH NEEDS



These four health topics will be broken down in further detail below in order to understand how these become a high priority health need for Hope Rising Lake County.

7.2.1 SUBSTANCE ABUSE AND TOBACCO ADDICTION

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state (World Health Organization, 2019).

Among all the topics of significant need that were yielded by data scoring, Substance Abuse was the 6th highest scoring topic with a score of 1.91, where 0 indicated the best and 3 indicated the worst outcomes in the county in comparison to other counties in the state. Table 11 includes all the indicators that were taken into account to yield the topic scores for Drug Abuse (including prescription drugs), Alcoholism and Tobacco Abuse. As shown in Table 11 indicators related to Substance Abuse (scores in red) have scores between 2 and 3, meaning that these warning indicators reflect poor rankings and outcomes for the county.

TABLE 11: TOPIC SCORE FOR SUBSTANCE ABUSE

SCORE	SUBSTANCE ABUSE	UNITS	LAKE COUNTY	CA	MEASUREMENT PERIOD
2.61	Alcohol-Impaired Driving Deaths	*percent*	39.7	29.4	2012-2016
2.61	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	44.1	11.8	2014-2016
2.33	Age-Adjusted ED Visit Rate due to Heroin Overdose	*Rate per 100,000 residents*	28	9.9	2017
2.28	Age-Adjusted Death Rate due to Drug Use	*deaths/ 100,000 population*	43.6	12.2	2014-2016
2.17	Adults who Smoke	*percent*	27	11	2016-2017
2.11	Age-Adjusted Death Rate due to Heroin Overdose	*deaths/ 100,000 population*	2.9	1.4	2017
2.11	Age-Adjusted ED Visit Rate due to All Drug Overdose	*Rate per 100,000 residents*	339	117.3	2017
2.11	Teens who have Used Alcohol	*percent*	46.2	33.4	2009
2.00	Age-Adjusted Death Rate due to Synthetic Opioid Overdose (excluding Methadone)	*Rate per 100,000 residents*	6	1.1	2017
2.00	Age-Adjusted ER Rate due to Alcohol Use	*ER visits/ 10,000 population 18+ years*	56.6	44.2	2013-2015
2.00	Age-Adjusted ER Rate due to Substance Use	*ER visits/ 10,000 population 18+ years*	41.2	18.6	2013-2015
2.00	Age-Adjusted Hospitalization Rate due to Alcohol Use	*hospitalizations/ 10,000 population 18+ years*	13.4	11.7	2013-2015
2.00	Age-Adjusted Hospitalization Rate due to All Drug Overdose	*Rate per 100,000 residents*	126.1	49.7	2016
2.00	Age-Adjusted Hospitalization Rate due to Heroin Overdose	*Rate per 100,000 residents*	3.5	1.6	2014
2.00	Age-Adjusted Hospitalization Rate due to Opioid Overdose (excluding Heroin)	*Rate per 100,000 residents*	18.6	8.5	2016
2.00	Age-Adjusted Hospitalization Rate due to Substance Use	*hospitalizations/ 10,000 population 18+ years*	9.5	6.1	2013-2015
2.00	Age-Adjusted Long Acting or Extended Release Opioid Prescription Rate to Opioid Naive Residents	*per 100,000 population*	2.6	1.4	2017
1.89	Age-Adjusted Death Rate due to All Opioid Overdose	*Rate per 100,000 residents*	15.2	4.5	2017
1.89	Age-Adjusted Death Rate due to Prescription Opioid Overdose	*Rate per 100,000 residents*	12.3	3.2	2017
1.89	Age-Adjusted ED Visit Rate due to Opioid Overdose (excluding Heroin)	*Rate per 100,000 residents*	20.8	10.3	2017
1.83	Consumer Expenditures: Tobacco	*percent*	0.7	0.4	2018
1.64	Opioid Prescription Patients	*percent*	6		43313
1.64	Opioid Prescription Rate	*prescriptions per 10,000 population*	754.7		43313
1.33	Consumer Expenditures: Alcoholic Beverages	*percent*	0.9	1.1	2018
0.89	Adults who Binge Drink: Year	*0*	26	32.6	2014
0.39	Liquor Store Density	*0*	6.2	10.1	2015

The table above shows that opioid prescription rates and alcohol abuse in adults were stable or improving. Opioid usage data from Partnership Health Plan shows positive downward trends on several fronts with opioid prescriptions (California Deparment of Health, 2017-2018). This was also corroborated by many of the health providers who were interviewed.

However, all other types of substance abuse were increasing in Lake County. Unfortunately, some female adults who engage in alcohol and drug use do so during their pregnancies. Besides the secondary data in table 13, other data of the Public Health Department show that for every 1,000 hospitalizations of pregnant women, 104.0 were diagnosed to have substance abuse. Additionally, there were 1,586.9 substance abuse hospitalization per 100,000 in persons aged 15-24 (California Department of Public Health, 2017-2018). Drug-induced deaths accounted for the 6th leading cause of premature death in Lake County. Lake County has the highest rate of drug-induced deaths in the state; between 2014 -2016, 30 deaths occurred in Lake County from drug overdose.

Teen alcohol abuse was a warning indicator for Lake County, with a score of 2.11. While more recent data is not available for Lake County, in 2009 46.2% of teens self-reported using alcohol while the percent was 33.4% in the state. Alcohol is the most widely used substance among the nation's young people and binge drinking, in particular, has been linked to risky health behaviors (e.g., unprotected sex, smoking), injuries, motor vehicle accidents, impaired cognitive functioning, poor academic performance, physical violence, and suicide attempts. Drinking during adolescence increases the likelihood of alcoholism in adulthood, and long-term health consequences of consumption including liver disease, cancer, and cardiovascular disease (Substance Abuse and Mental Health Services Administration, 2015). Not surprisingly, the Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury in Lake County in 2013-2015 was 91.3 ER visits/ 10,000 population aged 12-17, in comparison to the state which had a rate of 46.3 ER visits/ 10,000 population aged 12-17.

Primary data also highlighted substance abuse as the most important health challenge in the county. Drug and alcohol abuse were identified as the most important health problem in by 70.9% and 34.3% community survey participants respectively. Drug use (86.5%), alcohol abuse (64%) and tobacco addiction (20%) were also identified as the most important risky behaviors affecting Lake County.

Drug Abuse (including prescription drugs), Alcoholism and Tobacco (including other tobacco products such as snuff, snus, and vapes) among adults and adolescents were identified as the foremost topics of concern for community members and key informants alike. While tobacco addiction was mentioned as an important issue by key informants, drug abuse was the most frequently mentioned health challenge in the county by all community members and key informants interviewed. Drug addiction was stated to affect White communities more while alcoholism was seen more in American Indian tribes and Hispanics, according to the physicians interviewed for this assessment.

Per key informants and focus group participants, there are a lack of providers and treatment facilities in Lake County to be able to deal with the substance abuse issues. Clients in need of rehabilitation often need to be sent outside of the county for services which presents a barrier to receive the care. Key informants at another hospital stated that hospitals had worked hard to win the battle with opioid prescription drug abuse but they were seeing a diversion to heroin and other street drugs (methamphetamine, black tar heroin, benzodiazepines, marijuana, opioids,

and fentanyl) and were losing the battle despite never having worked as hard to combat the problem. Moreover, with the battle having moved into the community, the physicians felt that they had less control on prevention of the problem.

In the words of focus group participants, Lake County had a 'cycle' of poverty, drugs and hopelessness. Drug abuse was said to run in families, with children learning from observing their parents. In their experience, in a majority of cases, poor mental health accompanied drug abuse making their management a challenge for the community and the families.

Tobacco Addiction is also a health need that Hope Rising Lake County has prioritized. Table 13 shows that 27% of Lake County residents smoke as compared to 11% of Californians. This despite the recent passage of a bill that increased tax by $2 per pack besides an equivalent tax on other tobacco products like e-cigarettes (American Cancer Society , 2017). Tobacco has been implicated in almost one-third of all cancers, besides respiratory diseases (e.g. asthma, chronic obstructive pulmonary disorder), heart disease, stroke, and peripheral vascular disease (narrowing of the blood vessels outside your heart) among others. The healthcare costs of tobacco are higher than the costs of alcohol, illicit and prescription drugs (Figure 56). Thus, while drug abuse was a more visible problem in Lake County and one that impacted quality of life more widely, tobacco addiction was a problem with longer drawn and higher costs of healthcare.

"I've seen them do drugs. They need something to keep them occupied which is going to make your life much better. Or they are getting lined up in the E.R. getting an evaluation for suicide. That happens a lot"

—Women's Focus Group Participant

"It's definitely something bigger than each of the individual organizations. Hospitals are not incentivized to do things globally"

—Hospital Physician

FIGURE 56: NATIONAL COSTS OF SUBSTANCE ABUSE

SUBSTANCE	HEALTH CARE	OVERALL	YEAR ESTIMATE BASED ON
Tobacco	$168 billion	$300 billion	2010
Alcohol	$27 billion	$249 billion	2010
Illicit Drugs	$11 billion	$193 billion	2007
Prescription Opioids	$26 billion	$78.5 billion	2013

Source: National Institute of Drug Abuse

The Lake County Tobacco Education Program (LCTEP) is an education and policy-passed program that utilizes social norm change strategies to develop smoke-free policies. Hope Rising Lake County members have an interest in investing more efforts on this topic, especially with the surge in vaping and smokeless tobacco products in the recent years, among teens and young adults. Studies elsewhere have shown satisfactory returns on investment for tobacco control programs. Providing preventive services, such as tobacco cessation, and cancer screenings in the clinical setting is also crucial to preventing cancer and detecting it early. Analyses of these recommended services find that many are cost-effective and cost-saving. A 2012 analysis of the comprehensive tobacco cessation benefit provided to Massachusetts Medicaid enrollees showed that for every $1 spent on the benefit, the state gained $3.12 in medical cost savings.

Lake County had some behavioral, chemical, system and policy interventions in place at the time of this assessment. For instance, Comprehensive Perinatal Services Program (CPSP) services were being provided to incarcerated females in Lake County by Jail Medical – California Forensic Medical Group. Arresting law enforcement officers screened all females for pregnancy and if found to be pregnant, they were then taken to local emergency room for medical clearance

(California Department of Public Health, 2017-2018). Local Sheriff's Department officials had received training to administer Naloxone (Narcan). Medication-assisted treatment (MAT) is also offered by Lake County rural health clinics, combining behavioral therapy and medications to treat substance use disorders. Finally, SafeRx — a collaborative partnership that focuses on prevention, treatment and recovery — has had significant success in the county.

Hope Rising Lake County also has open to it many possible policy interventions for teen substance abuse. These include prioritizing screening and early identification of risk factors correlated with substance use, especially among middle school youth; screening for mental health issues; developing comprehensive policies that promote school and community connectedness among youth and help them develop the knowledge, skills, and motivation to avoid substance use; and, promoting youth-focused, mass media counter-marketing strategies to combat tobacco and alcohol advertising and reducing youth exposure at the points-of-sale (Lucille Packard Foundation for Children's Health , 2016-2017).

Thus, given the size of substance and tobacco abuse in Lake County, Hope Rising Lake County and its partners have chosen to seize the opportunity to expand evidence-based interventions like policies which influence the levels and patterns of substance use and related harm and interventions at the health care system level. Additionally, education, treatment, prevention for all substance abuse but with special emphasis on teen alcohol abuse will be undertaken.

7.2.2 HOMELESSNESS AND HOUSING STABILITY

Affordable housing and housing stability are important drivers of positive health outcomes. Stable housing is associated with economic stability and quality of life. The primary and secondary data showed that housing was a high priority for Lake County. Section 4.2.4 Housing provides data on housing for Lake County, including the cost of renting. The topic of Housing and Homelessness had a score of 2.28 through data scoring, where a score of 0 reflects the best outcomes and a score of 3 reflects the worst outcomes.

In the community survey conducted, 27.4% participants stated that they had been worried about housing in the past 12 months; 70.88% said they would prefer to see programs in the county that made small grants for repairs and improvements. Approximately 14% survey participants said that costs for housing, food etc. prevented them from seeking healthcare while more than 70% said hospitals should make available resources for social needs such as food and housing. This issue impact quality of life in the community; focus group participants said they felt unsafe and feared the rise in crime and substance abuse in the community was related to homelessness. A consensus, however, was that the community needed to take care of the homeless through temporary shelters and rehabilitation.

California has the highest number of chronically homelessness in the country. Between 2013 and 2017, California has seen 13.3% change in total homelessness (United States Department of Housing and Urban Development, 2017). Per the Homeless Management Information System data of the United States Department of Housing and Urban Development, the one-year estimate of sheltered homeless, between October 2016 and September 2017, was 150,630 households. In Lake County, much like California, housing stability as well as homelessness are both problems. Lake County (27.3%) and the state of California (27.9%) have comparable

percentages of people that report sever housing problems (see Appendix C. Lake County Data Scoring Results)

Costs of housing was one of the primary reasons quoted by key informants for the county's inability to attract talent. According to one physician interviewed, offering free housing to young professionals could be the solution to many problems in the community

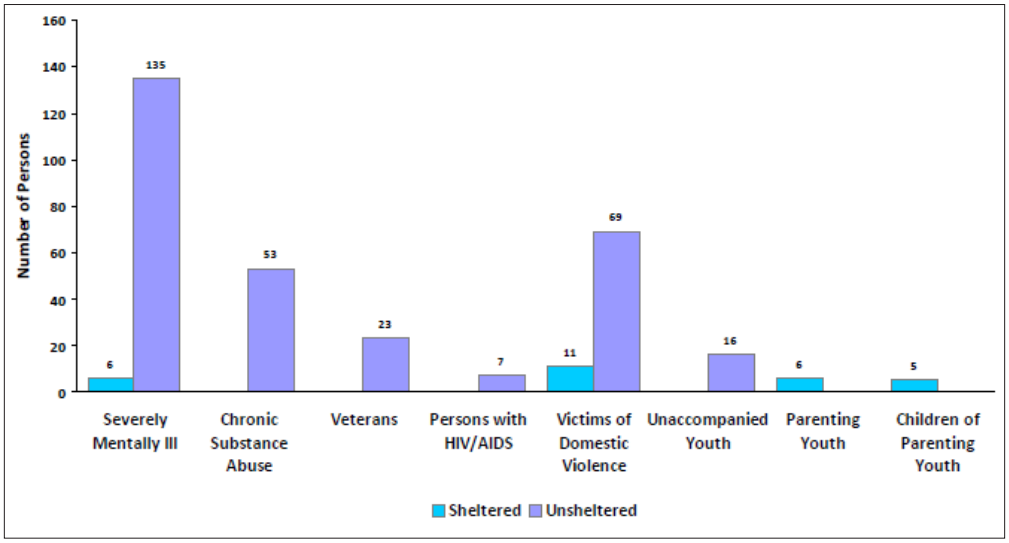
> **"I would have young nursing students on the premises with old people. Give them housing, fund their education and have that whole generation be compensated for caring for older people"**
>
> —Hospital Physician

Median gross rent in Lake County was $914 in 2013-2017, and the county had 159 building permits in 2017 (United States Census Bureau, 2018). Yet there was a shortage of housing and an unaffordability due to low median income. There have been as many as 10 major fires in Lake County from 2012. Just in 2018, 3 fires scorched over 93,000 acres combined and destroyed buildings and other housing structures. With the fires, according to interviewees, rents increased and housing become even more unaffordable. The numbers of homeless have increased in the county correspondingly.

Based on information provided to HUD by Continuums of Care (CoCs) (United States Department of Housing and Urban Development, 2017), Lake County had 54 beds in emergency shelters and 13 beds in transitional housing (figure not provided). The point-in-time estimate for the county shows that of 331 homeless persons, only 28 were sheltered but 303 were unsheltered (meaning 'living in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings; on the street') (Figure 57). More recent point-in-time data collected in 2019 by Hope Rising and its partners places the number of homeless people in the county at 408; of these, 26 were sheltered while 382 were unsheltered (Conduent Healthy Communities Institute, 2019).

Figure 57 provides a profile of the homeless in the county. As also seen in the figure, homeless persons lack healthcare and have many barriers to accessing healthcare, including an array of medical and mental health issues. The report recommends that homeless individuals may need specialized services or focused outreach, since these groups may experience less access to mental health services overall, whether through the perception that they can't afford it, or because of the stigma associated with those two statuses.

FIGURE 57: 2017 POINT IN TIME COUNT SUMMARIZED BY SUB-POPULATION



Source: Continuum of Care Data for CA-529, Lake County, 2017

With value based care gaining momentum, there is an increased recognition of the great returns on investments that housing stability and reduction in homelessness bring to hospitals and health agencies. While the estimates on the actual Returns on Investment are a function of additional case management and other treatment costs and vary from $2,249 per person per month to a savings of $1.57 for every $1 spent (The Commonwealth Fund, 2019), there is strong evidence that supportive housing to homeless individuals with a medical need like a chronic condition or behavioral health problem reduces Emergency Department visits, admissions, and inpatient days and results in large decreases in health care costs.

Hope Rising Lake County Collaborative prioritized housing stability and homelessness after the last CHNA conducted. They have made progress and deployed their combined resources in launching and sustaining the following initiatives.

- The Healthy Clearlake Collaborative
- Restoration House Respite Beds
- Project Restoration
- Hope Rising Lake County Center for Transformation
- Warming shelters
- Tully House

Housing stability and homelessness has been adopted as a priority by Hope Rising so that they can build upon their labors and continue to make gains in addressing this issue.

7.2.3 COMMUNITY OUTREACH AND EDUCATION

One of the goals of Healthy People 2020 is to Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life. In a community, health status and related health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Dynamic interactions between these personal, social and environmental factors work to determine an individual's health as well as the different points of intervention for organizations working in health promotion.

Though community outreach and education were not significant health needs that emerged from either secondary or primary data, there was a strong preference among Hope Rising Lake County partners for increasing health education and promotion efforts for various issues that ailed the county. While health outcomes are dependent on a well-functioning medical system, it was widely acknowledged by all the key informants interviewed that health began in the community and it was important to increase healthy behaviors at an early age. The Hope Rising Lake County partners realize that by intervening in schools through community programs, they could stem harmful behaviors of county residents in the formative years. Some of the issues that Hope Rising Lake County partners expressed an interest in addressing through schools were substance abuse, tobacco use, e-cigarettes, vaping, mental health, physical activity, diet and nutrition, sexually transmitted disease, completing school education, crime and violence. These health issues were also mentioned by community members during primary input.

"We need to shed our hubris and realize that it is the job of the school system (to educate young people) and we should partner with them to help them"
—Hospital Physician

"The young people lack of knowledge around family history. The diet of young kids, what is healthier to eat — it's very generational. Education is key because some of these diseases are preventable and reversible if we can empower them with knowledge"
—Practice Manager

"We have to be proactive and not reactive — raise people who will not have a heavy footprint on the entire health system"
—Hospital Physician

In fact, one very strong theme that the key informant interviews and focus group discussions yielded was the need for the community of Lake County to invest in education and life-skills training.

The community survey also revealed a community wide interest in developing opportunities for young county residents to break the cycle of poverty, drugs and hopelessness. In the survey, 82.8% of participants said it was very important to develop programs for youth like vocational training or dropout prevention programs for high-risk students, while 72.7% felt youth programs like Big Brothers, Big Sisters were needed to address the health challenges in Lake County. When asked to select three kinds of services that are needed more in Lake County, job training was mentioned by 36.2% of participants. The community members and key informants were also unanimous in stating that the best investment the county could make was in the children and youth.

One of the possible interventions available to Hope Rising Lake County is the Whole School, Whole Community, Whole Child (WSCC) model which expands on the 8 elements of the U.S. Centers for Disease Control and Prevention's (CDC) Coordinated School Health (CSH) approach and is combined with the whole child framework.

While the schools were a setting where future educational strategies were planned by Hope Rising Lake County, another setting where education was to be provided to target social needs was the community at-large. Health care leaders and health providers have long recognized the connection between unmet essential resource needs — e.g. food, housing and transportation — and the health of their patients. Studies have indicated that more than 50% of health outcomes are attributable to social and environmental factors — and the behaviors linked to them — that patients face outside of the practice or hospital. When patients lack resources like food or stable housing, it has a compounding and prolonging effect on the health conditions that they suffer from. An essential first step to addressing social needs is to uniformly screen all patients at all care points (e.g. clinics, free screenings, behavioral facilities, hospitals) for their social needs. Lake County is a designated Accountable Health Community. The Accountable Health Communities Model is an innovative payment and service delivery model to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while maintaining or enhancing the quality of beneficiaries' care. The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) have made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. This screening tool can be used consistently in all Lake County care points.

A second step is to connect patients to social needs resources and service within the community such as food pantries, temporary shelter, or heating and cooling assistance through a closed loop referral system. The survey found that over 70% of participants stated it was very important to them to have area hospitals improve their quality of service by providing the following: connections to services that provide shelter, housing, food support (74.7%); connections to agencies that provide social support like counselling (74.5%); and, providing a list of all the organizations that give support for housing, shelter, food (70.1%). Social needs came up in a focus group where some current and prior government employees stated that their task of helping beneficiaries would be made easier if there was a central county wide database of community resources that was updated regularly and to which referrals or appointments could be made for clients.

"We need to structure a rich life for the kids so they have something to do other than to follow in the footsteps of their parents who are on drugs"

—Men's Focus Group Participant

"It's a lack of mentorship and lack of leadership. Their parents are on drugs so these kids raise themselves"

—Men's Focus Group Participant

"The more educated the youth are — that is how you break the cycle of drugs and poverty. They need hope to go on"

—Hospital Physician

"If we don't take care of them now, they will not be there for us when we need them"

—Older Women's Focus Group Participant

"Why don't we know about these resources, why is there not a simple way of getting that out, why is there not a single place where this information rests?"

—Older Women's Focus Group Participant

While Hope Rising Lake County had previously explored the cost of installing a community resource database like 2-1-1, the partners expressed an interest in finding and engaging other cost-effective options like Aunt Bertha, CharityTracker, CrossTx, Healthify, NowPow, One Degree, Pieces Iris, TAVConnect (TAVHealth), and Unite U. Additionally, the data platform of Conduent HCI is also available to display community resources. With these resource based platforms, Hope Rising Lake County partners would be in a position to offer integrated social needs screening across care points in addition to case management and care coordination between health and service providers.

A third aspect of the proposed community outreach and education was to provide health promotional materials that speak to the concerns of target communities education and assistance in multiple languages. Communicating across language barriers is a challenge for clinicians and health systems. Federal law requires linguistic services for patients with limited English proficiency (LEP). In addition, health care organizations that receive federal funds in the form of public insurance payments (Medicaid or Medicare) must provide services in a language that a patient with LEP can understand. The Joint Commission, the main hospital accreditation body in the US, requires that hospitals collect and record patients' preferred languages for discussing health care and have included in their standards the use of qualified medical interpreters for patients whose preferred language is not English. According to the 2013-2017 American Community Survey, approximately 2,000 people in the county have limited English proficiency. However, the need for language access for patients with limited English proficiency was a strong need expressed by Hispanic key informants because language was deemed essential in establishing relationships of trust with the physician and patient satisfaction.

"Prevention is not great up here. There are educational programs but they don't meet the general criteria of the people that live in the county"

—Hispanic Council Member

Some resources available to Hope Rising Lake County to meet this objective are National Network of Libraries of Medicine's Consumer Health Information in Many Languages Resources and Health Reach. Thus, with this objective of improving health and wellness while addressing influences at all levels (e.g. personal, societal, environmental and policy) and in a variety of community settings (e.g. school, worksite, clinics, hospitals, and community), Hope Rising Lake County has chosen to prioritize Community Outreach and Education.

7.2.4 CANCER

According to the Centers for Disease Prevention and Control, chronic diseases like cancer are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as cancer and diabetes are the leading causes of death and disability in the United States and leading drivers of the nation's $3.3 trillion annual health care costs. Preventing chronic diseases, or managing symptoms when prevention is not possible, can reduce these costs. Chronic diseases like cancer are a factor of old age, meaning the chance of having these conditions increases with age. This has implications for Lake County which has a higher than average median age in comparison to the state and is one of the primary reasons for this topic being prioritized by Hope Rising Lake County. According to the National Cancer Institute, as the population ages, cancer prevalence and the absolute number of people treated for cancer will increase even if cancer incidence rates remain constant or decrease somewhat. Costs are also likely to increase as new, more advanced, and more expensive treatments are adopted as standards of care.

Lake County has the 18th highest rate of invasive cancer cases in the state. Between 2012 and 2016, the population at risk for cancer in the county was 320,379. In Lake County, California from 2012-2016, there were 2,054 new cases of cancer. For every 100,000 people, 410.97 cancer cases were reported. The rate of new invasive cancers is higher for males (448.8 per 100,000 males) than females (419.4 per 100,000 females). The rate of all new cancers is highest in Whites (433.7 per 100,000 people), followed by Blacks (352.6), American Indians/Alaskan Natives (332.2), Asians/Pacific Islanders (313.5) and Hispanics (318.0) (Centers for Disease Control and Prevention, 2012-2016).

Cancer was also the highest cause of mortality in Lake County, as seen in Section 4.8 Health Profile. Over 2012-2016, there were 945 people who died of cancer in the county. For every 100,000 people in Lake County, California, 192.7 per died of cancer compared to 140.2 for the state, conferring the rank of 57th to the county out of 58 counties in the state. The county also was ranked near bottom in the state for deaths by cancers of sites which have gold-standard screening tests that are covered free or at low cost by private and public health plans. Lake County ranked 53rd in deaths by colorectal cancer, 55th in lung cancer deaths, 56th in female breast cancer deaths, and 50th in prostate cancer deaths. The rate of cancer deaths is higher for males (222.5 per 100,000 males) than females (168.4 per 100,000 females). The rate of all new cancers is highest in Blacks (268.9 per 100,000 people), followed by Whites (194.7), American Indians/Alaskan Natives (152.5), and Hispanics (126.7) (Centers for Disease Control and Prevention, 2012-2016) in Lake County. Conduent HCI's Index of Disparity reports no disparities related to cancer.

While gathering community input, cancer was stated as a high concern by interviewed physicians but was not a topic of concern for community members who participated in the group discussions. It was also a low priority for survey participants, less than 10% of whom mentioned it was a health concern for the county.

Data scoring yielded the topic with a score of 1.79 (Table 10), where 0 indicates the best outcome and 3 the worst. However, there are many indicators which constituted the topic score with scores in the 2 to 3 range, indicating that Lake County performs poorly in comparison to other California counties on these measures (Table 12).

TABLE 12: INDICATOR SCORES FOR CANCER

SCORE	CANCER	UNITS	LAKE COUNTY	CA	U.S.	MEASUREMENT PERIOD
2.61	Mammography Screening: Medicare Population	*percent*	50.6	59.5	63.2	2015
2.50	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	29.5	19.1		2014-2016
2.44	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	73.9	43.3	60.2	2011-2015
2.44	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.2	10.3	11.6	2011-2015
2.28	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.4	19.7	19.5	2011-2015
2.17	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.8	13.3	14.5	2011-2015
2.06	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	192.7	140.2		2014-2016
1.94	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	46.5	28.9		2014-2016
1.72	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	41.8	36.2	39.2	2011-2015
0.56	Cancer: Medicare Population	*0*	6.2	7.5	7.8	2015
0.39	Breast Cancer Incidence Rate	*0*	101.8	121.5	124.7	2011-2015
0.39	Prostate Cancer Incidence Rate	*0*	80.5	101.2	109	2011-2015

In Lake County, 6.2% of the Medicare population had cancer in 2015 as compared to 7.6% in the state (Table 11) which is lower than both the state and national rates. However, the female breast cancer screening rates for the Medicare population was much lower than the state and country rate. While the screening data for other cancers and populations is not available, timely screening has the potential to save lives and healthcare costs for treatment.

Breast cancer is the most commonly occurring cancer in women nationwide. In Lake County, California from 2012-2016, there were 252 new cases of female breast cancer. For every 100,000 women, 107 female breast cancer cases were reported. Over those years, there were 64 women who died of Female Breast Cancer. For every 100,000 women in Lake County, 27 died of female breast cancer (Centers for Disease Control and Prevention, 2012-2016). The rate of new breast cancers is highest among White women (109.3 per 100,000 females) in Lake County, followed by Hispanic women (81.3). Five-year survival rates are 99% for localized stage, 86% for regional stage cancer, and 28% for cancers with distal spread (American Cancer Society, California Department of Public Health, California Cancer Registry, 2015).

In Lake County, from 2012-2016, there were 73 new cases of oral cavity and pharynx cancer. For every 100,000 people, 15 oral cavity and pharynx cancer cases were reported. Over those years, there were 22 people who died of oral cavity and pharynx cancer. For every 100,000 people in Lake County, 5 died of oral cavity and pharynx cancer. The oral cavity includes the lip, tongue, floor of the mouth, gingiva, buccal surface (mucosa), hard palate, and oropharynx. Primary risk factors for cancers of the oral cavity and pharynx include tobacco use, frequent alcohol consumption, and infection with human papillomavirus (HPV). The majority of oropharyngeal cancers (64%) are not diagnosed early, but instead at regional (45%)

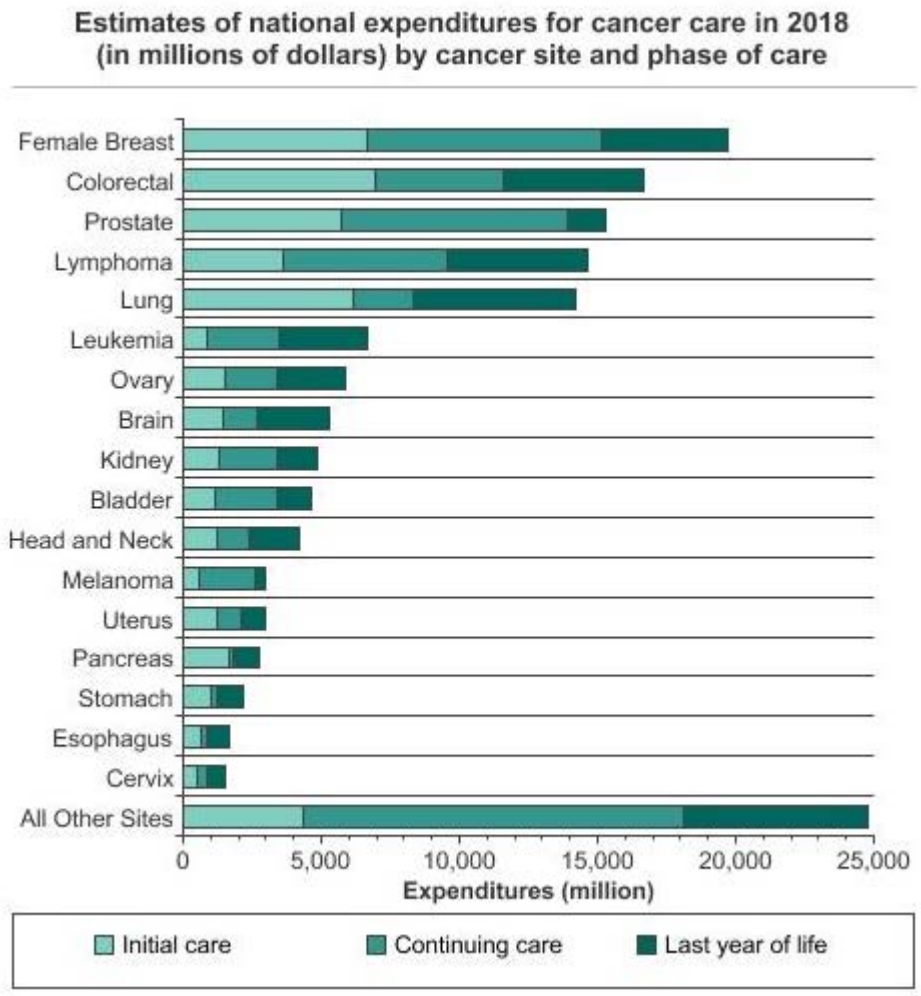
and remote (19%) stages (Surveillance Research Program, National Cancer Institute, 2015). The five year survival rate is 84% when diagnosed at a localized stage, 63% at a regional stage, and 38% at a distant stage (American Cancer Society, California Department of Public Health, California Cancer Registry, 2015).

In Lake County, California from 2012-2016, there were 171 new cases of colon and rectum cancer in 2012-2016. For every 100,000 people, 36 colon and rectum cancer cases were reported. Over those years, there were 69 people who died of colon and rectum cancer. For every 100,000 people in Lake County 14 died of colon and rectum cancer (Centers for Disease Control and Prevention, 2012-2016). Colorectal cancer screening offers opportunities for both prevention and early detection. When detected at a localized stage, the five year survival rate for colorectal cancer is 92%, compared to 13% when diagnosed after it has metastasized. While the county data are not available, in California, 57.5%-59.2% of colorectal cancers were diagnosed at an advanced stage in 2013 (UC Davis - Institute for Population Health Improvement, 2016).

Per a report published in 2016 that mapped trends, the percent of female breast cancer cases, melanoma cases, and oropharyngeal cancer cases diagnosed at an advanced stage by county (1988-2013) showed an increasing trend. In contrast, the percent of colorectal cancer cases and prostate cancer cases diagnosed at advanced stage had a decreasing trend (UC Davis - Institute for Population Health Improvement, 2016).

The National Cancer Institute has developed national estimates based on cancer prevalence estimates modeled to 2018 and the costs of care which came from the period 2008-2010 depending on the cancer site. National expenditures were largest for female breast, colorectal, prostate, lymphoma, and lung cancers, reflecting prevalence of disease, treatment patterns, and costs for different types of care as shown in Figure 58.

FIGURE 58: ESTIMATED NATIONAL COSTS FOR CANCER CARE IN 2018



Source: Mariotto AB, Yabroff KR, Shao Y, Feuer EJ, Brown ML. J National Cancer Institute 2011;103(2): 117–28

As shown in Table 13, the costs for the latter stages of cancer care are much more than for the initial phase. From 2010 to 2020, Mariotto et al. projected a 27% increase in medical costs based solely upon the increasing aging US population.

TABLE 13: NATIONAL ANNUALIZED MEAN NET COSTS OF CARE BY AGE, GENDER AND PHASE OF CARE (PER PATIENT). COSTS IN 2010 US DOLLARS

AGE 65+					
				Last Year of Life	
Sex	**Site**	**Initial**	**Continuing**	**Cancer Death**	**Other Cause**
Female	Breast	23,078	2,207	62,856	748
Female	Colorectal	51,327	3,159	84,519	14,641
Female	Lung	60,533	8,130	92,524	18,897
Female	Melanoma	5,047	915	56,784	252
Male	Colorectal	51,812	4,595	85,671	15,068
Male	Head/Neck	39,179	4,001	83,662	9,269
Male	Lung	60,885	7,591	95,318	25,008
Male	Melanoma	5,437	1,951	62,436	546
Male	Prostate	19,710	3,201	62,242	5,370

Source: National Cancer Institute

The high cost of cancer care is paid not only by employers, insurance companies, and taxpayer-funded public programs like Medicare and Medicaid, but by cancer patients and their families. Despite having insurance, the out-of-pocket costs of cancer prove to be prohibitive for patients. Preventing cancer in the first place or detecting it early is the best way to reduce many costs associated with cancer treatment which could include patient out-of-pocket costs, health care payer costs, and indirect costs, according to the American Cancer Society Cancer Action Network (ACS CAN).

A report by ACS CAN titled 'The Costs of Cancer — Addressing Patient Costs' (2017) states that an investment of $10 per person per year in community-based programs to increase physical activity, improve nutrition, and prevent tobacco use could save states and communities more than $16 billion annually within five years. This is a return of $5.60 for every $1 invested. This makes a strong business case for reducing cancer cases and deaths with prevention (including screening) and control (including early detection) measures implemented in the community.

7.3 NON-PRIORITIZED SIGNIFICANT NEEDS

These significant health needs emerged from a review of the primary and secondary data. However, Hope Rising Lake County did not elect to focus on these topics in their Implementation Strategy.

7.3.1 ACCESS TO HEALTH SERVICES

Access to health services means "the timely use of personal health services to achieve the best health outcomes." It requires 3 distinct steps: gaining entry into the health care system (usually through insurance coverage); accessing a location where needed health care services are provided (geographic availability); and, finding a health care provider whom the patient trusts and can communicate with (personal relationship) (Office of Disease Prevention and Health Promotion, 2019).

In the County Health Rankings and Roadmaps listing, Lake County is ranked 58 out of all California Counties in Health Outcomes. Some of the factors that contributed to this ranking are premature death, number of primary care physicians, utilization of free or low-cost preventive screening and vaccinations, and quality of life indicators in the community.

Access to Health was a significant health need that emerged from all the three sources of data collected in this project. In the community survey fielded in Lake County, a very small number of survey participants agreed with the statements that people in Lake County are mostly healthy and have long lives (3.0%) and take steps to stay healthy (6.1%). One area of improvement for the county that emerged was to increase the ability of residents to access healthcare upon need; in the survey, only 15.2% noted they were able to see doctors when need arose.

When asked to rate their own physical health, 23.16% rated it as fair or poor. Self-rated mental health was rated more negatively — 47.3% were sad or worried and 8.17% were finding day to day life difficult and were unable to function. The community survey revealed that behaviors related to accessing healthcare was impeded by multiple factors — lack of specialists (31.6%), costs of care (27.3%), unavailability of appointments (approximately 26%), co-pays (21.43%) and long wait times (19.4%). Cost of healthcare was stated to be a worry in the past 12 months by 35.6% of those surveyed. Finally over 70% of participants reported that it was very important to them to have area hospitals improve their quality of service by providing the following: easy to follow medical instructions and information (76.8%); connections to services that provide shelter, housing, food support (74.7%); connections to agencies that provide social support like counselling (74.5%); having staff speak in their language (71.6%); and, providing a list of all the organizations that give support for housing, shelter, food (70.1%).

As discussed in Section 6.2, interviews with key informants and group discussions revealed that Lake County had many barriers to optimal access to healthcare. These included among others: lack of specialists and appointments, low quality of care, lack of full range of medical services, transportation, cost of healthcare and coverage, limited clinic hours, and lack of cultural competency.

Data scoring led to a topic data score of 1.79 for Access to Health Services (Table 10) which is above the midpoint of the range, where 0 indicates the best outcome and 3 the worst. However, the topic score of Access to Health Services encompassed warning indicators that had higher scores. Table 14 highlights the issue of access in the percent of adults in Lake County that delayed or had difficulty obtaining care. Some of these indicators have been discussed in Section 4.2.5 Access to Health.

TABLE 14: INDICATORS SCORES FOR ACCESS TO HEALTH SERVICES

SCORE	ACCESS TO HEALTH SERVICES	UNITS	LAKE COUNTY	CA	U.S.	MEASUREMENT PERIOD
2.28	People Delayed or had Difficulty Obtaining Care	*percent*	15.5	10.7		2015-2016
2.17	Consumer Expenditures: Medical Services	*percent*	2	1.8	1.7	2018
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	*percent*	1.2	0.8	1	2018
2.11	Adults Needing and Receiving Behavioral Health Care Services	*percent*	52.5	60.5		2015-2016
2.11	Primary Care Provider Rate	*providers/ 100,000 population*	51.1	78.1	75.5	2015
2.00	Consumer Expenditures: Medical Supplies	*percent*	0.3	0.3	0.3	2018
1.83	Dentist Rate	*dentists/ 100,000 population*	45.2	82.4	67.4	2016
1.67	Adults Delayed or had Difficulty Obtaining Care	*percent*	22.2	21.2		2013-2014
1.50	People with a Usual Source of Health Care	*percent*	91	87.3		2013
1.42	Adults with Health Insurance: 18-64	*percent*	89.5	89.6		2016
1.14	Children with Health Insurance	*0*	98.2	96.9	95	2017
1.06	Non-Physician Primary Care Provider Rate	*0*	71.7	52.2	81.2	2017

The warning indicators (scores above 2) on consumer expenditure in Table 14 indicate the burden imposed by consumer expenditure on health on Lake County residents. Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums. Cost of healthcare is one reason for disparities in access to services. Let's Get Healthy California reports that the average annual family out-of-pocket spending in California, over time, for White families on premiums, co-pays, deductibles and co-insurance for services and prescription drugs was $3,955 for Whites, $3,456 for Asians, $1,969 for Hispanics and $1,946 for Blacks in 2017. In Lake County, the Real Cost Measure of United Ways Health estimates that the yearly expenses on healthcare for one person in $2,136, for two-persons is $4,266 and for a four person household is $8,526 in 2016.

Care costs are an important indicator of a health system's efficiency and affordability, and these costs must be balanced against the quality of health care provided in order to improve the efficiency of health care delivery. While research has shown that too little or too much spending leads to inferior or substandard health care outcomes, it is unknown what the ideal amount of spending on patients should be. The price-adjusted total Medicare reimbursements per enrollee (Parts A

and B) in 2016 for Lake County was $9,445.67, whereas the range for the state was from $7,118.16 to $12,498.05 (Dartmouth Atlas Project, 2016). According to County Health Rankings data, in 2016 the rate of preventable hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees is higher for Lake County; it is 3,782 preventable hospital stays per 100,000 Medicare enrollees as compared to 3,507 for California.

One of the possible reasons for people delaying or not utilizing regular care is likely that they lacked coverage by insurance. The Healthy People 2020 national health target is to increase the proportion of people with health insurance to 100%. According to the 2013-2017 American Community Survey, of the civilian non-institutionalized population in Lake County, 88.2% have health insurance coverage but 11.8% of this population have no health insurance coverage. The figure for persons under 65 years that have no health coverage in the county is 9.2% (United States Census Bureau, 2019). Further, 15.5% of the population below 138 percent of the poverty threshold that potentially should have been eligible for health insurance under Medicaid expansion have no insurance and an additional 12% between 138 to 399 percent of the poverty threshold are uninsured. Among the uninsured are 5.3% of disabled persons in Lake County (United States Census Bureau, 2013-2017).

Of those that are covered, 46.0% have private health insurance and 54.5% have public health insurance (United States Census Bureau, 2019). Public health insurance plans are plans that are in some way provided by the government. These plans are available to low-income individuals or families, the elderly, and other individuals that qualify for special groups. This includes the federal programs of Medicare, Medicaid, and Veteran Affairs Health Care (provided through Department of Veterans Affairs); the Children's Health Insurance Program (CHIP); and California State Health Plans. Further, undocumented immigrant children became eligible for Medi-Cal in 2016. Despite the provision of these plans, 3.7% children under 6 years and 8.0% children between 6 and 18 years in Lake County are not insured; in California, the rates of coverage for children under 6 years is 2.4% and for children between 6 and 18 years is 8.9%. The provisions of Medicaid through Medi-Cal and the Children's Health Insurance Program (CHIP) — which extend health coverage to children in poor families with modest incomes too high to qualify for Medicaid - could potentially cover these children indicating that enrollment efforts may need to be targeted to reach such families.

Pregnant women qualify with incomes up to 213 percent of FPL and the state has just begun to offer coverage to some undocumented young adults. According the most recent data, 69.8% of women in Lake County delivering a baby received prenatal care beginning in the first trimester of their pregnancy indicating more than 30% did not. This data also indicates that 22.1% of women ages 18-64 are without health insurance (California Deparment of Health, 2017-2018). This would indicate an opportunity to increase coverage rates among Lake County residents and a need to promote the open enrollment period among residents, simultaneously addressing any fears regarding the same.

One area clearly affecting access to health in Lake County is the provider to patient ratio. As seen earlier in section 4.2.5, the provider rate in Lake County is much lower than California. In 2016, there were only 30 primary care physicians in the county. The ratio of population to primary care physicians is 2,140 residents per one physician; in the same period, it was 1,274 residents per primary care physician in California and 1,326 residents per physician in the United States (County Health Rankings and Roadmaps, 2016).

The entire county of Lake is designated as Health Professional Shortage Area (HPSAs) by Health Resources & Services Administration (HRSA) as having shortages of primary care, dental care, or mental health providers. Currently, there are 37 Health Professional Shortage Areas (HPSA) and 1 Medically Underserved Areas/Populations (MUA/P) in Lake County (Health Resource & Services Administration, 2019). Of the 37 HPSA, 16 are for Primary Care, 10 for Dental Health and 11 for Mental Health.

HRSA makes grants to organizations and individuals to improve and expand health care services for underserved people, focusing on the following program areas: Primary Health Care/Health Centers, Ryan White HIV/AIDS Program, Health Workforce Development, School-based Scholarship and Loan Programs, Health Professions Training Grants to Support Institutions, Maternal and Child Health, Rural Health, Healthcare Systems, and Opioid Crisis Response. HRSA's workforce programs improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. The Bureau of Health Workforce (BHW) supports the health care workforce across the training continuum from training to service and expands the primary care workforce of clinicians who provide health care in high-need areas nationwide, including urban, rural, and frontier locations. Health professions programs support a wide array of fields including medicine, nursing, behavioral health, dentistry, public health, and others (Health Resources & Services Administration, 2018).

In 2018, Lake County had received $0 for special initiatives and other programs from HRSA (HRSA Data Warehouse, 2019). Lake County is also eligible for Rural Health Grants by HRSA. HRSA's Rural Health program helps build health care capacity and improve health outcomes for the estimated 62 million Americans who live in rural communities. This assessment and the Conduent HCI data platform seeks to provide the common ground for Lake County stakeholders to leverage shared capacities and resources to avail of grant opportunities in bringing workforce development to Lake County.

7.3.2 MENTAL HEALTH

Mental health and mental disorders had a data score of 1.94, where 0 reflects the best outcomes and 3 reflects the worst outcomes for the county. Mental health was a high priority among community survey participants; as mentioned earlier, 47.3% of those surveyed said they had been sad or worried in the last 30 days and 8.17% were finding day to day life difficult and were unable to function. In response to the kinds of service need gaps in Lake County, 44% said support for people re-entering community after addiction, prison, and mental health treatment was lacking and needed improvement. In fact, 51.3% of survey participants mentioned that mental health was the top priority in Lake County.

The key informants and focus groups also prioritized mental health due to the fact that the community faced many stressors and lacked providers that could either diagnose or treat mental health issues. Table 15 shows that depression and suicide were high for the county in comparison to the state for all life stages — pediatric, adolescent and adults. A further analysis of secondary data shows that 11.5% of adults self-reported having serious psychological stress. According to the same data source, 52.5% of Lake County adults needed or were receiving behavioral health care services (California Health Interview Survey, 2015-2016).

Yet the common refrain was that all mental health needs in the county were not being met currently. The county has 11 designated Mental Health Professional Shortage Areas, evidence of the high need in the county (Health Resources & Services Administration, 2019). With the high drug use rate, the incidence of mental health was stated to be rising.

TABLE 15: INDICATOR SCORES FOR MENTAL HEALTH AND MENTAL DISORDERS

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LAKE COUNTY	CA	MEASUREMENT PERIOD
2.28	Depression: Medicare Population	*percent*	16.8	14.3	2015
2.11	Adults Needing and Receiving Behavioral Health Care Services	*percent*	52.5	60.5	2015-2016
2.11	Adults Who Ever Thought Seriously About Committing Suicide	*percent*	16.3	10.4	2016-2017
2.11	Adults with Likely Serious Psychological Distress	*percent*	11.5	8.9	2015-2017
2.00	Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	*ER visits/ 10,000 population aged 12-17*	91.3	46.3	2013-2015
2.00	Age-Adjusted ER Rate due to Mental Health	*ER visits/ 10,000 population 18+ years*	202.7	93.4	2013-2015
2.00	Age-Adjusted ER Rate due to Pediatric Mental Health	*ER visits/ 10,000 population under 18 years*	69.4	30.4	2013-2015
2.00	Age-Adjusted ER Rate due to Suicide and Intentional Self-inflicted Injury	*ER visits/ 10,000 population 18+ years*	52.6	21.7	2013-2015
2.00	Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	*hospitalizations/ 10,000 population aged 12-17*	22.1	13.9	2013-2015
2.00	Age-Adjusted Hospitalization Rate due to Mental Health	*hospitalizations/ 10,000 population 18+ years*	66	51.3	2013-2015
2.00	Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	*hospitalizations/ 10,000 population under 18 years*	31.1	26.5	2013-2015
2.00	Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury	*hospitalizations/ 10,000 population 18+ years*	17.3	10.7	2013-2015
0.61	Alzheimer's Disease or Dementia: Medicare Population	*0*	7	9.3	2015

Mental Health was a topic that had been prioritized by Hope Rising Lake County partners in 2016. Since then, several initiatives had been launched as given below:

- Restoration House Respite Bed
- Project Restoration
- LiveWell

Since these activities were ongoing, Hope Rising Lake County partners chose not to focus on mental health in this iteration of the CHNA and focus its energies on the significant needs outlined above.

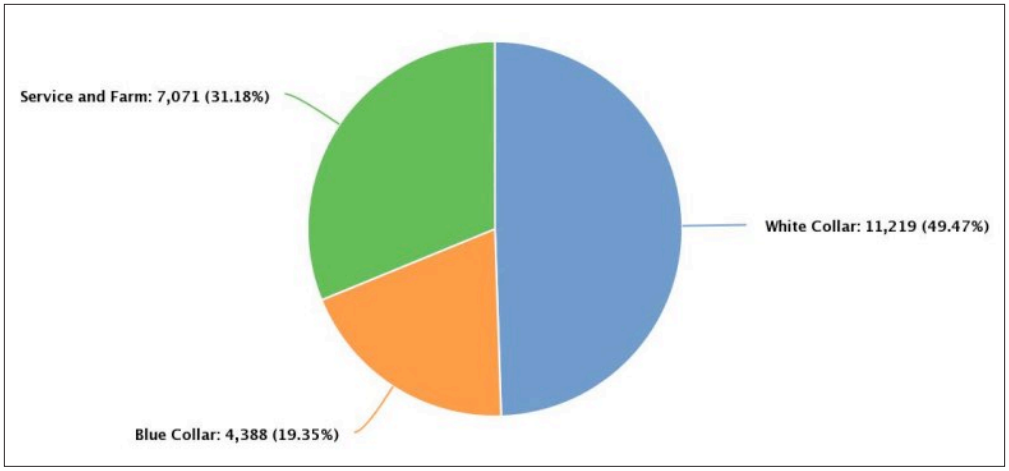
7.3.3 POVERTY AND UNEMPLOYMENT

Data scoring yielded high scores of 2.44 and 2.15 for unemployment and poverty respectively. Poverty and unemployment are associated closely and are being discussed here jointly. Households with incomes below the poverty line face many challenges. They find it difficult to meet their living expenses and to make health a priority. In the United States, good health is closely linked to having a job that provides employer sponsored health insurance. Prolonged unemployment increases the likelihood that individuals will earn lower wages or face more periods of unemployment throughout their lives.

The unemployment rate in 2013-2017 for Lake County residents 16+ years was very high at 11.2%; in California and nationally, that rate was 7.7% and 6.6% respectively. In Lake County 12.2% males and 7.1% females in the 16+ age group were unemployed during the same period. Among races in the county, the unemployment rate ranged from 18.6% in Black or African Americans, 12.2% in American Indian and Alaska Natives, 11.6% in Hispanics or Latinos to 10.4% in Whites (United States Census Bureau, 2013-2017). In Lake County, 8.1% of youth were neither in school nor working. Youth who are not in school and are not employed face both short- and long-term barriers to career success. Young people who lack financial stability may be forced to postpone major life decisions such as purchasing a home or starting a family. The most recent U.S. Bureau of Labor Statistics places the unemployment rate among workers in the labor force at 5.2% in April 2019; the same rates for California and the U.S. were 3.9% and 3.3% respectively. More importantly, the Mann-Kendall Test for Statistical Significance which is used by Conduent HCI to evaluate trends over 4 to 10 periods of time shows the Lake County unemployment value increasing significantly (Conduent Healthy Communities Institute, 2019).

Moreover, being employed does not necessarily mean that families are able to meet their basic living expenses, including health costs. As seen in the figure below, 31.8% of the population in the county were employed in the service sector and agriculture and another 19.3% were blue collar workers. Additionally, in Lake County, 28.2% of households are asset limited, income constrained, employed (ALICE) comprising households with income above the Federal Poverty Level but below the basic cost of living. Poverty and unemployment has been previously discussed in Sections 4.1.6 Employment and 4.2.1 Poverty.

FIGURE 59: EMPLOYED CIVILIANS 16+ BY OCCUPATION GROUP

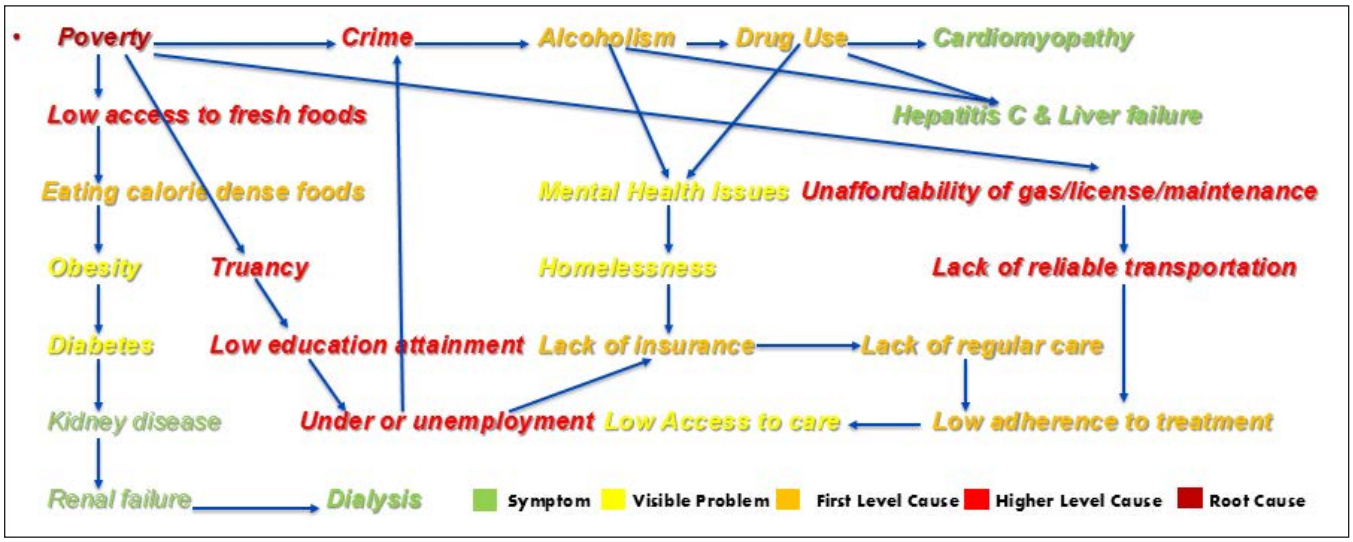


Source: Claritas Pop-Facts Population Estimate, 2019

During the key informants and focus group discussions, inter-generational poverty was repeated over and over for Lake County residents. The county had traditionally been a catchment area for retirees and others that wanted a lackadaisical lifestyle. The number of people with disability and subsisting on public assistance was also stated to be quite high, facts that are corroborated in Section 4.6 Social Profile.

During the focus groups and key informant interviews, an attempt was made to arrive at the root causes of the high priority health needs of Lake County. A post-hoc analysis pieced together the responses collected throughout the community input to arrive at the root cause for substance abuse (as shown in Figure 60). The analysis revealed the root cause to be poverty. The figure below display some of the links between poverty and diseases through the mediation of other social and economic factors.

FIGURE 60: ROOT CAUSE ANALYSIS OF HEALTH CHALLENGES IN LAKE COUNTY



While poverty and unemployment are economic indicators outside the purview of health agencies and their implementation strategies, it is possible for hospitals, health plans and local government to mitigate the health consequences of poverty and its impact. One of the suggestions put forth by key informants was to expand the Hope Rising Lake County Collaborative to include Department of Education, faith communities, the Chamber of Commerce as well as Local Businesses to address the health challenge from all angles and with combined focus. Additionally, economic prospects for youth can be improved by increasing high school graduation rates, increasing access to post-secondary education, and providing career counseling services to students as well as youth who have either completed or dropped out of school. Hope Rising Lake County partners will target these strategies through the umbrella priority of community outreach and education that has been prioritized.

7.4 COMMUNITY RESOURCES TO ADDRESS PRIORITY HEALTH ISSUES

Hope Rising Lake County has partnered with Conduent HCI and other Lake County organizations to connect residents to health information, social services, and health resources through their comprehensive resource database. This resource inventory is available publicly to all constituents of Lake County. The community resources are searchable by topic area such as housing, food, income and expenses, transportation, education or by target population such a children and family, youth, and seniors. Therefore, Hope Rising Lake County has made a direct link to all of the resources available through its website through the resource library instead of publishing a list of resources that becomes outdated. The resource library will be seamlessly updated by Conduent HCI at regular intervals. A list of other Lake County organizations, generated by asking survey participants to name those that they have interacted with recently and have relations of trust with, can also be accessed through the Appendix F. Community Resources in this report.

Additionally, Lake County has multiple Collaboratives and/or Coalitions such as Health Leadership Network, Lake County Health Coalition, Tribal Health Continuous Quality Improvement Committee (Home Visitation Program), Breastfeeding Coalition, Safe RX Opioid Task Force, Partnership HealthPlan — Public Health Committee, Oral Health Access Council, MCAH Advisory Board, Mother-Wise Program, Suicide Prevention Task Force, Healthy Start Collaborative, Children's Council, Lake County First 5 Commission, and Child Health and Disability (CHAD) (California Department of Public Health, 2017-2018).

7.5 CONCLUSION

The preceding community needs assessment (CHNA) describes barriers to health faced by the community, throwing into focus its priority health issues and providing information necessary to all levels of stakeholders to build upon each other's work and work in a coordinated, collaborative manner. Hope Rising Lake County's Community Health Needs Assessment Collaborative has established clear priorities based on the results of this assessment to improve health outcomes for the residents of Lake County. In collaboration with community stakeholders and residents, Hope Rising Lake County hopes to realize its vision of improving its ranking in the County Health Rankings and Roadmaps list by 2022.

APPENDIX A. EVALUATION SINCE PRIOR CHNA

ADVENTIST HEALTH HOSPITAL CLEARLAKE

SIGNIFICANT HEALTH NEED IDENTIFIED IN PRECEDING CHNA	PLANNED ACTIVITIES TO ADDRESS HEALTH NEEDS IDENTIFIED IN PRECEDING IMPLEMENTATION STRATEGY	WAS ACTIVITY IMPLEMENTED (YES/NO)	RESULTS, IMPACT & DATA SOURCES
Healthy Behaviors	Living Nicotine Free with Live Well	Yes	Number of Community Members Served: 19
	Live Well	Yes	Number of Community Members Served: 2653
	Point of Care Sepsis Protocol	Yes	Number of Community Members Served: 950
	Lake County Loves Babies	Yes	Projected Number of Community Members to be Served: 180
Clinical Care	Safe Rx	Yes	Number of Community Members Served: 2113
	Project Restoration	Yes	Number of Community Members Served: 13
	Restoration House Respite Bed	Yes	Number of Community Members Served: 6
	Live Well Intensive	Yes	Number of Community Members Served: 80
	Sepsis Protocol	Yes	Number of Community Members Served: 950
	Capitated Member Communication Strategy	Yes	Projected Number of Community Members Served: 7,500
	Paramedic Home Visit Program	Yes	Projected Number of Community Members Served: 50
	Senior VIP Strategy	Yes	Projected Number of Community Members Served: 1,500
Social and Economic Factors	Hope Rising Lake County Task Force	Yes	Number of Community Members Served: 65000
	The Healthy Clearlake Collaborative	Yes	Number of Community Members Served: 500
	Safe Rx	Yes	Number of Community Members Served: 15,000
	Project Restoration	Yes	Number of Community Members Served: 40
	Hope Rising Lake County Center for Transformation	Yes	Projected Number of Community Members to be Served: 400
Physical Environment	Project Restoration/ Restoration House	Yes	Number of Community Members Served: 13
	Nutritional Services	Yes	Number of Community Members Served: 2500
	Hope Rising Lake County Center for Transformation	No	Projected Number of Community Members to be Served: 200

SUTTER LAKESIDE HOSPITAL

SIGNIFICANT HEALTH NEEDS IDENTIFIED IN PRECEDING CHNA	PLANNED ACTIVITIES TO ADDRESS HEALTH NEEDS IDENTIFIED IN PRECEDING IMPLEMENTATION STRATEGY	WAS ACTIVITY IMPLEMENTED (YES/NO)	RESULTS, IMPACT & DATA SOURCES
Access to Healthcare Services	Breast Cancer Navigation	Yes	2016: 154 women served 2017: 103 women served 2018: 306 women served
Access to Healthcare Services	Way to Wellville	Yes	Formation of Hope Rising Lake County
Access to Healthcare Services	Heroes of Health and Safety Fair	Yes	2016: 1994 attendees, 96 diabetes education given, 100 blood pressure screenings, 100 oral cancer screenings, 121 dental educations, 150 A1C screenings, 470 flu vaccines administered, 100 health screenings 2017: 2500 attendees, 400 flu vaccines, 150 diabetes screenings, 43 HIV screenings 2018: 2500 attendees, 450 stroke educations, 50 medication educations, 61 HIV screenings, 550 dental educations, 425 flu vaccines given
Community Health Education	Stroke Community Education Outreach	Yes	350 persons served in 2016. In 2018, 5 persons were served. Currently holding stroke education booths at approximately 5 events per year.
Community Health Education	Wellness and Stroke Support Group	Yes, but discontinued	Offered support group once per month with average attendance of about 2, so we discontinued it.
Community Health Education	Wellness Classes Taught by Physical Therapy	Yes	Offering classes 3 days/week, 45 minutes long. Roughly 450 patients served.
Community Health Education	SLH Childbirth Education Series	Yes	4-part Childbirth education series offered for free every other month.
Alcohol and drug abuse prevention services	Reducing Emergency Department Over Utilization by Addressing Needs of the Community		Implemented a variety of processes which led to improvements in hospital readmission rates, thereby reducing unnecessary ED visits. 2017-2018 readmission rates for Sutter Lakeside were some of the lowest in all of Sutter Health, and ranked very high in the state and nationally.
Alcohol and drug abuse prevention services	Hope Rising Lake County	Yes	Formed Hope Rising Lake County
Alcohol and drug abuse prevention services	Hope Rising Safe RX Lake County	Yes	Impacted approximately 15,000 individuals; see county data below

SIGNIFICANT HEALTH NEED IDENTIFIED IN PRECEDING CHNA	ADDITIONAL ACTIVITIES IMPLEMENTED	RESULTS, IMPACT & DATA SOURCES
Access to Healthcare Services	Implementation of Tele-psychiatry service in ED and clinics	In 2018: 112 in ED, 36 inpatient consultations, 188 outpatient clinic visits
Access to Healthcare Services	Smart Start Baby Bundle — access to personal health resources	Provided 141 bundles in 2016 and 347 bundles of safe sleep supplies and materials in 2017
Access to Healthcare Services	Added numerous additional inpatient services in order to improve access to inpatient care here in the county. · Infectious Disease consultation contract · 24x7 eICU consultation contract · Tele-nephrology · Tele-gastroenterology · Tele-neonatology	Improved admission rate from ED visits from 5.5% to 7.5% in 2018. This means the hospital was able to provide inpatient services right here in Lake County to significantly more patients over the past few years as a better service to our community
Community Health Education	Smart Start Baby Bundle — Safe Sleep Education	Provided safe sleep education to approximately 600 residents since July 2017.
Community Health Education	Diabetes Education Program	Have held free monthly classes for over 2 years.
Community Health Education	Town Hall/Open House series	(Imaging, Cardiology, Orthopedics, PT/ST, Primary Care)

APPENDIX B. SOCIAL DETERMINANTS OF HEALTH: A GUIDING FRAMEWORK FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT

The Hope Rising Lake County Community health needs assessment process was based upon an established public health framework of Social Determinants of Health (SDOH) that will guide goal setting for all stakeholders engaged in the task of building healthy communities in the county.

According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as 'place.' In addition to the more material attributes of 'place,' the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins." (Office of Disease Prevention and Health Promotion, 2019)

FIGURE 61: HEALTHY PEOPLE 2020 APPROACH TO SOCIAL DETERMINANTS OF HEALTH

Source: SIM MDDHS State Innovation Model

A "place-based" organizing framework (Figure 61), reflecting five (5) key areas of social determinants of health (SDOH), was developed by Healthy People 2020.

These five key areas (determinants) include:

- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and Built Environment

Each of these five determinant areas reflects a number of key issues that make up the underlying factors in the arena of SDOH (Office of Disease Prevention and Health Promotion, 2019).

TABLE 16: KEY AREAS OF SOCIAL DETERMINANTS OF HEALTH

ECONOMIC STABILITY	EDUCATION	SOCIAL AND COMMUNITY CONTEXT	HEALTH AND HEALTH CARE	NEIGHBORHOOD AND BUILT ENVIRONMENT
• Employment • Food Insecurity • Housing Instability • Poverty	• Early Childhood Education and Development • Enrollment in Higher Education • High School Graduation • Language and Literacy	• Civic Participation • Discrimination • Incarceration • Social Cohesion	• Access to Health Care • Access to Primary Care • Health Literacy	• Access to Foods that Support Healthy Eating Patterns • Crime and Violence • Environmental Conditions • Quality of Housing

This assessment provides community health practitioners with the opportunity to engage a wide variety of stakeholders, including community members, to achieve the objectives set forth, using the SDOH framework as a guide for program planning and policy adoption to promote community health and prevent disease. Social Determinants of Health create a strategic framework that delivers equity within the broader aim of targeting health promotion and disease prevention issues. With this assessment, Hope Rising Lake County aims to identify and address population health disparities categorized by race/ethnicity, socioeconomic status, gender, age, disability status, sexual orientation and geographic location. Most importantly, this framework allows for tracking of upstream, data-driven outcomes to monitor progress and focus proposed population health interventions for a healthier Lake County.

APPENDIX C. SECONDARY DATA METHODOLOGY

SECONDARY DATA SOURCES

The main source for the secondary data, or data that have been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national sources used in Hope Rising Lake County's Community Health Needs Assessment.

1. American Community Survey
2. National Center for Education Statistics
3. County Health Rankings
4. The Dartmouth Atlas of Health Care
5. California Department of Public Health
6. Centers for Medicare & Medicaid Services
7. National Cancer Institute
8. U.S. Bureau of Labor Statistics
9. California Opioid Overdose Surveillance Dashboard
10. California Department of Justice
11. California Health Interview Survey
12. Feeding America
13. Claritas Consumer Buying Power
14. Child Welfare Dynamic Report System
15. California Department of Public Health, STD Control Branch
16. California Department of Education
17. Institute for Health Metrics and Evaluation
18. California Office of Statewide Health Planning and Development
19. California Secretary of State
20. U.S. Department of Agriculture - Food Environment Atlas
21. Controlled Substance Utilization Review and Evaluation System
22. National Environmental Public Health Tracking Network
23. California Department of Public Health, Immunization Branch
24. Lucile Packard Foundation for Children's Health
25. Small Area Health Insurance Estimates
26. American Lung Association
27. California State Highway Patrol
28. U.S. Census — County Business Patterns

SECONDARY DATA SCORING

For each indicator, Hope Rising Lake County's service area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

COMPARISON TO A DISTRIBUTION OF COUNTY VALUES: WITHIN STATE AND NATION

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

COMPARISON TO VALUES: STATE, NATIONAL, AND TARGETS

Each county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2020 (HP2020) goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

TREND OVER TIME

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

MISSING VALUES

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

INDICATOR SCORING

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

TOPIC SCORING

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

The health and quality of life topic areas are described and defined as follows:

TOPIC AREA	DESCRIPTION & DEFINITION
Access to Health Services	Indicators of or directly related to the availability and ease of access to adequate health services, including primary care, specialty care, oral health care, and mental health care
Children's Health	Indicators of or directly related to children's physical or mental health
Diabetes	Indicators of or directly related to the incidence, prevalence, mortality, screening, treatment, or management of diabetes
Disabilities	Indicators of or directly related to the population affected by disabilities
Economy	Indicators of or directly related to economic factors affecting of an individual's health and quality of life, including income and poverty
Education	Indicators of or directly related to education, specifically educational attainment, proficiency, and educational institutions
Environment	Indicators of or directly related to the surroundings or conditions in which individuals live and operate, including the natural environment and man-made effects on environmental conditions
Environmental & Occupational Health	Indicators of or directly related to the health effects of the physical environment, including those related to one's occupation
Exercise, Nutrition, & Weight	Indicators of or directly related to physical activity and diet behaviors or measures of healthy weight
Heart Disease & Stroke	Indicators of or directly related to cardiovascular health
Immunizations & Infectious Diseases	Indicators of or directly related to vaccinations, influenza & pneumonia, HIV/AIDS, STDs, TB, etc.
Maternal, Fetal & Infant Health	Indicators of or directly related to the health of a mother or child before, during, and after pregnancy
Mental Health & Mental Disorders	Indicators of or directly related to access to mental health care, prevalence of mental illness, and general mental health status
Older Adults & Aging	Indicators of or directly related to health issues specific or especially pertinent to Older Adults (usually age 65+)
Oral Health	Indicators of or directly related to access to oral health care, prevalence of oral diseases, and general oral health status
Prevention & Safety	Indicators of or directly related to injury prevention
Respiratory Diseases	Indicators of or directly related to any disease affecting the respiratory system, including asthma, COPD, lung cancer, and tuberculosis
Social Environment	Indicators of or directly related to the immediate physical and social settings in which people live, including culture, institutions, and interpersonal interactions
Substance Abuse	Indicators of or directly related to alcohol abuse, tobacco use, illegal substance use, and abuse of prescription drugs
Teen & Adolescent Health	Indicators of or directly related to health behaviors and outcomes of adolescents (usually ages 12-17 or grades 7-12)
Transportation	Indicators of or directly related to transportation and its effects on health and quality of life, notably with regards to access to care, commuting, and availability of needed services.

LAKE COUNTY DATA SCORING RESULTS

The following tables list each indicator by topic area for Hope Rising Lake County's service area. Secondary data for this report are up to date as of March 13th, 2019.

SCORE	ACCESS TO HEALTH SERVICES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	SOURCE
2.28	People Delayed or had Difficulty Obtaining Care	percent	15.5	4.2	10.7		2015-2016	N/A	23
2.17	Consumer Expenditures: Medical Services	percent	2		1.8	1.7	2018	N/A	27
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	percent	1.2		0.8	1	2018	N/A	27
2.11	Adults Needing and Receiving Behavioral Health Care Services	percent	52.5		60.5		2015-2016	N/A	23
2.11	Primary Care Provider Rate	providers/ 100,000 population	51.1		78.1	75.5	2015	N/A	27
2.00	Consumer Expenditures: Medical Supplies	percent	0.3		0.3	0.3	2018	N/A	27
1.83	Dentist Rate	dentists/ 100,000 population	45.2		82.4	67.4	2016	N/A	27
1.67	Adults Delayed or had Difficulty Obtaining Care	percent	22.2		21.2		2013-2014	N/A	23
1.50	People with a Usual Source of Health Care	percent	91	95	87.3		2013	N/A	23
1.42	Adults with Health Insurance: 18-64	percent	89.5	100	89.6		2016	N	27
1.14	Children with Health Insurance	0	98.2	100	96.9	95	2017	N	1
1.06	Non-Physician Primary Care Provider Rate	0	71.7		52.2	81.2	2017	N/A	27
SCORE	ALTERNATIVE MEDICINE	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	percent	1.2		0.8	1	2018	N/A	27

SCORE	CANCER	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Mammography Screening: Medicare Population	percent	50.6		59.5	63.2	2015	N/A	27
2.50	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	29.5	20.7	19.1		2014-2016	N/A	1
2.44	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	73.9		43.3	60.2	2011-2015	N	27
2.44	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14.2		10.3	11.6	2011-2015	N	27
2.28	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	23.4	21.8	19.7	19.5	2011-2015	N	27
2.17	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.8	14.5	13.3	14.5	2011-2015	N	27
2.06	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	192.7	161.4	140.2		2014-2016	N/A	1
1.94	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	46.5	45.5	28.9		2014-2016	N/A	1
1.72	Colorectal Cancer Incidence Rate	cases/ 100,000 population	41.8	39.9	36.2	39.2	2011-2015	N	27
0.56	Cancer: Medicare Population	0	6.2		7.5	7.8	2015	N/A	27
0.39	Breast Cancer Incidence Rate	0	101.8		121.5	124.7	2011-2015	N	27
0.39	Prostate Cancer Incidence Rate	0	80.5		101.2	109	2011-2015	N	27

SCORE	CHILDREN'S HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.17	Child Food Insecurity Rate	percent	24.5		19	17.9	2016	N/A	27
2.17	Substantiated Child Abuse Rate	cases/ 1,000 children	9.9		7.5		2017	N/A	27
2.00	Age-Adjusted ER Rate due to Pediatric Mental Health	ER visits/ 10,000 population under 18 years	69.4		30.4		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	hospitalizations/ 10,000 population under 18 years	31.1		26.5		2013-2015	Y	23
1.78	5th Grade Students who are at a Healthy Weight or Underweight	percent	57.4		59.5		2017-2018	N/A	1
1.67	Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	72.5		70.9		2013-2015	N	23
1.56	Kindergartners with Required Immunizations	percent	93.9		95.1		2017	N/A	1
1.39	Children and Teens with Asthma	percent	15.1				2014	N/A	23
1.33	Children with Low Access to a Grocery Store	percent	3.9				2015	N/A	28
1.17	Age-Adjusted Hospitalization Rate due to Pediatric Asthma	0	6.9		9.8		2013-2015	N/A	23
1.14	Children with Health Insurance	0	98.2	100	96.9	95	2017	N	1
0.67	Consumer Expenditures: Childcare	0	0.3		0.5	0.5	2018	N/A	27
0.61	Food Insecure Children Likely Ineligible for Assistance	0	18		33	20	2016	N/A	27

SCORE	DIABETES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.00	Age-Adjusted ER Rate due to Diabetes	ER visits/ 10,000 population 18+ years	51.3		26.6		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Long-Term Complications of Diabetes	ER visits/ 10,000 population 18+ years	18.6		12.4		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Short-Term Complications of Diabetes	ER visits/ 10,000 population 18+ years	10.2		1.8		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Uncontrolled Diabetes	ER visits/ 10,000 population 18+ years	6.3		2.2		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Diabetes	hospitalizations/ 10,000 population 18+ years	29.4		17.2		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	hospitalizations/ 10,000 population 18+ years	12.3		10.2		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes	hospitalizations/ 10,000 population 18+ years	16		5.9		2013-2015	N/A	23
1.89	Adults with Diabetes	percent	12.8		9.4		2015-2016	N/A	23
1.33	Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes	hospitalizations/ 10,000 population 18+ years	0.8		0.9		2013-2015	N/A	23
0.78	Diabetes: Medicare Population	0	21.1		25.3	26.5	2015	N/A	27
0.64	Age-Adjusted Death Rate due to Diabetes	0	14.6		20.7	21.1	2014-2016	N/A	1
SCORE	DISABILITIES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.25	Persons with Disability Living in Poverty (5-year)	percent	37.1		25.5	27.1	2013-2017	N/A	1

SCORE	ECONOMY	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.83	Families Living Below Poverty Level	percent	17.8		11.1	10.5	2013-2017	Y	1
2.83	Students Eligible for the Free Lunch Program	percent	66.3		50.1	42.6	2015-2016	N/A	27
2.44	Unemployed Workers in Civilian Labor Force	percent	4.9		3.9	3.5	November 2018	N/A	27
2.39	Children Living Below Poverty Level	percent	31.6		20.8	20.3	2013-2017	Y	1
2.39	Median Household Income	dollars	40446		67169	57652	2013-2017	Y	1
2.39	People Living 200% Above Poverty Level	percent	53.2		66.1	67.2	2013-2017	N/A	1
2.39	People Living Below Poverty Level	percent	22.8		15.1	14.6	2013-2017	Y	1
2.39	Renters Spending 30% or More of Household Income on Rent	percent	62.6		56	50.6	2013-2017	N	1
2.39	Youth not in School or Working	percent	8.1		2.1	2.1	2013-2017	N	1
2.28	Severe Housing Problems	percent	27.3		27.9	18.8	2010-2014	N/A	27
2.25	Persons with Disability Living in Poverty (5-year)	percent	37.1		25.5	27.1	2013-2017	N/A	1
2.22	Homeownership	percent	48.6		50.2	56	2013-2017	N/A	1
2.17	Child Food Insecurity Rate	percent	24.5		19	17.9	2016	N/A	27
2.17	Food Insecurity Rate	percent	17		11.7	12.9	2016	N/A	27
1.83	Low-Income and Low Access to a Grocery Store	percent	8.8				2015	N/A	28
1.83	Per Capita Income	dollars	23345		33128	31177	2013-2017	Y	1
0.89	People 65+ Living Below Poverty Level	0	8.6		10.2	9.3	2013-2017	N	1
0.61	Food Insecure Children Likely Ineligible for Assistance	0	18		33	20	2016	N/A	27

SCORE	EDUCATION	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.44	People 25+ with a Bachelor's Degree or Higher	percent	15.3		32.6	30.9	2013-2017	Y	1
2.11	High School Graduation	percent	75.5	87	82.7		2016-2017	N/A	1
2.00	11th Grade Students Proficient in English/Language Arts	percent	46		56		2018	N/A	1
2.00	11th Grade Students Proficient in Math	percent	14.6		31.4		2018	N/A	1
2.00	3rd Grade Students Proficient in English/Language Arts	percent	34.4		48.2		2018	N/A	1
2.00	3rd Grade Students Proficient in Math	percent	31		48.9		2018	N/A	1
2.00	4th Grade Students Proficient in English/Language Arts	percent	28.5		48.7		2018	N/A	1
2.00	4th Grade Students Proficient in Math	percent	25.9		42.9		2018	N/A	1
2.00	5th Grade Students Proficient in English/Language Arts	percent	30.1		49.4		2018	N/A	1
2.00	5th Grade Students Proficient in Math	percent	18.3		36		2018	N/A	1
2.00	6th Grade Students Proficient in English/Language Arts	percent	25.5		47.8		2018	N/A	1
2.00	6th Grade Students Proficient in Math	percent	16.2		37.5		2018	N/A	1
2.00	7th Grade Students Proficient in English/Language Arts	percent	34.6		50.2		2018	N/A	1
2.00	7th Grade Students Proficient in Math	percent	22.3		37.3		2018	N/A	1
2.00	8th Grade Students Proficient in English/Language Arts	percent	32.3		49.1		2018	N/A	1
2.00	8th Grade Students Proficient in Math	percent	16.4		36.9		2018	N/A	1
1.89	Student-to-Teacher Ratio	students/ teacher	23		24	18	2015-2016	N/A	27
1.78	People 25+ with a High School Degree or Higher	percent	84.7		82.5	87.3	2013-2017	Y	1
0.67	Consumer Expenditures: Childcare	0	0.3		0.5	0.5	2018	N/A	27

SCORE	ENVIRONMENT	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.39	Food Environment Index		6.7		8.8	7.7	2018	N/A	27
2.28	Severe Housing Problems	percent	27.3		27.9	18.8	2010-2014	N/A	27
1.83	Access to Exercise Opportunities	percent	75		89.6	83.1	2018	N/A	27
1.83	Households with No Car and Low Access to a Grocery Store	percent	3.6				2015	N/A	28
1.83	Low-Income and Low Access to a Grocery Store	percent	8.8				2015	N/A	28
1.67	People 65+ with Low Access to a Grocery Store	percent	3.5				2015	N/A	28
1.61	Number of Extreme Precipitation Days	days	99				2016	N/A	27
1.61	Weeks of Moderate Drought or Worse	weeks per year	52				2016	N/A	27
1.50	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014	N/A	28
1.39	Months of Mild Drought or Worse	months per year	7				2016	N/A	27
1.39	Number of Extreme Heat Events	events	5				2016	N/A	27
1.33	Children with Low Access to a Grocery Store	percent	3.9				2015	N/A	28
1.28	Annual Particle Pollution	grade	B				2014-2016	N/A	1
1.28	Fast Food Restaurant Density	0	0.5				2014	N/A	28
1.22	Daily Dose of UV Irradiance	0	3077		3216		2015	N/A	27
1.11	Farmers Market Density	0	0.1				2016	N/A	28
1.11	Grocery Store Density	0	0.3				2014	N/A	28
0.89	Annual Ozone Air Quality	grade	A				2014-2016	N/A	1
0.39	Liquor Store Density	0	6.2		10.1	10.5	2015	N/A	28

SCORE	ENVIRONMENTAL & OCCUPATIONAL HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.50	Asthma: Medicare Population	percent	8.7		7.5	8.2	2015	N/A	27
2.00	Age-Adjusted ER Rate due to Adult Asthma	ER visits/ 10,000 population 18+ years	65		34.6		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	66.9		44		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Adult Asthma	hospitalizations/ 10,000 population 18+ years	9.1		6.8		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Asthma	hospitalizations/ 10,000 population	8.5		7.6		2013-2015	N/A	23
1.67	Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	72.5		70.9		2013-2015	N	23
1.39	Adults with Asthma	percent	15.9		15		2016-2017	N	23
1.17	Age-Adjusted Hospitalization Rate due to Pediatric Asthma	0	6.9		9.8		2013-2015	N/A	23

SCORE	EXERCISE, NUTRITION, & WEIGHT	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.39	Food Environment Index		6.7		8.8	7.7	2018	N/A	27
2.17	Child Food Insecurity Rate	percent	24.5		19	17.9	2016	N/A	27
2.17	Food Insecurity Rate	percent	17		11.7	12.9	2016	N/A	27
2.00	7th Grade Students who are Physically Fit	percent	49.6		63.6		2017-2018	N/A	1
2.00	Adults who Walk Regularly	percent	29.2		33		2013-2014	N/A	23
2.00	Consumer Expenditures: High Sugar Beverages	percent	0.6		0.5	0.6	2018	N/A	27
2.00	Consumer Expenditures: High Sugar Foods	percent	0.9		0.8	0.8	2018	N/A	27
1.94	9th Grade Students who are at a Healthy Weight or Underweight	percent	56.6		62.7		2017-2018	N/A	1
1.83	Access to Exercise Opportunities	percent	75		89.6	83.1	2018	N/A	27
1.83	Adults who Drink Sugar-Sweetened Beverages	percent	20.5		17.4		2013-2014	N/A	23
1.83	Households with No Car and Low Access to a Grocery Store	percent	3.6				2015	N/A	28
1.83	Low-Income and Low Access to a Grocery Store	percent	8.8				2015	N/A	28
1.78	5th Grade Students who are at a Healthy Weight or Underweight	percent	57.4		59.5		2017-2018	N/A	1
1.67	People 65+ with Low Access to a Grocery Store	percent	3.5				2015	N/A	28
1.56	Adults who are Overweight or Obese	percent	65.5		60.4		2017	N	23
1.50	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2014	N/A	28
1.33	Children with Low Access to a Grocery Store	percent	3.9				2015	N/A	28
1.28	Fast Food Restaurant Density	0	0.5				2014	N/A	28
1.25	Adults Who Are Obese	0	28.1	30.5	27.9	29.9	2016	N/A	23
1.22	Workers who Walk to Work	0	3	3.1	2.7	2.7	2013-2017	N	1
1.11	Adult Fast Food Consumption	0	48.5		65.6		2016	N	23
1.11	Farmers Market Density	0	0.1				2016	N/A	28
1.11	Grocery Store Density	0	0.3				2014	N/A	28
0.67	Consumer Expenditures: Fruits and Vegetables	0	1.6		1.5	1.4	2018	N/A	27
0.61	Food Insecure Children Likely Ineligible for Assistance	0	18		33	20	2016	N/A	27

SCORE	FAMILY PLANNING	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
1.92	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	30.5		17.6	22.3	2014-2016	N/A	1
SCORE	GOVERNMENT & POLITICS	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
1.94	Voter Turnout: Presidential Election	percent	72.3		75.3		2016	N/A	23
SCORE	HEART DISEASE & STROKE	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.17	High Blood Pressure Prevalence	percent	43.9	26.9	29		2017	N	23
2.08	Age-Adjusted Death Rate due to Coronary Heart Disease	deaths/ 100,000 population	115.7	103.4	89.1	96.8	2014-2016	N/A	1
2.00	Adults with Heart Disease	percent	8.7		5.9		2013-2014	N/A	23
2.00	Age-Adjusted ER Rate due to Heart Failure	ER visits/ 10,000 population 18+ years	34		9.4		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	29.8		26.4		2013-2015	Y	23
1.83	Ischemic Heart Disease: Medicare Population	percent	26.8		23.6	26.5	2015	N/A	27
1.75	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	40.8	34.8	35.3	37.2	2014-2016	N/A	1
1.67	Age-Adjusted Hospitalization Rate due to Heart Failure	hospitalizations/ 10,000 population 18+ years	31.8		29.1		2013-2015	N/A	23
1.56	Age-Adjusted Death Rate due to Heart Attacks	deaths/ 100,000 population	54		50.7		2015	N/A	27
1.44	Heart Failure: Medicare Population	percent	12.8		12.9	13.5	2015	N/A	27
1.17	Age-Adjusted Hospitalization Rate due to Hypertension	0	2.4		3.3		2013-2015	N	23
1.00	Age-Adjusted Hospitalization Rate due to Heart Attack	0	20.9		23.6		2014	N/A	27
0.72	Hyperlipidemia: Medicare Population	0	35.1		41.5	44.6	2015	N/A	27
0.61	Atrial Fibrillation: Medicare Population	0	6.3		7.3	8.1	2015	N/A	27
0.56	Hypertension: Medicare Population	0	44.5		49.6	55	2015	N/A	27
0.39	Stroke: Medicare Population	0	2.9		3.7	4	2015	N/A	27

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.14	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	19.6		14.3	14.6	2014-2016	N/A	1
2.11	Death Rate Among Persons with Diagnosed HIV Infection	deaths/ 100,000 population	9.2		4.4		2016	N/A	1
2.11	Gonorrhea Incidence Rate	cases/ 100,000 population	286.2		190.3		2017	N/A	15
2.00	Age-Adjusted ER Rate due to Community Acquired Pneumonia	ER visits/ 10,000 population 18+ years	69.8		19		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Hepatitis	ER visits/ 10,000 population 18+ years	2.7		0.9		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia	hospitalizations/ 10,000 population 18+ years	30.6		16.7		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Hepatitis	hospitalizations/ 10,000 population 18+ years	4		2.3		2013-2015	N/A	23
1.67	Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza	ER visits/ 10,000 population 18+ years	9.6		9.5		2013-2015	N	23
1.56	Kindergartners with Required Immunizations	percent	93.9		95.1		2017	N/A	1
1.50	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	hospitalizations/ 10,000 population 18+ years	1.4		1.5		2013-2015	N/A	23
1.50	Reported Incidence of Persons Diagnosed with HIV/ AIDS: 13+	cases/ 100,000 population 13+ years	257.5		391.7		2013-2015	N/A	1
1.44	Chlamydia Incidence Rate	cases/ 100,000 population	404.7		552.2		2017	N/A	15
1.28	Syphilis Incidence Rate	0	6.2		16.8		2017	N/A	15
1.00	Congenital Syphilis Incidence Rate	0	0		58.2		2017	N/A	15
1.00	Persons Living and Diagnosed with HIV who are in Care	0	89.1		73.2		2016	N/A	1
0.89	HIV Incidence Rate	0	1.5		12.9		2016	N/A	1

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.53	Infant Mortality Rate	deaths/ 1,000 live births	11.2	6	4.8	6.1	2011	N/A	1
2.17	Mothers who Received Early Prenatal Care	percent	69.9	77.9	83.3		2014-2016	N/A	1
1.92	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	30.5		17.6	22.3	2014-2016	N/A	1
1.47	Preterm Births	percent	9.4	9.4	8.8	11.4	2013	N/A	27
1.39	Mothers who Breastfeed	percent	92.5	81.9	93.8		2014-2016	N/A	1
1.00	Congenital Syphilis Incidence Rate	0	0		58.2		2017	N/A	15
0.92	Babies with Low Birth Weight	0	6.3	7.8	6.8	8.1	2014-2016	N/A	1
0.67	Consumer Expenditures: Childcare	0	0.3		0.5	0.5	2018	N/A	27
SCORE	MEDICINE, DRUGS, & MEDICAL TECHNOLOGY	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.17	Consumer Expenditures: Medical Services	percent	2		1.8	1.7	2018	N/A	27
2.17	Consumer Expenditures: Prescription and Non-Prescription Drugs	percent	1.2		0.8	1	2018	N/A	27
2.00	Consumer Expenditures: Medical Supplies	percent	0.3		0.3	0.3	2018	N/A	27
1.64	Opioid Prescription Patients	percent	6				43313	N/A	27
1.64	Opioid Prescription Rate	prescriptions per 10,000 population	754.7				43313	N/A	27
SCORE	MEN'S HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.28	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	23.4	21.8	19.7	19.5	2011-2015	N	27
2.06	Life Expectancy for Males	years	73.3		78.6	76.7	2014	N/A	27
0.39	Prostate Cancer Incidence Rate	0	80.5		101.2	109	2011-2015	N	27

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.28	Depression: Medicare Population	percent	16.8		14.3	16.7	2015	N/A	27
2.11	Adults Needing and Receiving Behavioral Health Care Services	percent	52.5		60.5		2015-2016	N/A	23
2.11	Adults Who Ever Thought Seriously About Committing Suicide	percent	16.3		10.4		2016-2017	N	23
2.11	Adults with Likely Serious Psychological Distress	percent	11.5		8.9		2015-2017	N	23
2.00	Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population aged 12-17	91.3		46.3		2013-2015	Y	23
2.00	Age-Adjusted ER Rate due to Mental Health	ER visits/ 10,000 population 18+ years	202.7		93.4		2013-2015	Y	23
2.00	Age-Adjusted ER Rate due to Pediatric Mental Health	ER visits/ 10,000 population under 18 years	69.4		30.4		2013-2015	Y	23
2.00	Age-Adjusted ER Rate due to Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population 18+ years	52.6		21.7		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population aged 12-17	22.1		13.9		2013-2015	N	23
2.00	Age-Adjusted Hospitalization Rate due to Mental Health	hospitalizations/ 10,000 population 18+ years	66		51.3		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	hospitalizations/ 10,000 population under 18 years	31.1		26.5		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population 18+ years	17.3		10.7		2013-2015	N	23
0.61	Alzheimer's Disease or Dementia: Medicare Population	0	7		9.3	9.9	2015	N/A	27

SCORE	MORTALITY DATA	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Alcohol-Impaired Driving Deaths	percent	39.7		29.4	29.3	2012-2016	N/A	27
2.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	44.1		11.8	16.9	2014-2016	N/A	27
2.53	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	88.5	36.4	30.3	43.2	2014-2016	N/A	1
2.53	Infant Mortality Rate	deaths/ 1,000 live births	11.2	6	4.8	6.1	2011	N/A	1
2.50	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	29.5	20.7	19.1		2014-2016	N/A	1
2.31	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000 population	22.8	12.4	8.8	11	2014-2016	N/A	1
2.28	Age-Adjusted Death Rate due to Drug Use	deaths/ 100,000 population	43.6	11.3	12.2		2014-2016	N/A	1
2.28	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	23.4	21.8	19.7	19.5	2011-2015	N	27
2.17	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.8	14.5	13.3	14.5	2011-2015	N	27
2.14	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	19.6		14.3	14.6	2014-2016	N/A	1
2.11	Age-Adjusted Death Rate due to Heroin Overdose	deaths/ 100,000 population	2.9		1.4		2017	N/A	23
2.11	Death Rate Among Persons with Diagnosed HIV Infection	deaths/ 100,000 population	9.2		4.4		2016	N/A	1
2.08	Age-Adjusted Death Rate due to Coronary Heart Disease	deaths/ 100,000 population	115.7	103.4	89.1	96.8	2014-2016	N/A	1
2.06	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	192.7	161.4	140.2		2014-2016	N/A	1
1.94	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	46.5	45.5	28.9		2014-2016	N/A	1
1.75	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	40.8	34.8	35.3	37.2	2014-2016	N/A	1
1.56	Age-Adjusted Death Rate due to Heart Attacks	deaths/ 100,000 population	54		50.7		2015	N/A	27
0.64	Age-Adjusted Death Rate due to Diabetes	0	14.6		20.7	21.1	2014-2016	N/A	1

SCORE	OLDER ADULTS & AGING	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Mammography Screening: Medicare Population	percent	50.6		59.5	63.2	2015	N/A	27
2.61	People 65+ Living Alone	percent	30.3		22.8	26.2	2013-2017	N/A	1
2.50	Asthma: Medicare Population	percent	8.7		7.5	8.2	2015	N/A	27
2.28	Depression: Medicare Population	percent	16.8		14.3	16.7	2015	N/A	27
2.22	COPD: Medicare Population	percent	14		8.9	11.2	2015	N/A	27
1.83	Ischemic Heart Disease: Medicare Population	percent	26.8		23.6	26.5	2015	N/A	27
1.67	Consumer Expenditures: Eldercare	percent	0.2		0.2	0.2	2018	N/A	27
1.67	People 65+ with Low Access to a Grocery Store	percent	3.5				2015	N/A	28
1.44	Heart Failure: Medicare Population	percent	12.8		12.9	13.5	2015	N/A	27
1.17	Chronic Kidney Disease: Medicare Population	0	14.9		17.9	18.1	2015	N/A	27
0.89	People 65+ Living Below Poverty Level	0	8.6		10.2	9.3	2013-2017	N	1
0.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	0	25.6		27.6	30	2015	N/A	27
0.78	Diabetes: Medicare Population	0	21.1		25.3	26.5	2015	N/A	27
0.72	Hyperlipidemia: Medicare Population	0	35.1		41.5	44.6	2015	N/A	27
0.61	Alzheimer's Disease or Dementia: Medicare Population	0	7		9.3	9.9	2015	N/A	27
0.61	Atrial Fibrillation: Medicare Population	0	6.3		7.3	8.1	2015	N/A	27
0.56	Cancer: Medicare Population	0	6.2		7.5	7.8	2015	N/A	27
0.56	Hypertension: Medicare Population	0	44.5		49.6	55	2015	N/A	27
0.39	Osteoporosis: Medicare Population	0	3.1		6.7	6	2015	N/A	27
0.39	Stroke: Medicare Population	0	2.9		3.7	4	2015	N/A	27
SCORE	ORAL HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.44	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14.2		10.3	11.6	2011-2015	N	27
2.00	Age-Adjusted ER Rate due to Dental Problems	ER visits/ 10,000 population	154.4		36.6		2013-2015	Y	23
1.83	Dentist Rate	dentists/ 100,000 population	45.2		82.4	67.4	2016	N/A	27

SCORE	OTHER CHRONIC DISEASES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
1.17	Chronic Kidney Disease: Medicare Population	0	14.9		17.9	18.1	2015	N/A	27
0.83	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	0	25.6		27.6	30	2015	N/A	27
0.39	Osteoporosis: Medicare Population	0	3.1		6.7	6	2015	N/A	27
SCORE	OTHER CONDITIONS	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.00	Age-Adjusted ER Rate due to Dehydration	ER visits/ 10,000 population 18+ years	39.6		14.4		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Urinary Tract Infections	ER visits/ 10,000 population 18+ years	167.7		93.9		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Dehydration	hospitalizations/ 10,000 population 18+ years	13		9		2013-2015	N/A	23
1.50	Age-Adjusted Hospitalization Rate due to Urinary Tract Infections	hospitalizations/ 10,000 population 18+ years	12.9		12.9		2013-2015	N/A	23
SCORE	PREVENTION & SAFETY	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	44.1		11.8	16.9	2014-2016	N/A	27
2.53	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	88.5	36.4	30.3	43.2	2014-2016	N/A	1
2.28	Severe Housing Problems	percent	27.3		27.9	18.8	2010-2014	N/A	27

SCORE	PUBLIC SAFETY	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Alcohol-Impaired Driving Deaths	percent	39.7		29.4	29.3	2012-2016	N/A	27
2.33	Violent Crime Rate	crimes/ 100,000 population	609.4		450.7		2017	N/A	1
2.31	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000 population	22.8	12.4	8.8	11	2014-2016	N/A	1
2.17	Substantiated Child Abuse Rate	cases/ 1,000 children	9.9		7.5		2017	N/A	27
1.28	Bicycle-Involved Collision Rate	collisions/ 100,000 population	18.5		32.7		2015	N/A	27
SCORE	RESPIRATORY DISEASES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.50	Asthma: Medicare Population	percent	8.7		7.5	8.2	2015	N/A	27
2.44	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	73.9		43.3	60.2	2011-2015	N	27
2.22	COPD: Medicare Population	percent	14		8.9	11.2	2015	N/A	27
2.14	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	19.6		14.3	14.6	2014-2016	N/A	1
2.00	Age-Adjusted ER Rate due to Adult Asthma	ER visits/ 10,000 population 18+ years	65		34.6		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Asthma	ER visits/ 10,000 population	66.9		44		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to Community Acquired Pneumonia	ER visits/ 10,000 population 18+ years	69.8		19		2013-2015	N/A	23
2.00	Age-Adjusted ER Rate due to COPD	ER visits/ 10,000 population 18+ years	78.7		16.4		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Adult Asthma	hospitalizations/ 10,000 population 18+ years	9.1		6.8		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Asthma	hospitalizations/ 10,000 population	8.5		7.6		2013-2015	N/A	23

SCORE	RESPIRATORY DISEASES	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.00	Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia	hospitalizations/ 10,000 population 18+ years	30.6		16.7		2013-2015	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to COPD	hospitalizations/ 10,000 population 18+ years	20.1		12.9		2013-2015	N/A	23
1.94	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	46.5	45.5	28.9		2014-2016	N/A	1
1.67	Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza	ER visits/ 10,000 population 18+ years	9.6		9.5		2013-2015	N	23
1.67	Age-Adjusted ER Rate due to Pediatric Asthma	ER visits/ 10,000 population under 18 years	72.5		70.9		2013-2015	N	23
1.50	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	hospitalizations/ 10,000 population 18+ years	1.4		1.5		2013-2015	N/A	23
1.39	Adults with Asthma	percent	15.9		15		2016-2017	N	23
1.39	Children and Teens with Asthma	percent	15.1				2014	N/A	23
1.17	Age-Adjusted Hospitalization Rate due to Pediatric Asthma	0	6.9		9.8		2013-2015	N/A	23

SCORE	SOCIAL ENVIRONMENT	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	People 65+ Living Alone	percent	30.3		22.8	26.2	2013-2017	N/A	1
2.61	Single-Parent Households	percent	44.5		31.4	33.3	2013-2017	N/A	1
2.44	People 25+ with a Bachelor's Degree or Higher	percent	15.3		32.6	30.9	2013-2017	Y	1
2.39	Children Living Below Poverty Level	percent	31.6		20.8	20.3	2013-2017	Y	1
2.39	Median Household Income	dollars	40446		67169	57652	2013-2017	Y	1
2.39	People Living Below Poverty Level	percent	22.8		15.1	14.6	2013-2017	Y	1
2.39	Youth not in School or Working	percent	8.1		2.1	2.1	2013-2017	N	1
2.33	Mean Travel Time to Work	minutes	28.9		28.8	26.4	2013-2017	N	1
2.22	Homeownership	percent	48.6		50.2	56	2013-2017	N/A	1
2.17	Substantiated Child Abuse Rate	cases/ 1,000 children	9.9		7.5		2017	N/A	27
1.94	Voter Turnout: Presidential Election	percent	72.3		75.3		2016	N/A	23
1.83	Per Capita Income	dollars	23345		33128	31177	2013-2017	Y	1
1.78	People 25+ with a High School Degree or Higher	percent	84.7		82.5	87.3	2013-2017	Y	1
SCORE	SUBSTANCE ABUSE	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Alcohol-Impaired Driving Deaths	percent	39.7		29.4	29.3	2012-2016	N/A	27
2.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	44.1		11.8	16.9	2014-2016	N/A	27
2.33	Age-Adjusted ED Visit Rate due to Heroin Overdose	Rate per 100,000 residents	28		9.9		2017	N	23
2.28	Age-Adjusted Death Rate due to Drug Use	deaths/ 100,000 population	43.6	11.3	12.2		2014-2016	N/A	1
2.17	Adults who Smoke	percent	27	12	11		2016-2017	N	23
2.11	Age-Adjusted Death Rate due to Heroin Overdose	deaths/ 100,000 population	2.9		1.4		2017	N/A	23
2.11	Age-Adjusted ED Visit Rate due to All Drug Overdose	Rate per 100,000 residents	339		117.3		2017	N/A	23
2.11	Teens who have Used Alcohol	percent	46.2		33.4		2009	N/A	23
2.00	Age-Adjusted Death Rate due to Synthetic Opioid Overdose (excluding Methadone)	Rate per 100,000 residents	6		1.1		2017	N/A	23

SCORE	SUBSTANCE ABUSE	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.00	Age-Adjusted ER Rate due to Alcohol Use	ER visits/ 10,000 population 18+ years	56.6		44.2		2013-2015	Y	23
2.00	Age-Adjusted ER Rate due to Substance Use	ER visits/ 10,000 population 18+ years	41.2		18.6		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to Alcohol Use	hospitalizations/ 10,000 population 18+ years	13.4		11.7		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to All Drug Overdose	Rate per 100,000 residents	126.1		49.7		2016	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Heroin Overdose	Rate per 100,000 residents	3.5		1.6		2014	N/A	23
2.00	Age-Adjusted Hospitalization Rate due to Opioid Overdose (excluding Heroin)	Rate per 100,000 residents	18.6		8.5		2016	N	23
2.00	Age-Adjusted Hospitalization Rate due to Substance Use	hospitalizations/ 10,000 population 18+ years	9.5		6.1		2013-2015	N	23
2.00	Age-Adjusted Long Acting or Extended Release Opioid Prescription Rate to Opioid Naive Residents	per 100,000 population	2.6		1.4		2017	N/A	23
1.89	Age-Adjusted Death Rate due to All Opioid Overdose	Rate per 100,000 residents	15.2		4.5		2017	N	23
1.89	Age-Adjusted Death Rate due to Prescription Opioid Overdose	Rate per 100,000 residents	12.3		3.2		2017	N/A	23
1.89	Age-Adjusted ED Visit Rate due to Opioid Overdose (excluding Heroin)	Rate per 100,000 residents	20.8		10.3		2017	N	23
1.83	Consumer Expenditures: Tobacco	percent	0.7		0.4	0.7	2018	N/A	27
1.64	Opioid Prescription Patients	percent	6				43313	N/A	27
1.64	Opioid Prescription Rate	prescriptions per 10,000 population	754.7				43313	N/A	27
1.33	Consumer Expenditures: Alcoholic Beverages	percent	0.9		1.1	1	2018	N/A	27
0.89	Adults who Binge Drink: Year	0	26		32.6		2014	N/A	23
0.39	Liquor Store Density	0	6.2		10.1	10.5	2015	N/A	28

SCORE	TEEN & ADOLESCENT HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.11	Teens who have Used Alcohol	percent	46.2		33.4		2009	N/A	23
2.00	7th Grade Students who are Physically Fit	percent	49.6		63.6		2017-2018	N/A	1
2.00	Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	ER visits/ 10,000 population aged 12-17	91.3		46.3		2013-2015	Y	23
2.00	Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury	hospitalizations/ 10,000 population aged 12-17	22.1		13.9		2013-2015	N	23
1.94	9th Grade Students who are at a Healthy Weight or Underweight	percent	56.6		62.7		2017-2018	N/A	1
1.92	Teen Birth Rate: 15-19	live births/ 1,000 females aged 15-19	30.5		17.6	22.3	2014-2016	N/A	1
1.39	Children and Teens with Asthma	percent	15.1				2014	N/A	23
SCORE	TRANSPORTATION	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.33	Mean Travel Time to Work	minutes	28.9		28.8	26.4	2013-2017	N	1
2.31	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000 population	22.8	12.4	8.8	11	2014-2016	N/A	1
2.17	Solo Drivers with a Long Commute	percent	38.8		39.3	34.7	2012-2016	N/A	27
1.89	Workers Commuting by Public Transportation	percent	1	5.5	5.2	5.1	2013-2017	N	1
1.83	Households with No Car and Low Access to a Grocery Store	percent	3.6				2015	N/A	28
1.28	Bicycle-Involved Collision Rate	collisions/ 100,000 population	18.5		32.7		2015	N/A	27
1.22	Workers who Walk to Work	0	3	3.1	2.7	2.7	2013-2017	N	1
0.67	Workers who Drive Alone to Work	0	71.3		73.6	76.4	2013-2017	Y	1

SCORE	WELLNESS & LIFESTYLE	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.06	Life Expectancy for Females	years	78.6		83	81.5	2014	N/A	27
2.06	Life Expectancy for Males	years	73.3		78.6	76.7	2014	N/A	27
2.00	Self-Reported General Health Assessment: Good or Better	percent	72.5		83.1		2016-2017	N	23
1.17	Insufficient Sleep	0	32.2		34.5	38	2016	N/A	27
SCORE	WOMEN'S HEALTH	UNITS	LAKE COUNTY	HP2020	CA	U.S.	MEASUREMENT PERIOD	HIGH RACE DISPARITY*	Source
2.61	Mammography Screening: Medicare Population	percent	50.6		59.5	63.2	2015	N/A	27
2.50	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	29.5	20.7	19.1		2014-2016	N/A	1
2.06	Life Expectancy for Females	years	78.6		83	81.5	2014	N/A	27
0.39	Breast Cancer Incidence Rate	0	101.8		121.5	124.7	2011-2015	N	27

APPENDIX D. PRIMARY DATA METHODOLOGY

DATA COLLECTION INSTRUMENTS

Key Informant Interview Questionnaire (Conduent Healthy Communities Institute)

I. BACKGROUND & COMMUNITY ISSUES

- Goal: Elicit unbiased perceptions of the county
    - o How would you describe Lake County?
    - o How would you describe the community? (examples include demographics, cohesiveness, active engagement/involvement, socio-economic conditions)
        - ▪ What are strengths of this community?
        - ▪ What are some of the problems and/or threats that people face?
        - ▪ Why are these important? What has gotten better and worse over the years?
        - ▪ What factors contribute to these problems?
        - ▪ What has been/can be done to reduce the magnitude of these?
        - ▪ What are some opportunities that the county may have had in improving these problems?
    - o What are the main assets in the community? (examples include educational, health, faith based, social, recreational facilities/ organizations)

- Goal: Ascertain the perceived health status of the county
    - o How would you describe the overall health of Lake County?
    - o What are some of the dominant health issues or topics of concern for the county?

II. AREA OF WORK AND PRIORITIES

- Goal: Ascertain the participant's organization, affiliation and role in the community and experience with health topics as well as social determinants of health
    - o Please tell me a little bit about your organization and the services it provides.
    - o Please tell me about your specific role
    - o Who are the target/beneficiaries that are in need of your services? (definition by areas of residence, age, gender, race, income, insurance status, health profile)
    - o Who do you consider to be the populations in the community who suffer the worst impact from these conditions/issues? (vulnerable populations)

- o From your experience, what are your clients'/beneficiaries' biggest barriers to addressing the health issues you identified and to achieving optimal health?
    - PROBE: Social determinants of health?
    - PROBE: Barriers to accessing medical care?
    - PROBE: Barriers to accessing preventive services or programs?
- o What has your organization done to address some of these issues?
- o What has the impact of your efforts been so far? What else is needed?
- o What kind of agencies have you collaborated with in these efforts? (multi-organizational, multi-sectoral collaborations)
- o What funding, programs and/or grants do you know of exist within your organization or within the county that address these issues?

III. IMPROVING THE HEALTH OF THE COMMUNITY/RESIDENTS

- o Goal: Identify opportunities for community engagement, and community improvement
- o If you could make one suggestion to improving community health, what would that be?
- o What do you think needs to happen in the community for this improvement to be carried out? (policy, laws, infrastructure, resources, personnel, organization) Who should have the responsibility for seeing it through?
- o What do you think hospitals/health systems/public health departments can do to address these issues that they are not doing right now?
- o The last exercise similar to this that was carried out had identified 4 priorities:
    - Mental Health
    - Substance Abuse
    - Homelessness
    - Access to programs and services

How would you rate the county on these priorities and what improvements can be made in these areas?

LAKE COUNTY FOCUS GROUP DISCUSSION QUESTIONS

- What do you like most about living in Lake County?
- What concerns you most about living here?
- How do you define a healthy community?
- What kinds of resources are needed to create a healthy community?
- Who is responsible for keeping a community healthy?
- What community values promote a healthy neighborhood? How can county residents contribute to their own health and to the health of others?
- What do you think are the most important health related problems faced by Lake County residents?
- What do you think are the main reasons for these health issues or problems?
- What do you think are the main factors that contribute to the reasons you mentioned for poor health in Lake County?
- The data for our county shows that some of the high priorities for our county are [mention those that disproportionately affect the population being interviewed]. What reactions do you have?
- What are the strengths of the health services available in Lake County? And what are the weaknesses?
- What do you think are some changes in healthcare that need to be made in Lake County?
- What one or two things would you recommend as priorities for improving health in Lake County? What would be most useful to you?

COMMUNITY SURVEY INSTRUMENT (ENGLISH)

Hope Rising Lake County Collaborative

Welcome to the Hope Rising Lake County Community Survey

INSTRUCTIONS:
Hope Rising Lake County Collaborative is a partnership of hospitals, health centers, county leaders, non-profit organizations and other relevant organizations of Lake County to improve the overall health and wellness of Lake County, California.

Thank you very much for being willing to help Hope Rising to understand the health care needs of the Lake County population and for answering this short survey. Your answers are completely confidential and will be used in combination with all other answers to help us better understand the needs of the community. Please read each question and mark the choice that best reflects your answer.

Note: Open only to residents of Lake County and to those 18 years and above. Please respond before 28 February, 2019.

1. What zip code do you live in?

2. How old are you?

- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65-74
- ◯ 75+

3. What is your gender identity?

- ◯ Female
- ◯ Male
- ◯ Transgender
- ◯ Non-conforming
- ◯ Not listed

4. What is the highest grade or year of school you completed?

- ◯ Never attended school or only attended kindergarten
- ◯ Grades 1 through 8
- ◯ Grades 9 through 11
- ◯ Grade 12 or GED
- ◯ College 1 year to 3 years (Some college or technical school)
- ◯ College 4 years or more (College graduate)
- ◯ More than 4 year College degree

5. What language(s) do you speak at home?

- [ ] English
- [ ] Spanish
- [ ] Other (please specify)

6. What is your race or ethnicity?

- ◯ White or Caucasian
- ◯ Black or African American
- ◯ Hispanic or Latino
- ◯ Asian
- ◯ Other (please specify)
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or other Pacific Islander
- ◯ Multi-racial
- ◯ Not listed

7. Write the number of adults (age 18 years and above) in your household, including yourself.

8. Write the number of children (below age 18 years) in your household.

9. Select your total household income level.

- ◯ Under $25,000
- ◯ Between $25,000 and $34,999
- ◯ Between $35,000 and $49,999
- ◯ Between $50,000 and $74,999
- ◯ $75,000 and more

2

Hope Rising Lake County Collaborative

10. In the past 30 days, would you say your health has been:

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

11. In the past 30 days have you felt mostly:

- ◯ Peaceful and calm
- ◯ A little bit sad or off
- ◯ Worried or upset
- ◯ So upset that day-to-day life is difficult
- ◯ Close to a breakdown and cannot function

12. What do you think are the **three most important factors** that make Lake County a good place to live?

- ☐ Being able to see a doctor upon need
- ☐ Housing that is easily available, safe and affordable
- ☐ Arts and cultural events
- ☐ Clean spaces, water and air
- ☐ Races getting along with each other
- ☐ Good jobs and equal opportunities
- ☐ Good place to raise children
- ☐ Good schools
- ☐ People take steps to stay healthy
- ☐ People are mostly healthy and live long
- ☐ Low crime / safe neighborhoods
- ☐ Babies have a good chance to make it past the first birthday
- ☐ Parks and places to meet others
- ☐ Places to worship and practice religion
- ☐ Strong family life

Other (please specify)

3

13. What do you think are the **three most important health problems** facing people living in Lake County?

- ☐ Aging problems (e.g., arthritis, hearing/vision loss)
- ☐ Alcohol misuse
- ☐ Drug misuse
- ☐ Cancers
- ☐ Dental problems
- ☐ Diabetes
- ☐ Domestic Violence
- ☐ Gun-related injuries
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Housing that is not adequate, safe and affordable
- ☐ Deaths of babies before the first birthday
- ☐ Diseases that spread from person to person (e.g., hepatitis, TB)
- ☐ Mental health problems like sadness, worry, anger over many days
- ☐ Car/Motor crash injuries
- ☐ Obesity
- ☐ Rape/sexual assault
- ☐ Respiratory/lung disease
- ☐ Diseases caused through sexual contact (e.g., gonorrhea, chlamydia)
- ☐ Suicide
- ☐ Birth to teenage girls

14. What do you think are the **three most important risky behaviors** in our community that have the greatest impact on the overall health of Lake County?

- ☐ Alcohol misuse
- ☐ Being overweight
- ☐ Dropping out of school
- ☐ Drug misuse
- ☐ Lack of exercise
- ☐ Not using birth control
- ☐ Not getting “shots” to prevent disease
- ☐ Not using seat belts / child safety seats
- ☐ Poor eating habits
- ☐ Racism
- ☐ Tobacco use
- ☐ Unsafe sex

Other (please specify)

4

15. Where do you receive routine health care?

- ◯ Regular Doctor's Office
- ◯ Lakeview Health Center
- ◯ Hospital Emergency Room
- ◯ Urgent Care
- ◯ Other (please specify)
- ◯ Migrant Health Center
- ◯ Indian/Tribal Health Center
- ◯ I do not receive routine healthcare

16. How do you pay for your health care?

- ◯ Pay cash
- ◯ Health Insurance (e.g., Partnership Health Plan, private insurance, HMO through employer)
- ◯ Medi-Cal
- ◯ Other (please specify)
- ◯ Medicare
- ◯ Veterans Administration
- ◯ Indian Health Services

17. In general what prevents you from seeking health care? (**check all that apply**)

- ☐ Cost of care
- ☐ Co-pays
- ☐ Distance to health facilities
- ☐ Disability/Lack of mobility
- ☐ Fear or distrust of health care system
- ☐ Lack of doctors/staff that speak my language
- ☐ Lack of insurance
- ☐ Other (please specify)
- ☐ Lack of specialists in the county
- ☐ Lack of transportation
- ☐ Long wait time
- ☐ Other living expenses such as housing, utilities, food
- ☐ Too much paperwork
- ☐ Unavailability of appointments
- ☐ Nothing

5

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18. Which of the following have you been worried about in the past 12 months? (**check all that apply**)

- ☐ Availability of employment
- ☐ Ability to afford food
- ☐ Cost of healthcare
- ☐ Cost of medicines
- ☐ Cost of transportation
- ☐ Cost of utilities
- ☐ Crime and violence
- ☐ Housing
- ☐ Illegal and prescription drugs in the community
- ☐ Lack of assistance in completing daily activities (such as bathing, preparing meals etc.)
- ☐ Lack of social support
- ☐ Nothing
- ☐ Other (please specify)

19. From the list below, **select three kinds of services** that are needed more in Lake County.

- ☐ Food pantries
- ☐ Job training or employment camps
- ☐ Housing aid
- ☐ Free screenings and vaccinations
- ☐ Crises and counseling centers
- ☐ Public transportation
- ☐ Utility assistance
- ☐ Programs to help stop smoking
- ☐ Other (please specify)
- ☐ Support for people re-entering communities after addiction, prison, or mental health treatment
- ☐ Help with transportation to appointments
- ☐ Meal assistance
- ☐ Free community exercise classes
- ☐ Free classes that teach people to manage diseases like diabetes, heart disease, cancer through diet and exercise
- ☐ Community support groups
- ☐ Nothing

6

20. From the list below, **rate each of the things** that area hospitals can do to improve quality of service to the people of Lake County based on their importance to you.

	Very Important	Somewhat Important	Not Important
Having staff speak in your language	○	○	○
Have Hospital Patient Navigators to explain hospital procedures	○	○	○
Have Community Health Workers to connect people to community resources	○	○	○
Give easy to follow medical instructions and information	○	○	○
Give all information and instructions on personal health issues in one Care Plan	○	○	○
Send text or voice reminders for regular appointments	○	○	○
Give medical advice through telephone or video	○	○	○
Conduct classes in healthy eating, diabetes management, fitness etc.	○	○	○
Provide a list of organizations that provide shelter, housing, food etc.	○	○	○
Connect patients who need help to agencies that provide shelter, housing, food etc.	○	○	○
Connect members who need help to agencies that provide social support like counseling	○	○	○

Other (please specify)

7

21. From the list below, **rate each of the programs** that could tackle some of the current health challenges of Lake County based on their importance to you.

	Very Important	Somewhat Important	Not Important
Increasing parks, walkways and bike paths	○	○	○
Fresh food markets in communities lacking access to fresh produce	○	○	○
Community gardens or food programs	○	○	○
Reduce alcohol use in public places or stores that sell alcohol	○	○	○
Restrict advertising of tobacco products (including e-cigarettes, vaping, snuff etc.) to young adults	○	○	○
Vocational training or dropout prevention programs for high risk students	○	○	○
Computer based education programs to prevent diseases passed through sexual contact	○	○	○
Provide medical prescription to partners of those diagnosed with diseases passed through sexual contact without doctor visit	○	○	○
Youth programs like Big Brother, Big Sisters	○	○	○
Community Centers for socializing and seeking support	○	○	○
Community policing	○	○	○
Family Courts for substance using parents	○	○	○
Internet based or doctor monitored programs to stop smoking with medicines or counseling	○	○	○
Small grants for housing repairs and improvements	○	○	○

Other (please specify)

22. Where do you get information about health resources available in your community? (**check all that apply**)

- ☐ School
- ☐ Church
- ☐ Neighbors
- ☐ Family
- ☐ Television
- ☐ Local radio shows
- ☐ Newspaper
- ☐ Other (please specify)
- ☐ Internet
- ☐ Hospital
- ☐ Hospital websites
- ☐ Facebook
- ☐ County Government office/website
- ☐ Agencies that provide services and programs in your community

8

23. What agencies that provide services and programs do you interact with regularly or know are active in Lake County?

Name:

Name:

Name:

Name:

Name:

24. How did you get this survey?

- ◯ Church
- ◯ Hospital
- ◯ Your doctor's office
- ◯ Lakeview Health Center
- ◯ Indian/Tribal Health Center
- ◯ Community Meeting
- ◯ Grocery Store / Shopping Mall
- ◯ E-Mail
- ◯ Mail
- ◯ Personal Contact
- ◯ Workplace
- ◯ County of Lake Government

9

COMMUNITY SURVEY INSTRUMENT (SPANISH)

Hope Rising Lake County Collaborative

Bienvenidos a la Encuesta Comunitaria del Condado Hope Rising Lake

INSTRUCCIONES:

El Colaborativo de Hope Rising del Condado de Lake es un consorcio de hospitales, centros de salud, líderes del condado, organizaciones sin fines de lucro y otras organizaciones pertinente del Condado de Lake para mejorar la salud y el bienestar en general del Condado de Lake, California.

Muchas gracias por estar dispuesto de ayudar a Hope Rising a entender las necesidades de salud médica de la población de Lake County y por responder a esta breve encuesta. Sus respuestas son completamente confidenciales y serán utilizadas en combinación con todas las demás respuestas para ayudarnos a entender mejor las necesidades de la comunidad. Por favor, lea cada pregunta y marque la opción que mejor refleje su respuesta.

Nota: Solamente para los residentes de Lake County y a los mayores de 18 años. Por favor, responda antes del 15 de marzo de 2019. Por favor responda todas las preguntas.

1. ¿En qué código postal vive?

2. ¿Cuántos años tienes?

- ☐ Entre 18 y 24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ Mas de 75

3. ¿Cuál es su identidad de género?

- ☐ Mujer
- ☐ Masculino
- ☐ Transgéneros
- ☐ No conforme
- ☐ No está en la lista

4. ¿Cuál es el grado o año escolar más alto que ha completado?

- ☐ Nunca asistió a la escuela o sólo asistió al kindergarten
- ☐ Grados 1 al 8

- ☐ Grados 9 a 11
- ☐ Grado 12 o GED
- ☐ Universidad 1 año a 3 años (algunas universidades o escuelas técnicas)
- ☐ Universidad 4 años o más (graduado universitario)
- ☐ Más de 4 años de estudios universitarios

5. ¿Qué idioma(s) habla en su casa?

- ☐ Inglés
- ☐ Español
- ☐ Otro (especifique

☐

6. ¿Cuál es su raza u origen étnico?

- ☐ Blanco o caucásico
- ☐ Negro o Afroamericano
- ☐ Hispano o Latino
- ☐ Asiático
- ☐ Otro (especifique
- ☐ Indio Americano o Nativo de Alaska
- ☐ Hawaiano nativo u otro isleño del Pacífico
- ☐ Multi-racial
- ☐ No está en la lista

☐

7. Escriba el número de adultos (de 18 años o más) en su hogar, incluyéndose a sí mis

☐

8. Escriba el número de niños (menores de 18 años de edad) en su hogar.

☐

9. Seleccione el nivel de ingresos totales de su hogar.

- ☐ Menos de $25,000
- ☐ Entre $25,000 y $34,999
- ☐ Between $35,000 and $49,999
- ☐ Entre $50,000 y $74,999
- ☐ $75,000 y más

10. En los últimos 30 días, ¿diría que su salud ha sido:

- ☐ Excelente
- ☐ Muy Bueno
- ☐ Bueno
- ☐ Justo
- ☐ Pobre

11. En los últimos 30 días te has sentido más que nada:

- ☐ Pacífica y tranquila
- ☐ Un poco triste o fuera de lugar
- ☐ Preocupado o molesto
- ☐ Tan molesto que la vida cotidiana es difícil
- ☐ Cerca de una avería y no puede funcionar

12. ¿Cuáles crees que son los tres factores más importantes que hacen del Condado de Lake un buen lugar para vivir? (Esta pregunta requiere una respuesta.)

- ☐ Poder ver a un médico cuando sea necesario
- ☐ Viviendas de fácil acceso, seguras y asequibles
- ☐ Eventos artísticos y culturales
- ☐ Espacios limpios, agua y aire
- ☐ Las razas se llevan bien entre sí
- ☐ Buenos empleos e igualdad de oportunidades
- ☐ Un buen lugar para criar a los niños
- ☐ Buenas escuelas
- ☐ La gente toma medidas para mantenerse saludable
- ☐ La mayoría de las personas están sanas y viven mucho tiempo
- ☐ Baja criminalidad / vecindarios seguros
- ☐ Los bebés tienen una buena oportunidad de pasar del primer cumpleaños
- ☐ Parques y lugares de encuentro
- ☐ Lugares para adorar y practicar la religion
- ☐ Fuerte vida familiar
- ☐ Otro (especifique)

13. ¿Cuáles crees que son los tres problemas de salud más importantes a los que se enfrentan las personas que viven en el Condado de Lake? (Esta pregunta requiere una respuesta.)

- ☐ Problemas de envejecimiento (por ejemplo, artritis, pérdida de audición/visión)

- ☐ Abuso de alcohol
- ☐ Abuso de drogas
- ☐ Cánceres
- ☐ Problemas dentales
- ☐ Diabetes
- ☐ Violencia doméstica
- ☐ Lesiones relacionadas con armas
- ☐ Enfermedad cardíaca y accidente cerebrovascular
- ☐ Presión arterial alta
- ☐ VIH/SIDA
- ☐ Obesidad
- ☐ Violación/agresión sexual
- ☐ Enfermedad respiratoria/pulmonar
- ☐ Suicidio
- ☐ Vivienda que no es adecuada, segura y asequible
- ☐ Muertes de bebés antes del primer cumpleaños
- ☐ Lesiones por choques automovilísticos
- ☐ Enfermedades causadas por contacto sexual (por ejemplo, gonorrea, clamidia)
- ☐ Del nacimiento a la adolescencia
- ☐ Enfermedades que se propagan de persona a persona (por ejemplo, hepatitis, tuberculosis)
- ☐ Problemas de salud mental como tristeza, preocupación, enojo durante muchos días

14. ¿Cuáles cree usted que son las tres conductas de riesgo más importantes en nuestra comunidad que tienen el mayor impacto en la salud general de Lake County? (Esta pregunta requiere una respuesta.)

- ☐ Abuso de alcohol
- ☐ Tener sobrepeso
- ☐ Abandonar la escuela
- ☐ Abuso de drogas

- ☐ Falta de ejercicio
- ☐ No usar anticonceptivos
- ☐ No ponerse las "vacunas" para prevenir enfermedades
- ☐ No usar cinturones de seguridad / asientos de seguridad para niños
- ☐ Malos hábitos alimenticios
- ☐ Racismo
- ☐ Consumo de tabaco
- ☐ Sexo inseguro
- ☐ Otro (especifique)

15. ¿Dónde recibe atención médica de rutina?

- ☐ Consultorio médico habitual
- ☐ Centro de Salud de Lakeview
- ☐ Sala de Emergencia de un Hospital
- ☐ Atención de urgencia
- ☐ Centro de Salud para Migrantes
- ☐ Centro de Salud Indígena/Tribal
- ☐ No recibo atención médica de rutina
- ☐ Otro (especifique)

16. ¿Cómo paga usted por su atención médica?

- ☐ Pague en efectivo
- ☐ Seguro de Salud (por ejemplo, Plan de Salud de la Asociación, seguro privado, HMO a través del empleador)
- ☐ Medi-Cal
- ☐ Medicare
- ☐ Administración de Veteranos
- ☐ Servicios de Salud para Indígenas
- ☐ Otro (especifique)

17. En general, ¿qué es lo que le impide buscar atención médica? (marque todo lo que corresponda)

- ☐ Costo de la atención
- ☐ Copagos
- ☐ Distancia a los centros de salud

- ☐ Discapacidad/Falta de movilidad
- ☐ Miedo o desconfianza en el sistema de salud
- ☐ Falta de médicos y personal que hablen mi idioma
- ☐ Falta de seguro
- ☐ Falta de especialistas en la comarca
- ☐ Falta de transporte
- ☐ Tiempo de espera
- ☐ Otros gastos de subsistencia como vivienda, servicios públicos, alimentos
- ☐ Demasiado papeleo
- ☐ Falta de disponibilidad de citas
- ☐ Nada
- ☐ Otro (especifique)

☐

18. ¿Cuál de los siguientes aspectos le ha preocupado en los últimos 12 meses? (marque todo lo que corresponda)

- ☐ Disponibilidad de empleo
- ☐ Capacidad de comprar alimentos
- ☐ Costo de la atención médica
- ☐ Costo de los medicamentos
- ☐ Costo de transporte
- ☐ Costo de los servicios
- ☐ Crimen y violencia
- ☐ Alojamiento
- ☐ Medicamentos ilegales y recetados en la comunidad
- ☐ Falta de asistencia para completar las actividades diarias (como bañarse, preparar las comidas, etc.)
- ☐ Falta de apoyo social
- ☐ Nada
- ☐ Otro (especifique)

☐

19. De la siguiente lista, seleccione tres tipos de servicios que se necesitan más en el Condado de Lake.

- ☐ Despensa de alimentos
- ☐ Capacitación laboral o campamentos de empleo
- ☐ Ayuda para la vivienda
- ☐ Pruebas de detección y vacunas gratuitas
- ☐ Crisis y centros de asesoramiento
- ☐ Transporte público
- ☐ Ayuda con los servicios públicos
- ☐ Programas para ayudar a dejar de fumar
- ☐ Apoyo a las personas que se reincorporan a la comunidad después de un tratamiento de adicción, prisión o salud mental

- ☐ Ayuda con el transporte a las citas
- ☐ Asistencia en la comida
- ☐ Clases de ejercicios comunitarios gratuitos
- ☐ Clases gratuitas que enseñan a las personas a controlar enfermedades como la diabetes, las enfermedades cardíacas, el cáncer a través de la dieta y el ejercicio
- ☐ Grupos de apoyo comunitario
- ☐ Nada
- ☐ Otro (especifique)

☐

20. De la lista de abajo, valore cada una de las cosas que los hospitales del área pueden hacer para mejorar la calidad del servicio a la gente del Condado de Lake basado en su importancia para usted.

	Muy importante	Algo Importante	Sin Importancia
Hacer que el personal hable en su idioma			
Tenga Navegadores de Pacientes del Hospital para explicar los procedimientos del hospital			
Contar con Trabajadores Comunitarios de Salud para conectar a las personas con los recursos de la comunidad			
Dar instrucciones e información médica fácil de seguir			
Dar toda la información e instrucciones sobre temas de salud personal en un solo Plan de Cuidados			
Enviar recordatorios de texto o de voz para citas regulares			
Dar consejos médicos por teléfono o video			
Llevar a cabo clases de alimentación saludable, control de la diabetes, acondicionamiento físico, etc.			
Proporcione una lista de organizaciones que proporcionan refugio, vivienda, alimentos, etc.			
Conectar a los pacientes que necesitan ayuda con agencias que proveen refugio, vivienda, comida, etc.			
Proporcione una lista de organizaciones que proporcionan refugio, vivienda, alimentos, etc.			

- ☐ Otro (especifique)

☐

21. De la lista siguiente, calificar cada uno de los programas que podría abordar algunos de los desafíos de salud actuales del Condado de Lake basado en su importancia para usted.

	Muy importante	Algo Importante	Sin Importancia

Aumentar los parques, las pasarelas y los carriles para bicicletas			
Mercados de alimentos frescos en comunidades que carecen de acceso a productos frescos			
Huertos comunitarios o programas de alimentación			
Reducir el consumo de alcohol en lugares públicos o tiendas que venden alcohol			
Restringir la publicidad de los productos del tabaco (incluyendo los cigarrillos electrónicos, el vapor, el tabaco en polvo, etc.) a los adultos jóvenes			
Programas de capacitación vocacional o de prevención de la deserción escolar para estudiantes de alto riesgo			
Programas de educación basados en la computadora para prevenir enfermedades transmitidas por contacto sexual			
Proporcionar prescripción médica a las parejas de personas diagnosticadas con enfermedades transmitidas por contacto sexual sin visita al médico			
Programas juveniles como Big Brothers, Big Sisters			
Centros comunitarios para socializar y buscar apoyo			
Policía de proximidad			
Tribunales de Familia para padres que consumen drogas			
Programas basados en Internet o monitoreados por un médico para dejar de fumar con medicamentos u orientación			
Pequeñas subvenciones para reparaciones y mejoras de viviendas			

☐ Otro (especifique)

☐

22. ¿Dónde obtener información sobre los recursos de salud disponibles en su comunidad? (Marque todas las que apliquen)

☐ Escuela
☐ Iglesia
☐ Vecinos
☐ Familia
☐ Televisión
☐ Programas de radio locales
☐ Periódico
☐ Internet
☐ Hospital
☐ Sitios web de hospitales
☐ Facebook
☐ Oficina gubernamental del condado/sitio web
Agencias que proporcionan servicios y programas en su comunidad

☐ Otro (especifique)

23. ¿Qué agencias que brindan servicios y programas con los que interactúa regularmente o saben que están activas en el Condado de Lake?

Nombre:

Nombre:

Nombre:

Nombre:

Nombre:

24. ¿Cómo obtuviste esta encuesta?

☐ Iglesia

☐ Hospital

☐ El consultorio de su médico

☐ Centro de Salud de Lakeview

☐ Centro de Salud Indígena/Tribal

☐ Reunión de la comunidad

☐ Tienda de comestibles / Centro comercial

☐ Correo electrónico

☐ Correo

☐ Contacto personal

☐ Lugar de trabajo

☐ Gobierno del Condado de Lake

APPENDIX E. PRIORITIZATION PROCESS

PRIORITIZATION SURVEY

LAKE COUNTY PRIORITIZATION SURVEY

Prioritization Criteria Survey

Thank you for your participation as a Lake County and Hope Rising partner in this prioritization process.

The Community Health Needs Assessment (CHNA) process has multiple steps. Conduent HCI is currently engaged in the process of identifying the significant health needs in Lake County, where after these health needs will be prioritized. Prioritization is the process of determining the most important or urgent health needs to address in communities.

This survey is being done to rate the criteria that will be used to prioritize significant health problems for future strategic planning and implementation efforts.

If you have any questions or concerns about this process, please email Anindita Fahad at Anindita Fahad@conduent.com

* 1. Please Indicate the level of importance that should be given to the listed criteria in deciding which health problems your organization will to address in the next few years.

	Not important	Slightly Important	Important	Fairly Important	Very Important
Number or percentage of people affected by the health problem in the county	○	○	○	○	○
Alignment of problem with your organization's strengths, priorities, mission	○	○	○	○	○
Availability and commitment from leadership in the involved organizations	○	○	○	○	○
Degree of death, disability, suffering or complications for patients and care givers	○	○	○	○	○
County rates are poorer than state, national and Healthy 2020 benchmarks	○	○	○	○	○
State mandates requiring the public health system prioritizes this health problem	○	○	○	○	○
Health problem impacts other health outcomes and/or is a driver of other conditions	○	○	○	○	○
Expertise and resources within the county to address this health problem	○	○	○	○	○
High community demand to address this health problem	○	○	○	○	○
Existence of evidence backed solutions that have ease of implementation	○	○	○	○	○
Targeting the health problem eases the economic burden on the community	○	○	○	○	○

	Not important	Slightly Important	Important	Fairly Important	Very Important
Correction of social or economic inequalities that contribute to poor health	○	○	○	○	○
Opportunities for partnerships that will allow leveraging of shared resources	○	○	○	○	○
Oportunities to address the health problem before it gets exacerbated	○	○	○	○	○
Availability of or opportunity to raise funding to target this health problem	○	○	○	○	○
Reduction in Emergency Department utilization and subsequent return in investment	○	○	○	○	○
Availability of county data colected by state or federal agencies to measure success	○	○	○	○	○
Potential to impact multiple problems with solution and benefit the community at large	○	○	○	○	○
Potential to add physical or social community assests with solution	○	○	○	○	○
Easing of disproportionate impact that is felt by vulnerable populations	○	○	○	○	○

2. Please provide your name.

3. Please provide your email address.

4. Please provide the name of your organization.

PRIORITIZATION MATRIX

This packet will help you assess each of the pressing health needs identified by Conduen HCI's data analysis, and how each of those health needs relate to the criteria set forth by you through the survey for prioritizing health topics in your service area. For each health need you will score how well you believe the health need meets the criteria. After you have completed the ranking, please submit your results to the Conduent HCI team. The team will collate your results with those of other participants, and will instantaneously show the group's collective ranking of the most pressing health needs in your service area.

INSTRUCTIONS

Given below is a list of Health Topics that have emerged as priorities for Lake County through the Data Synthesis exercise. On the following page, score each health need for how well it meets each criteria:

1=does not meet criteria through 3=meets criteria

HEALTH TOPICS	KEY THEMES FROM SECONDARY DATA (*INDICATOR SHOWS A SIGNIFICANT RACE/ETHNIC DISPARITY)	TOPIC SCORE
Drug Use	***Indicators:*** Alcohol-Impaired Driving Deaths, Death Rate due to Drug Poisoning, Age-Adjusted ED Visit Rate due to Heroin Overdose, Age-Adjusted Death Rate due to Drug Use, Adults who Smoke, Age-Adjusted Death Rate due to Heroin Overdose, Age-Adjusted ED Visit Rate due to All Drug Overdose, Teens who have Used Alcohol, Age-Adjusted Death Rate due to, Synthetic Opioid Overdose (excluding Methadone), Age-Adjusted ER Rate due to Alcohol Use, Age-Adjusted ER Rate due to Substance Use, Age-Adjusted Hospitalization Rate due to Alcohol Use, Age-Adjusted Hospitalization Rate due to All Drug Overdose, Age-Adjusted Hospitalization Rate due to Heroin Overdose, Age-Adjusted Hospitalization Rate due to Opioid Overdose (excluding Heroin), Age-Adjusted Hospitalization Rate due to Substance Use, Age-Adjusted Long Acting or Extended Release Opioid Prescription Rate to Opioid Naive Residents, Age-Adjusted Death Rate due to All Opioid Overdose, Age-Adjusted Death Rate due to Prescription Opioid Overdose, Age-Adjusted ED Visit Rate due to Opioid Overdose (excluding Heroin), Consumer Expenditures: Tobacco, Opioid Prescription Patients, Opioid Prescription Rate, Consumer Expenditures: Alcoholic Beverages, Adults who Binge Drink: Year, Liquor Store Density	1.91
Mental Health	***Indicators:*** Depression: Medicare Population, Adults Needing and Receiving Behavioral Health Care Services, **Adults Who Ever Thought Seriously About Committing Suicide, Adults with Likely Serious Psychological Distress, Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury, Age-Adjusted ER Rate due to Mental Health, Age-Adjusted ER Rate due to Pediatric Mental Health, Age-Adjusted ER Rate due to Suicide and Intentional Self-inflicted Injury, Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury, Age-Adjusted Hospitalization Rate due to Mental Health, Age-Adjusted Hospitalization Rate due to Pediatric Mental Health, Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury, Alzheimer's Disease or Dementia: Medicare Population	1.94

HEALTH TOPICS	KEY THEMES FROM SECONDARY DATA (*INDICATOR SHOWS A SIGNIFICANT RACE/ETHNIC DISPARITY)	TOPIC SCORE
Alcoholism	***Indicators:*** Alcohol-Impaired Driving Deaths, Death Rate due to Drug Poisoning, Age-Adjusted ED Visit Rate due to Heroin Overdose, Age-Adjusted Death Rate due to Drug Use, Adults who Smoke, Age-Adjusted Death Rate due to Heroin Overdose, Age-Adjusted ED Visit Rate due to All Drug Overdose, Teens who have Used Alcohol, Age-Adjusted Death Rate due to, Synthetic Opioid Overdose (excluding Methadone), Age-Adjusted ER Rate due to Alcohol Use, Age-Adjusted ER Rate due to Substance Use, Age-Adjusted Hospitalization Rate due to Alcohol Use, Age-Adjusted Hospitalization Rate due to All Drug Overdose, Age-Adjusted Hospitalization Rate due to Heroin Overdose, Age-Adjusted Hospitalization Rate due to Opioid Overdose (excluding Heroin), Age-Adjusted Hospitalization Rate due to Substance Use, Age-Adjusted Long Acting or Extended Release Opioid Prescription Rate to Opioid Naive Residents, Age-Adjusted Death Rate due to All Opioid Overdose, Age-Adjusted Death Rate due to Prescription Opioid Overdose, Age-Adjusted ED Visit Rate due to Opioid Overdose (excluding Heroin), Consumer Expenditures: Tobacco, Opioid Prescription Patients, Opioid Prescription Rate, Consumer Expenditures: Alcoholic Beverages, Adults who Binge Drink: Year, Liquor Store Density	1.91
Housing and Homelessness	***Indicators:*** Severe Housing Problems, Homeownership, Median Household Income	2.28
Access to Specialists	***Indicators:*** People Delayed or had Difficulty Obtaining Care, Consumer Expenditures: Medical Services, Consumer Expenditures: Prescription and Non-Prescription Drugs, Adults Needing and Receiving Behavioral Health Care Services, Primary Care Provider Rate, Consumer Expenditures: Medical Supplies, Dentist Rate, Adults Delayed or had Difficulty Obtaining Care, People with a Usual Source of Health Care, Adults with Health Insurance: 18-64, Children with Health Insurance, Non-Physician Primary Care Provider Rate	1.79
Unemployment	***Indicators:*** Unemployed Workers in Civilian Labor Force	2.44
Poverty	***Indicators:*** **Families Living Below Poverty Level, Students Eligible for the Free Lunch Program, Unemployed Workers in Civilian Labor Force, Children Living Below Poverty Level, Median Household Income, People Living 200% Above Poverty Level, **People Living Below Poverty Level, Renters Spending 30% or More of Household Income on Rent, Youth not in School or Working, Severe Housing Problems, Persons with Disability Living in Poverty (5-year, Homeownership, Child Food Insecurity Rate, Food Insecurity Rate, Low-Income and Low Access to a Grocery Store, Per Capita Income, People 65+ Living Below Poverty Level, Food Insecure Children Likely Ineligible for Assistance	2.15
Cancer	***Indicators:*** Mammography Screening: Medicare Population, Age-Adjusted Death Rate due to Breast Cancer, Lung and Bronchus Cancer Incidence Rate, Oral Cavity and Pharynx Cancer Incidence Rate, Age-Adjusted Death Rate due to Prostate Cancer, Age-Adjusted Death Rate due to Colorectal Cancer, Age-Adjusted Death Rate due to Cancer. Age-Adjusted Death Rate due to Lung Cancer, Colorectal Cancer Incidence Rate, Cancer: Medicare Population, Breast Cancer Incidence Rate, Prostate Cancer Incidence Rate	1.79

Health Need	Availability and commitment from leadership in the involved organizations 1 – criterion not met 2 – criterion met 3 – criterion met well	Expertise and resources within the county to address this health problem 1 – criterion not met 2 – criterion met 3 – criterion met well	Opportunities for partnerships that will allow leveraging of shared resources 1 – criterion not met 2 – criterion met 3 – criterion met well	Opportunities to address the health problem before it gets exacerbated 1 – criterion not met 2 – criterion met 3 – criterion met well	Alignment of problem with your organization's strengths, priorities, mission 1 – criterion not met 2 – criterion met 3 – criterion met well	TOTAL
Drug Use						
Mental Health						
Alcoholism						
Housing and Homelessness						
Access to Specialists						
Unemployment						
Poverty						
Cancer						

PRIORTIZATION MATRIX RESULTS

	Availability and commitment from leadership in the involved organizations		Expertise and resources within the county to address this health problem		Opportunities for partnerships that will allow leveraging of shared resources		Opportunities to address the health problem before it gets exacerbated		Alignment of problem with your organization's strengths, priorities, mission		
Weights	4.8		4.6		4.6		4.6		4.47		Total
Drug Use (n=17)	33	158.4	26	119.6	37	170.2	26	119.6	36	160.92	8.57
Mental Health (n=17)	33	158.4	25	115	37	170.2	26	119.6	33	147.51	8.36
Housing and Homelessness (n=17)	34	163.2	23	105.8	32	147.2	22	101.2	28	125.16	7.56
Cancer (n=16)	27	129.6	24	110.4	26	119.6	26	119.6	27	120.69	7.50
Alcoholism (n=17)	25	120	25	115	28	128.8	24	110.4	30	134.1	7.16
Access to Specialists (n=17)	26	124.8	23	105.8	24	110.4	19	87.4	27	120.69	6.46
Unemployment (n=17)	25	120	19	87.4	22	101.2	21	96.6	28	125.16	6.24
Poverty (n=17)	25	120	19	87.4	23	105.8	19	87.4	27	120.69	6.13

APPENDIX F. COMMUNITY RESOURCES

The following is a list of community resources in Lake County mentioned by community input participants.

1. 4-H Youth Development Program
2. Adult Protective Services
3. Adventist Health Clear Lake
4. Alcoholics Anonymous
5. American Red Cross
6. Area Agency on Aging
7. Behavioral Health Services
8. Calvary Chapel
9. Career Point Lake County
10. Child Welfare Services
11. Circle of Native Minds Wellness Center
12. Clear Lake Gleaners Inc.
13. Clear Lake Senior Community Center
14. Community Garden
15. Continuum of Care
16. Disaster Recovery Center
17. Easter Seals
18. Elder Day Services of Lake County
19. First 5 Lake County
20. Free Friday Produce Pantry
21. Grace Church Kelseyville
22. Habitat for Humanity
23. Healthy Start Youth & Family Services
24. Hilltop Recovery Services
25. Home Energy Assistance Program (HEAP)
26. Hope Harbor Warming Center
27. Hope Rising Lake County
28. Hospice Services of Lake County
29. In-Home Supportive Services
30. Konocti Unified School District
31. La Voz de la Esperanza Latino Center
32. Lake County Alcohol & Other Drugs Services
33. Lake County Be Well
34. Lake County Campus of Woodland Community College
35. Lake County Chamber of Commerce
36. Lake County Channel Cats
37. Lake County Child Welfare Services
38. Lake County Children's Council
39. Lake County Community Development
40. Lake County Family Law Facilitator
41. Lake County Haven
42. Lake County Hunger Task Force
43. Lake County Office of Education
44. Lake County PRIDE Foundation
45. Lake County Sherriff's Department
46. Lake County Social Services Department
47. Lake County Tribal Health Consortium
48. Lake County Vector Control District
49. Lake County Veteran Services Office
50. Lake County Victim Witness
51. Lake County Women, Infants & Children
52. Lake Family Resource Center
53. Lakeview Health Center
54. Lower Lake Community Action Group
55. Meals on Wheels
56. Mendo-Lake Home Respiratory Services
57. Middletown Art Center
58. Mother-Wise
59. New Hope Fellowship
60. North Coast Opportunities
61. Planned Parenthood - Clearlake Health Center
62. Redwood Children's Services
63. Redwood Coast Regional Center
64. Redwood Community Services
65. Restoration House Lower Lake County
66. Rural Arts Initiative
67. SafeRx Lake County
68. Salvation Army
69. Senior Community Center
70. St. Helena Physical Therapy Center
71. St. Vincent DePaul Lower Lake
72. Sutter Lakeside Hospital
73. The Harbor on Main
74. Tribal Health
75. Tule House
76. Upper Lake Citizens Patrol
77. Veteran Affairs Clinic
78. Workforce Lake Business and Career Center
79. Worldwide Healing Hands

APPENDIX G: IRS GUIDELINES FOR FORM 990, SCHEDULE H COMPLIANCE

	REQUIREMENT	SECTION AND PAGE NUMBER(S) IN WRITTEN CHNA REPORT
The CHNA report adopted for the hospital facility by an authorized body of the hospital facility must include:		
	A definition of the community served by the hospital facility	Section 2.2
	A description of how the community served was determined	Section 2.2
	A description of the process and methods used to conduct the CHNA, and	Section 3
	A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves	Section 3
A prioritized description of the significant health needs of the community identified through the CHNA along with		
	A description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs	Section 7; Appendix E
	A description of the resources potentially available to address the significant health needs	Appendix F
	An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address significant health needs identified in the hospital facility's prior CHNA	Appendix A
A hospital facility's CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report		
	Describes the data and other information used in the assessment	Section 4-7; Appendix C
	Describes the methods of collecting and analyzing this data and information, and	Appendix C; Appendix D
	Identifies any parties with whom the hospital collaborated, or contracted for assistance	Section 2.8
A hospital facility's CHNA report* will be considered to describe how the hospital facility took into account input received from persons who represent the broad interest of the community it serves if it		
	Summarizes any input provided by such persons and how and over what time period such input was provided	Section 6; Section 7.2; Appendix D
	Provides the names of any organizations providing input, and	Section 6.2
	Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input	All through the report
JOINT CHNA: This section to be completed only if your hospital facility conducted a joint CHNA**. A hospital facility may conduct its CHNA in collaboration with other organizations and facilities including, but not limited to: related and unrelated hospital organizations and facilities; for-profit and government hospitals; governmental departments; and non-profit organizations. However, every hospital facility must document its CHNA in a separate CHNA report unless it adopts a joint CHNA report.		
	A joint CHNA report produced for the hospital facility and one or more of the collaborating facilities and/or organizations is permitted provided that the following conditions are met	Yes
	The joint CHNA report includes all required content	Yes
	The joint CHNA report is clearly identified as applying to the hospital facility, and	Yes
	All of the collaborating hospital facilities and organizations included in the joint CHNA report define their community to be the same	Yes

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Appendix E. Mendocino County Community Health Needs Assessment





2019 Mendocino County Community Health Needs Assessment

A Summary of Key Findings

A collaborative project to identify priorities and establish initiatives with specific goals and strategies for a healthier Mendocino County

October 2019




ACKNOWLEDGEMENTS

Thank you!

On behalf of the 2018-2019 Community Health Needs Assessment Planning Group, thanks to the 1,324 people who completed the community health survey and shared their views about health care, safety, public services, and more in Mendocino County. Thank you, as well, to the 90 representatives of community-based organizations, nonprofits, city government, county government, the tribal community, education, health care, law enforcement, private business, agriculture, and health and human services who completed a key informant interview/survey.

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The preparation of this report was directed by the Community Health Needs Assessment (CHNA) Planning Group, with funding provided by these collaborating organizations: Adventist Health Howard Memorial, Adventist Health Ukiah Valley, Alliance for Rural Community Health & Community Health Resource Network, Community Foundation of Mendocino County, FIRST 5 Mendocino, Healthy Mendocino, Mendocino Community Health Clinics, Mendocino County Health & Human Services Agency, Public Health Branch, Mendocino County Office of Education, North Coast Opportunities, Partnership HealthPlan of California, Redwood Community Services, Inc., Redwood Quality Management Company, and United Way of the Wine Country. The CHNA is a project of Healthy Mendocino, which facilitated the Planning Group.

TABLE OF CONTENTS

Appendices: Data Reports

A. Community Health Survey

B. Key Informant Interviews/Survey

C. Community Health Status Assessment

ACRONYMS

CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHSA	Community Health Status Assessment
CHS	Community Health Survey
CTSA	Community Themes and Strengths Assessment
EPHS	Essential Public Health Services
ES	Essential Services
HHSA	Health & Human Services Agency
KIIS	Key Informant Interviews/Surveys
LPHS	Local Public Health System
MAPP	Mobilizing for Action through Planning and Partnerships
NACCHO	National Association of County and City Health Officials
PG	Planning Group
PH	Public Health
RQMC	Redwood Quality Management Company

HOW HEALTHY ARE OUR RESIDENTS?

Introduction and Background

This report presents the findings from a collaborative process carried out to assess the health and well-being of the people of Mendocino County. It begins with a summary of the needs assessment process and presents key findings from each of four data collection methods, which are provided as Appendices to this document.

This Community Health Needs Assessment is a follow-up to the assessment conducted in 2015-2016. This assessment process began in 2018, when 13 Mendocino County agencies initiated the second collaborative community health needs assessment process. Adventist Health Howard Memorial, Adventist Health Ukiah Valley, Alliance for Rural Community Health & Community Health Resource Network, Community Foundation of Mendocino County, FIRST 5 Mendocino, Healthy Mendocino, Mendocino Community Health Clinics, Mendocino County Health & Human Services Agency, Public Health Branch, North Coast Opportunities, Partnership HealthPlan of California, Redwood Community Services, Inc., Redwood Quality Management Company, and United Way of the Wine Country all provided funding and representatives to the Planning Group. Healthy Mendocino coordinated the project.

The purpose of the community health needs assessment process is to identify the most pressing health priorities facing Mendocino County residents and commit to a coordinated set of strategies to improve the health and well-being of our residents. While many agencies and organizations in Mendocino County collect and act on health information, this process was distinct because it was community-driven, with several local agencies collaborating on a single community health needs assessment. The purpose of collaborating is to achieve a greater combined impact on local health than the partners could achieve separately. In addition to being more efficient, this collaboration makes it possible to involve a wide array of community members and local public health system partners (e.g., hospitals and clinics) in efforts that are designed to be sustainable. The goal is to build on collective wisdom and use resources from throughout the community to improve health and well-being in our county.

Community Health Needs Assessment

The Community Health Needs Assessment (CHNA) for Mendocino County is a compilation of quantitative and qualitative data from multiple sources, woven together to provide a comprehensive picture of the health of county residents. Many community members, key formal and informal leaders, and community partners shared their wisdom, knowledge, experiences, and perceptions about the health of residents and the capacity of the health care system to provide essential public health services. The health care system is defined broadly in this context to include all of the organizations and entities that contribute to the public's health in a community, including the county public health department as well as public, private and volunteer organizations; all contributed to this assessment.

The CHNA findings presented here will be used to inform the prioritization of health issues and the development of a Community Health Improvement Plan (CHIP). A CHIP is an action-oriented plan for addressing the most significant issues identified by community partners.

The goal of the CHNA and CHIP is to align and leverage resources, initiatives and programs to improve local health. The ultimate goal is to ensure coordinated, measurable health improvement throughout the county, with all agencies and organizations working together toward collective impact.

Meeting External Requirements

In addition to the goal of aligning and leveraging resources, initiatives and programs to improve health, the CHNA and CHIP help to fulfill requirements of the participating organizations. First, they are required prerequisites for Public Health Accreditation, which the Mendocino County Health & Human Services Agency, Public Health Branch is now undertaking. National accreditation standards define expectations whereby public health departments across the United States can continuously improve the quality of their services and promote accountability and credibility to the public, funders, elected officials, and other community partners.

The CHNA and CHIP are also required prerequisites for our local hospitals. The Affordable Care Act (ACA), through the new Internal Revenue Code §501(r), creates additional conditions for charitable 501(c)(3) hospitals to qualify for federal income tax exemption and related benefits.[1] To maintain such status, hospitals must conduct community health needs assessments and adopt implementation strategies to meet those needs at least once every three years. Other tax-exempt conditions for nonprofit hospitals include providing benefits, such as charity care, to their communities.

Our local community health clinics are also required to assess and document the needs of their target populations as a condition of receiving Federal grant funding through Section 330 of the Public Health Service Act (42 U.S.C. ss 254b). This information is then used to inform and improve the delivery of services.

Finally, the CHNA is also required of our local community action agency (administered by North Coast Opportunities) in order to assess and document the needs of our county's low-income populations. This information is used to establish priorities and inform a bi-annual Community Action Plan, in compliance with the Community Services Block Grant Act (Public Law 105-285).

Comparison of the 2016 and 2019 CHNA on Select Indicators

At the conclusion of the 2016 CHNA process, a countywide forum with over 100 community members from across Mendocino County was held in 2016 to choose a set of priorities. As a result of the forum, a CHIP was formed with five priority areas:

1. Childhood Obesity and Family Wellness
2. Childhood Trauma
3. Housing
4. Mental Health
5. Poverty

This CHNA includes a comparison between the 2016 and 2019 CHNA data on select Public Health Indicators. This comparison may help determine possible impacts and effectiveness of the strategies utilized by teams formed to work on the five priority areas.

Community Planning Framework

Mobilizing for Action Through Planning and Partnerships (MAPP)

Mendocino County's Community Health Needs Assessment Planning Group adopted the MAPP Model as its planning framework to guide the CHNA process. The National Association of County and City Health Officials (NACCHO) developed the MAPP tool to capture an in depth picture of community health status through quantitative and qualitative data collection methods. The MAPP framework includes four assessments.[2] Of these, two assessments were selected for the 2019 CHNA:

- The **Community Themes and Strengths Assessment** provides a deep understanding of the issues that local residents and community leaders feel are important to the health of their communities. Both the Community Health Survey (Appendix A) and Key Informant Interviews/Survey (Appendix B) were used in this assessment.
- The **Community Health Status Assessment** (Appendix C) uses data to illuminate the health status of Mendocino County and its residents, helping to answer questions including: *How healthy are Mendocino County residents?*

Table 1. Key Determinants of Health and Well-Being

KEY DETERMINANTS	SUCH AS . . .
Social and Economic Opportunities and Resources	· Economic development · Job opportunities · Educational attainment · Reducing poverty · Child and youth development · Civic and community engagement
Living and Working Conditions in Homes and Communities	· Build environment · Natural environment · Healthy schools · Healthy worksites · Healthy homes and neighborhoods · Healthy systems: food, transportation, housing
Medical and Social Services / Personal Behavior	· Access to prevention-focused medical and social services · Health literacy · Healthy lifestyles

Healthy Equity/Social Determinants of Health Framework

The CHNA project looks at the community's health through a wide lens. When people think of health, they may think of it only in relation to disease or illness; but health is part of every aspect of our daily lives. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3] This definition indicates that improving health necessitates moving beyond addressing just illness to consider a range of factors that influence health.

Social determinants of health are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."[4] These economic, social, cultural and environmental factors affect a wide range of health risk and outcomes and impact the health status of individuals and groups. In Mendocino County, as in most

communities, some of the most serious health concerns relate to the wide differences in health status among different population groups and geographic areas—health disparities. These disparities generally stem from root causes and inequities such as the toxic effects of poverty, lack of safety, and inadequate housing that can also lead to poor school performance and other concerns. Such root causes cannot be addressed by individuals or even by individual systems or organizations. Health inequities can only be addressed by moving "upstream" from a focus on individual responsibility to a focus on our collective responsibility to create the conditions that enable all residents to make healthy choices and have better health outcomes.[5]

COMMUNITY HEALTH NEEDS ASSESSMENT

Overview of the Community Health Needs Assessment Process

MAPP Phases 1-2: Organize For Success and Partnerships

The assessment process began in September 2018 with the formation of the CHNA Planning Group. The Planning Group included representatives from the sponsoring agencies who guided the assessment planning efforts and helped to conduct the assessments. The participation of CHNA Planning Group members resulted in broad representation of key community leaders, advocates and allies who collectively helped shape and inform the process. Planning Group members' knowledge of their organizations' priorities and the communities and population groups they serve greatly enriched the CHNA process.

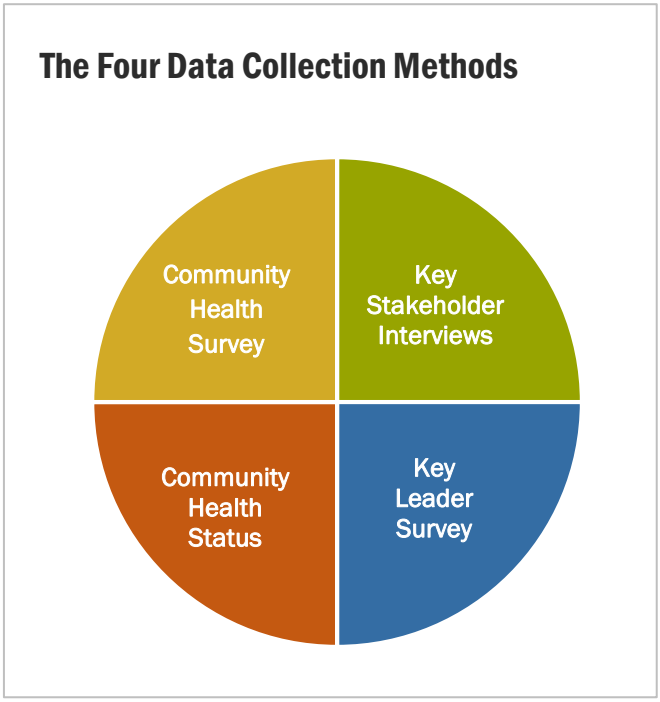
The CHNA was designed to identify the extent and types of existing and potential problems in the community, and the extent of unmet needs, underutilized resources, and shortcomings of the service delivery system. For the purposes of the CHNA, community was defined as Mendocino County, as a whole.

The needs assessment is not an end in itself, but the initial step in the development of a comprehensive community health improvement plan.

MAPP Phase 3: Assessments

The Planning Group met at least monthly from September 2018 to September 2019 to provide guidance and feedback on the proposed methodologies for each of the two MAPP assessments utilized during this process and to evaluate the findings. The two MAPP assessments (using four forms of data collection) were completed in September 2019. The data collection methods are described below.

- The **Community Health Survey** (Appendix A) provides residents' opinions about health status, access to services, and any barriers to obtaining health care.
- The **Key Stakeholder Interviews/Key Leader Survey** (Appendix B) identifies views on health and well-being in Mendocino County among key stakeholders in the community, both formal and informal leaders. Two data collection methods were used in this assessment (i.e., an interview and a survey).
- The **Community Health Status Assessment** (Appendix C) uses secondary data from a variety of sources such as vital statistics data, accident and injury rates, infectious and chronic disease rates, and others, to illuminate the health status of Mendocino County and its residents, helping to answer questions including, *What is the health of Mendocino County residents?*



The key findings from the MAPP assessments are summarized in the next section and provided in greater detail in the three data reports in the Appendices (Appendix A. Community Health Survey, Appendix B. Key Stakeholder Interviews/Survey, and Appendix C. Community Health Status Assessment). As noted, these findings will be used to prioritize the most salient community health issues to be addressed in the Community Health Improvement Plan (CHIP) which will begin in November 2019. The CHIP will be reported in a separate document.

A review of the findings will occur among each of the partner organizations and the Healthy Mendocino Advisory Council beginning November 2019, with comments from the general public being accepted via the Healthy Mendocino website (www.healthymendocino.org).

Limitations of the Data

This needs assessment uses a combination of primary data – data collected through the perspective of key informants' and community members in Mendocino County – as well as secondary data – which requires collecting information from many sources. Data availability varies among different sources, can sometimes be in a format not conducive for inclusion in this report, and new data are continually being released. Finally, no one data set in this report tells the whole story about Mendocino County's unmet or under-met needs. All of the data collected by this process collectively paint the picture. For these reasons, it is suggested that readers consider the entirety of the findings when drawing conclusions or making policy changes and funding decisions.

MAPP Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment (CTSA) provides a snapshot of Mendocino County by gathering information on community members' thoughts, concerns and opinions on the following questions: [6]

1. How is quality of life perceived in our community?
2. What factors are most important for our community's health?
3. What assets do we have that can be used to improve community health?

The CTSA was conducted via three methods. The first method was through a **Community Health Survey** that was provided to Mendocino County residents online as well as in hardcopy format. A total of 1,324 residents completed the Community Health Survey; 1,276 were completed in English and 48 in Spanish; 94 were completed by Native Americans, mostly from the Round Valley area.

The second method was via **Key Informant Interviews** of 34 key stakeholders in the community, including representatives of county and city government, private businesses, health and human services, hospitals and clinics, community-based organizations and nonprofits, law enforcement, children and youth services, education, media, geography, and racial/ethnic groups, among others. Interviews were conducted in person or by phone. Some questions were also provided in hardcopy format for written response. While an effort was made to have diverse representation, the opinions provided by the key informants are not necessarily representative of the county as a whole. (A list of the key informants who participated is provided in Appendix B on p. 10).

The third method was via a **Key Leader Survey** of 56 formal and informal leaders in the community that was provided online. Together with the Key Informant Interviews, a total of 90 key informants/leaders in Mendocino County participated.

The three CTSA methods were modified by the CHNA Planning Group such that the **first five questions** of the Community Health Survey, the Key Informant Interviews and the Key Leader Survey were made the same for the 2019 CHNA. This was fine-tuning of the Community Themes and Strengths Assessment, building on the strengths and lessons learned during the 2015 CHNA. Ensuring that the first five questions were the same, closed-ended questions, allowed for a comparison between the three CTSA data collection methods, i.e., between the perception of the community at large and that of policy makers and other leaders in the county on select topics.

The following sections outline illustrative and interesting findings, drawing on responses to the **Community Health Survey** and **Key Informant Interviews/Survey.** These and other findings are discussed in greater detail in the reports in the Appendices. Note that the results reported for Hispanics/Latinos is drawn exclusively from the surveys that were completed in Spanish, rather than from all of the Hispanics/Latinos that completed a survey.

Assessment Findings: A Synthesis of Data from the Community Health Survey and Key Informant Interviews/Survey

Question 1: How is quality of life perceived in our community?

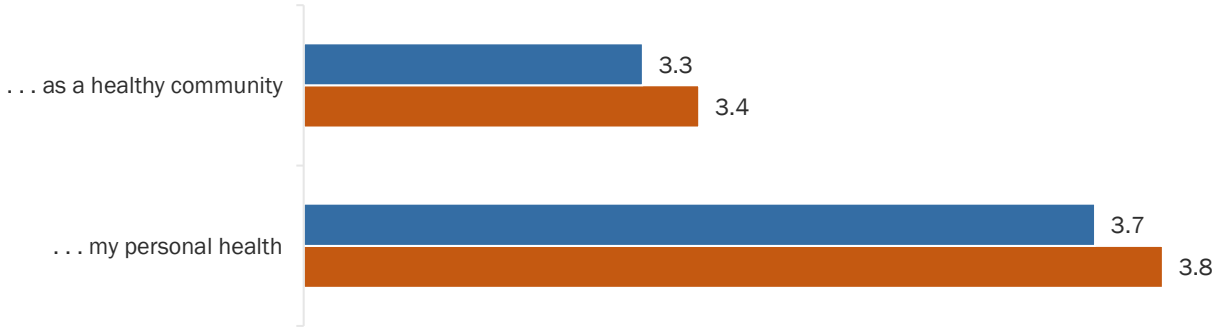
The data in this section depicts several facets of the quality of life in Mendocino County including perceptions of quality of life, health and wellness, basic needs, and safety.

Quality of Life

In the Community Health Survey, the majority of adult respondents rated Mendocino County as a "healthy" or "somewhat healthy" community in which to live, an average of 3.3 (on a scale of 1 to 5, with 5 being the highest) (Figure 1). The average score was higher for Hispanic/Latino respondents (4.0), but lower for Native American respondents (3.0).

Figure 1

Residents and Key Leaders rated Mendocino County lower than their rating for their own personal health Scale: 1 to 5, with 5 being the highest, n=1,414



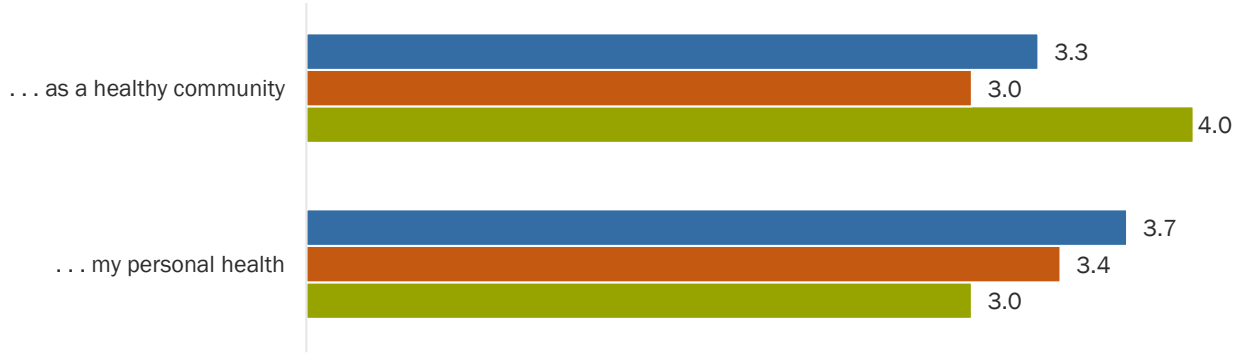
In the interviews/survey, key leaders rated Mendocino County similarly to residents, with an average of 3.4. The lowest ratings had to do with mental health issues, the normalization of the drug culture, the criminality associated with the drug culture, and the lack of equal access to services by the disadvantaged in the county. In contrast, personal health ratings averaged 3.7 for residents and 3.8 for key informants, with the majority selecting a "healthy" or "very healthy" rating. One informant noted:

> *"I get out in nature and use the local trails. I have access to healthy food. But, I have high stress at work from the mentally ill and substance abuse populations, and this affects my emotional health."*

In comparing the average ratings for all respondents to those of Native Americans and Hispanics/Latinos, specifically, there is a difference of opinion (Figure 2). Native Americans rate their personal health (3.4) higher than Mendocino County as a healthy community (3.0). Hispanic/Latino respondents rated their personal health (3.0) much lower than Mendocino County as a healthy community in which to live (4.0).

Figure 2

The healthy community and personal health ratings varied among All Respondents, Native Americans and Hispanics/Latinos Scale: 1 to 5, with 5 being the highest, n=1,324



Health and Wellness

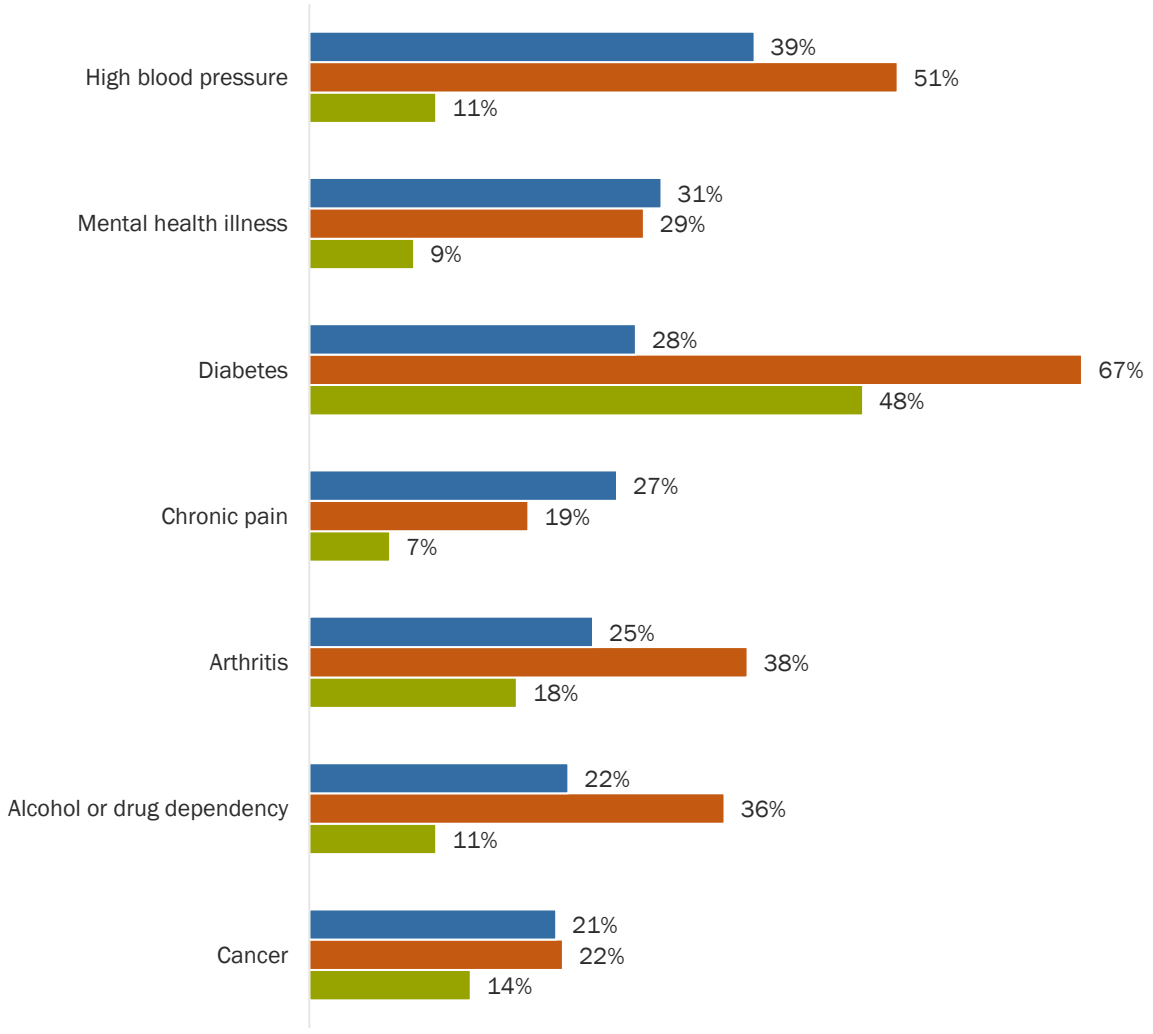
In the 2019 Community Health Survey, respondents were asked which chronic illnesses or conditions they or family members were living with. Of 1,215 respondents to this question, the top seven chronic conditions reported were high blood pressure (39%), mental health illness (depression, bi-polar, schizophrenia, etc., 31%), diabetes (28%), chronic pain (27%), arthritis (25%), alcohol or drug dependency (22%), and cancer (21%) (Figure 3).

For Native Americans, the top seven chronic conditions were almost identical but varied in frequency with the top condition reported as diabetes (67%), followed by high blood pressure (51%), arthritis (38%), alcohol or drug dependency (36%), mental health illness (29%), and cancer (22%).

Hispanics/Latinos reported the least chronic conditions; the top seven were: diabetes (48%), arthritis (18%), cancer (13%), high blood pressure (11%), alcohol or drug dependency (11%), and chronic pain (7%). Important to note is that almost all of the Hispanic/Latino respondents were under 54 years of age. Nonetheless, almost half of the Hispanic/Latino respondents reported living with diabetes.

Figure 3

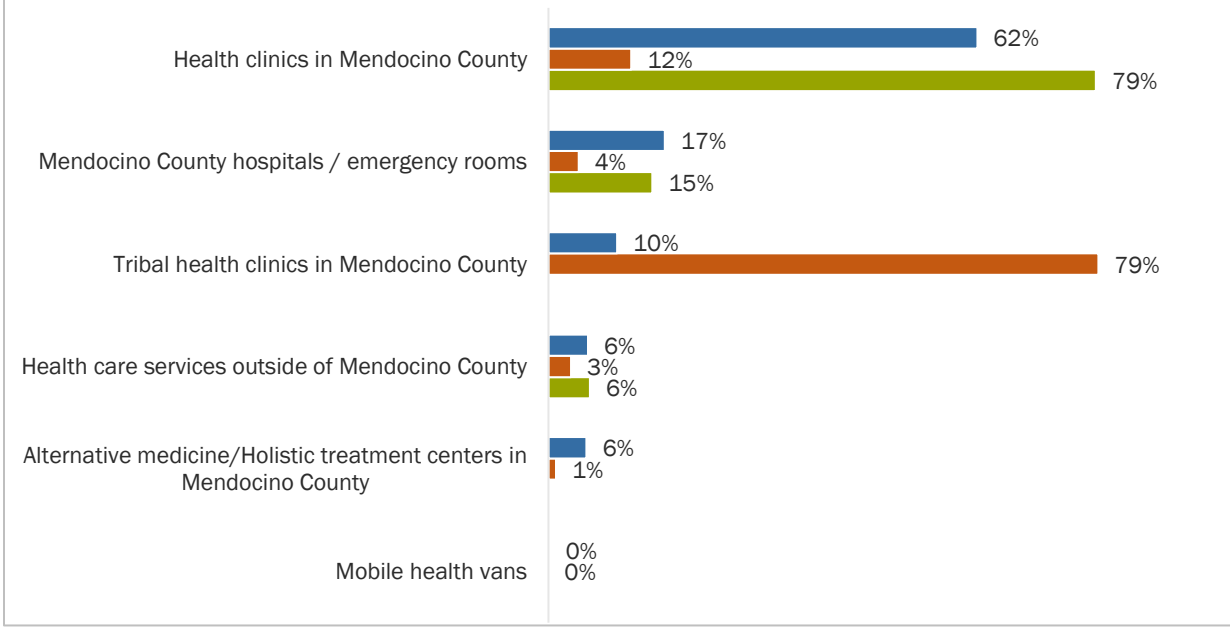
All Respondents, Native Americans and Hispanics/Latinos reported living with chronic illness or chronic conditions n=1,215



When it comes to getting needed health care services, residents were asked, "Where do you most often go to access health care services for yourself and your family?" Of 1,155 respondents to this question, 94% reported that they access health care within Mendocino County, with 6% most often going outside of the county for care. Of those that get care within the county, most (62%) utilize the health clinics; secondarily the county hospitals and emergency rooms (17%). For Native American respondents, the tribal health clinics are most often utilized (79%). For Hispanics/Latinos, the health clinics (non-tribal) in the county are also most often used (79%) (Figure 4).

Figure 4

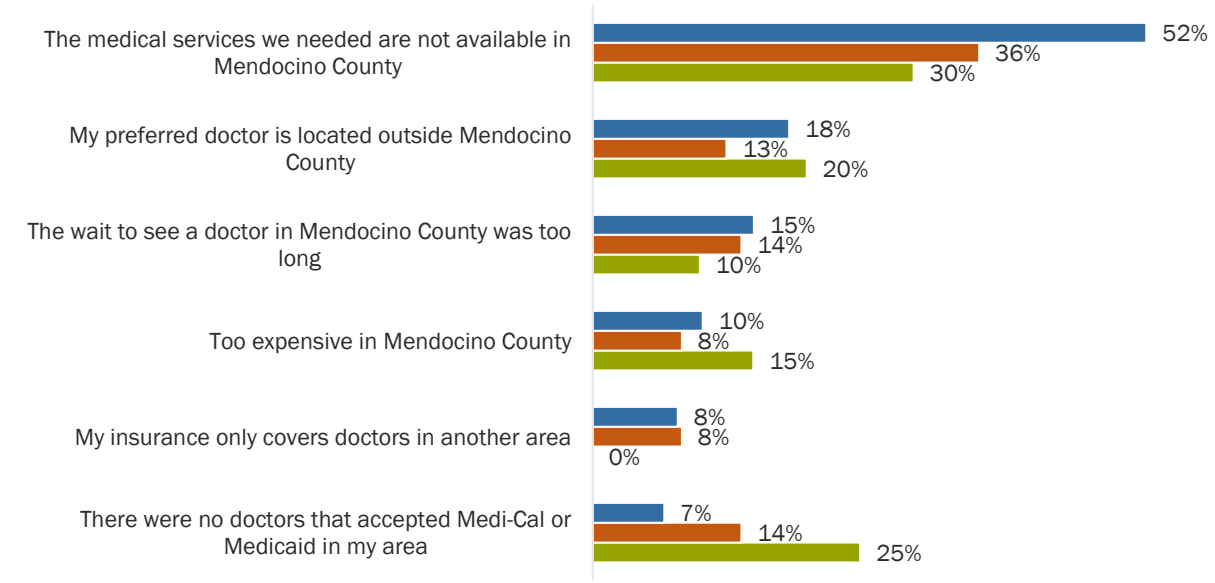
All Respondents, Native Americans and Hispanics/Latinos reported where they most often go to access health care services for themselves and their family n=1,155



In general, the biggest barriers associated with accessing health care services in Mendocino County were that needed medical services were not available locally (52%). This was true for Native American (36%) and Hispanic/Latino (30%) respondents, as well (Figure 5).

Figure 5

Barriers to access to care varied between All Respondents, Native Americans and Hispanics/Latinos n=963



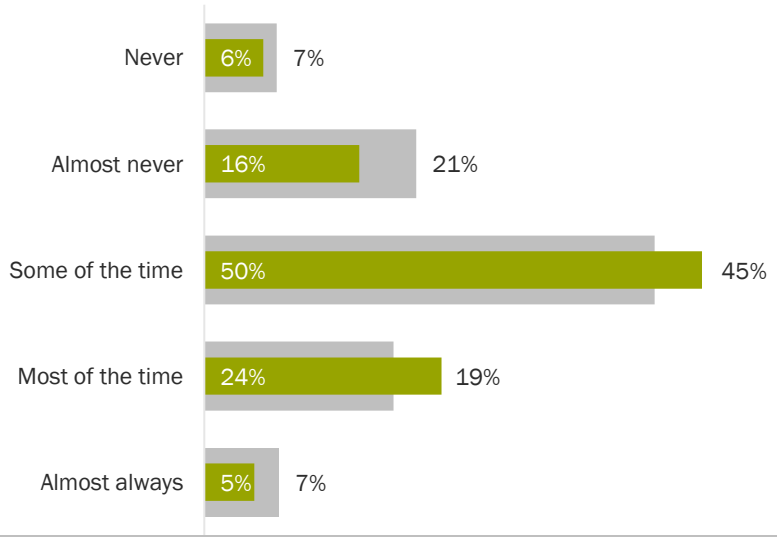
When asked about stress, 50% of respondents indicated that their daily activities are affected by stress some of the time and 24% most of the time, both of which indicate an increase in stress since the 2015 Community Health Survey (Figure 6).

Native American respondents indicated having daily activities affected by stress some of the time (42%) and most of the time (18%).

Hispanics/Latinos indicated that stress affects their daily lives never (30%) or almost never (41%).

Figure 6

Residents reported an increase between 2015 and 2019 in daily activities negatively affected by stress some or most of the time n=1,414



Basic Needs

Housing.

- The majority of respondents live in a single family home (72%) or apartment/condo/duplex (16%).
- Most rent their home 39%, with 51% of Native Americans and 68% of Hispanics/Latinos indicating they also rent. One-third (32%) of respondents own their home with a mortgage; 8% of Native Americans and 20% of Hispanics/Latinos.
- The majority of respondents stated that they were happy with their housing situation (64%); this was also true for Native American (60%) and Hispanic/Latino (61%) respondents.
- Causes for not being satisfied with their housing situation included it being too expensive, too small, and too run down or old.

Employment.

- Most (45%) of respondents are employed more than 30 hours a week; 48% of Native Americans and 53% of Hispanics/Latinos.

Safety

In the Community Health Survey, the majority of adult respondents rated Mendocino County as a "somewhat safe" or "safe" community in which to grow up or raise children, an average of 3.6 (on a scale

of 1 to 5, with 5 being the highest). Key leaders rated Mendocino County similarly with an average score of 3.7 (Figure 7).

The lowest ratings had to do with drug and alcohol use and the most rural, isolated areas in the county "where anything can happen without it necessarily being noticed" (key informant). Another informant said:

Figure 7

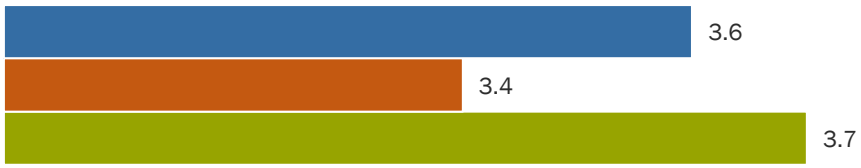
The majority of Residents and Key Leaders rated Mendocino County a safe place to grow up or raise children Scale: 1 to 5 with 5 being the highest, n=1,414

"Drugs have made things risky for kids . . . the community is safe for preteens, but more dangerous for teens."

In comparing the average ratings for all respondents to those of Native Americans and Hispanics/Latinos, specifically, Native Americans rated Mendocino County as a safe community in which to live lower (3.4) than the average among all respondents (3.6). Hispanic / Latino respondents rated Mendocino County the highest, with a rating of 3.7 (on a scale of 1 to 5, with 5 being the highest) (Figure 8).

Figure 8

The ratings regarding Mendocino County as a safe community varied among All Respondents, Native Americans and Hispanics/Latinos Scale: 1 to 5 with 5 being the highest, n=1,324

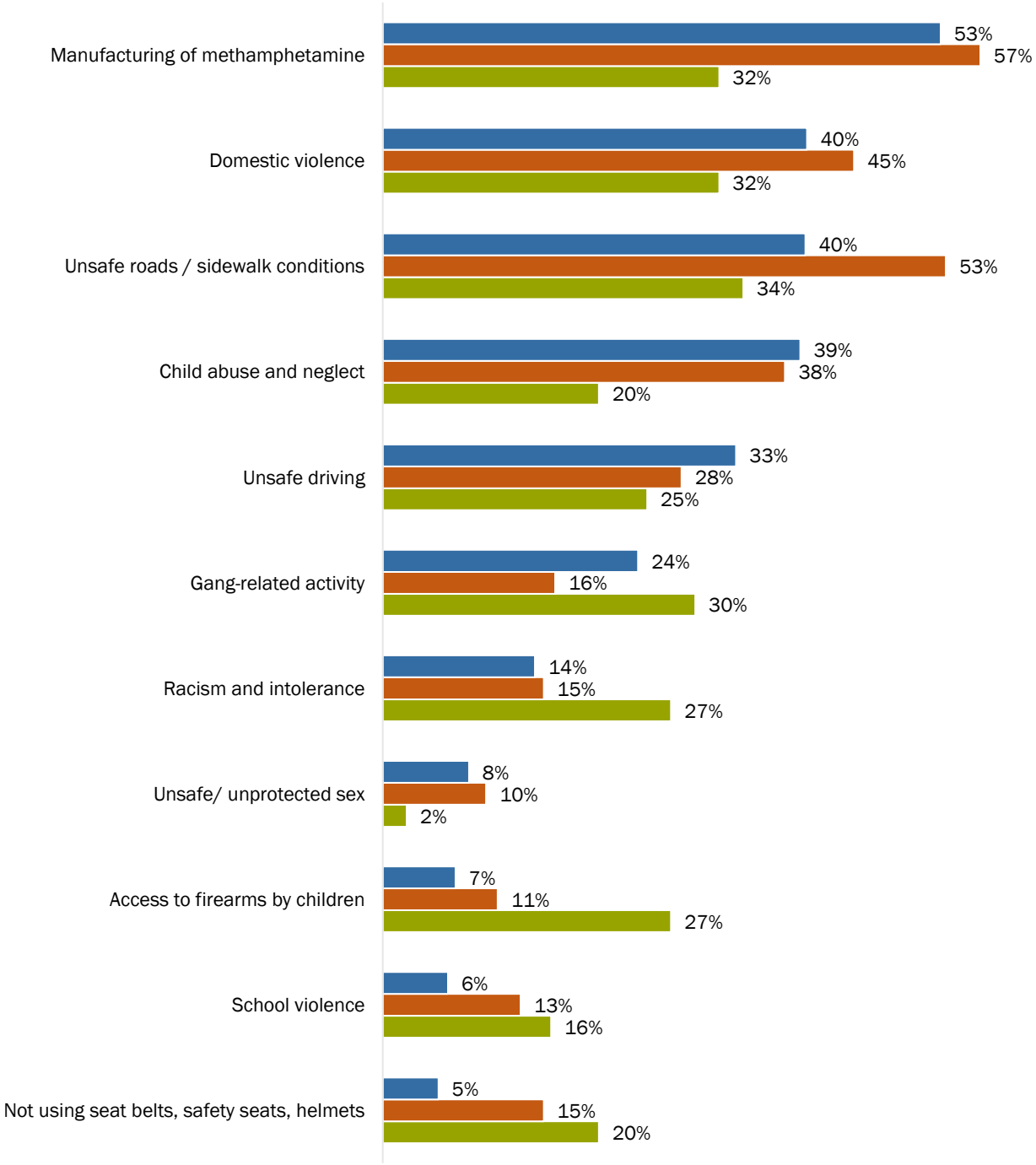


The top three safety problems identified by respondents were: 1) manufacturing of methamphetamine, 2) domestic violence, and 3) unsafe roads/sidewalk conditions (Figure 9).

Figure 9

All Respondents, Native Americans and Hispanics/Latinos say the biggest safety problems are manufacturing meth, domestic violence and unsafe roads / sidewalks

n=1,324



Question 2: What factors are most important for our community's health?

The data in this section depicts several facets of the quality of life in Mendocino County including perceptions of what makes Mendocino County a good place to live and the most important health problems.

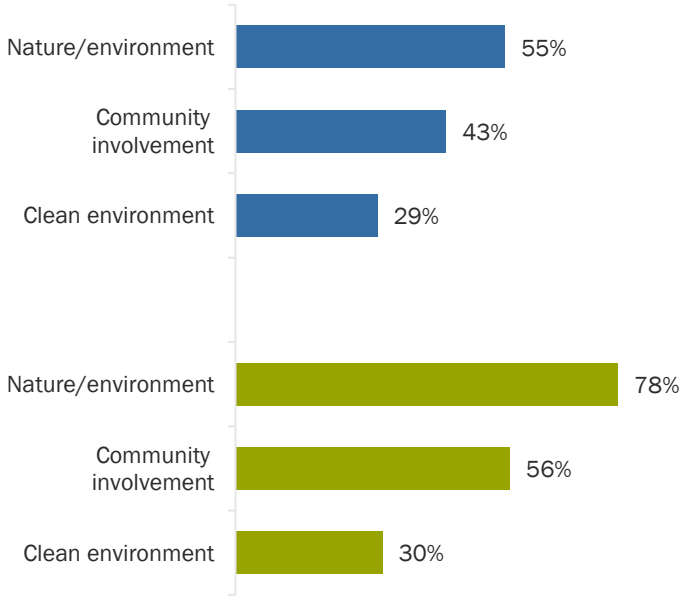
Factors That Make Mendocino County a Good Place to Live

When asked what factors make Mendocino County a good place to live, survey respondents most often selected nature/environment (55%), community involvement (43%), clean environment (29%), low crime/safe neighborhoods (24%), and arts and cultural events (22%) (Figure 10).

Key leaders had the same responses for the top three factors that make Mendocino County a good place to live, nature/environment (78%), community involvement (56%), and clean environment (30%). The factors that ranked four and five were parks and recreation (20%) and low crime/safe neighborhoods (17%).

Figure 10

Residents and Key Leaders agree on the Top 3 Factors that make Mendocino County a good place to live n=1,414

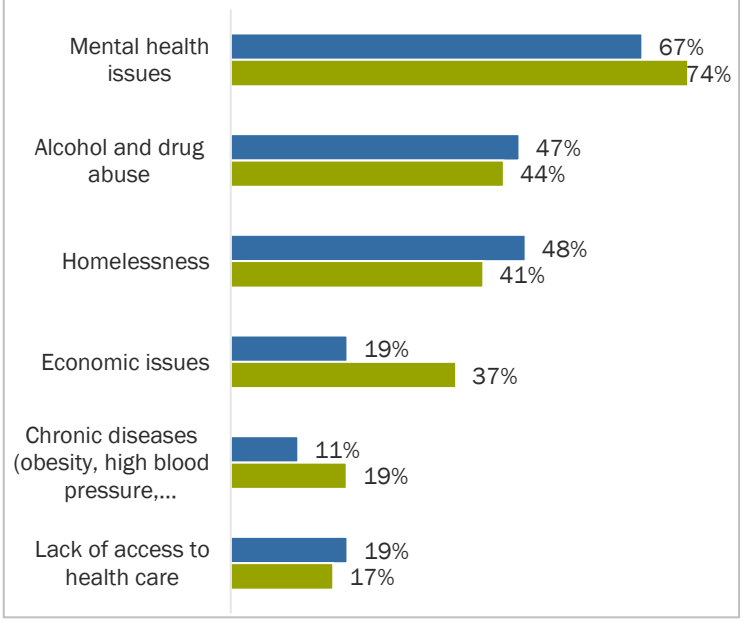


Most Important Health Problems

Residents and key leaders also agree on the top 6 most important health problems in Mendocino County: 1) mental health issues, 2) alcohol and drug abuse, 3) homelessness, 4) economic issues, 5) chronic diseases (e.g., obesity, high blood pressure, diabetes, etc.), and 6) lack of access to health care (Figure 11). These results were identical to the 2015 Community Health Survey with one exception: marijuana use/industry as one of the most important health problems in the 2015 survey was replaced by chronic diseases in the 2019 survey.

Figure 11

Residents and Key Leaders agree on the Top 6 Most Important Health Problems in Mendocino County n=1,414



Most Significant Barriers to Addressing These Issues

Key informants were asked to identify, overall, what are the **most significant challenges or barriers** to addressing the most important health problems identified in the previous section (above and in Figure 11). The top six issues identified by informants are:

1. **Lack of funding** to support infrastructure and programs
2. **Lack of affordable housing,** particularly for the mentally ill and homeless
3. The **need for mental health services exceeds the capacity** of the current system
4. **Duplication of effort** among local agencies and nonprofits
5. The **pervasiveness of the drug culture** and widespread acceptability of marijuana
6. The **current state of the economy**, overall

These barriers, and their relationship to the most important health problems described above, are defined in more detail in the 2019 Key Leader Interviews/Survey report (Appendix B). Also included are approaches suggested by informants, challenges and barriers to overcoming these health problems, and sample quotes from the interviews. Assets in the community that can be leveraged to address the most important health problems identified by informants are provided in the next section.

Question 3: What assets can be used to improve the community's health?

In the interviews, key informants identified the following as some of the assets in Mendocino County that can be leveraged to address many of the most important health problems identified above.

1. **Mental Health**
   a. Measure B Funding
   b. Redwood Quality Management Company
   c. Redwood Community Services
   d. Innovations Project
2. **Alcohol & Drug Abuse**
   a. Prop 64 Funding
   b. HUD/Ford Street Residential Treatment Pilot Project
3. **Homelessness**
   a. Government
   b. Large businesses and nonprofits
   c. Redwood Quality Management Company
   d. Redwood Community Services
4. **Economic Issues**
   a. City/county partnerships
   b. Nonprofits

For more information about the 2019 Community Health Survey and the 2019 Key Informant Interviews/Survey, please see Appendices A and B, respectively.

A Special Focus on Mental Health

Mental health issues were identified as one of the most important health problems in Mendocino County by community members and key leaders during the 2019 Community Health Survey and 2019 Key Leader Interviews/Survey, respectively. These results were consistent with the most recent CHNA in 2015.

In the 2019 Community Health Survey, approximately 40% of respondents indicated that they or their immediate family members were unable to access mental health services when they needed them. Of those that explained their response, the most frequently stated comments were concerns about confidentiality, that mental health treatment for youth was unavailable, and that they felt there was a lack of qualified mental health professionals in the county.

For Medicaid eligible persons, services have been increasing in the county for youth and adults with the most urgent and severe mental health needs.[7] As shown in Figure 12, unduplicated persons receiving specialty mental health services in Mendocino County has risen from 2,324 in fiscal year 2016/2017 to 3,017 in fiscal year 2018/2019. While total number of calls has varied from year to year, the total number of assessments and hospitalizations has risen from 2016/2017 to 2018/2019 (Figure 13).

Figure 12

Mental Health crisis services in Mendocino County have grown over the past 3 years

Source: Redwood Quality Management Company (RQMC), 2019

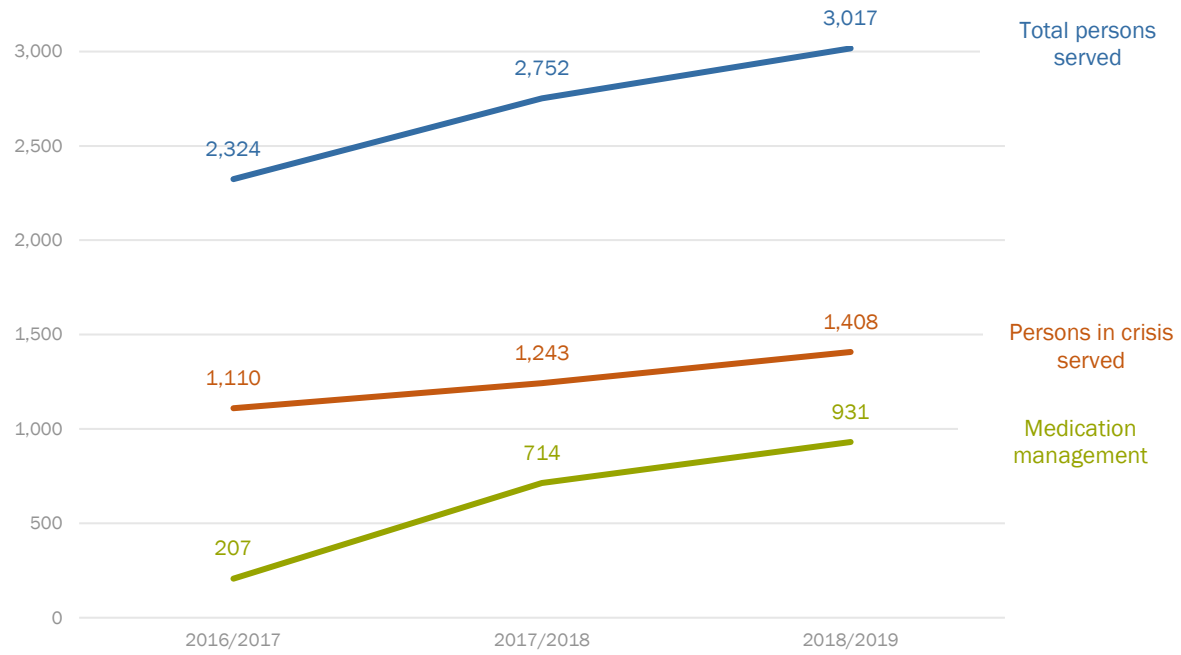
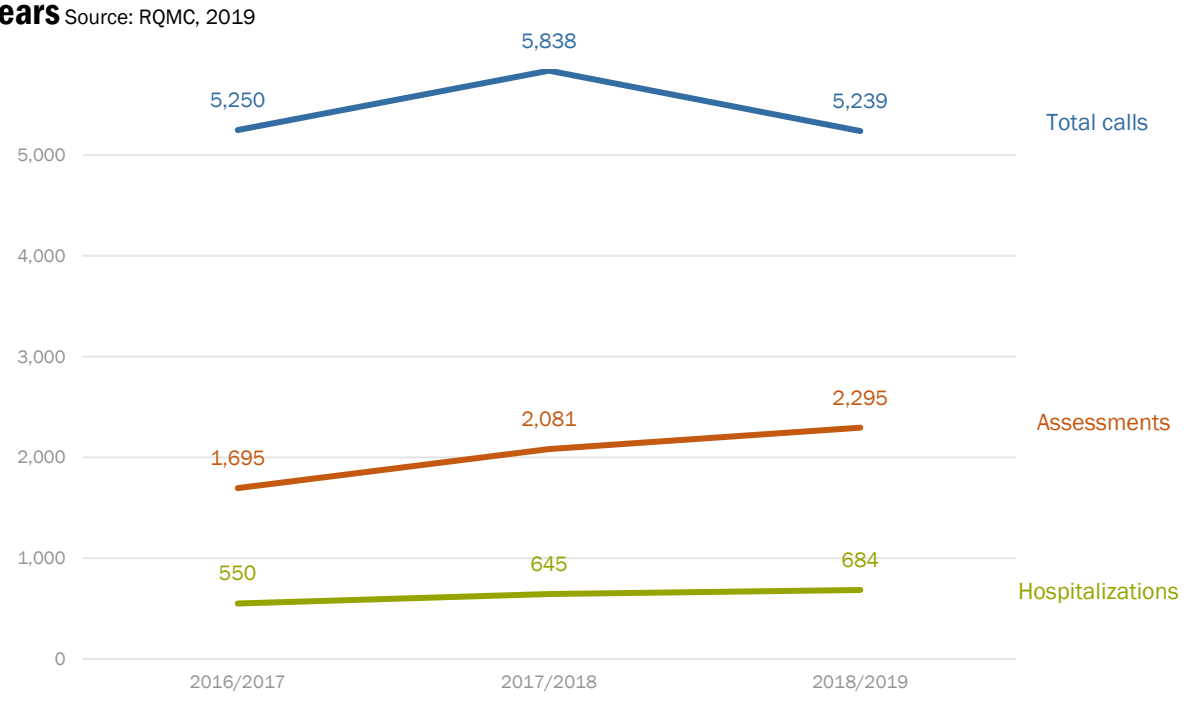


Figure 13

Types of Mental Health crisis services provided in Mendocino County over the past 3 years

Source: RQMC, 2019



MAPP Community Health Status Assessment

The Community Health Status Assessment (CHSA) is a compilation of local and comparative data from multiple sources that was collected and analyzed to gauge the health of the county's population and identify health disparities among age, gender, racial and ethnic groups. The CHSA seeks to address three questions:[8]

1. How healthy are our residents?
2. What does the health status of our community look like?
3. What are the disparities in our community?

The Mendocino County Health & Human Services Agency, Public Health Branch reviewed approximately 165 indicators describing aspects of community health that are derived from dozens of state, federal, and other data sources. These indicators include measurements for illness and disease, disparities in access to care, environmental and economic indicators, and more. The community indicators with graphic dials in the red zone point to major opportunities for improvement. The indicators for the CHSA report are organized into the following categories:

- Socioeconomic Characteristics
- Social Determinants of Health
- Behavioral Risk Factors
- Maternal Child and Adolescent Health
- Healthcare and Preventive Services
- Hospitalization and Emergency Room Utilization
- Dental Health
- Illness, Injury and Deaths

Below is a summary overview of the demographic characteristics of the county, including population characteristics; education, income and employment; and housing and homelessness. The demographic data highlighted in this section will be important considerations in the planning for health improvements. For more information about the 2019 Community Health Status Assessment, please see Appendix C.

Mendocino County Demographic Profile

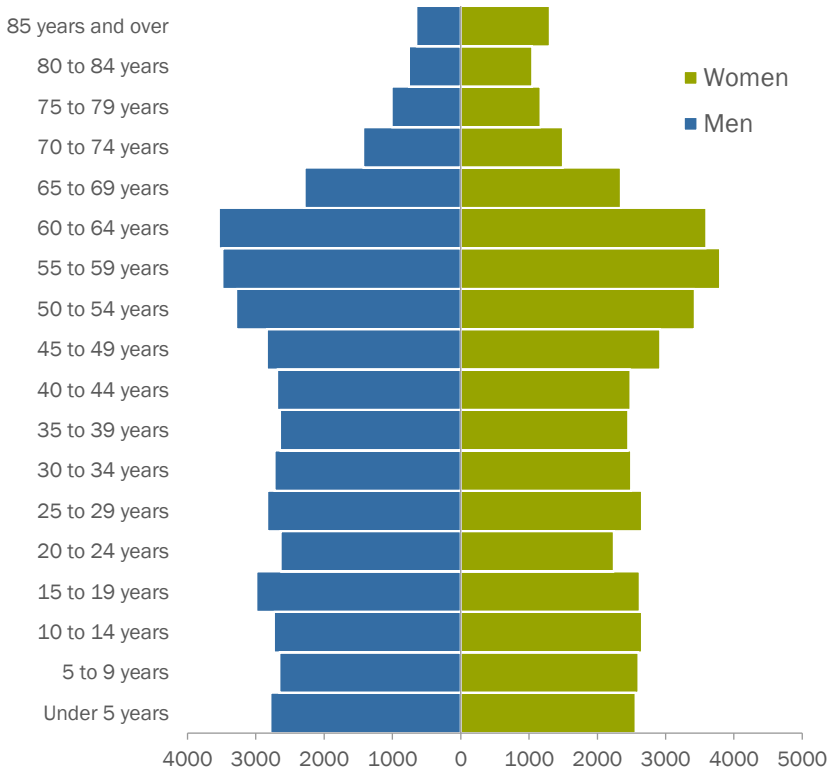
Population Characteristics

Mendocino County is a rural county in Northern California with a land area of 3,509 square miles. According to 2018 data from the U.S. Census Bureau, Mendocino County has an estimated population of 87,580, slightly lower than the 87,869 reported in the 2014 U.S. Census data. More than one-half (55%) of the population live in urban areas, while 45% live in rural communities, on farms or ranches. The proportion of residents who are ages 65 years and over make up 21.7% of the county population, higher than the proportion in the state with 14.5%.[9]

Figure 14

2019 Mendocino County Population by Age and Gender

Source: U.S. Census Bureau, 2018



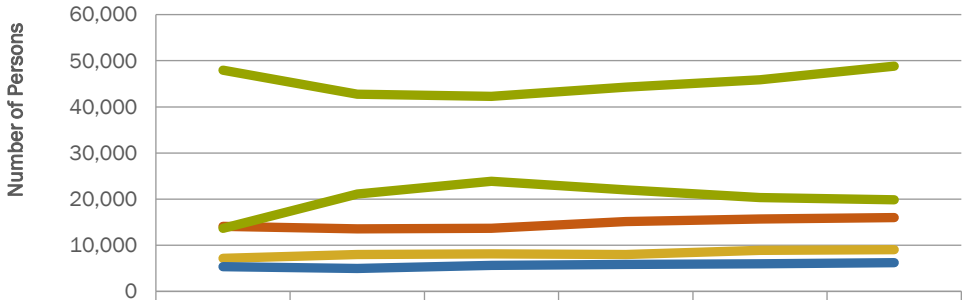
The population pyramid shows the "Baby Boomer" demographic aging into their 50's to 60's. Mendocino County has a slightly older median age of 42.3 years, compared with California's median age of 36.4 years (Figure 14).[10]

Between 2010 and 2060, the working age population (25-64) is expected to increase from 47,955 to 48,818, or to 49% of the county population, while retirees and seniors (65 years and up) will grow from 13,672 to 19,861 (to 20% of the county population) (Figure 15).[11]

Figure 15

Mendocino County Population Projects by Age 2010-2060

Source: California Department of Finance, 2015



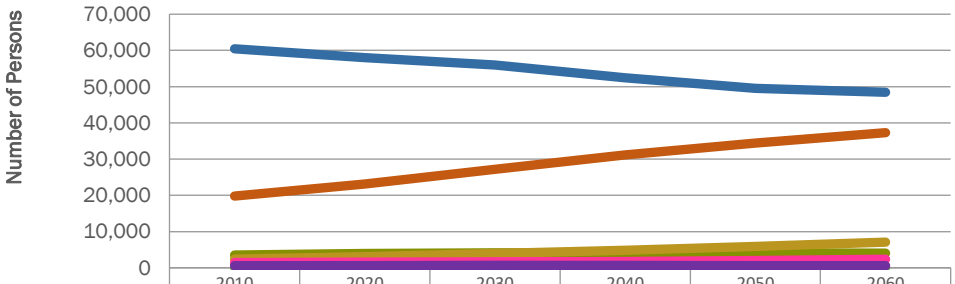
	2010	2020	2030	2040	2050	2060
Working Age: (25-64 years)	47,955	42,774	42,277	44,244	45,874	48,818
School Age: (5-17 years)	14,115	13,559	13,677	15,118	15,687	15,999
Retirees and Seniors: (65 years and up)	13,672	21,132	23,866	22,002	20,345	19,861
College Age: (18-24 years)	7,168	7,970	8,106	7,996	8,889	9,047
Preschool Age: (0-4 years)	5,382	4,976	5,651	5,847	5,956	6,227

In 2018, the county's population was 76% White, 22% Hispanic, 4% Native American, 1% Asian, .7% African American, .6% Pacific Islander, and 15.4% Two or More Races.[12] As shown in Figure 16, between 2010 and 2060, the Hispanic/Latino population is expected to increase from 19,802 to 37,293 or to 37% of the county population, while Whites will decrease from 60,449 to 48,450 (to 48% of the county population).[13]

Figure 16

Mendocino County Population Projects by Race 2010-2060

Source: California Department of Finance, 2015



	2010	2020	2030	2040	2050	2060
White	60,449	58,047	55,950	52,476	49,512	48,450
Hispanic or Latino	19,802	23,076	27,191	31,175	34,427	37,293
American Indian	3,521	3,912	4,090	4,123	4,102	4,062
Multi-Race, not Hispanic or Latino	2,393	3,093	3,921	4,869	5,922	7,081
Asian	1,451	1,550	1,658	1,772	2,021	2,370
Native Hawaiian and other Pacific Islander	104	123	121	131	138	121
Black	572	610	646	661	629	575

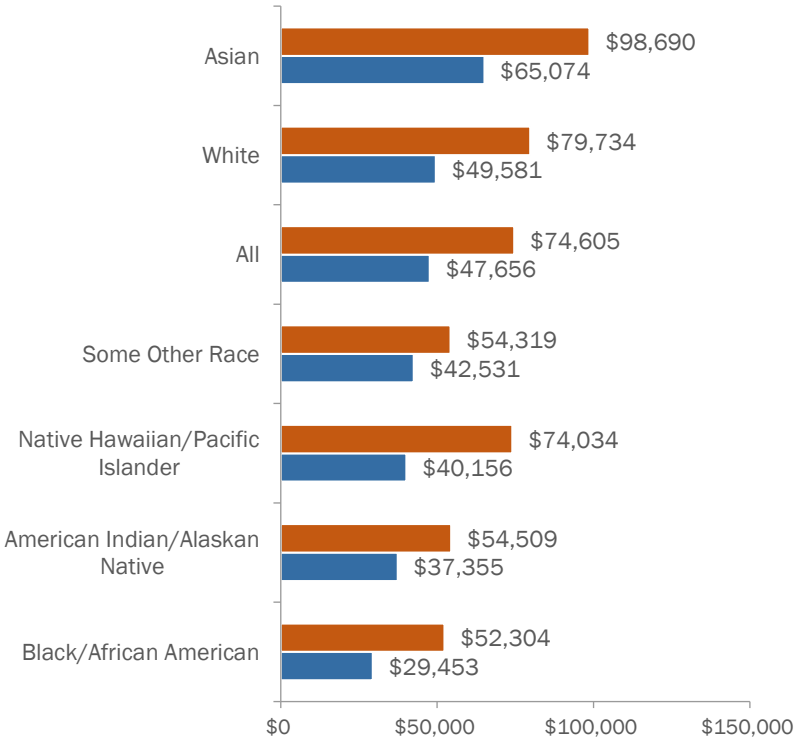
Education, Income & Employment

In 2017, nearly one-quarter of adults in Mendocino County ages 25 and older (22%) had a bachelor's degree or higher, and 7% had less than a high school diploma (compared to 31% and 10%, respectively, for California as a whole).[14]

Figure 17

Median Household Income by Race for Mendocino County & California, 2017

Source: U.S. Census Bureau, 2017

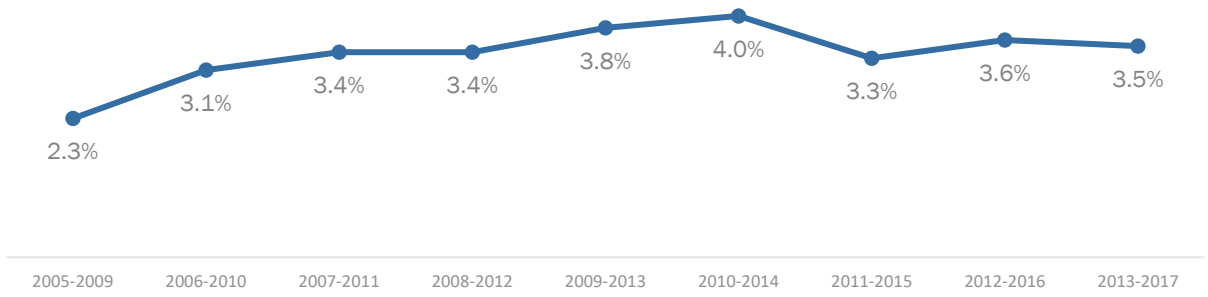


Also in 2017, as seen in Figure 17, the median household income in Mendocino County, at $47,656, was 36% lower than that of the state ($74,605), compared to 2014 when the median household income in Mendocino County was 29% lower than the state.[15] The median income in Asian ($65,074) and White ($49,581) households was higher than in Some Other Race ($47,656), Hawaiian/Pacific Islander ($40,156), Native American ($37,355), and African American ($29,453) households.

In 2018, 16.3% of the county's population overall and approximately more than one-third each of Some Other Race, Native Hawaiian/Pacific Islander, American Indian and African American populations were living below the Federal Poverty Level (40.4%, 40.9%, 40.5% and 44.9%, respectively).[16] The percentage of households receiving cash public assistance income for the 2013-2017 time frame was 3.5%, a decrease from 4.0% in 2010-2014 (Figure 18).[17]

Figure 18

Percent Change in Households Receiving Cash Public Assistance Income: Time Series 2005-2017 Source: U.S. Census Bureau, American Community Survey 2017



During 2017, 40% of households with children in Mendocino County were headed by a single parent, compared with 31% for the state.[18] The percentage of households headed by a single parent reflected an increase from 37% in 2013.[19] Grandparent-headed households responsible for grandchildren under 18 years of age rose from 6.5% in 2009-2013 to 7.2% in 2010-2014.[20]

Housing and Homelessness

Mendocino County experiences significant housing issues, including a lack of affordable housing, overcrowding, and homelessness. The 2019 County Health Rankings estimate that about 27% of the county population lives in substandard housing, i.e., without a kitchen or adequate plumbing, or lives in crowded conditions. In addition to substandard or crowded housing, over one-half of Mendocino County residents who rent (52%) pay more than a third (35%) of their total income for rent.[21] The lack of housing negatively affects businesses, schools, and the health-care system because would-be employees are unable to find adequate housing.

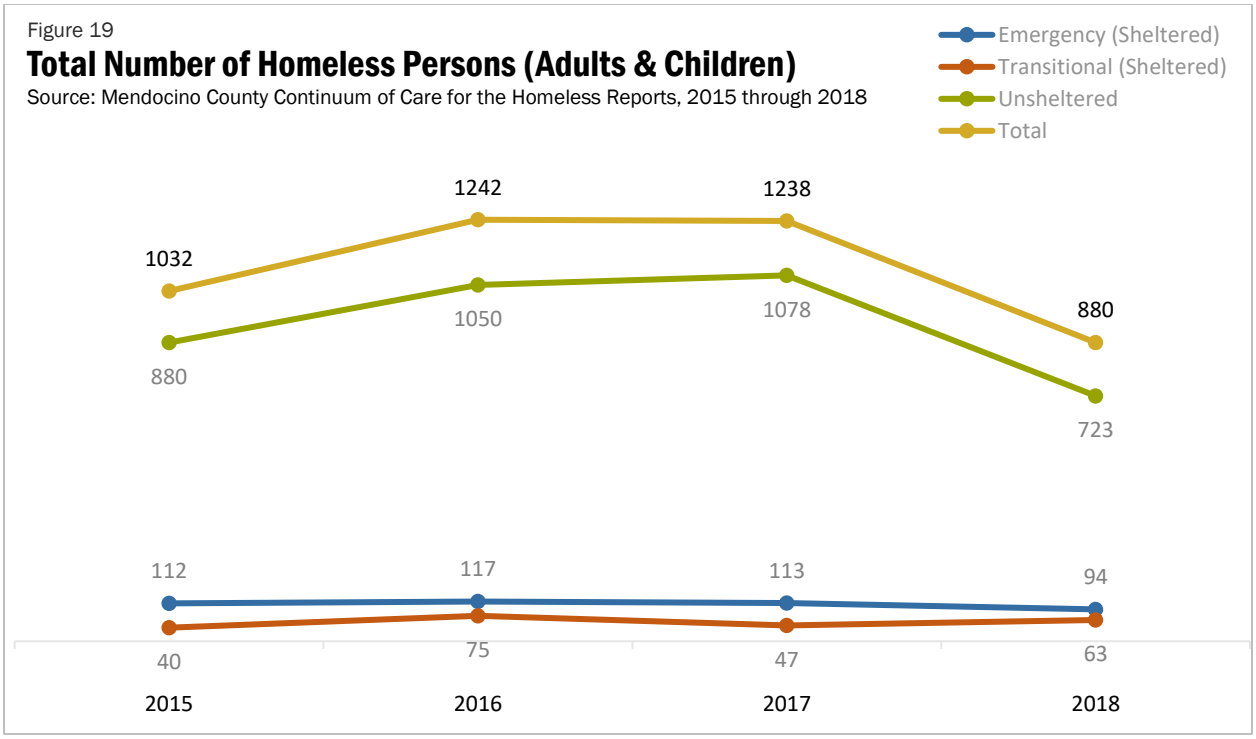
A total of 880 homeless individuals were counted during the 2018 Mendocino County Point in Time Census and Survey, a significant decrease over the 2017 Point in Time census of 1,238.[22] Of these, most (723 or 82%) were unsheltered (living on the street, in abandoned buildings, cars/vans/RVs or encampment areas) (Figure 19). Additional survey findings include the following:

- Of homeless individuals, 33 (4%) were children under the age of 18.
- Eighteen (2%) were young adults age 18-24.

Figure 19

Total Number of Homeless Persons (Adults & Children)

Source: Mendocino County Continuum of Care for the Homeless Reports, 2015 through 2018



For more information about the 2019 Community Health Status Assessment, please see Appendix C.

County Health Ranking

According to the University of Wisconsin's Population Health Institute in its yearly County Health Ranking Report, Mendocino County's overall health status ranked 41 out of 57 California counties for 2019. This was a decline in ranking compared to the 2016 & 2015 County Health Ranking reports in which Mendocino County ranked 40 out of 57, and 35 out of 57, respectively.

For More Information

As noted, further information on each of the assessments described above can be found in the Appendices: Community Health Survey (Appendix A), Key Informant Interviews/Survey (Appendix B), and Community Health Status Assessment (Appendix C).

Strategies Implemented Since the 2016 CHNA

At the conclusion of the 2016 CHNA process, a countywide forum with over 100 community members from across Mendocino County was held in 2016 to choose a set of priorities. As a result of the forum, a CHIP was formed with five priority areas:

1. Childhood Obesity and Family Wellness
2. Childhood Trauma
3. Housing
4. Mental Health
5. Poverty

Due to the geographic distances in Mendocino County, the intent is to establish Action Teams in each of five county regions: Ukiah/Calpella/Anderson Valley/Hopland; Willits; Laytonville/Leggett; North Coast; and South Coast/Redwood Coast. To date, Action Teams have been established in Inland Ukiah/Anderson Valley, North Coast and South Coast. Each Action Team was formed with a variety of key stakeholders including health and human service agency employees, educators, farmers, healthcare workers, recreation department employees, lawmakers, residents, government employees, and other groups interested in working towards the health and well-being of Mendocino County. The Action Teams were facilitated by Healthy Mendocino. Each of the Action Teams subsequently developed goals, objectives/measures, key strategies, and an action plan.

Below is a snapshot of the strategies/actions implemented by the Action Teams to date (Table 2). Immediately after the snapshot is a comparison between the 2015 and 2019 CHNA data on select Public Health indicators. This comparison may help determine possible impacts and effectiveness of the strategies utilized by these Action Teams. However, note that the Action Teams developed multi-year work plans which are still in the process of being implemented. The data collection for the 2019 CHNA began in 2018 before the Action Teams had completed implementation. For these reasons, direct impacts may be difficult to determine and require additional data collection once implementation is complete.

Table 2. Strategies/Actions Implemented by Action Teams Since the 2016 CHNA

Priority Area	Geographic Area	Strategies/Actions Implemented To Date
1. Childhood Obesity and Family Wellness	Ukiah area	… Developed the first annual Ukiah Kids Triathlon in 2016 … Each Action Team member implemented 1 wellness activity in their organization, e.g., a 30-minute lunch time stress management workshop … Currently implementing Let's Go! 5210 Community-Based, Multisetting Childhood Obesity Prevention Campaign
	Fort Bragg	… Developed the first annual Fort Bragg Kids Triathlon in 2017
	Ukiah and countywide	… Developed *Healthy Food at a Community Event Guidelines* (available countywide on the healthymendocino.org website)

Priority Area	Geographic Area	Strategies/Actions Implemented To Date
2. Childhood Trauma	Inland Mendocino County	… Developed a strategic action plan that outlines the work of the team, and goals of partners for monthly prevention, community engagement and education … Coordinated with partners on a range of trainings focused on mental health, professional development and resilience for community members (see Mental Health below) … Created a countywide capacity/asset map for resources across the prevention/intervention spectrum for childhood trauma and resilience work
3. Housing	Fort Bragg	… Hosted 2 Accessory Dwelling Unit workshops for more than 180 residents addressing logistics, code and zoning, tax implications, financing, and structure options … Participated in the Fort Bragg 2019 Housing Element Plan Update process and made recommendations for changes, e.g., for a variety of housing types (more senior housing, etc.), simplified processes, and flexible development standards … Currently exploring a Community Land Trust option
	Ukiah area	… Hosted an Accessory Dwelling Unit workshop … Participated in the Ukiah 2019-2027 Housing Element Update process and made recommendations, e.g., help land owners manage and update current housing stock; change zoning on non-conforming properties to align with historical uses, develop an amnesty/legalization program for residents that are illegal or non-conforming
	Countywide	… Participated in 2019-2027 Mendocino County Housing Element Plan Update process and made recommendations regarding, e.g., encouraging mixed-use development and facilitating construction of secondary dwelling units on residential properties … Hosted a Community Land Trust forum for policy makers, planners, and community members to begin to assess feasibility … Created recommendations for the Healthy Mendocino Advisory Council for the 2019-2020 workplan
4. Mental Health	Mendocino Coast	… Trained 200+ residents, mental health professionals, crisis workers and first responders in a series of trauma-informed and resiliency trainings on the Mendocino Coast … Hosted monthly cross-sector practice groups to provide a place to practice skills learned in the trainings (mentioned immediately above)

Priority Area	Geographic Area	Strategies/Actions Implemented To Date
		… Conducted a survey of Mendocino Coast school districts to gather information about current policies on suicide prevention, intervention, and postvention (per AB 2246 requirements) … Submitted an article to coastal media for Suicide Prevention Awareness Month (September) … Developed recommendations for the Healthy Mendocino Advisory Council for the 2019-2020 work plan
5. Poverty	Ukiah area	… The Poverty Action Team partners created an entrepreneurial incubator course and community marketplace to assist in the development of small businesses for people of low-income
	Countywide	… Developed a community asset map for alleviating poverty in the county … Developed recommendations for the Healthy Mendocino Advisory Council for the 2019-2020 work plan

Comparison of 2016 and 2019 on Select Health Status Indicators

The "Community Health Indicators" are a list of approximately 150 data statistics that provide a snapshot-in-time view of the health of our community. The list was first compiled in 2016, and with the addition of updates in 2019, the list now shows the direction each indicator is trending. Some indicators show improvement, while a few are trending in a negative direction. This narrative focuses on the indicators that showed significant change from 2015 to 2018. An upward arrow (⬆) indicates a positive trend. A downward arrow (⬇) indicates a negative trend.

Indicators Trending Positively	
⬆	The population of Mendocino County increased from 87,318 in 2015 to 88,018 in 2018.
⬆	The percentage of individuals living below the Federal Poverty Level declined from 21% to 20% (2011-2013 and 2013-2017 estimates, respectively).
⬆	In 2015 the percentage of children under age 18 living in poverty was 29%. By 2018, the percentage had dropped to 27%. However, the percentage for Hispanic children living in poverty was 35%; the percentage for white children was 19%.
⬆	The unemployment rate dropped from 6.6% in 2014 to 4.5% in 2018.
⬆	The median household income (one-half of households are above this figure and one-half have incomes below this figure) was $42,111 in 2013 and rose to $43,510 in 2016. This jump of about $1,000 is still well below the California median, which increased by $4,000 from $59,645 in 2013 to $63,738 in 2018. The living-wage annual income required to support a household with two adults and two children in Mendocino County was $50,438 in 2018.

Indicators Trending Positively	
↑	Overall, the indicators for poverty, such as the percentage of families spending 30% or more for rent, persons on public assistance, or experiencing food insecurity were all down, showing improvement in the economy.
↑	The high school graduate rate improved a percentage point, from 84% to 85%.
↑	The number of births to teens aged 15-19 years declined from 39 per 1,000, to 32 per 1,000.
↑	The number of adults who smoked declined from 18% in 2015 to 14% in 2018.
↑	Percentage of adults drinking to excess or binge drinking at least once in the prior month fell from 24% in 2015 to 19% in 2018.
↑	The ratio of population to mental health providers in 2018 was 180:1, an improvement from 241:1 in 2015.

Indicators Trending Negatively	
↓	The percentage of seniors 65+ living alone increased from 11.6% to 14.1% (2008-2012 and 2013 to 2017 estimates, respectively).
↓	The number of grandparent-headed households has increased by more than 1,000 households, a 57% increase, in the five-year period between 2010 and 2014 (from 1,000 to 1,750 grandparent-headed households).
↓	The number of reported violent crime offenses per 100,000 increased from 501 in 2015 to 510 in 2018.
↓	The rate of children aged 0-17 with entries to foster care rose from 8.4 per 1,000 children in 2013 to 12.3 per 1,000 children in 2015.
↓	The percentage of people who reported being divorced rose from 15% in 2013 to 17% in 2017.
↓	The rate of non-fatal emergency department visits for self-inflicted injuries among youth aged 5-19 rose from 180 to 267 per 100,000 youths between 2014 and 2015.
↓	The number of domestic violence calls for assistance increased from 7% in 2013 to 9% in 2014 (latest figures available from the California Department of Justice).
↓	Female mortality ages 15-44 years rose from 583.2 per 100,000 to 648.7 per 100,000 population.
↓	The number of newly diagnosed chlamydia cases rose from 403 per 100,000 in 2015 to 434.7 per 100,000 in 2018.
↓	In 2015, the years of potential life lost (YPLL) before age 75 per 100,000 was 7,323. However, by 2018 the YPLL had increased to 8,000 per 100,000 compared with the YPLL in California for the same year of 5,200 per 100,000.
↓	Examining deaths of individuals under age 55 between the years 2013 and 2018, who died of causes other than illnesses (52%), when adjusted for age, deaths from vehicular accidents made up 14% of premature deaths, drug overdoses 13%, death from gunshot 9%, and death

Indicators Trending Negatively	
	by hanging 9%. Other causes made up the remaining 3%. Males comprised 68% and females 32%.

For more information regarding Community Health Indicators, please see the 2019 Community Health Status Assessment (Appendix C).

Community Health Needs/Priorities - Recommendations

To define a starting place for discussion and planning for collective action to improve community health, the CHNA Planning Group examined and prioritized the CHNA data according to the themes and issues that emerged from the Community Themes and Strengths Assessment and the Community Health Status Assessment. The Community Health Survey (Appendix A), the Key Leader Interviews/Survey (Appendix B), and the Community Health Status Assessment (Appendix C) were examined separately, then collectively.

With Planning Group members' knowledge of their organizations' priorities and the communities and population groups they serve, members were asked a series of questions using the ORID method, a structured discussion and decision-making process. A description of the acronym ORID, including the overarching questions utilized during the data evaluation process, are provided next.

O-Objective: Which issues stand out? Which issues emerge that have the greatest impact on health, quality of life and health disparities?

R-Reflective: What are our gut feelings about these issues? What else do we know? What are the underlying causes?

I-Interpretive: Which issues have the most severe negative health repercussions in our rural county? What does this mean for Mendocino County organizations?

D-Decisional: On which issues would concerted action by community-based organizations, hospitals, clinics, public health and other partners be most likely to bring about meaningful improvement/ impact?

Using this method, the CHNA Planning Group identified the following issues based on the analysis of the primary and secondary data sources as leading **Community Health Needs / Priorities** in Mendocino County:

1. Mental Health
2. Domestic Abuse (including sexual and child abuse)
3. Substance Abuse (including drugs, opioids, and alcohol)

The Planning Group proposes these three issue areas as the focus of the Community Health Improvement Plan and collective action as outlined in the Next Steps section below. First, a brief description of these three priority areas.

Mental Health

Mental health needs and services are a significant concern in Mendocino County. Two-thirds (67%) of adults surveyed indicate that mental health issues are among the most important health issues facing our community (2019 Community Health Survey). Accessing mental health treatment in Mendocino County is improving (2019 RQMC Mental Health Medicaid Services) but can still be a challenge for individuals in need, partly as a result of the geographic isolation inherent in a large, rural county. The rate of suicides in Mendocino County is 29.5 per 100,000; three times the California rate of 10.5 per 100,000.

There are complex interactions among mental health, mental illness, the high poverty rate, unemployment and homelessness. Poor mental health can both result from and contribute to other poor health and social conditions. The barriers to accessing timely and appropriate mental health services contribute to crises that local emergency departments or law enforcement must address. Community members and providers indicated that mental health services are most likely to be used when they are in the local community, financially accessible and culturally relevant.[23]

Despite an improvement in the ratio of population to mental health providers, the demand for practitioners has not matched the need for mental health services. There is currently no in-patient psychiatric facility in the county. In 2017, the voters approved Measure B, an initiative calling for a half-cent sales tax increase to fund inpatient mental health facilities. These facilities are in the planning stage.

Domestic Abuse (including sexual and child abuse)

Two of the most serious safety issues for adults surveyed in the 2019 Community Health Survey were domestic violence (40%) and child abuse (39%). The total number of calls for domestic violence reported in the 2019 Community Health Status Assessment indicated a decrease from 544 calls in 2016 to 468 in 2017. However, the rate of violent crime offenses in Mendocino County – which includes domestic violence, sexual assault and abuse, assault and battery – indicate 640 violent crime incidences in 2017, compared to 421 for the state.[24]

The rate of substantiated allegations of child maltreatment per 1,000 children ages 0-17 years rose from 17 per 1,000 in 2013 to 19 per 1,000 in 2017 (compared to 7.5 per 1,000 for California). In addition, the rate of children aged 0-17 with entries to foster care per 1,000 rose from 8.4 per 1,000 in 2013, to 12.3 per 1,000 in 2015, compared to 5.8 per 1,000 children for the state.

Domestic violence may include physical, emotional, verbal, sexual, spiritual, and/or financial abuse. Numerous studies show that domestic violence and child abuse affect the mental health and cognitive development of children. As discussed in the 2019 Community Health Status Assessment, “Children exposed to domestic violence can experience physical, emotional and behavioral responses which include feeling afraid, guilty and sad, having sleep disturbances, stomach aches and headaches, bedwetting, and inability to concentrate, among other problems.” [25] These negative consequences last through their adult lives. Studies show that there is a correlation between adverse childhood experiences (ACEs) (including

all types of domestic violence) and the increased incidence of heart disease, lung cancer, and diabetes, as well as depression and suicide amongst individuals who were exposed to domestic violence and abuse as children.

Domestic violence also impacts the sexual and reproductive health of women; sixteen percent (16%) of women who are abused are likely to have a low-birth weight baby, are 1.5 times more likely to acquire HIV, and 1.5 times more likely to acquire syphilis infection, chlamydia and gonorrhea.

The impact of domestic violence goes beyond the family and includes friends, neighbors and the community at large.

Substance Abuse (including drugs, opioids, and alcohol)

Alcohol and drug abuse was chosen as one of the top 3 most important health issues in Mendocino County by 47% of adults surveyed. The percentage of adults who admit to drinking to excess or binge drinking at least once in the prior month fell from 24% in 2015 to 19% in 2018 (2019 Community Health Status Assessment). Nonetheless, this percentage continues to be high. For young people, alcohol is the most widely abused substance and binge drinking, in particular, has been linked to risky health behaviors.

The drug induced mortality rate per 100,000 has increased from 14.4 (2010-2012) to 26.2 (2018). Further, the age-adjusted rate of deaths from opioids in 2018 was 14.6 per 100,000 residents, compared to 5.4 per 100,000 for California. Mendocino County averages two deaths a month from unintentional prescription opioid overdose, per capita, twice the state average. In response to this crisis, Mendocino County has formed the Safe Rx Mendocino Coalition promoting all efforts to build a healthy community that is free of opioid abuse and related stigma. However, there is more work that needs to be done in Mendocino County to reduce substance abuse.

Over half of the respondents mentioned manufacturing of methamphetamine as one of the most serious safety problems in Mendocino County (2019 Community Health Survey). However, in recent years, the State of California passed laws severely limiting the availability of medications containing ephedrine. Now, most of the manufacturing of methamphetamine is done outside of the U.S. and smuggled into California. This choice as a top safety concern may be more indicative of an awareness of people using the drug, rather than actual laboratories in a neighborhood.

Community Assets and Resources

As the county's residents and organizations move toward addressing the concerns highlighted above and/or others identified through community meetings, they can draw on many existing assets, resources, and programs. Some were named in the Community Health Survey and Key Informant Interviews, including our healthy natural environment, our active community organizations, and our health care and cultural resources. The CHIP process outlined below will offer opportunities to examine these strengths

and assets vis-à-vis each of the Community Health Needs /Priorities, to determine how they can be deployed in the action plans for each priority area.

Next Steps

The findings of the 2019 Community Health Needs Assessment contained in this report and its appendices provide a great deal of information to support the selection of strategic issues for collective impact efforts. The CHNA Planning Group recommends the three aforementioned Community Health Needs / Priorities as a starting point in the discussion and prioritization of health issues and the development of a Community Health Improvement Plan. The final priorities and action plans will be determined by the Healthy Mendocino Advisory Council, which will be convened in November 2019. Further planning and prioritization will occur at that time.

While the CHIP will focus on specific arenas for collective action, there are many ways to improve community health. All community members are encouraged to use the information provided in this document to help enhance wellness and quality of life in Mendocino County.

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2019 Mendocino County Community Health Needs Assessment

APPENDIX A

Community Health Survey

October 2019

TABLE OF CONTENTS

Community Health Survey

Results

Addendums

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COMMUNITY HEALTH SURVEY

Introduction & Background

Purpose of Survey

Mendocino County conducted a Community Health Survey to learn the opinions of individuals about community health characteristics, problems, and assets in the county. This survey is part of the 2019 Mendocino County Community Health Needs Assessment (CHNA).

The 2019 CHNA is sponsored by a coalition of local organizations and agencies: Adventist Health Howard Memorial, Adventist Health Ukiah Valley, Alliance for Rural Community Health & Community Health Resource Network, Community Foundation of Mendocino County, FIRST 5 Mendocino, Healthy Mendocino, Mendocino Community Health Clinics, Mendocino County Health & Human Services Agency, Public Health Branch, Mendocino County Office of Education, North Coast Opportunities, Partnership HealthPlan of California, Redwood Community Services, Inc., Redwood Quality Management Company, and United Way of the Wine Country. The CHNA is a project of Healthy Mendocino, which facilitated the Planning Group.

Background

In preparing for the community health survey, the CHNA Planning Group reviewed instruments previously used during the 2002 and 2015 CHNA processes. Revisions were kept to a minimum so that a direct comparison could be made to the most recent CHNA conducted in 2015. However, at 41 questions, the Planning Group felt the survey was too long, so the number of questions was reduced by ten to 31 questions.

A total of 1,324 individual Mendocino County residents completed the survey, with 48 surveys completed in Spanish, and 94 surveys completed by those identifying themselves as Native American. The survey was promoted throughout the county, on the HealthyMendocino.org website, at local libraries, senior centers, regional clinics, businesses, schools and churches. (For a complete list if distribution sites, please see Addendum C.)

Paper copies of the survey were manually entered into Survey Monkey, and the data analyzed to tabulate frequencies and percentages and trends in SPSS statistical software.

Limitations

The Community Health Survey was conducted with a convenience sampling methodology, causing limitations to the data when interpreting the results. Although efforts were made to reach all geographic areas of the community and ensure demographic diversity among respondents, the survey is not assumed to capture a statistical representation of the community's population.

Social Determinants of Health

The Center for Disease Control defines the Social Determinants of Health (SDOH), as the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. There are five key areas of SDOH:

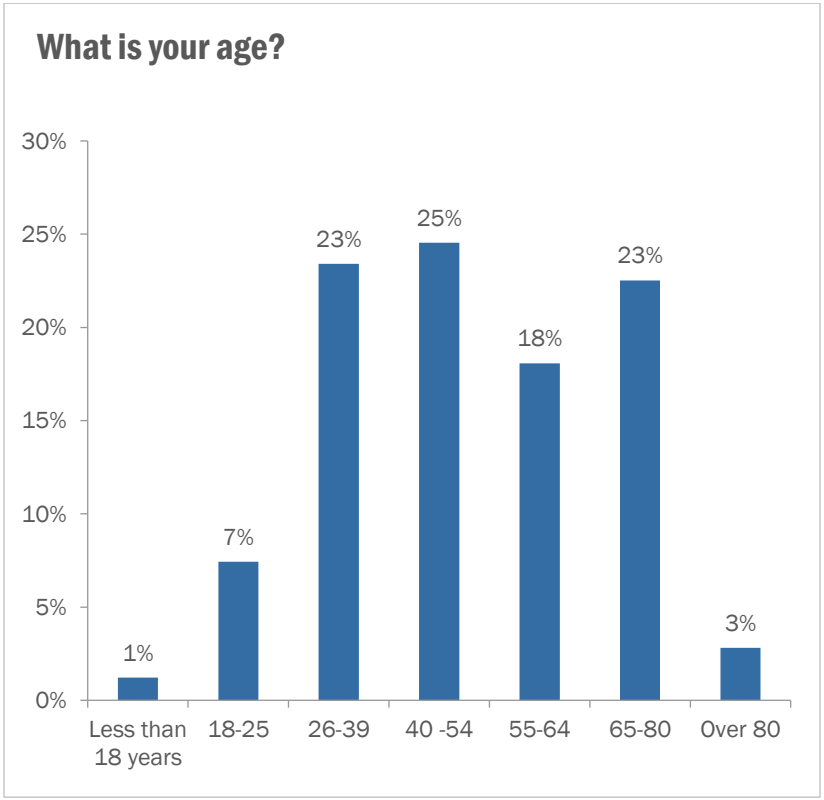
- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and the Built Environment

Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, access to natural environments for recreation, and environments free of life-threatening toxins.

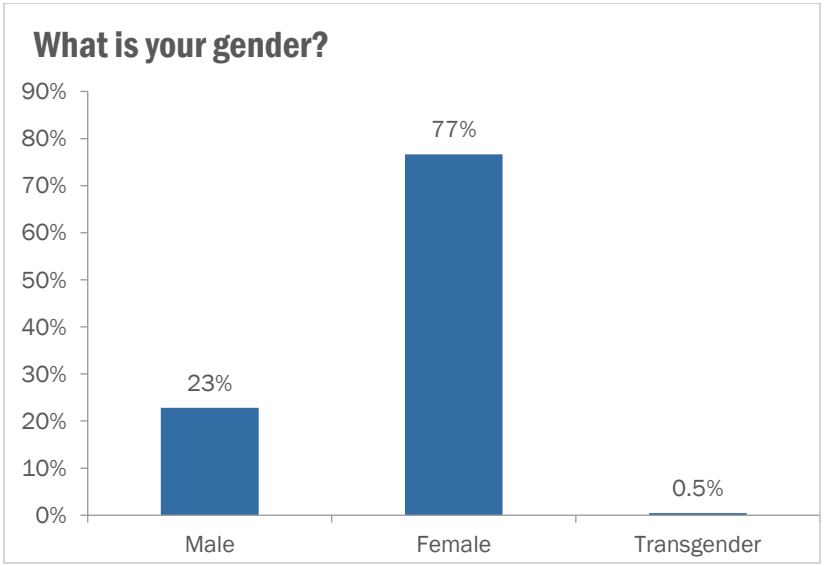
Mendocino County is fortunate in having many of these resources. However, the vast geography of the county creates challenges in access to health care, communications and public safety. In addition, natural disasters such as the recent wildfires that destroyed entire neighborhoods in 2017, further stressed an already tight housing market. Changes in the local economy continue to negatively impact families, who are often struggling to make ends meet. There are some areas in Mendocino County that continue to have higher rates of poverty when compared to others, and any adverse event can severely impact those living in these communities. On a positive note, respondents cited strong community ties as one of the top factors that made Mendocino County a good place to live.

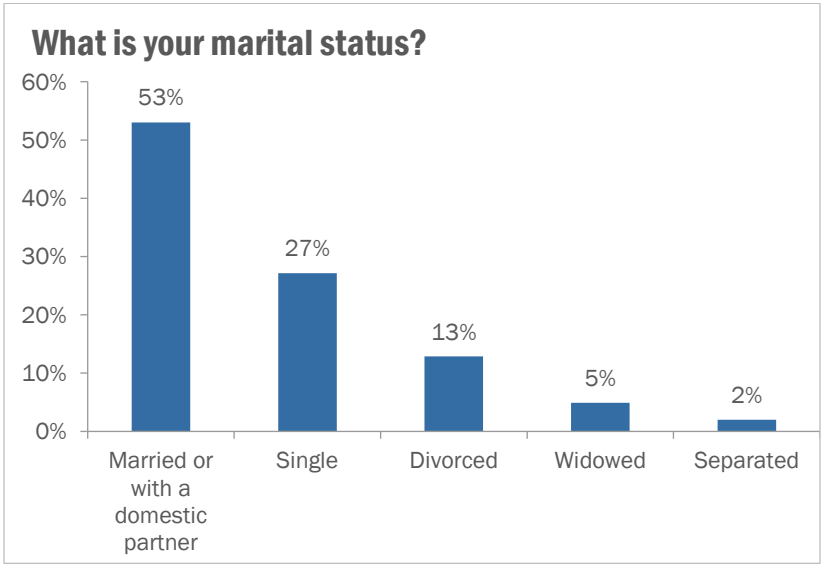
RESULTS

Demographic Characteristics

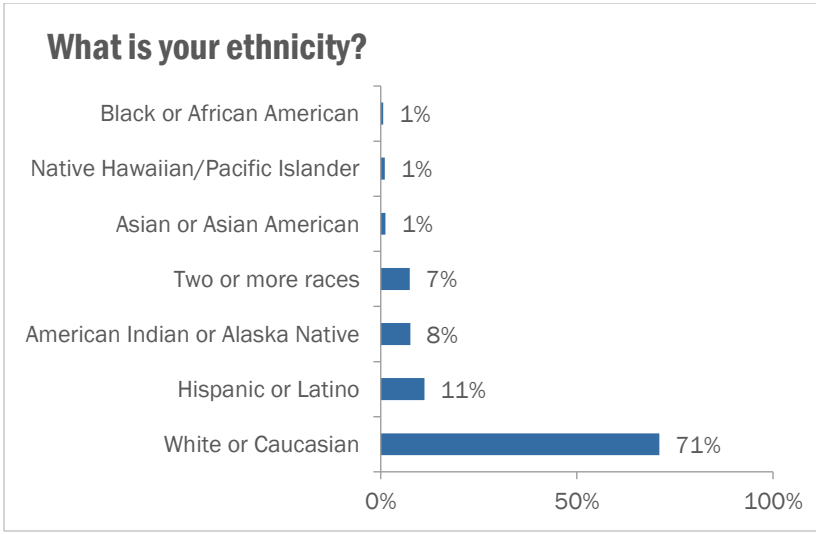


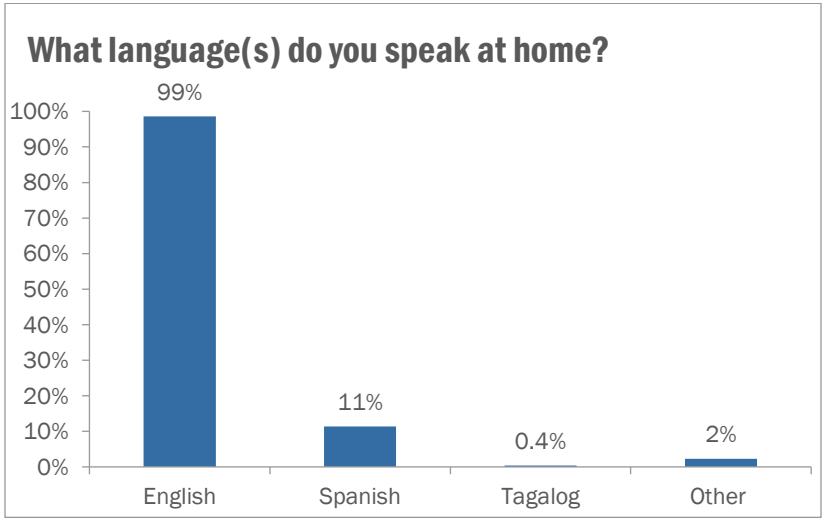
Most respondents (69%) were over age 40. Mendocino County has a population that skews older than surrounding counties or the state overall. The median age in 2017 was 42.2 years, compared with the State of California at 36.5 years. Individuals who completed the questionnaire in Spanish were younger, with 68% being under age 40.



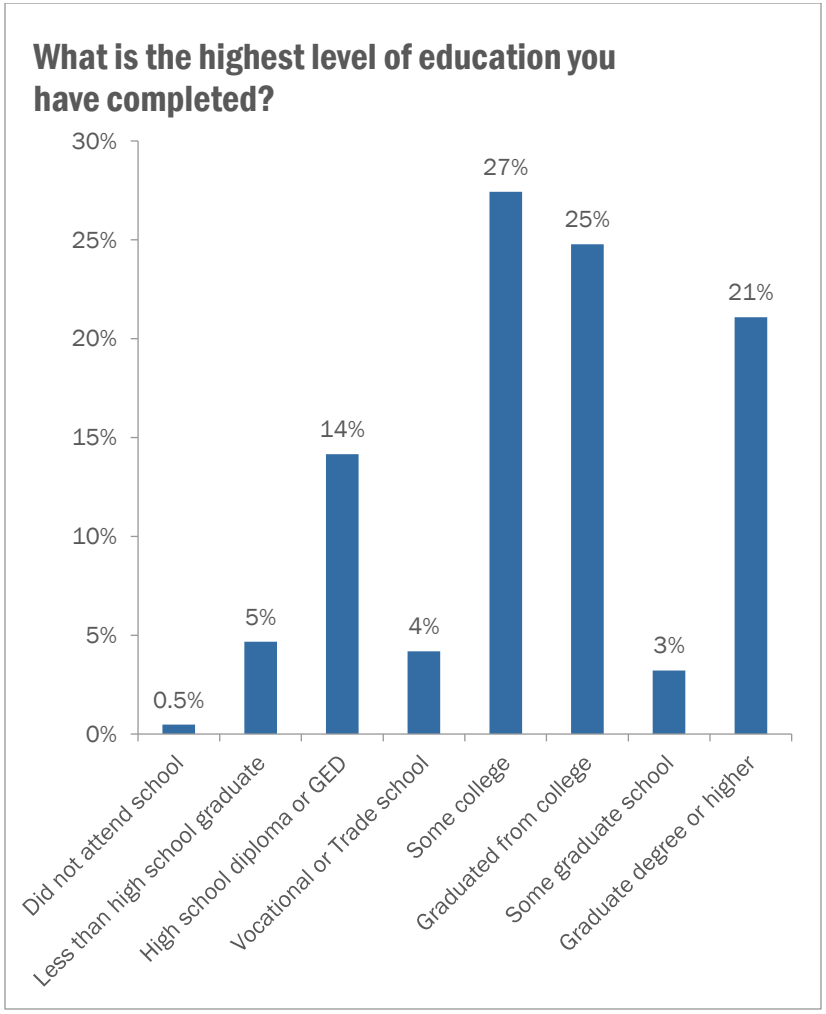


Most respondents were married or with a partner, while about 47% were not.

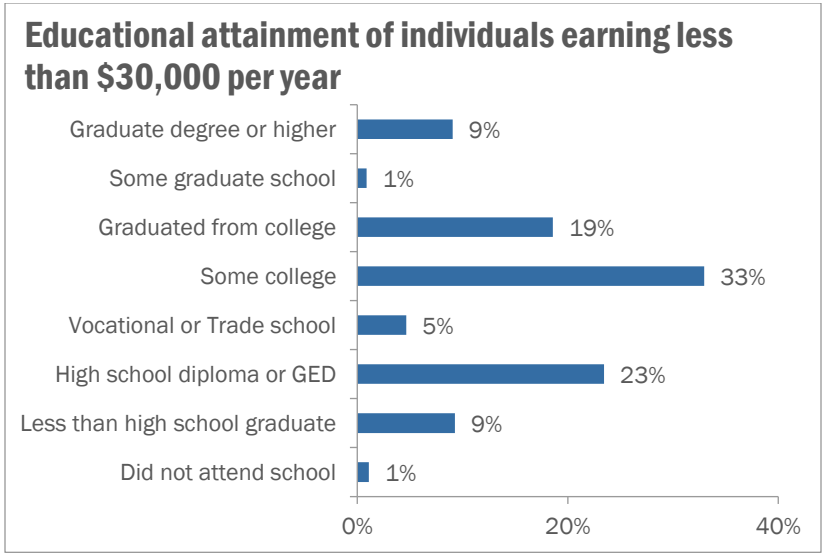


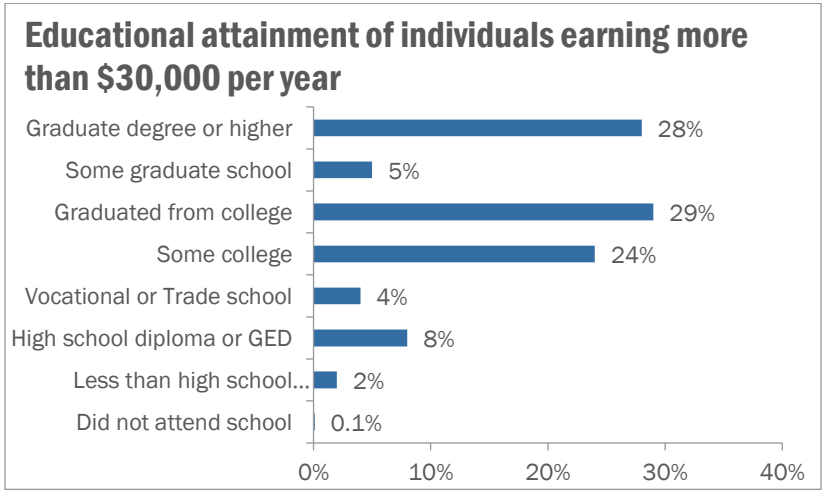


In the "Other" category, respondents included: German, French, Wailaki Northern Pomo, Navajo, Japanese, Mandarin Chinese, Portuguese, Russian, Hebrew and American Sign Language.

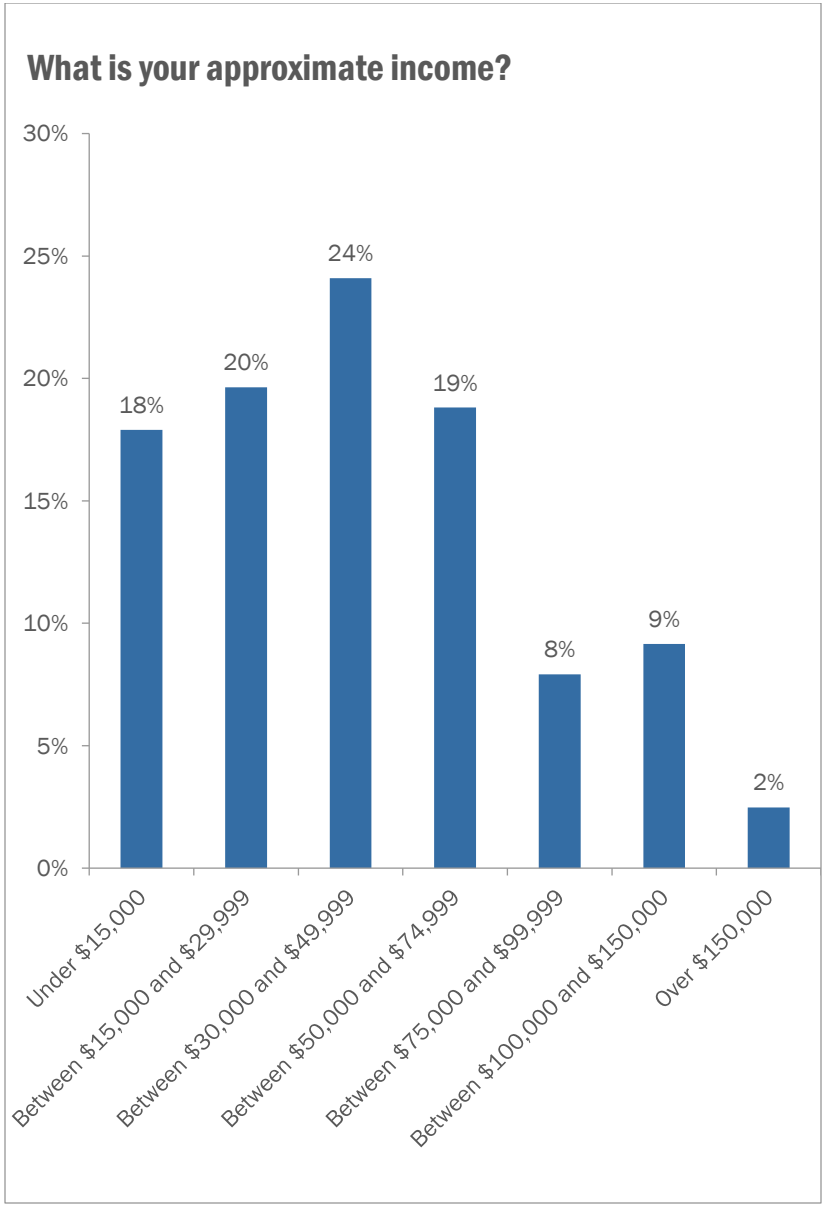


Two-thirds of Mendocino County's survey respondents have at least some college.



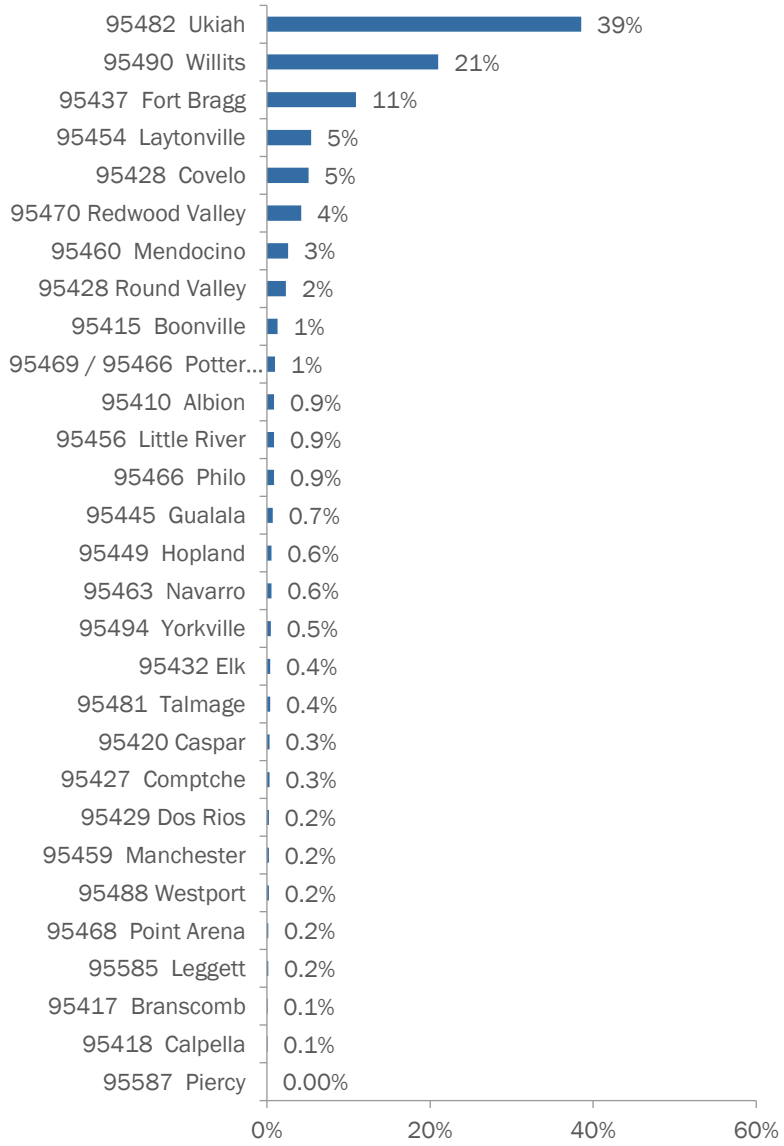


Educational attainment is positively correlated with increased income. Individuals with college degrees earned significantly more per year than those with less education. Over a third of individuals with a college degree or greater earned over $75,000 per year.

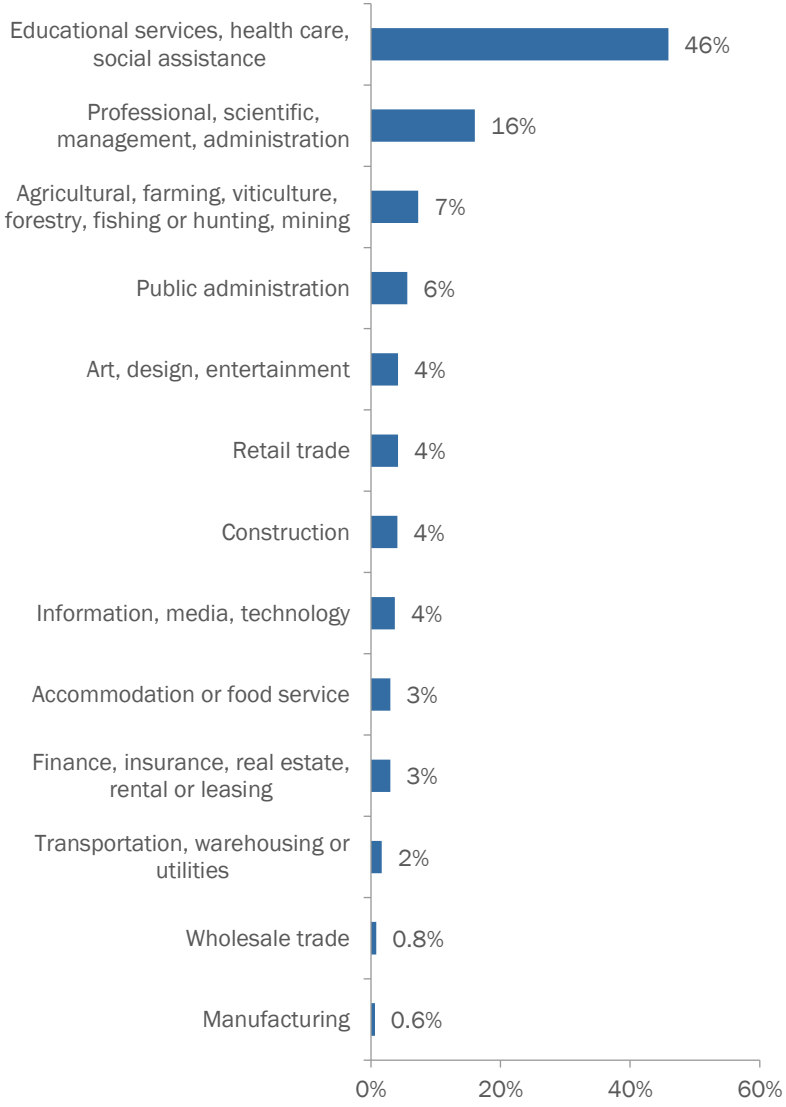


Household income level has been significantly linked to health. The higher one's income, the less likely you are to die of premature death and the likelihood of disease is reduced. Wealthier areas tend to have healthier people. For minorities, this is especially true, and wealthier minorities also have better health. Low income families are defined by the Federal Poverty Level (FPL) guidelines. In 2018, a family of four with household incomes at or above 100% of the FPL had an annual income of about $25,100. When asked about income, 62% reported making less than $50,000 a year. The median household income in 2018 for Mendocino County is $46,528, compared to the California median household income of $67,169.

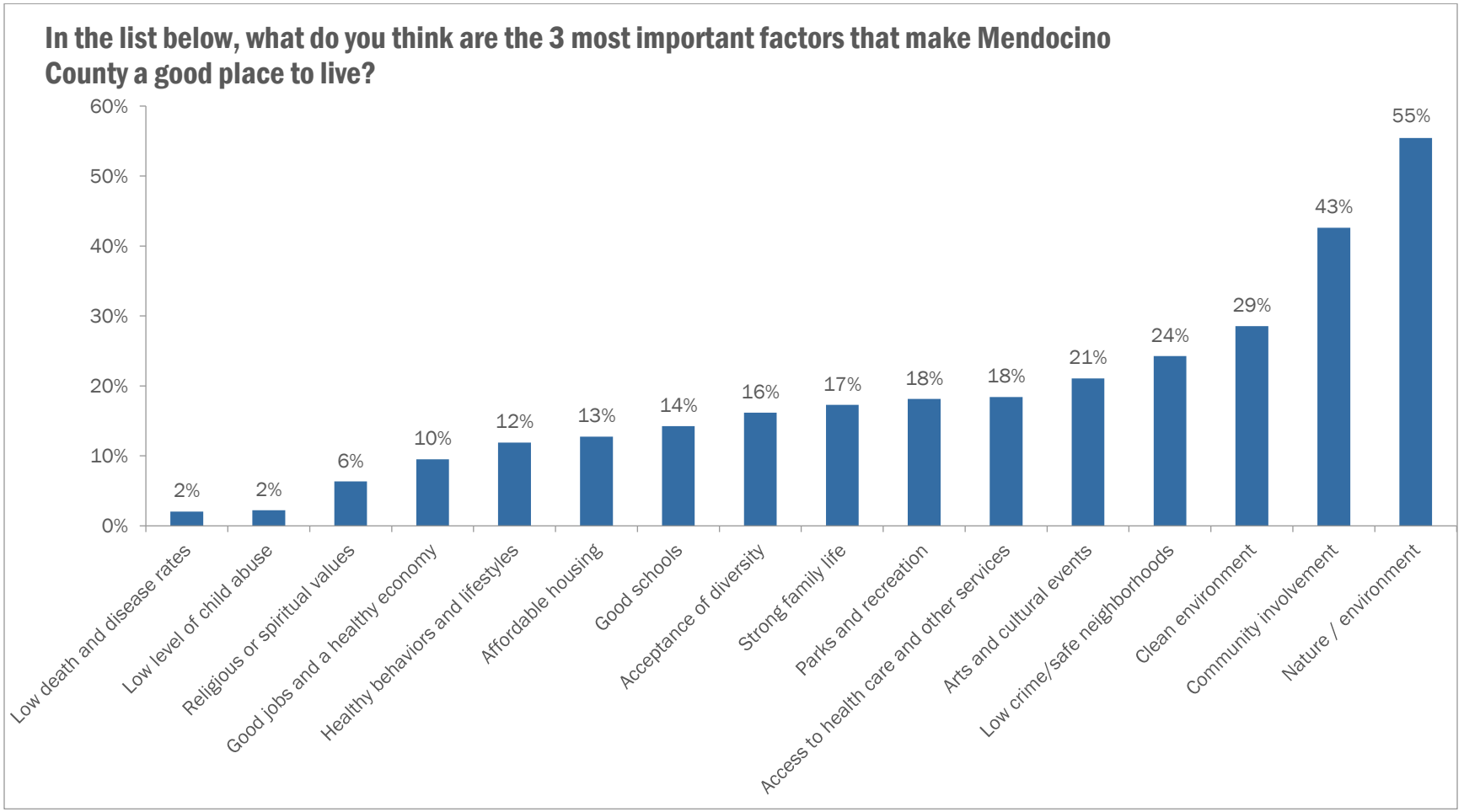
What is your home zip code?



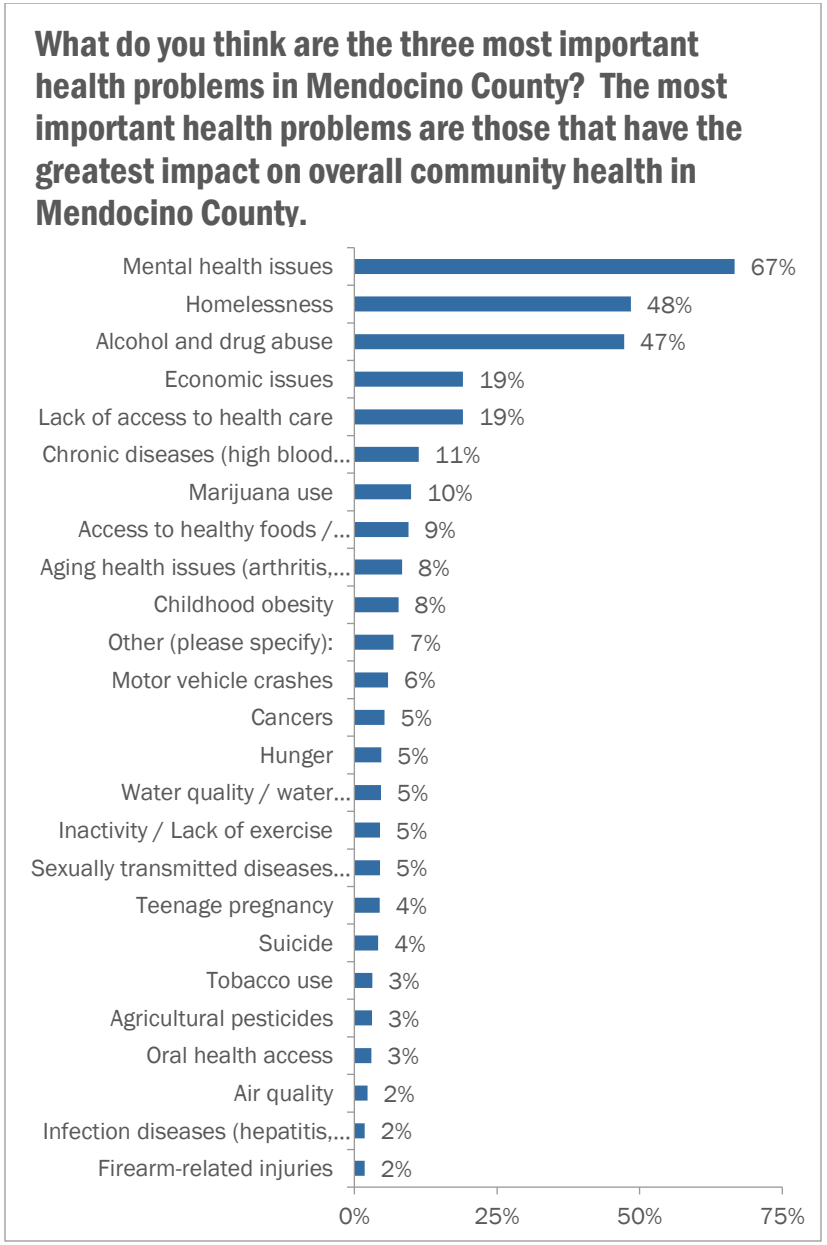
Which of the following best describes your current occupation?



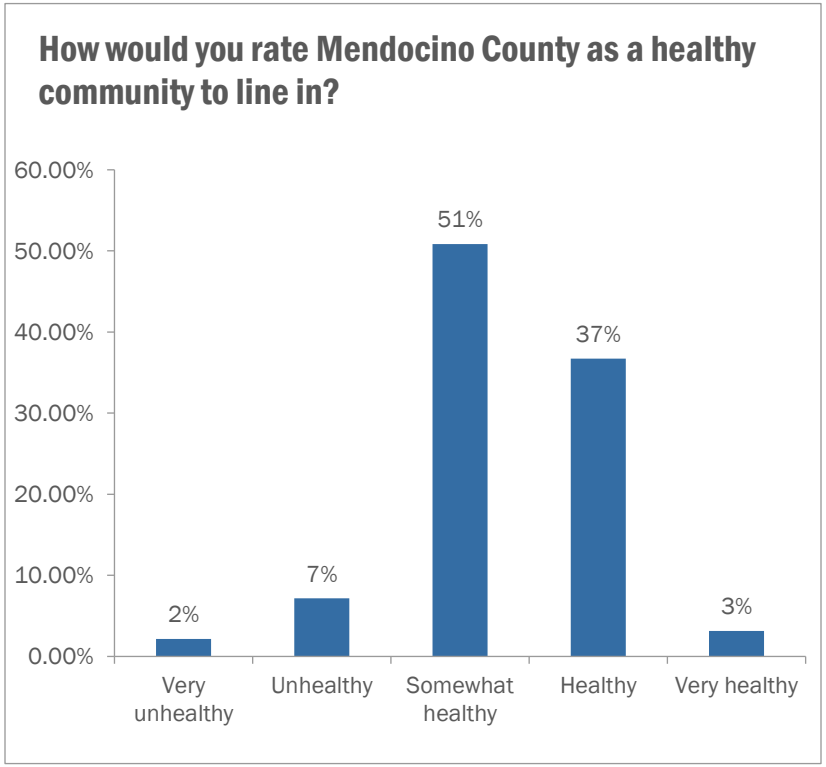
Perspective of Health in Mendocino County



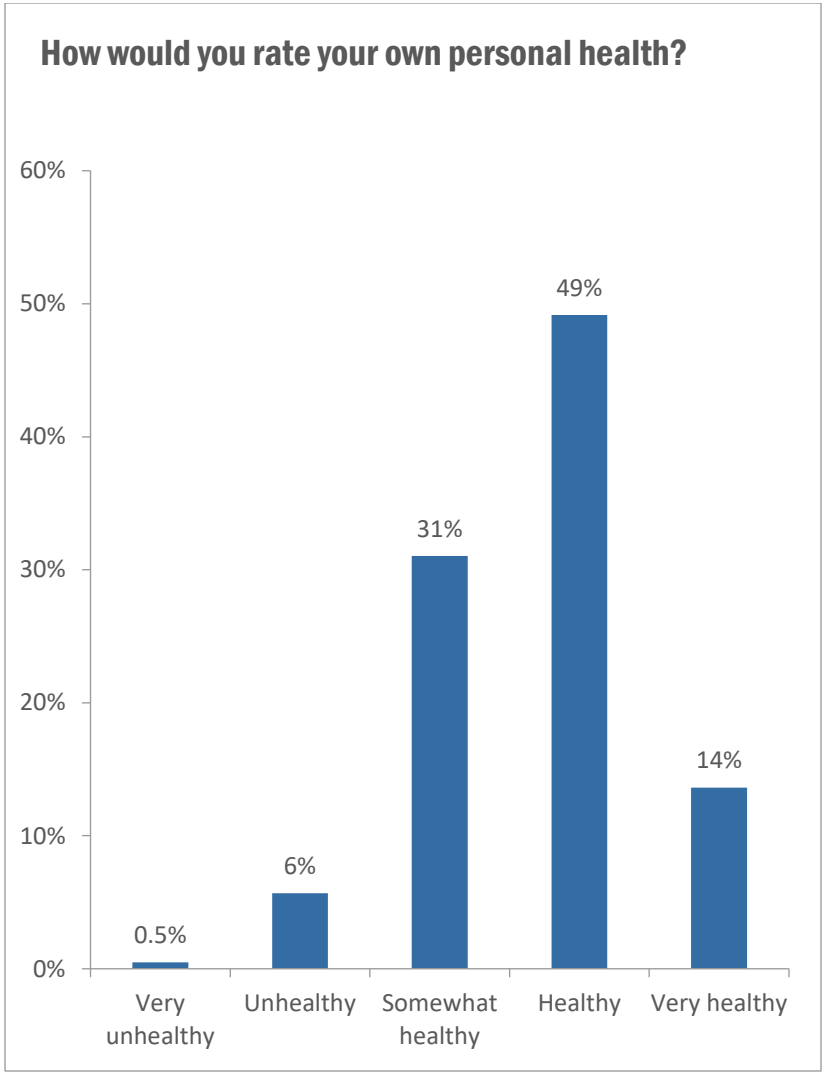
Residents said that the top three most important factors that make Mendocino County a good place to live are nature/environment (or overall location/being rural), community involvement and clean environment. Other responses included low/crime or safe neighborhoods, arts and cultural events and access to healthcare and other services. Community involvement was at the top of the list and could be attributed to the small town culture and the presence and active community involvement of many non-profit organizations in the county.



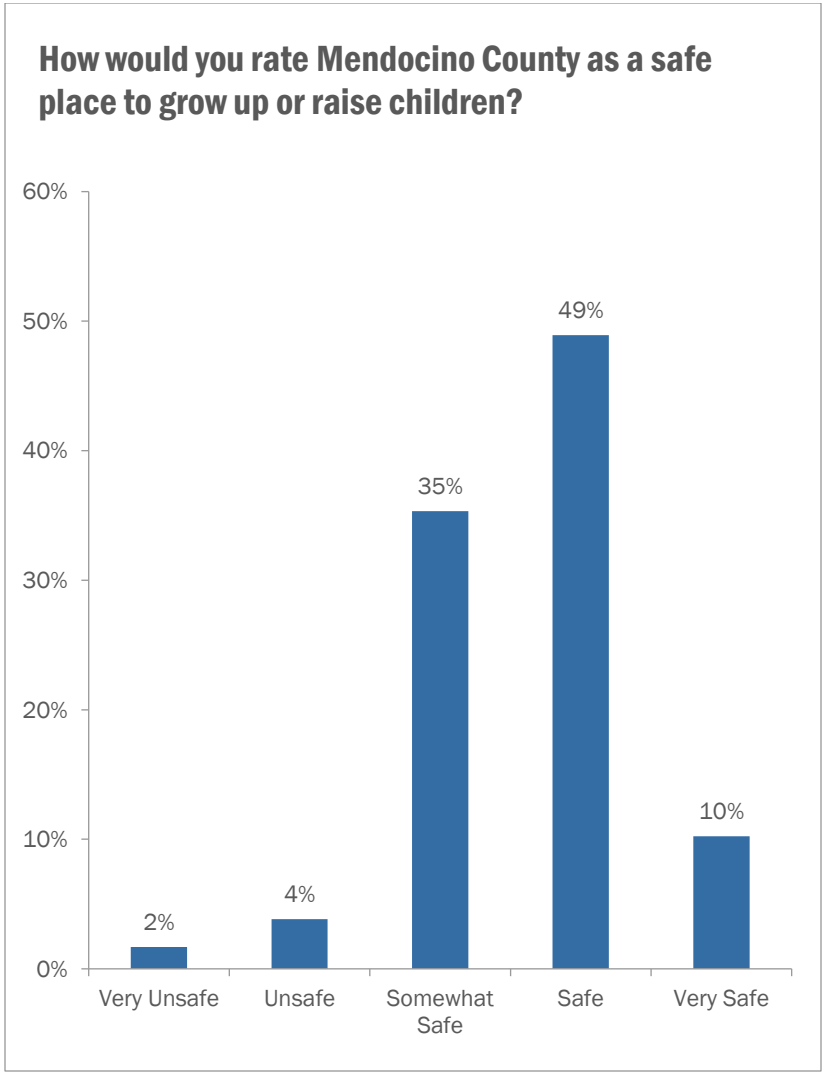
Mental health was listed by 67% of the respondents as the most important health problem in Mendocino County. This was followed by homelessness at 48% and alcohol and drug abuse at 47%. "Other" responses with over 10% saying so, included economic issues, lack of access to health care and chronic disease. Marijuana use, access to healthy food/poor diet, aging health issues and childhood obesity were in the top ten health problems.



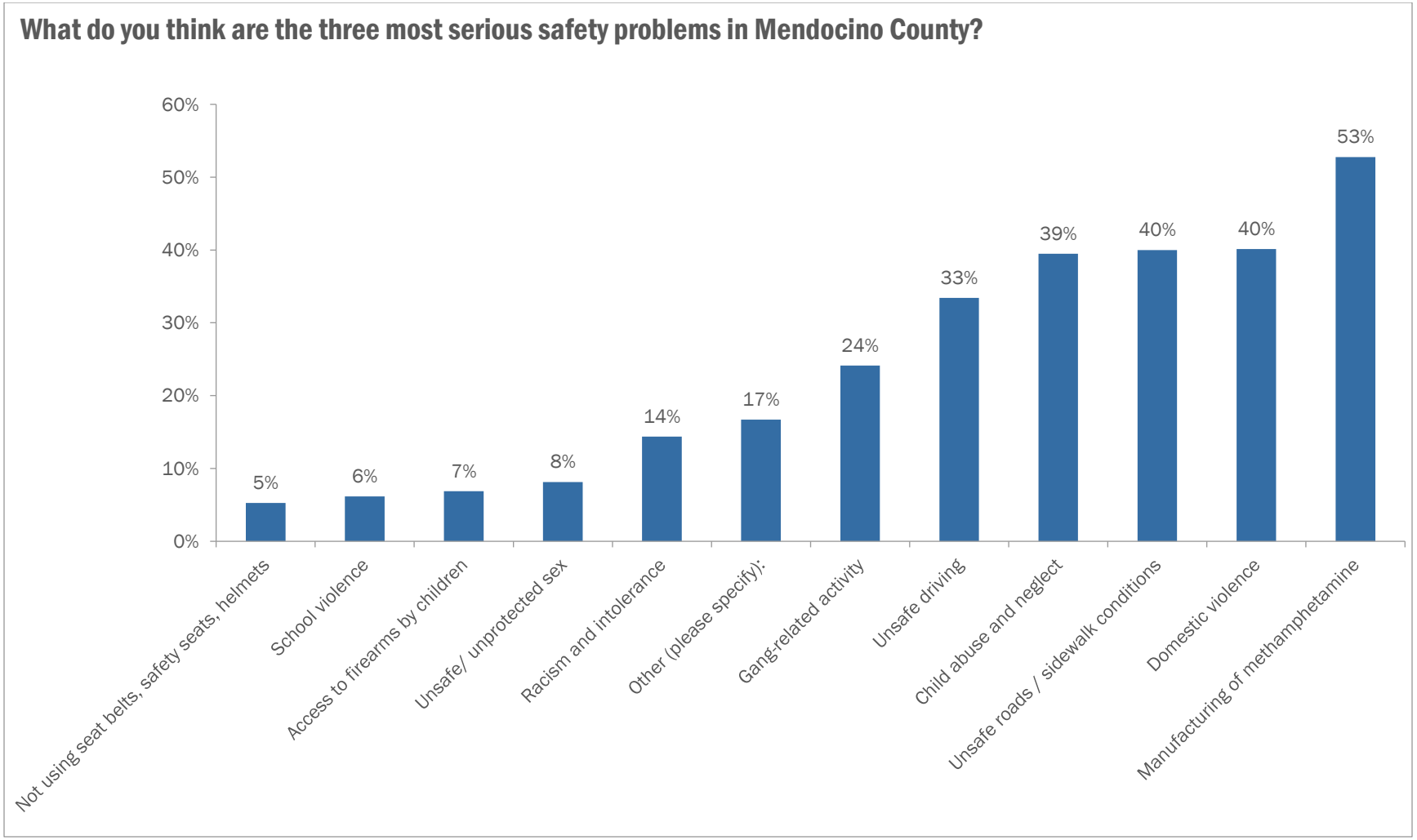
Half of the respondents said Mendocino County was a "somewhat healthy" community to live, while 37% said it is "healthy". A small percentage said Mendocino County was "very unhealthy".



Most respondents (63%) consider themselves "healthy" or "very healthy" when asked to rate their personal health.

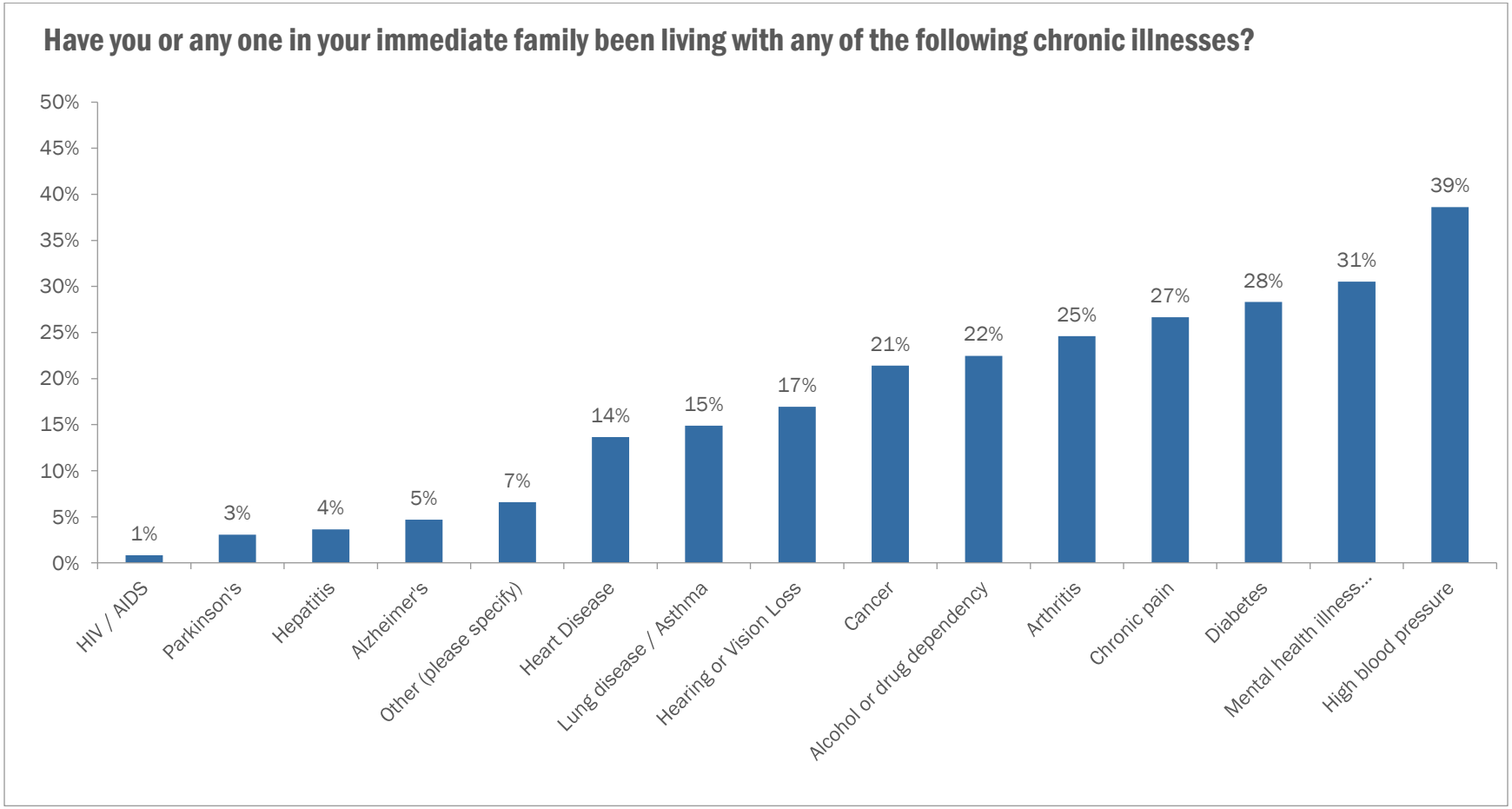


Almost half of respondents believe that Mendocino County is a safe place to grow up or raise children with 49%, followed closely by those who said it was "somewhat safe" with 35%.

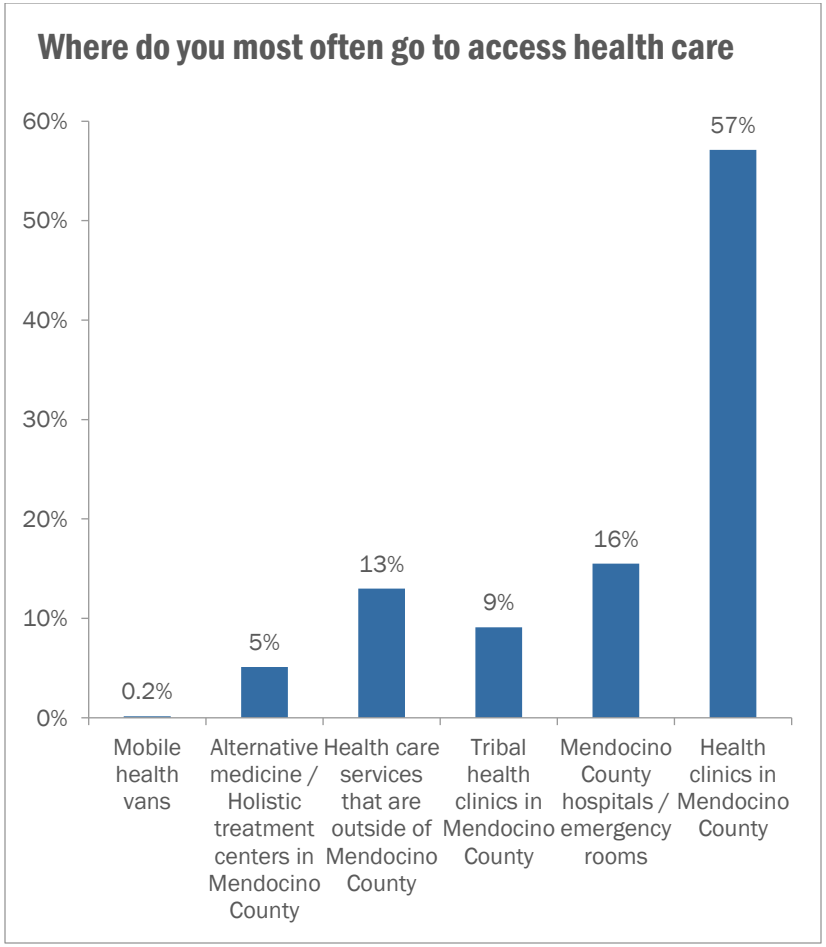


Over half of respondents mentioned manufacturing of methamphetamine as one of most serious safety problems in the county. Domestic violence and child abuse were also top concerns, and this is borne out by the data presented in this report. Unsafe roads, sidewalk conditions and unsafe driving were chosen predominately by respondents in more rural areas of the county. A majority of "other" issues mentioned that were not on the list are alcohol and drug use, including access to drugs (cannabis and other drugs), the culture of acceptance of using drugs and the violence or criminal activity it brings to the area due to the business of selling/growing it

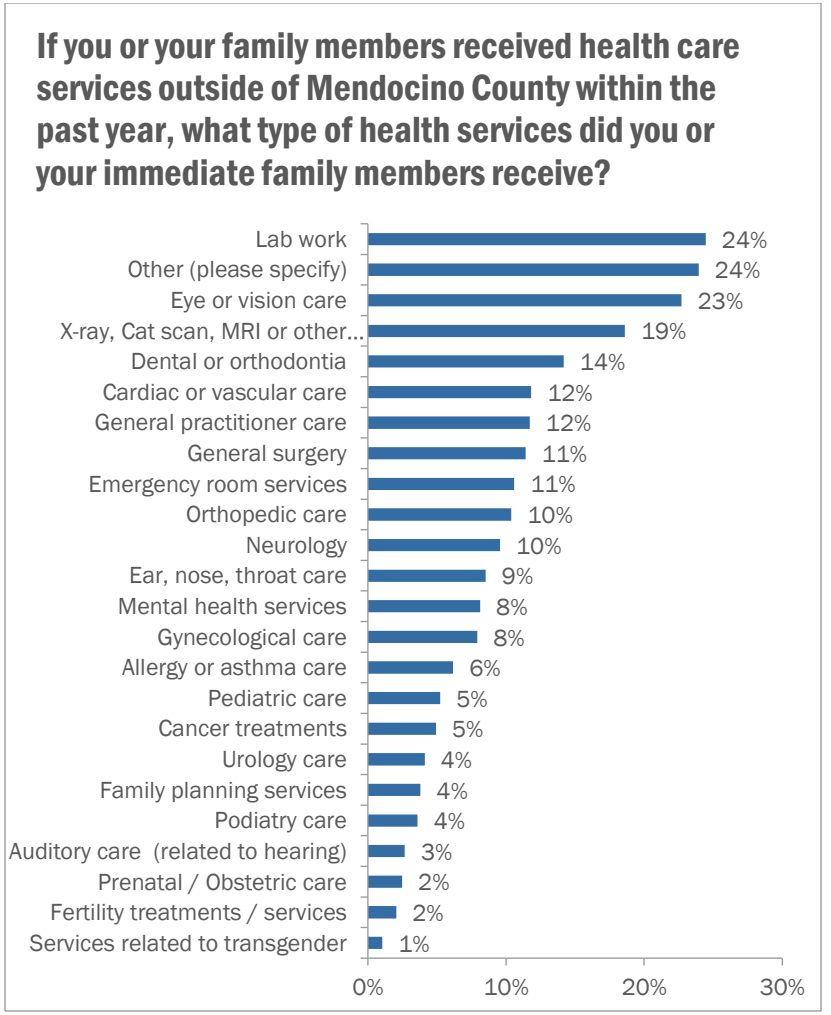
Access to Health Care Services



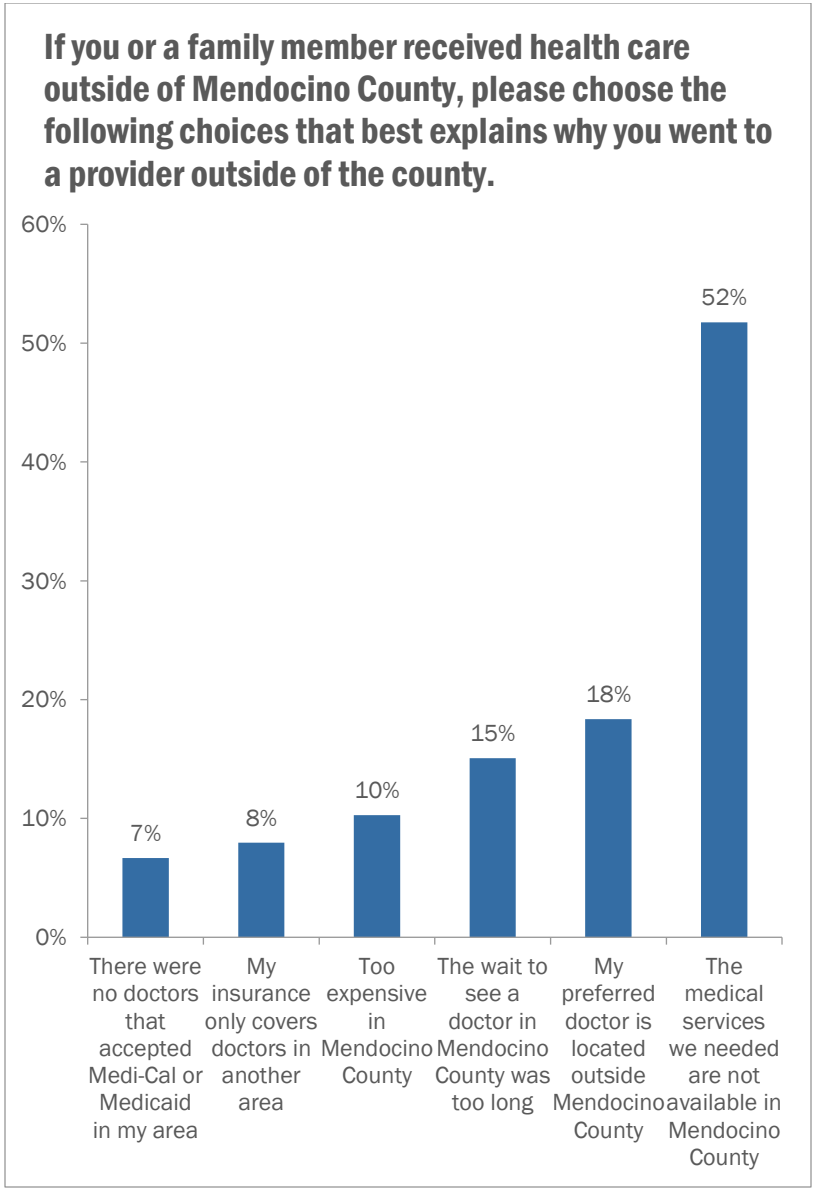
Over one-third of respondents stated that a mental health illness affected themselves or their families. In addition, over 20% of respondents stated alcohol or drug dependency was a problem for themselves or for family members. The Healthy Communities Institute surveys found that 13% of adults in Mendocino County reported feeling frequent mental distress. Other chronic illnesses included diabetes, high blood pressure and conditions normally found in older populations. “Other” chronic health conditions respondents mentioned include: allergies, autoimmune disease (lupus, multiple sclerosis, rheumatoid arthritis) and Lyme Disease.



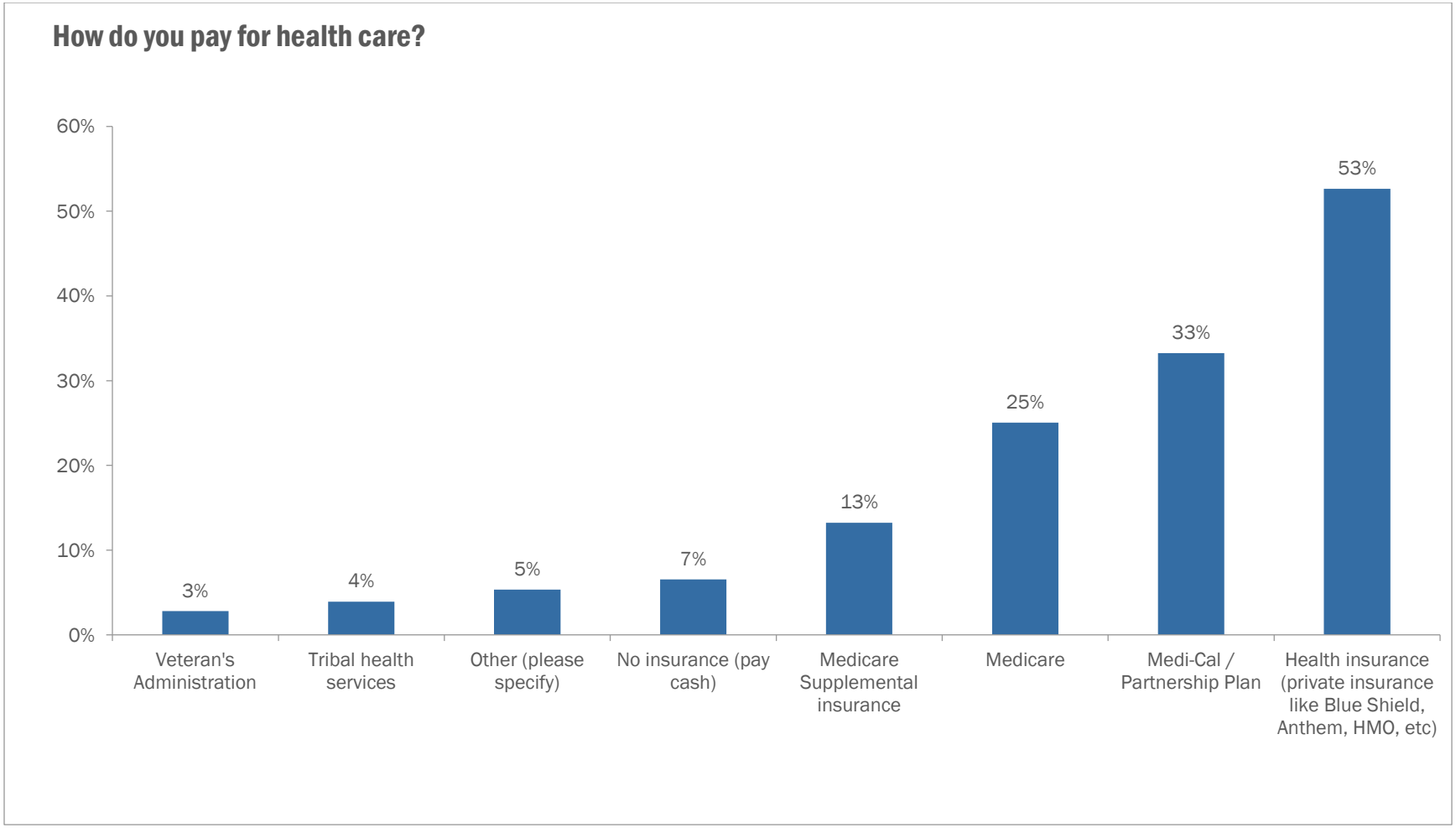
Most respondents accessed health care services in Mendocino County (87%), however 16% stated they went to Emergency Departments when they needed to see a physician. Seven percent of respondents stated they had no health insurance. Those who sought health care outside of the county most often said they went to health care providers in Santa Rosa, or to clinics or hospitals in the Bay Area.



Lab work, eye and vision care, X-rays and MRI, dental services, and cardiac or vascular care were among the main reasons people sought health care services outside Mendocino County. “Other” answers included: dermatology, GI, endocrinology, rheumatology, pediatric specialties and treatment for sleep apnea.



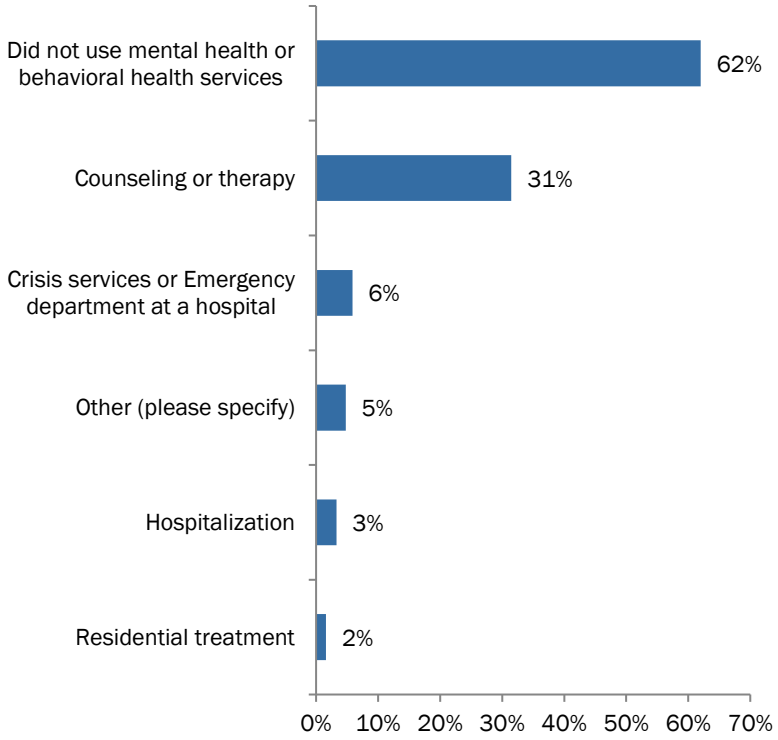
The majority of those who stated they received health care services outside of Mendocino County cited a lack of providers for specific services (52%), and long waits to see a health care provider (15%). "Other" reasons provided by respondents included: the perception that local health care providers offer a lower standard of care and a lack of confidence in local providers; the inability to be seen in a timely manner; issues resolving billing problems; high costs; confidentiality issues and a lack of providers who accept Medi-Cal insurance.



Seven percent of respondents stated they have no health insurance. Lack of health insurance can result in individuals delaying care and can contribute to higher rates of mortality. A 2002 study by the Institute of Medicine[1] found that the uninsured have worse survival rates and lack of health coverage which is associated with the lower use of preventative services. Delaying care worsens disease outcomes and leaves people exposed to high health care costs. These expenses can quickly turn into medical debt. Individuals with no insurance are also more likely to present at Emergency Departments for their care. [1]Institute of Medicine; Committee on the Consequences of Uninsurance, Care Without Coverage: Too Little, Too Late. Washington, DC., National Academies Pr 2002

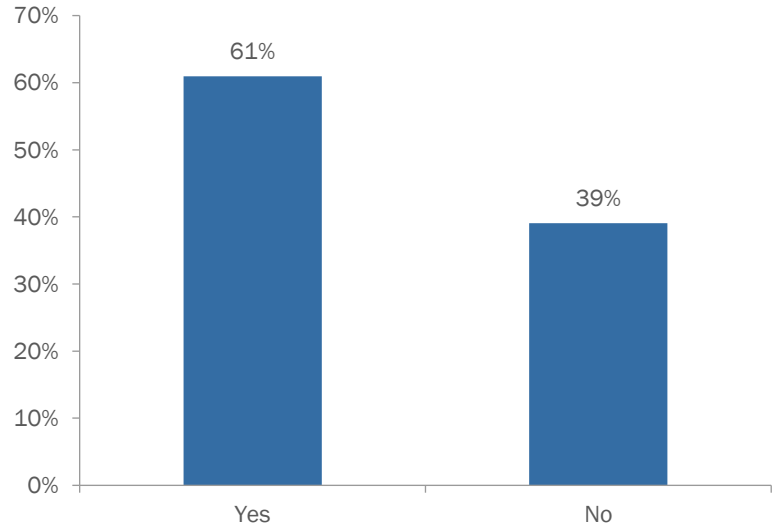
Mental Health Stability

During the past year did you or any one of your immediate family members use mental health or behavioral health services?

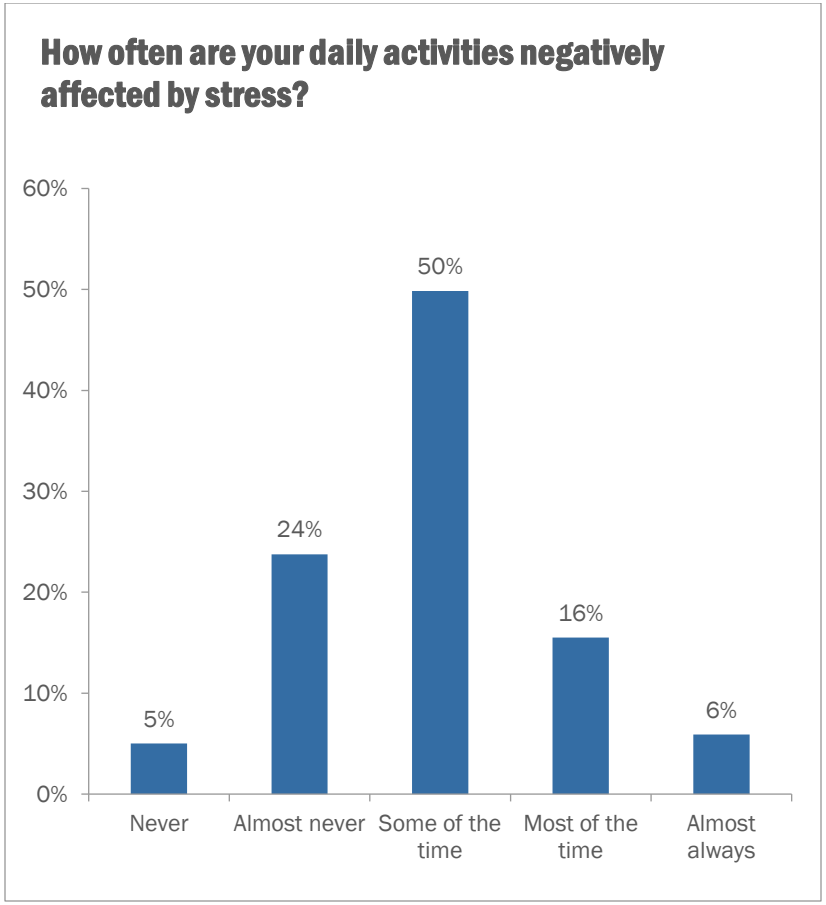


Forty-eight percent of respondents stated they or a family member had used some form of mental health services during the past year. "Other" answers provided include: seeking care from a psychiatrist, and for mental health/behavioral health services for children.

If you or anyone in your immediate family needed mental health or behavioral health services were you able to get them in Mendocino County?

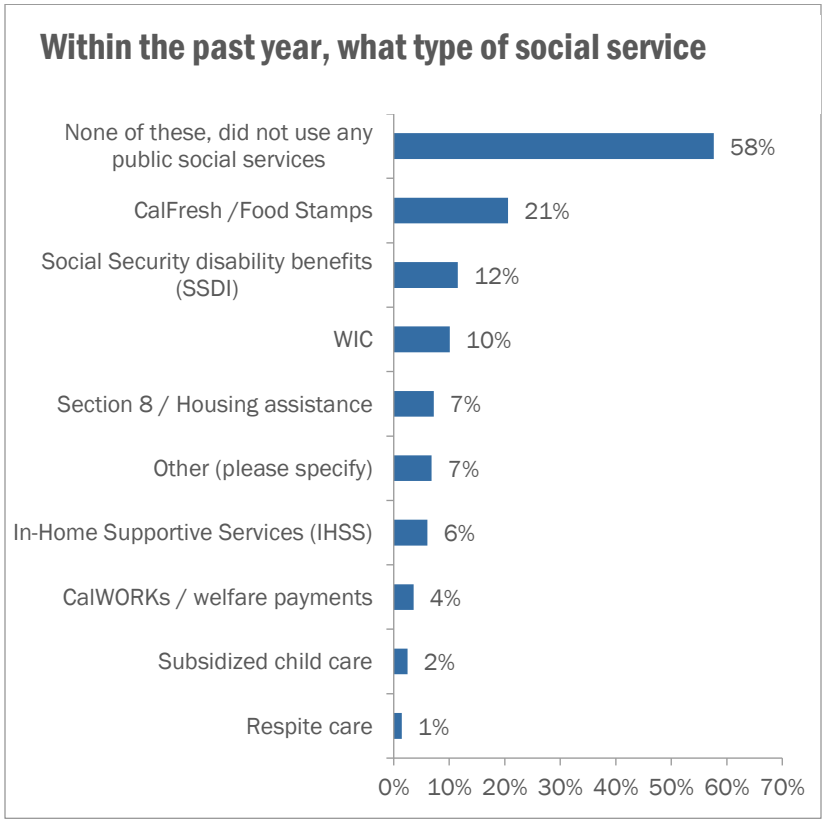


Approximately 40% of individuals or their immediate family members were unable to access mental health services when they needed them. Respondents had the opportunity to write in comments for this question and many stated they had concerns about confidentiality, that mental health treatment for youth was unavailable, and that they felt there was a lack of qualified mental health professionals. The California Department of Public Health estimates that Mendocino County has an age-adjusted rate of suicide at 21.3 per 100,000, compared to California's rate of 10.4 per 100,000.

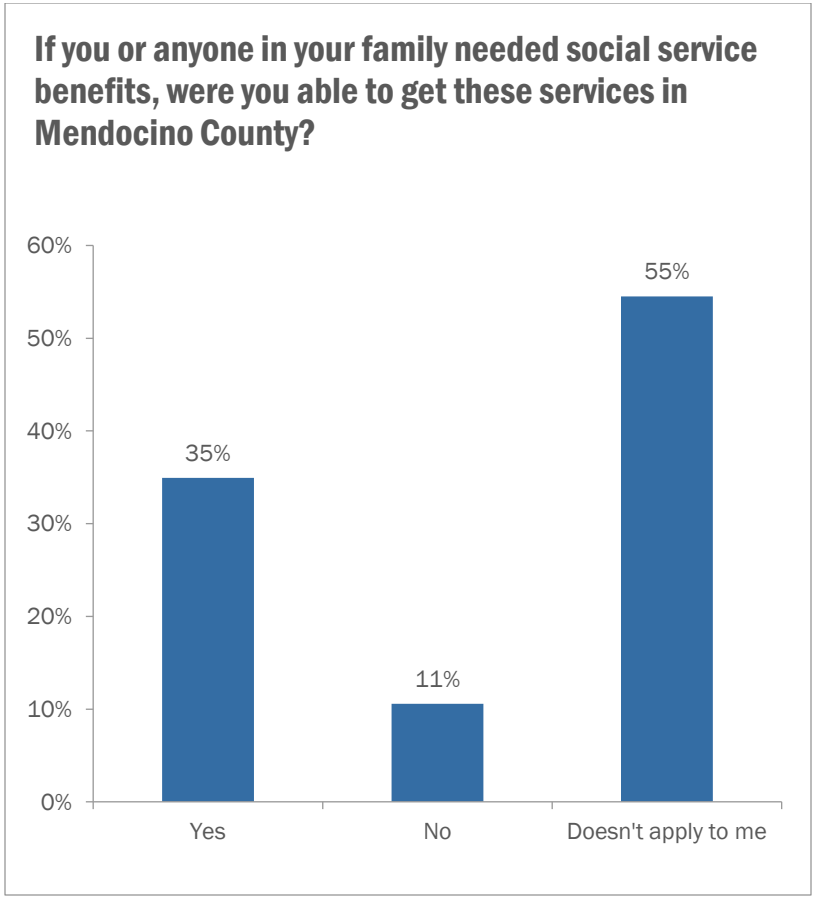


Almost half of respondents said their daily activities were negatively affected by stress "some of the time", another 15% said most of the time and almost 6% said "almost always". That makes 72% of the respondents reporting that they felt stressed in their everyday life. Chronic ongoing stress can cause serious health problems including cardiovascular disease, high blood pressure, heart attacks and stroke, and may make existing conditions worsen.

Access to Social Services Benefits

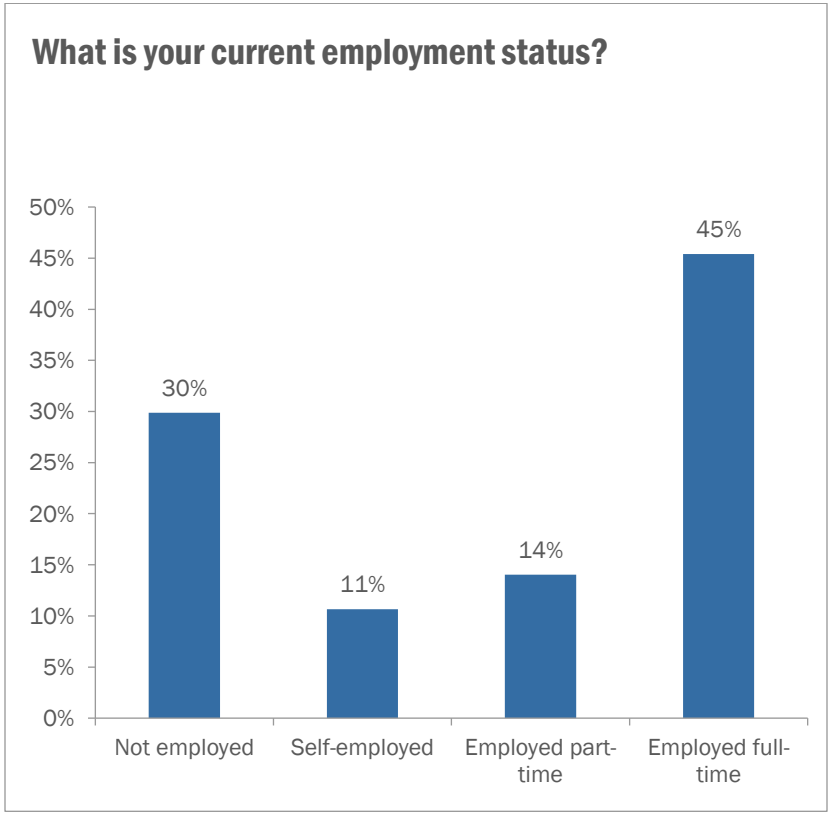


While most respondents did not use any type of social services (58%), help with providing food was the most utilized service. Many people stated that they were the "working poor", and that they could use some help, but made just over the income threshold to qualify. Several people said that they were victims of the 2017 fires and had used relief funds. Others stated they used Home Energy Assistance, tribal commodities, Meals-on-Wheels, Medicare, and free school lunches.

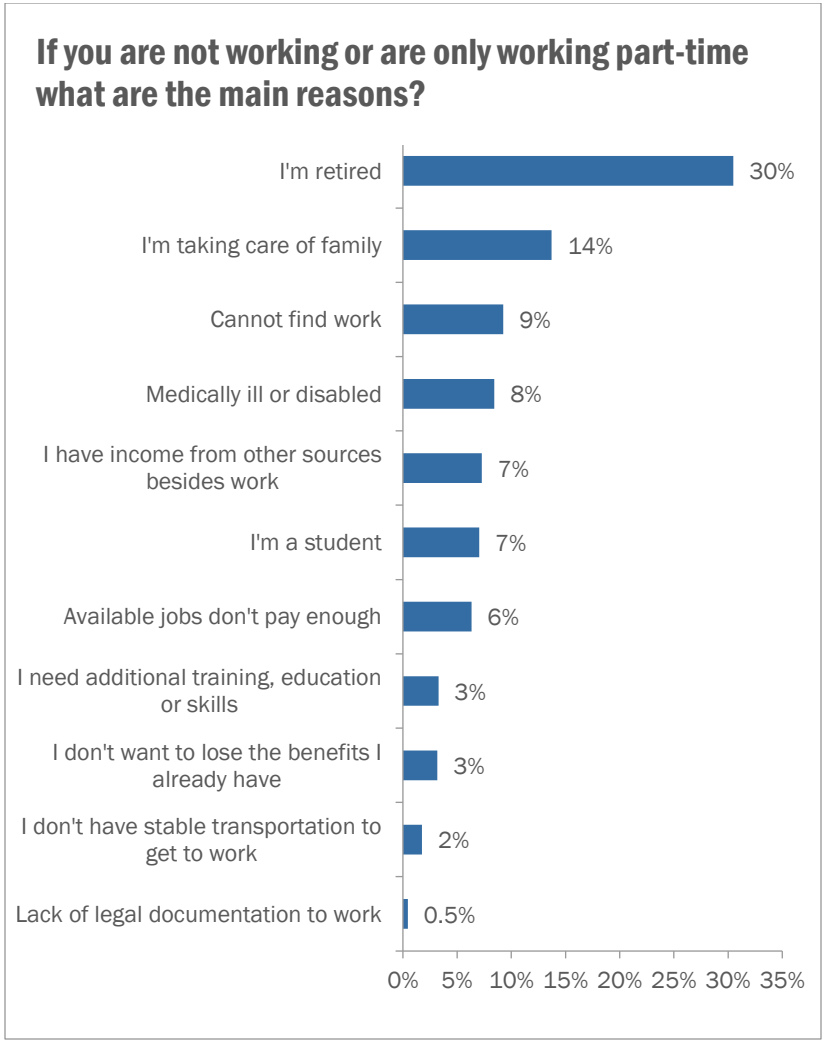


Individuals who stated they were not able to access social services provided a variety of answers. Many stated they needed services but earned just over the limit on income to be able to qualify; some stated they had felony convictions and so were not eligible for services; some stated they'd applied, but had not heard back from social services.

Employment Status

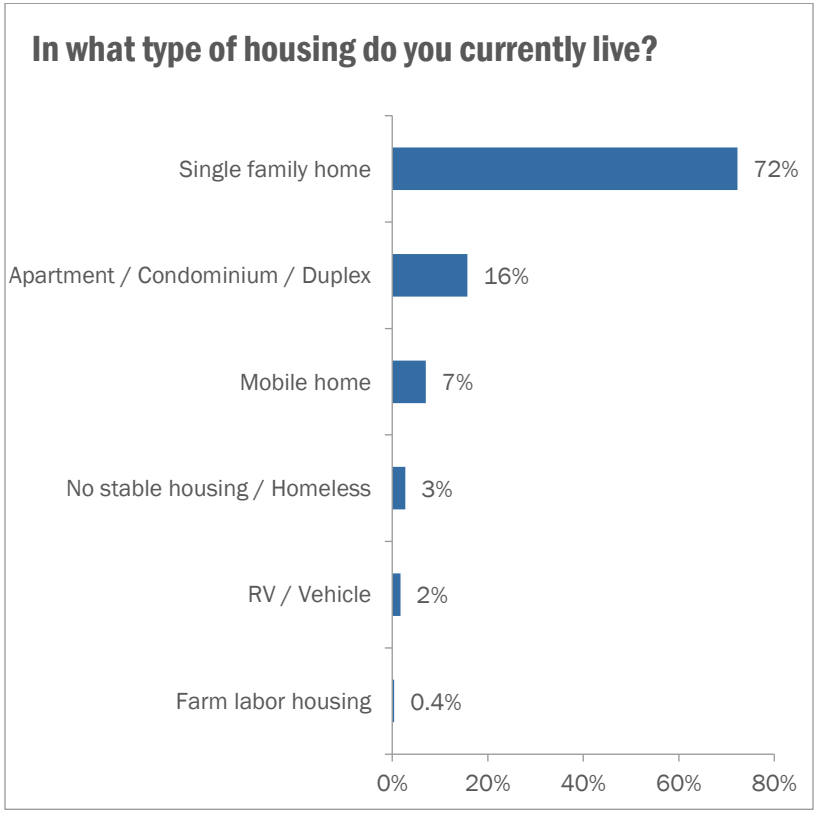


Almost one-half of the respondents were employed full-time. Part-time employment was no more than 30 hours a week. The unemployment rate in Mendocino County has been declining since the recession of 2010, and as of May, 2019 was 3.2%. Many individuals said they were working multiple jobs.

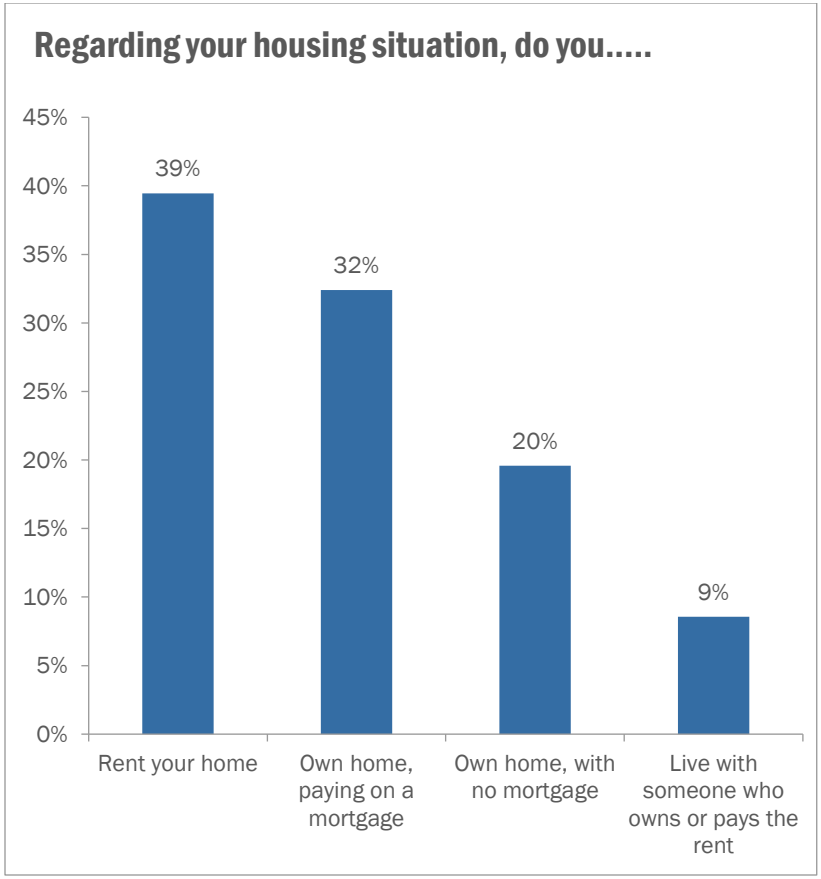


For those who were not working, about one-third identified as being retired. “Other” answers included being in a treatment program, not being able to find trusted childcare, not finding jobs, working at lumber mills, and being under too much stress to work.

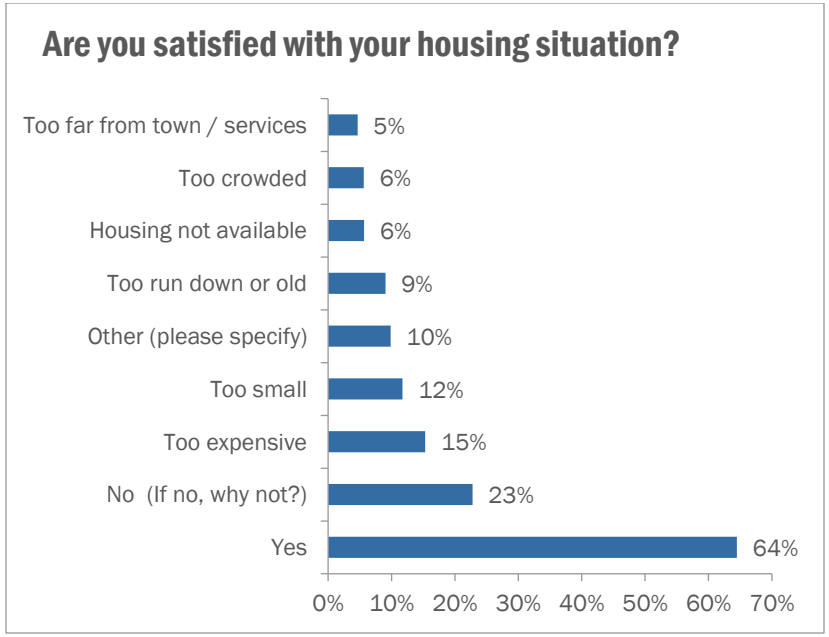
Satisfaction with Housing Situation



While single family homes are the most common form of housing in Mendocino County, apartments and mobile homes made up about 24%, and 5% of respondents indicated they were homeless or lived in other types of housing. When people said they lived in “Other” kinds of housing the answers included: a barn, community housing, camping, rebuilding after fire, a motel or hotel, a wooden yurt, renting a room, senior housing, sober living environment, safe haven sanctuary, and transitional housing.



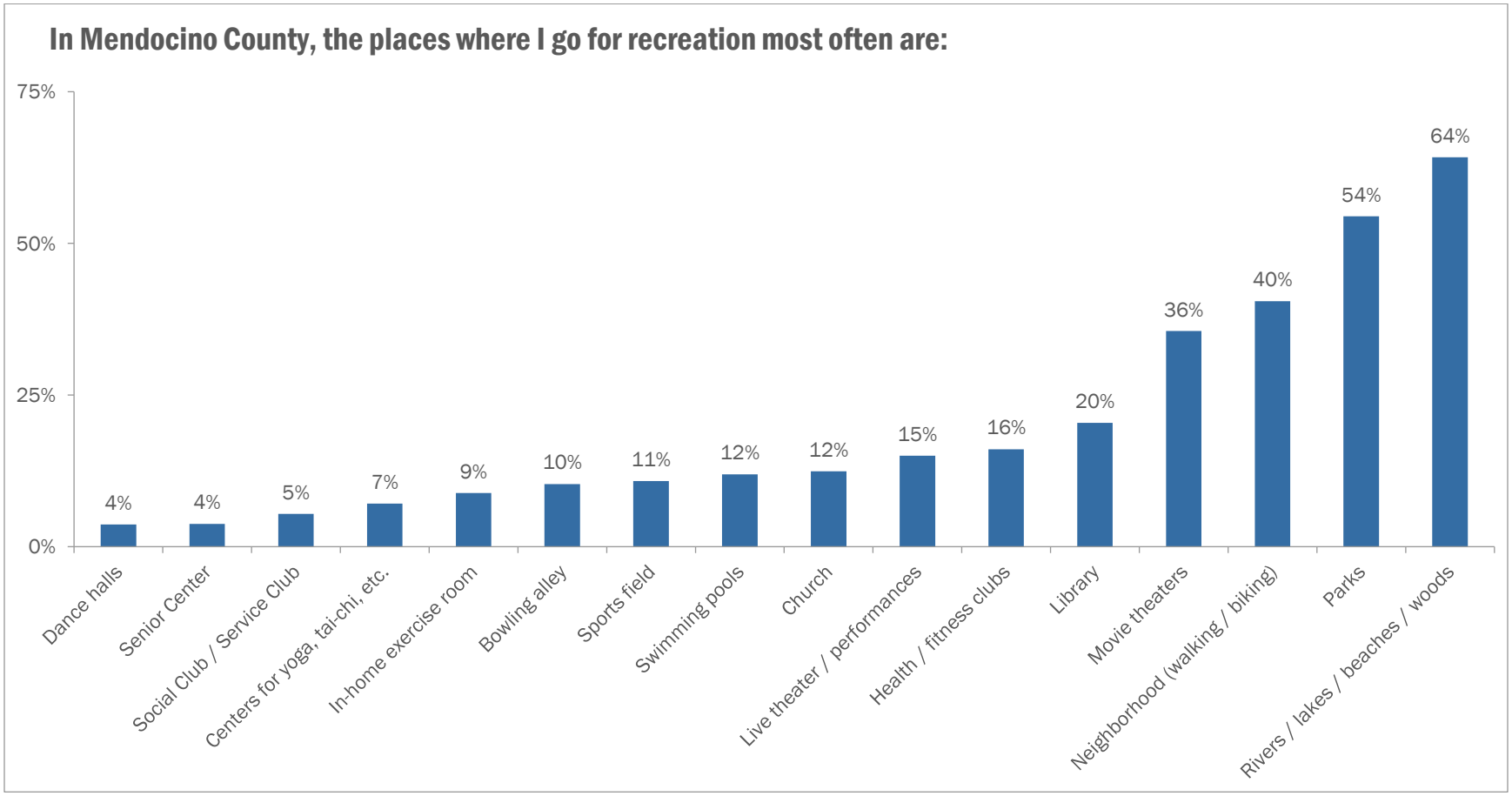
Whether it is better to rent or to own your home depends upon factors unique to each individual or family. Owning a home provides stability, appreciation of the home, tax and other advantages. Renting is often cheaper and allows for greater flexibility making life or job changes. The majority (52%) of respondents owned their own home, 40% rented a home and 9% lived with someone who owned or paid the rent.



The high costs of housing in Mendocino County are demonstrated by the 15% of respondents who said their housing costs were too high. This is borne out by data from the U.S. Census Bureau's American Community Survey (ACS), which found that 54% of renters in Mendocino County spend a third or more of their total household income on rent. This is high, but still slightly lower than California overall, where 57% of renters spend a third or more on rent.

"Other" responses describing dissatisfaction with housing included: "my house has black mold", "I have bad neighbors", "I am concerned about fire danger", "no garden space", "hard to get around in electric wheelchair", "inadequate infrastructure", "living in a FEMA trailer since the fires", "no internet access", "no cell phone reception", "property taxes too high", "too hot in summer" and "too cold in winter".

Favorite Places for Recreation/Social Activities in Mendocino County



With an abundance of natural beauty and places for outdoor recreation, it's clear that a majority of respondents said they enjoyed spending time out of doors.

"Other" answers included: AA meetings, sports practice, arts center, bars, the stable for my horse, coffee shops, golf courses, religious gatherings, enrichment centers at the Community College, museums, tribal gatherings, race track, working on the ranch, symphonies, shooting ranges, thrift stores, foot massage parlors, yard sales and "who has the time for recreation?"

ADDENDUM A

Community Health Survey Distribution

- Adventist Health Ukiah Valley
- Adventist Health Howard Memorial
- Mendocino Community Health Clinic
- Consolidated Tribal Health
- Anderson Valley Health Center
- Long Valley Health Clinic - Laytonville
- Round Valley Indian Health Center
- Mendocino Coast Clinics
- Redwood Coast Medical Services
- Dr. DeGroot, Dermatologist - Ukiah
- Family Resource Centers – Ukiah, Willits, Round Valley, Laytonville, Fort Bragg, Gualala
- Senior Centers – Ukiah, Anderson Valley, Willits, Fort Bragg, Mendocino, Caspar, Point Arena
- Mendocino County Health & Human Services Agency: Social Services Offices – Ukiah, Willits, Fort Bragg
- Mendocino County Health & Human Services Agency: WIC – Ukiah
- Mendocino County Health & Human Services Agency: Behavioral Health – Ukiah
- Mendocino County Health & Human Services Agency: Public Health - Ukiah
- Rural Community Child Care - NCO
- Head Start & Early Head Start - NCO
- School Districts – Ukiah, Willits, Fort Bragg, Mendocino, Albion, Comptche, Point Arena, Gualala
- Mendocino County Libraries – Ukiah, Willits, Laytonville, Point Fort Bragg, Mendocino, Point Arena, Bookmobile
- Plowshares & Meals on Wheels
- Nor-Cal Ministry – Ukiah
- Ukiah Food Bank
- Tapestry – Ukiah
- Manzanita – Ukiah MCHVAN – Ukiah
- Project Sanctuary – Ukiah, Fort Bragg
- Mendocino Coast Hospitality Center – Fort Bragg
- Boys and Girls Club – Ukiah
- Volunteer Income Tax Program - NCO – Ukiah
- North Coast Opportunities - employees and clients
- Mendocino County - employees
- Ukiah Vecinos En Accion (UVA)
- Round Valley Indian Tribes
- Ukiah Natural Foods Co-op
- Mariposa Market - Willits

ADDENDUM B

2019 COMMUNITY HEALTH SURVEY

2019 Community Health Needs Assessment

We Need Your Help!

Please take a few minutes to complete the survey below. The purpose of the survey is to get your input about community health issues in Mendocino County. This information will be used by the Healthy Mendocino and Community Health Needs Assessment Planning Group to identify the most important problems that can be addressed through community action. The survey should only take about 10 minutes to complete. Be assured that all answers you provide will be kept in the strictest confidence. To complete the survey online use this link: https://www.surveymonkey.com/r/BVQ5KCZ or scan the QR code:

Thank you!

For the following questions, please **circle** the letter to the left of your answer.

1. In the list below, what do you think are the **three** most important **factors** that make this county a **good place to live**? (Please choose just 3 answers.)

a. Community involvement
b. Low crime / safe neighborhoods
c. Low level of child abuse
d. Good schools
e. Access to health care & other services
f. Parks and recreation
g. Strong family life
h. Clean environment
i. Affordable housing
j. Acceptance of diversity
k. Nature / environment
l. Good jobs and healthy economy
m. Healthy behaviors and lifestyles
n. Low death and disease rates
o. Religious or spiritual values
p. Arts and cultural events

2. In the list below, what do you think are the **three** most important **health problems** in Mendocino County? The most important health problems are those that have the greatest impact on overall community health in Mendocino County. (Please choose just 3 answers.)

a. Motor vehicle crashes
b. Firearm-related injuries
c. Mental health issues
j. Hunger
k. Access to healthy food / Poor diet
l. Inactivity / Lack of exercise
s. Air quality
t. Chronic diseases (high blood pressure, diabetes, etc.)

d. Sexually transmitted diseases (HIV, HPV, etc.)
e. Teenage pregnancy
f. Childhood obesity
g. Lack of access to health care
h. Suicide
i. Water quality / water conservation
m. Homelessness
n. Economic issues
o. Tobacco use
p. Marijuana use
q. Alcohol and drug abuse
r. Agricultural pesticides
u. Infectious Diseases (hepatitis, TB, influenza, etc.)
v. Aging health issues (arthritis, hearing loss, isolation, etc.)
w. Oral health access
x. Cancers
y. Other: _____

3. How would you rate Mendocino County as **a healthy community** to live in? (Please select just 1 answer.)

1	2	3	4	5
Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy

4. How would you rate your **own personal health**? (Please select just 1 answer.)

1	2	3	4	5
Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy

5. How would you rate Mendocino County as **a safe place** to grow up or raise children? (Please select just 1 answer.)

1	2	3	4	5
Very Unsafe	Unsafe	Somewhat Safe	Safe	Very Safe

6. In the list below, what do you think are the **three** most serious **safety problems** in Mendocino County? (Please choose just 3 answers.)

a. Unsafe driving
b. Racism and intolerance
c. Not using seat belts, safety seats, helmets
d. Unsafe / unprotected sex
e. Unsafe roads / sidewalk conditions
f. Access to firearms by children
g. Manufacturing of methamphetamines
h. School violence
i. Child abuse and neglect
j. Domestic violence
k. Gang-related activity
l. Other: _____

7. Have you or any one in your immediate family been living with any of the following **chronic illnesses**? (Select all that apply.)

a. Diabetes
b. Cancer
g. Parkinson's
h. Hepatitis
k. High blood pressure
l. Arthritis

c. Heart Disease
d. Lung Disease / Asthma
e. HIV / AIDS
f. Alzheimer's
i. Mental Health (depression, bipolar, schizophrenia, etc.)
j. Alcohol or drug dependency
m. Hearing or Vision Loss
n. Chronic Pain
o. None of these
p. Other: _____

8. Where do you **most often** go to access health care services for yourself and your family? (Please select the one answer that best applies.)

a. Mendocino County hospitals / emergency rooms
b. Health clinics in Mendocino County
c. Tribal health clinics in Mendocino County
d. Mobile health vans
e. Alternative Medicine / Holistic treatment centers in Mendocino County
f. Health care services outside of Mendocino County, in / near: _____
g. Other: _____

9. If you or your family members received health care services **outside of Mendocino County** within the past year, what type of **health services** did you or your immediate family members receive? (Please select all that apply.)

a. Lab work
b. General surgery
c. Urology care
d. Ear, nose, throat care
e. Podiatry care
f. X-Ray, CAT scan, MRI, other imaging service
g. Auditory care (related to hearing)
h. Family planning services
i. Transgender related services
j. Emergency room services
Cancer treatments
k. Fertility treatments/services
l. Allergy / asthma care
m. General practitioner care
n. Mental health services
o. Eye or vision care
p. Orthopedic care
q. Neurology
r. Cardiac or vascular care
Dental or orthodontia care
s. Prenatal / Obstetrics
t. Pediatric care
u. Gynecological care
v. Other: _____

10. If you or a family member received health care **outside of Mendocino County**, please choose the following choices that best explains why you went to a provider outside of the county. (Please select all that apply.)

a. Medical services I / we needed are not available in Mendocino County
b. The wait to see a doctor in Mendocino County was too long
c. My insurance only covers doctors in another area
d. There were no doctors that accepted Medi-Cal or Medicaid in my area
e. Too expensive in Mendocino County
f. My preferred doctor is located outside Mendocino county
g. Other: _____

11. How do you **pay** for health care? (Please select all that apply.)
    a. No insurance (pay cash)
    b. Health insurance (i.e., private insurance like Blue Shield, Anthem, HMO, etc.)
    c. Medi-Cal / Partnership Plan
    d. Medicare
    e. Medicare Supplemental Insurance
    f. Veteran's Administration
    g. Indian Health Services
    h. Other: _____

12. During the past year did you or any one of your immediate family members use **mental / behavioral health services**? (Please select all that apply.)

1	2	3	4	5
None	Crisis / ER	Hospitalization	Counseling / Therapy	Residential treatment

Other:_____

13. If you or anyone in your immediate family needed mental health or behavioral health services, were you able to get these services **in Mendocino County**? Check 1. _____YES _____NO

    If no, please describe/explain: _____

14. How often are your daily activities negatively affected by **stress**? (Please select just 1 answer.)

1	2	3	4	5
Never	Almost never	Some of the time	Most of the time	Almost always

15. Within the past year, what type of **social service benefits**, if any, did you or anyone in your family need? (Please select all that apply.)
    a. Food stamps / Cal Fresh
    b. WIC
    c. Welfare payments / Calworks
    d. Housing assistance (Section 8)
    e. In-Home Supportive Services (IHSS)
    f. Social Security disability benefits (SSDI)
    g. Respite care
    h. Subsidized childcare
    i. None of these
    j. Other: _____

16. If you or anyone in your family needed **social services benefits,** were you able to get these services **in Mendocino County**? Check 1. _____YES _____NO

    If no, please describe/explain: _____

17. What is your current **employment** status? (Please select just 1 answer.)

1	2	3	4
Not employed	Self-employed	Employed part-time (8-30 hours a week)	Employed full-time (more than 30 hours a week)

If you are employed **part-time**, and have more than one job, please list the number of jobs you work: _____

18. If you are **not working or are only working part-time**, what are the main reasons? (Please select all that apply.)

a. Medically ill or disabled
b. Cannot find work
c. Cannot find full-time work
d. Retired
e. Student
f. Taking care of family
g. Available jobs do not pay enough
h. I don't want to lose the benefits I already have
i. Lack of legal documentation to work
j. Lack of stable transportation to job site
k. I have income from other sources beside work
l. I need additional training, education or skills (e.g., English language, reading and writing, math, computers, etc.) Please list what you fell you need: _____

19. What type of **housing** do you currently live in? (Please choose just 1answer.)

a. Apartment / Condominium/Duplex
b. Mobile home
c. Single family house
d. Farm labor housing
e. RV / Vehicle
f. No stable housing
g. Other: _____

20. Regarding your **housing situation**, do you: (Please choose just 1 answer.)

a. Rent
b. Own home with a mortgage or loan
c. Own home without a mortgage or loan
d. Live with other who owns or pays rent
e. Other: _____

21. Are you **satisfied** with your housing situation? Check 1. _____YES _____NO

If no, **why not**? (Please select all that apply.)

a. Too small
b. Too crowded
c. Housing not available
d. Too run down or old
e. Too expensive
f. Too far from town / services
g. Other: _____

22. In Mendocino County, the places where I go **for recreation most often** are: (Please choose just 3 answers.)

a. Parks
b. Movie theaters
c. Live theater / performances
d. Social club / Service club
e. Rivers / lakes / beaches / woods
f. Sports fields
g. Bowling alley
h. Swimming pools
i. Health / fitness clubs
j. Dance halls
k. Centers for yoga, tai-chi, etc.
l. Church
m. Senior Center
n. Library
o. Neighborhood (walking / biking)
p. In-home exercise room
q. Other: _____

The following questions are for **demographic purposes** only to ensure we are getting responses from a wide range of people in the county. Your responses will remain **completely anonymous.**

23. What is your **gender**?

a. Male
b. Female
c. Transgender
d. If your identity is not listed above, please self-identify:

_____

24. What is your **marital status**?

a. Married
b. Domestic Partner
c. Divorced
d. Single
e. Widowed
f. Separated

25. What is your **age**?

a. Under 18 years
b. 18 to 25 years
c. 26 to 39 years
d. 40 to 54 years
e. 55 to 64 years
f. 65 to 80 years
g. Over 80 years

26. Which **ethnicity** you most identify with? (Select all that apply.)

a. White or Caucasian
b. Black / African American
c. Hispanic or Latino
d. Asian or Asian American
e. Native Hawaiian and other Pacific Islander
f. American Indian and Alaska Native
g. Two or more races

27. What **language(s)** do you speak in your home? (Select all that apply.)

a. English
b. Spanish
c. Tagalog
d. Other: _____

28. What is your highest **education** level? (Please select just 1 answer.)

a. Did not attend school
b. Less than High School Graduate
c. High School Diploma
d. GED
e. Some college
f. Vocational / trade school
g. College degree
h. Graduate or professional degree or higher

29. What is your home **zip code**? (Please select just 1 answer.)

a. 95410 Albion
b. 95415 Boonville
c. 95417 Branscomb
d. 95418 Calpella
e. 95420 Caspar
f. 95427 Comptche
g. 95428 Covelo
h. 95429 Dos Rios
i. 95432 Elk
j. 95437 Fort Bragg
k. 95445 Gualala
l. 95449 Hopland
m. 95454 Laytonville
n. 95585 Leggett
o. 95456 Little River
p. 95459 Manchester
q. 95460 Mendocino
r. 95463 Navarro
s. 95466 Philo
t. 95587 Piercy
u. 95468 Point Arena
v. 95469/95466 Potter Valley
w. 95470 Redwood Valley
x. 95481 Talmage
y. 95482 Ukiah
z. 95488 Westport
aa. 95494 Willits
bb. 95494 Yorkville
cc. Round Valley Indian Tribes

30. Which of the following best describes your **current occupation**? (Please select just 1 answer.)

a. Agriculture, farming, viticulture, forestry, fishing, hunting, mining
b. Construction
c. Manufacturing
d. Wholesale trade
e. Retail trade
f. Transportation, warehousing, utilities
g. Information, media, technology
h. Finance, insurance, real estate, rental, leasing
i. Professional, scientific, management, administrative
j. Educational services, health care, social assistance
k. Art, design, entertainment
l. Accommodation, food service
m. Public administration
n. Other: _____

31. Your annual household **income**? (Please select just 1 answer.)

a. Under $15,000
b. Between $15,000 and 29,999
c. Between $30,000 and $49,999
d. Between $50,000 and $74,999
e. Between $75,000 and $99,999
f. Between $100,000 and $149,999
g. Over $150,000

Thank you very much for your response!

If you would like more information about this project, please contact us at the telephone / email below.

Phone: 707-467-3228

Email: healthymendocino@ncoinc.org

Mail to:

Attn: Healthy Mendocino

413 North State Street

Ukiah, CA 95482

ADDENDUM C

ENCUESTA DE SALUD COMUNITARIA 2019 - Evaluación de las necesidades de salud de la comunidad

2019 ENCUESTA DE SALUD COMUNITARIA - Evaluación de las necesidades de salud de la comun

Tómese unos minutos para completar la encuesta a continuación. El propósito de la encuesta es obtener su opinión sobre los problemas de salud de la comunidad en el Condado de Mendocino. Esta información será utilizada por Healthy Mendocino y el Grupo de Planificación de la Evaluación de las Necesidades de Salud de la Comunidad para identificar los problemas más importantes que pueden abordarse a través de la acción comunitaria. La encuesta sólo debe tomar unos 10 minutos para completar. Tenga la seguridad de que todas las respuestas que proporcione se mantendrán en la más estricta confidencialidad. ¡Gracias!

1. ¿Cuáles cree que son los tres factores más importantes que hacen que este condado sea un buen lugar para vivir ? Por favor, elija 3.

- ☐ Participación de la comunidad
- ☐ Baja delincuencia / barrios seguros
- ☐ Bajo nivel de maltrato infantil.
- ☐ Buenas escuelas
- ☐ Acceso a servicios de salud y otros servicios.
- ☐ Parques y Recreación
- ☐ Otro:
- ☐ Vida familiar fuerte
- ☐ Ambiente limpio
- ☐ Vivienda asequible
- ☐ Naturaleza / medio ambiente
- ☐ Aceptación de la diversidad.
- ☐ Buenos empleos y economía saludable.
- ☐ Conductas y estilos de vida saludables.
- ☐ Bajos índices de mortalidad y enfermedades.
- ☐ Valores religiosos o espirituales.
- ☐ Eventos artísticos y culturales.

1

2. En la lista a continuación, ¿cuáles cree que son los tres problemas de salud más importantes en el condado de Mendocino? Los problemas de salud más importantes son aquellos que tienen el mayor impacto en la salud general de la comunidad en el Condado de Mendocino. Por favor, elija 3.

- [ ] Accidentes automovilísticos
- [ ] Lesiones relacionadas con armas de fuego
- [ ] Problemas de salud mental
- [ ] Enfermedades de transmisión sexual (VIH, VPH , etc.)
- [ ] Embarazo en la adolescencia
- [ ] Obesidad infantil
- [ ] Falta de acceso a servicios de salud.
- [ ] Suicidio
- [ ] Calidad del agua / conservación del agua.
- [ ] Hambre
- [ ] Acceso a alimentos saludables / mala alimentación.
- [ ] Inactividad / Falta de ejercicio
- [ ] La falta de vivienda
- [ ] Problemas económicos
- [ ] El consumo de tabaco
- [ ] Consumo de marihuana
- [ ] Abuso de alcohol y drogas
- [ ] Calidad del aire
- [ ] Pesticidas agrícolas
- [ ] Enfermedades crónicas (obesidad, hipertensión arterial , diabetes, etc.)
- [ ] Enfermedades infecciosas (hepatitis, tuberculosis, etc.)
- [ ] Problemas de salud por el envejecimiento (artritis, pérdida auditiva, aislamiento, etc.)
- [ ] Acceso a la salud oral.
- [ ] Cánceres
- [ ] Oteo::

3. ¿Cómo calificaría al Condado de Mendocino como una comunidad saludable para vivir? Seleccione 1.

Muy poco saludable	Insalubre	Algo saludable	Sano	Muy saludable
○	○	○	○	○

4. ¿Cómo calificaría su propia salud personal ? Seleccione 1.

Muy poco saludable	Insalubre	Algo saludable	Sano	Muy saludable
○	○	○	○	○

5. ¿Cómo calificaría al Condado de Mendocino como un lugar seguro para crecer o criar hijos? Seleccione 1.

Muy inseguro	Inseguro	Algo seguro	Seguro	Muy seguro
○	○	○	○	○

2

6. En la siguiente lista, ¿cuáles cree que son los tres problemas más graves de seguridad en el condado de Mendocino? Seleccione 3.

- [ ] Conducción insegura
- [ ] Racismo e intolerancia
- [ ] No usar cinturones de seguridad, asientos de seguridad, cascos.
- [ ] Sexo inseguro / desprotegido
- [ ] Condiciones inseguras de caminos / aceras
- [ ] Acceso a armas de fuego por parte de niños.
- [ ] Fabricación de metanfetaminas.
- [ ] La violencia escolar
- [ ] Abuso y abandono infantil
- [ ] Violencia doméstica
- [ ] Actividad relacionada con pandillas
- [ ] Otro:

7. ¿Usted o alguno de su familia inmediata viviendo con alguna de las siguientes enfermedades crónicas ? Seleccione todo lo que corresponda .

- [ ] Diabetes
- [ ] Cáncer
- [ ] Enfermedad del corazón
- [ ] Enfermedad pulmonar / asma
- [ ] VIH / SIDA
- [ ] Alzheimer
- [ ] Parkinson
- [ ] Hepatitis
- [ ] Salud mental (depresión, bipolar, esquizofrenia, etc.)
- [ ] Alcohol o dependencia de drogas
- [ ] Alta presion sanguinea
- [ ] Artritis
- [ ] Audición / pérdida de la visión
- [ ] Dolor crónico
- [ ] Ninguno de esos
- [ ] Otro:

8. ¿A dónde va más a menudo para recibir atención médica para usted y su familia? Seleccione 1 que mejor se aplica .

- ( ) Hospitales / Salas de Emergencia del condado de Mendocino
- ( ) Clínicas / centros de salud en el condado de Mendocino
- ( ) Centros tribales de salud
- ( ) Furgonetas móviles de salud
- ( ) Centros de medicina alternative
- ( ) Fuera del condado de Mendocino

Si se encuentra fuera del Condado de Mendocino, indique la ubicación de su (s) proveedor (es):

3

9. Durante el año pasado, ¿qué tipo de servicios de salud recibieron usted o sus familiares directos fuera del Condado de Mendocino (si corresponde) ? Seleccione todo lo que corresponda .

- [ ] Trabajo de laboratorio
- [ ] Cirugía General
- [ ] Atención de urología
- [ ] Cuidado de oído, nariz, garganta
- [ ] Cuidado de podiatría
- [ ] Rayos X / MRI
- [ ] Servicios de audición
- [ ] Planificación familiar
- [ ] Servicios relacionados con personas transgénero
- [ ] Servicios de urgencias
- [ ] Tratamientos de cancer
- [ ] Servicios de fertilidad
- [ ] Cuidado de la alergia / asma
- [ ] Atención médica general
- [ ] Servicios de salud mental
- [ ] Cuidado de ojos
- [ ] Orthopedic care
- [ ] Neurología
- [ ] Cuidado cardíaco / cardíaco
- [ ] Cuidado dental / Ortodoncia
- [ ] Obstetricia / Cuidado prenatal
- [ ] Cuidado pediátrica
- [ ] Cuidado ginecología
- [ ] Ninguno de esos
- [ ] Otro:

10. Si usted o un miembro de su familia recibió atención médica fuera del Condado de Mendocino, seleccione 1 de la lista a continuación que corresponda.

- ( ) Servicios que necesito no estamos disponibles en el condado de Mendocino
- ( ) La espera para ver a un médico en el condado de Mendocino fue demasiado larga
- ( ) Mi seguro solo cubre médicos en otra área.
- ( ) Ningún médico apropiado acepta Medi-Cal / Medicaid
- ( ) Los médicos son demasiado caros en el condado de Mendocino
- ( ) Mi médico preferido está ubicado fuera del condado de Mendocino

Otro:

11. ¿Cómo paga por la atención médica que recibe? Seleccione todo lo que corresponda .

- [ ] Sin seguro (pago en efectivo)
- [ ] Seguro de salud (es decir , seguro privado, Blue Shield, HMO, etc.)
- [ ] Medi-Cal / Plan de asociación
- [ ] Otro:
- [ ] Seguro médico del estado
- [ ] Seguro suplementario de Medicare
- [ ] Administración de Veteranos
- [ ] Servicio de Salud Indio

4

12. ¿En el último año, qué tipo de servicios de salud mental , si las hay, necesitó usted o alguien de su familia? Seleccione todas las que correspondan.

- [ ] No utilizó servicios de salud mental o de salud mental.
- [ ] Consejería / Terapia
- [ ] Servicios de crisis o servicio de urgencias en un hospital.
- [ ] Tratamiento residencial
- [ ] Hospitalización
- [ ] Otro:

13. Si usted o alguien de su familia necesitaba servicios de salud mental, ¿pudo obtener estos servicios en el Condado de Mendocino ?

( ) Si ( ) No

Si no, por favor describa / explique:

14. ¿Con qué frecuencia se ven afectadas negativamente sus actividades diarias por el estrés? Seleccione 1.

Nunca	Casi nunca	Algo de tiempo	La mayor parte del tiempo	Casi siempre
( )	( )	( )	( )	( )

15. En el último año, ¿qué tipo de beneficios de servicio social , si los hay, necesitó usted o alguien de su familia? Seleccione todas las que correspondan.

- [ ] Cupones de alimentos / Cal Fresh
- [ ] Servicios de apoyo en el hogar (IHSS)
- [ ] WIC
- [ ] Ingreso por discapacidad del Seguro Social (SSDI)
- [ ] Pagos de bienestar / Calworks
- [ ] Cuidado de relevo
- [ ] Asistencia de vivienda (Sección 8)
- [ ] Cuidado de niños subsidiado
- [ ] Medi-Cal / Plan de asociación
- [ ] Ninguno de estos, no utilizó ningún servicio social público.
- [ ] Otro:

5

16. **Si usted o alguien de su familia necesitaba beneficios de servicios sociales, ¿pudo obtener estos servicios en el Condado de Mendocino ?**

◯ Si ◯ No

Si no, por favor describa / explique:

17. ¿Cuál es su situación laboral actual? Seleccione 1.

◯ Desempleado
◯ Empleado a tiempo parcial (8-30 horas a la semana)
◯ Trabajadores por cuenta propia
◯ Empleado de tiempo completo (más de 30 horas a la semana)

Si está empleado a tiempo parcial: _____ # de trabajos a tiempo parcial (si tiene más de uno)

18. Si no está trabajando o está trabajando a tiempo parcial, ¿cuál es la razón principal? Por favor seleccione todas las respuestas válidas.

☐ Médicamente enfermo o discapacitado
☐ No puedo encontrar trabajo
☐ No se puede encontrar trabajo a tiempo complete
☐ Soy un retirado
☐ Soy un estudiante
☐ Estoy cuidando de la familia
☐ Los trabajos disponibles no pagan lo suficiente
☐ No quiero perder los beneficios que ya tengo.
☐ Falta de documentación legal para trabajar.
☐ Falta de transporte estable al sitio de trabajo
☐ Necesito entrenamiento adicional
☐ Obtengo ingresos de otras fuentes.
☐ Obtengo ingresos de otras fuentes además del trabajo.

☐ Si necesita capacitación, educación o habilidades adicionales, indique lo que cree que necesita: (por ejemplo, idioma inglés, lectura y escritura, matemáticas, computadoras, etc.)

19. ¿En qué tipo de vivienda vive actualmente? Por favor elija 1.

◯ Apartamento / Condominio / Dúplex
◯ Casa para una sola familia
◯ Casa móvil
◯ Vivienda para trabajadores agrícolas
◯ RV / Vehículo
◯ No hay vivienda estable / sin hogar

Otro:

6

20. Con respecto a su situación de vivienda, usted: Por favor elija 1.

- ◯ Alquila
- ◯ Poseer sin hipoteca o préstamo.
- ◯ Poseer con una hipoteca o préstamo
- ◯ Vivo con otro que paga el alquiler o la hipoteca

Otro:

21. ¿Está satisfecho con su situación de vivienda? (Si no está satisfecho con su vivienda, seleccione por qué no)

- ☐ Si
- ☐ Vivienda no disponible
- ☐ No
- ☐ Demasiado agotado
- ☐ Demasiado pequeña
- ☐ Muy caro
- ☐ Demasiadas personas en la misma casa
- ☐ Muy lejos de la ciudad y de los servicios.
- ☐ Otro:

22. En el condado de Mendocino, los lugares a los que voy a menudo para recreación son: Por favor seleccione todas las respuestas válidas.

- ☐ Parques
- ☐ Bolera
- ☐ Centro para personas mayors
- ☐ Salas de cine
- ☐ Piscinas
- ☐ Biblioteca
- ☐ Teatro en vivo / actuaciones
- ☐ Salud / gimnasios
- ☐ Barrio (caminar / andar en bicicleta)
- ☐ Club social / club de servicio
- ☐ Salones de baile
- ☐ Sala de ejercicios en casa
- ☐ Ríos / lagos / playas / bosques
- ☐ Centros de yoga, tai-chi, etc.
- ☐ Campos deportivos
- ☐ Iglesia
- ☐ Otro:

23. Las siguientes preguntas son solo para fines demográficos, por lo que podemos asegurarnos de escuchar a muchas personas diferentes en el condado. Sus respuestas serán totalmente anónimas.

¿Cuál es su género?

◯ Masculino ◯ Hembra ◯ Transgénero

24. Cuál es su estado civil?

- ◯ Casado o con una pareja doméstica
- ◯ Soltero
- ◯ Divorciado
- ◯ Viudo
- ◯ Apartado

25. ¿Cual es su edad?

- ◯ Menor de 18 años
- ◯ 18 a 25 años
- ◯ 26 a 39 años
- ◯ 40 a 54 años
- ◯ 55 a 64 años
- ◯ 65 a 80 años
- ◯ Mas de 80 años

26. ¿Con qué etnicidad se identificas más? Seleccione todo lo que corresponda .

- ◯ Blanco
- ◯ Negro / Afroamericano
- ◯ Hispano o Latino
- ◯ Asiático / Asiático Americano
- ◯ Indio americano y Nativo de Alaska
- ◯ Nativo Hawaiano y Isleño del Pacífico
- ◯ Dos o mas carreras

27. ¿Qué idioma (s) habla en su casa? Seleccione todas las que correspondan

- ☐ Inglés
- ☐ Español
- ☐ Otro:
- ☐ Tagalo

28. ¿Cuál es el nivel más alto de escuela que ha completado?

- ◯ Menos que el título de secundaria
- ◯ Diploma de escuela secundaria o GED
- ◯ Alguna educación superior
- ◯ Título universitario
- ◯ Alguna escuela de posgrado
- ◯ Graduado o título profesional o mas alto
- ◯ Escuela vocacional / comercio

8

29. ¿En qué código postal esta la ubicacion de su hogar? Por favor elija 1.

- 95410 Albion
- 95415 Boonville
- 95417 Branscomb
- 95418 Calpella
- 95420 Caspar
- 95427 Comptche
- 95428 Covelo
- 95429 Dos Rios
- 95432 Elk
- 95437 Fort Bragg
- 95445 Gualala
- 95449 Hopland
- 95585 Leggett
- 95454 Laytonville
- 95456 Little River
- 95459 Manchester
- 95460 Mendocino
- 95463 Navarro
- 95466 Philo
- 95587 Piercy
- 95468 Point Arena
- 95469 / 95466 Potter Valley
- 95481 Talmage
- 95482 Ukiah
- 95488 Westport
- 95490 Willits
- 95494 Yorkville

30. ¿Cuál de las siguientes opciones describe mejor su ocupación actual? Por favor elija 1.

- Agricultura, silvicultura, pesca y caza, y minería.
- Construcción
- Fabricación
- Comercio al por mayor
- Comercio al por menor
- Transporte y almacenaje, y servicios públicos.
- Tecnología, información y medios de comunicación
- Finanzas y seguros, bienes inmuebles, y alquiler y leasing
- Profesional, científico, administrativo y administrativo.
- Servicios educativos, asistencia sanitaria y asistencia social
- Servicios de arte, diseño, entretenimiento
- Alojamiento y alimentación.
- Administración Pública

Otro:

31. ¿Su ingreso familiar anual? Por favor elija 1.

- Menos que $15,000
- En medio de $15,000 and $29,999
- En medio de $30,000 and $49,999
- En medio de $50,000 and $74,999
- En medio de $75,000 and $99,999
- En medio de $100,000 and $150,000
- Mas que $150,000

9

ENCUESTA DE SALUD COMUNITARIA 2019 - Evaluación de las necesidades de salud de la comunidad

¡Muchas gracias por su respuestas!

Si desea más información sobre este proyecto, contáctenos por teléfono / correo electrónico. A contunuación se encuetran nuestros datos de contacto.

Teléfono: 707-467-3200 ext. 228
Correo electrónico: healthymendocino@ncoinc.org

Correo a
Atención: Mendocino Saludable
413 North State Street
Ukiah, CA 95482

Mail to:
Attn: Healthy Mendocino
413 North State Street
Ukiah, CA 95482

10

2019 Mendocino County Community Health Needs Assessment

APPENDIX B
Key Informant Interviews/Survey

October 2019

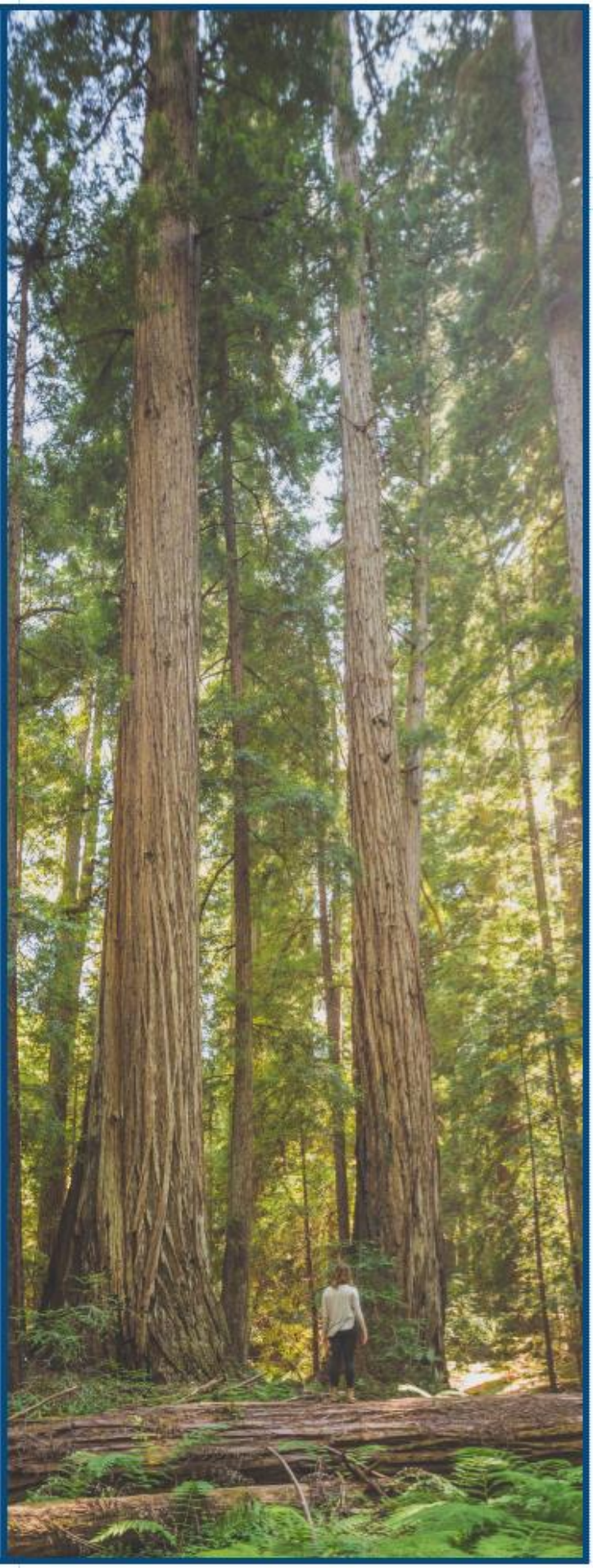


TABLE OF CONTENTS

Key Leader Interviews/Surveys

Results

Figures & Tables

Addendums

Cover Photo credit Brendan McGuigan

KEY LEADER INTERVIEWS / SURVEY

Introduction & Background

Purpose

The purpose of the key informant interviews/survey was to identify views on health and well-being in Mendocino County among key leaders – both formal and informal leaders – in the community. This approach is one data-gathering component of the 2019 Mendocino County Community Health Needs Assessment (CHNA).

The 2019 CHNA is sponsored by a coalition of local organizations and agencies: Adventist Health Howard Memorial, Adventist Health Ukiah Valley, Alliance for Rural Community Health & Community Health Resource Network, Community Foundation of Mendocino County, FIRST 5 Mendocino, Healthy Mendocino, Mendocino Community Health Clinics, Mendocino County Health & Human Services Agency, Public Health Branch, Mendocino County Office of Education, North Coast Opportunities, Partnership HealthPlan of California, Redwood Community Services, Inc., Redwood Quality Management Company, and United Way of the Wine Country. The CHNA is a project of Healthy Mendocino, which facilitated the Planning Group.

Background

In preparing for the key informant interviews/survey, the CHNA Planning Group members reviewed instruments previously used during the 2002 and 2015 CHNA processes. Revisions were kept to a minimum so that a direct comparison could be made to the most recent CHNA conducted in 2015.

Methodology

The target group consisted of a diverse group of key community leaders and informants in Mendocino County: representatives of county and city government, private businesses, health and human services, hospitals and clinics, community-based organizations and nonprofits, law enforcement, children and youth services, education, media, geography, and racial/ethnic groups, among others.

The key informant interviews were conducted in-person or by-phone by Planning Group members between January and March 2019. The online survey was conducted via SurveyMonkey in February 2019.

Each of the key informants interviewed were asked the same 10 questions. The online survey contained a total of five questions, identical to the first five questions of the interviews. The questions were designed to identify health and quality of life issues in Mendocino County, possible solutions to addressing critical areas, as well as barriers to change. A copy of the interview questions and the online survey questions are included in Addendums A and C of this document.

A total of 54 key leader informants were contacted for an interview. In addition, approximately 170 formal and informal leaders were contacted to participate in an online survey. Of these, 34 interviews and 56 written surveys were completed for a total sample size

of 90 key informants/leaders in Mendocino County.

A content analysis was conducted on summary notes taken of the interviews to identify common themes represented by the informants. These results were combined with a quantitative analysis, e.g., descriptive statistics, of the online survey.

Acknowledgements

Healthy Mendocino and the 2019 CHNA Planning Group would like to thank all the leaders in our community that participated and contributed their time, energy and expertise to this endeavor.

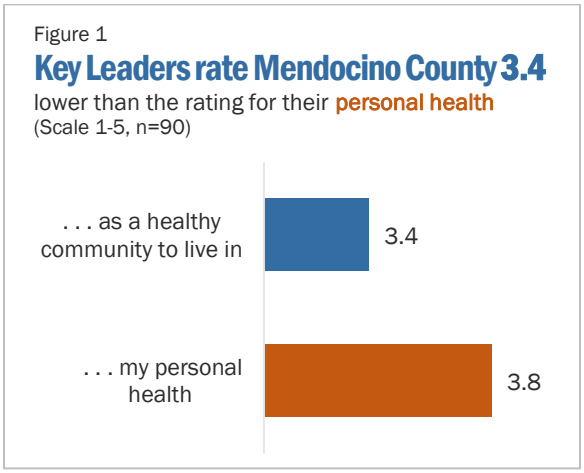
* * * * *

RESULTS

Health & Quality of Life

Key informants/respondents were asked to rate Mendocino County as **a healthy community** in which to live (Q1) and their own **personal health** (for comparison purpose only) (Q2). As Figure 1 illustrates, key leaders rated Mendocino County 3.4 as a healthy community to live in, lower than their own personal health.

Figure 1



Ratings regarding community health ranged from a low of 1 to a high of 5 (*Very Unhealthy* to *Very Healthy*) for the county as a whole. Comments from informants included the following:

→ *"There are so many outdoor activities. It's not like a big city. The beaches here are for exploring . . . and there are gardens and orchards throughout the county that encourage people to do things outside."* (Rating: 5, *Very Healthy.*)

→ *"There are a lot of activities and ways to be active in a healthy lifestyle [in Mendocino County], but it is obvious that there are many of us that live very unhealthy lifestyles. Some examples: alcohol/drugs, diabetes/obesity, the health and wellness of our children, marijuana use. Healthy lifestyles don't seem to be culturally embedded in this community."* (Rating: 3, *Somewhat Healthy.*)

→ *"I would say that the physical environment – the air quality, water quality, that sort of thing is good. But because of poverty, because of the geographical distances, the drug and alcohol issues, some of the violence issues, you get to the social determinants of health and these issues bring the score down."* (Rating: 3, *Somewhat Healthy.*)

The rating of 3.4 is consistent with the 2015 CHNA process during which key leaders were also interviewed and surveyed, as well as with

the results of the community health surveys in 2015 and 2019.

Safety

When it comes to Mendocino County as **a safe place** to grow up and raise children, key informants gave the county an overall score of 3.7, on a scale of 1 to 5.

3.7
On a scale of 1 to 5

Ratings from respondents regarding safety ranged from a low of 1 to a high of 5 *(Very Unsafe* to *Very Safe*) for the county as a whole. Comments from informants included the following:

→ *"Compared to other places, we are very safe. We have real crime issues, but not like in other areas. We have a drug problem like everywhere, but safety for kids is good. It is worse out in other areas."* (Rating: 5, *Very Safe.*)

→ *" . . . raised two children here [and have] intimate connections between families. . . . small town feel."* (Rating of 5, *Very Safe.*)

→ *"Have heard that there is a high rate of drug and alcohol use. There are many rural, isolated areas where anything can happen without it necessarily being noticed. Kids are probably pretty safe walking on the street, but there are other dangers."* (Rating: 3, *Somewhat Safe.*)

→ *"Homeless people are living under the creek in my neighborhood and I am not sure if they have mental health issues or not. There is a lack of infrastructure and I think there isn't enough lighting or sidewalks on the street in south Ukiah where I live."* (Rating: 3, *Somewhat Safe.*)

Key leaders were not asked to rate safety during the 2015 CHNA process so a comparison cannot be made here. However, the rating of 3.7 is consistent with the results of the 2015 and 2019 community health survey.

Factors That Make Mendocino County
A Good Place to Live

In addition to being asked to rate Mendocino County as a healthy community, key leaders were asked to identify the three most important factors that make Mendocino County **a good place to live** (Q4). The top four characteristics identified were as follows (Figure 2):

1. **Nature/environment**
2. **Community involvement**
3. **Clean environment**
4. **Parks and recreation**

Comments from informants regarding these areas included the following:

→ *"We have a rural area that is very conducive to our well-being. We have open spaces and parks and murals."*

→ *"In terms of community involvement, it seemed to me that when there are problems, the community comes together and helps each other."*

→ *"There is engagement and people involved and interested in the community. I see a lot of fundraisers and financial support for non-profits and organizations. I am impressed with how much folks are involved and supportive."*

→ *"As a Hispanic person I believe there is more inclusion here because it is a small community. People get to know each other; their kids play sports together. They get to know who you really are, know you as a person and appreciate you."*

The first three characteristics identified by key leaders were the same as the top three characteristics identified in the 2019 community health survey.

Figure 2

What makes Mendocino County a good place to live?

Responses from key leaders in Mendocino County, n=90.

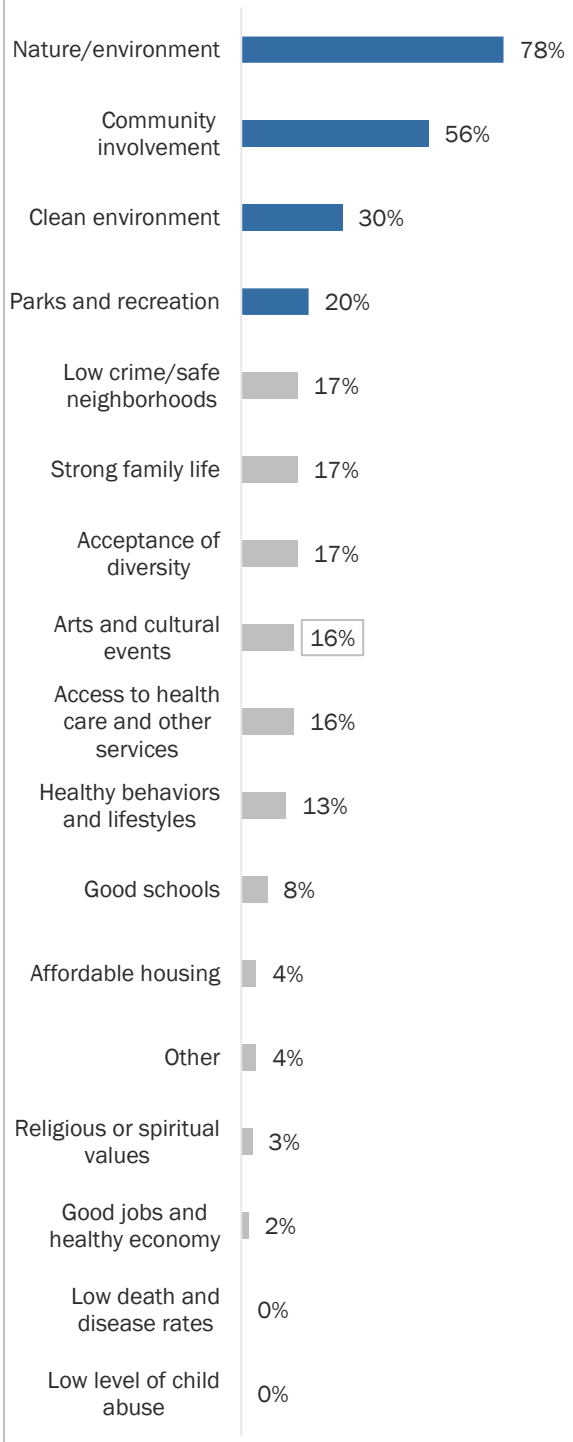
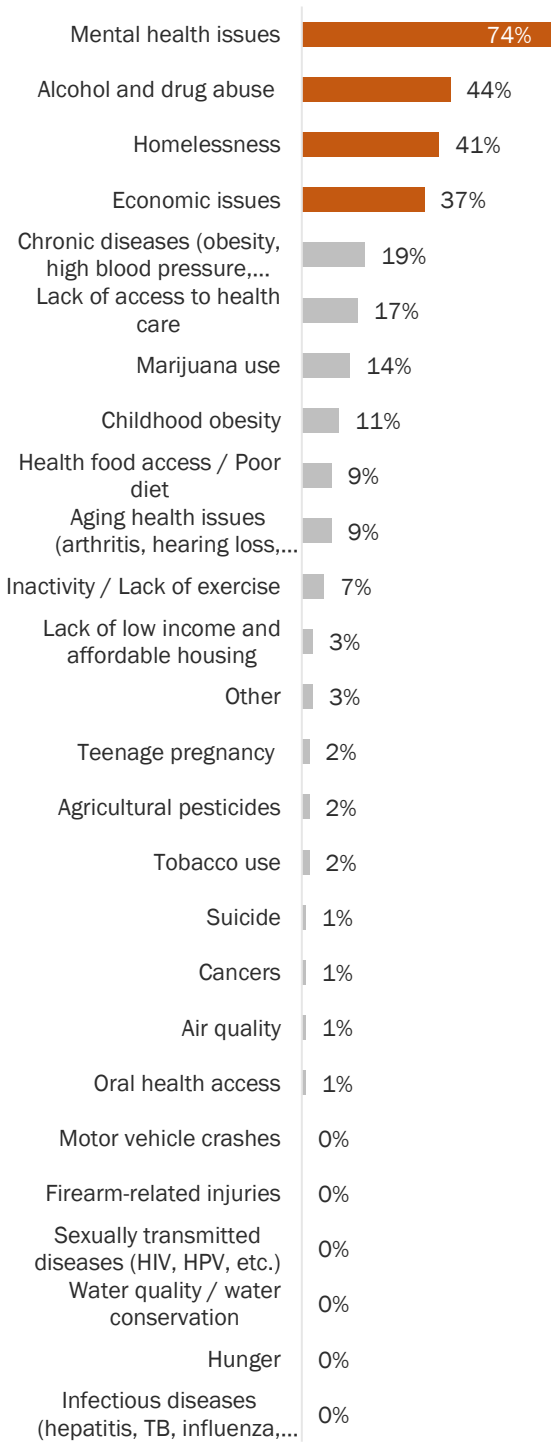


Figure 3

What are the most important health problems in Mendocino County?

Responses from key leaders in Mendocino County, n=90.



Most Important Health Problems

As shown in Figure 3 on the previous page, key leaders were asked to identify the **most important health problems** in Mendocino County (Q5). The top four issues identified were:

1. **Mental health issues**
2. **Alcohol and drug abuse**
3. **Homelessness**
4. **Economic issues**

Comments from informants regarding these areas included the following:

→ *"I had an employee who had a schizophrenic episode and had to wait 2 months to get help – there weren't services for the employee or for me as an employer to support my employee."*

→ *My rankings are formulated due to my view through the lens of a non-profit director. When people begin to recover [from alcohol, tobacco and other drug abuse], there are too few appropriate jobs . . . and a lack of affordable housing.*

→ *"I think addressing our economic issues, by bringing in more jobs, addressing poverty and providing more opportunities for people is probably the most important, and the key to [addressing mental health issues and homelessness]. I think poverty contributes to homelessness and mental health issues, as well. So addressing that can lead to addressing these two as well [as some of the other issues in the county] . . ."*

Note that the top four health problems identified by key leaders are the same four health problems identified by community members in the 2019 community health survey.

Most Significant Barriers to Addressing These Problems

Key informants were asked to identify, overall, what are the **most significant challenges or barriers** (Q6) to addressing the most important health problems identified in the previous section. The top six issues identified by informants are:

1. **Lack of funding** to support infrastructure and programs
2. **Lack of affordable housing,** particularly for the mentally ill and homeless
3. The **need for mental health services exceeds the capacity** of the current system
4. **Duplication of effort** among local agencies and nonprofits
5. The **pervasiveness of the drug culture** and widespread acceptability of marijuana
6. The **current state of the economy**, overall.

These barriers, and their relationship to the most important health problems described at left, are defined in more detail in the next section. Also included are approaches suggested by informants, challenges and barriers to overcoming these health problems, assets in the community that can be leveraged, and sample quotes from the interviews.

Table 1. The Top Four Most Important Health Problems in Mendocino County Identified by Key Leaders/Informants, n=34.

Suggested Approaches, Challenges/Barriers, Assets and Sample Quotes.

SUGGESTED APPROACHES	CHALLENGES/BARRIERS	ASSETS/ FACILITATORS	SAMPLE QUOTES
1. Mental Health			
Coordinate and combine services Increase information given to the community Mental health and substance abuse safety net for low income people Coordinate priorities with Healthy Mendocino and healthcare providers Embed mental health supports into non-profits	The Mental Health System of Care is difficult to navigate Mental illness is often combined with alcohol/ drugs/homelessness Lack of coordination of care Stigma – beliefs about who deserves care Capacity of system – too many vacancies in behavioral health. Issues in attracting and keeping trained providers due to housing costs and low wages.	Measure B – needs persistent public scrutiny and participation to make sure it goes towards a robust continuum of care Redwood Community Services– lots of engagement with Mental Health and homelessness Innovations Project at IHC – build a layer of trust	*"Combining services to prevent duplication of services and waste of resources."* *"Get them to buy into a collaborative framework with outside forces, in a positive, forward thinking way."* *"It is hard to know who is responsible for what. The public goes to law enforcement first to fix problems instead of to the agencies that are responsible."*
2. Alcohol & Drug Abuse			
Preventative education needs to start at an earlier age Treatment needs to address entire family Provide alternate activities Need a good case management system	Widespread acceptability Overlap of existing services limiting effectiveness of current funding Shortage of funding and staff causes more reactive approach and less prevention	Prop 64 – funding for communities impacted by drug war HUD/Ford Street – expand treatment and recovery services	*"Develop core teams, systems thinking, to better get and retain funding in a collaborative manner."* *"Drug use is subject to generational patterns and there are few treatment programs."*
3. Homelessness			
Create more affordable housing inventory Address underlying causes on an individual basis Progressive co-housing projects as in surrounding areas Regulations needed for low income housing	Lack of funding Need more coordination with mental health, and alcohol and drug abuse programs Homelessness is showing up as trespass, theft and an adverse environmental impact – empathy is turning into frustration Overregulation at the county limiting home construction	Government – County to lead Large businesses and non-profits to invest in building community Redwood Community Services – doing a great job running the shelter with more organized leadership	*"A vacancy tax for those with extra homes could fund homeless programs"* *"We need to prioritize dual diagnosis treatment through collaborative funding, will, and service provision."* *"Make the winter shelter year-round and leverage county property to build tiny home communities."*

SUGGESTED APPROACHES	CHALLENGES/BARRIERS	ASSETS/ FACILITATORS	SAMPLE QUOTES
4. Economic Issues			
Job creation needed Opportunities needed for those addressing other issues (drugs, homelessness)	Lack of housing for new workers Defining a strategic plan with milestones Very complex, systemic issue Gap in financial literacy	City/County partnerships are essential Non-profits – room for better coordination	*"If people are able to make a living wage, they would be able to take better care of their family's health."* *"Need innovation to come up with new ways to do things. Be creative and look for resources to bring into the county."*

ADDENDUM A

2019 Key Leader Interview Questions

1. How would you rate Mendocino County as **a healthy community** to live in? Select 1. [Please explain.]

1	2	3	4	5
Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy

2. How would you rate your **own personal health**? Select 1. [Please explain.]

1	2	3	4	5
Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy

3. How would you rate Mendocino County as **a safe place** to grow up or raise children? Select 1. [Please explain.]

1	2	3	4	5
Very Unsafe	Unsafe	Somewhat Safe	Safe	Very Safe

4. In the list below, what do you think are the **three** most important **factors** that make this county a **good place to live**? Please choose 3. [Please explain.]

a. Community involvement
b. Low crime/safe neighborhoods
c. Low level of child abuse
d. Good schools
e. Access to health care and other services
f. Parks and recreation
g. Strong family life
h. Clean environment
i. Affordable housing
j. Acceptance of diversity
k. Nature/environment
l. Good jobs and healthy economy
m. Healthy behaviors and lifestyles
n. Low death and disease rates
o. Religious or spiritual values
p. Arts and cultural events
q. Other: _____

5. In the list below, what do you think are the **three** most important **health problems** in Mendocino County? The most important health problems are those that have the greatest impact on overall community health in Mendocino County. Please choose 3. [Please explain.]

a. Motor vehicle crashes
b. Firearm-related injuries
c. Mental health issues
d. Sexually transmitted diseases (HIV, HPV, etc.)
e. Teenage pregnancy
f. Childhood obesity
g. Lack of access to health care
h. Suicide
i. Water quality / water conservation
j. Hunger
k. Health food access / Poor diet
l. Inactivity / Lack of exercise
m. Homelessness
n. Economic issues
o. Tobacco use
p. Marijuana use
q. Alcohol and drug abuse
r. Agricultural pesticides
s. Air quality
t. Chronic diseases (obesity, high blood pressure, diabetes, etc.)
u. Infectious diseases (hepatitis, TB, influenza, etc.)
v. Aging health issues (arthritis, hearing loss, isolation, etc.)
w. Oral health access
x. Cancers
y. Other:_____

6. What are the most significant challenges or barriers to addressing these issues in Mendocino County? [Probe: If so, how do you think they could be overcome?]

7. What are the opportunities or assets or facilitators in the community that could be used to address these issues? [Probe: Are there any we are not currently taking advantage of? Please be specific – people, organizations, funding sources, etc. that could be leveraged to improve community health.]

8. Are there any individuals, organizations or groups that would be influential on addressing these community health issues? [Probe: In what way? This is to ID who we could engage in helping address certain issues.]

9. Final question, if you had a magic wand, what one thing would you do to improve the health in Mendocino County?

10. Is there anything else that you would like to add?

ADDENDUM B

2019 Key Informants (n=34).

January – March 2019

Representatives of county and city government, private businesses, agriculture, cannabis, health and human services, nonprofits, social services, law enforcement, the media, community-based organizations and community leaders, race/ethnic groups, the geography of Mendocino County, among others - were targeted to participate in an interview or to complete a brief, online survey. A total of 223 key informants and key formal and informal leaders in the county were invited to participate in an in-person or by-phone interview or to complete a written survey. Of these, 34 participated in an interview and 56 completed a written survey, resulting in a total of 90 key informant/key leader participants. A list of those interviewed follows.

County & City Government

City of Ukiah – Sage Sangiacomo
City of Willits – Stephanie Garrabrani-Sierra
Mendocino County Board of Supervisors – Carre Brown
Mendocino County Board of Supervisors – Ted Williams
Community Development Commission Housing – Heather Blough
Mendocino County Farm Bureau – Devon Jones

Education

Mendocino County Office of Education – Michelle Hutchins
Tribal Early Childhood Education Programs – Joleen Whipple

Health Care

Adventist Health Ukiah Valley & Howard Memorial – Jason Wells
Dharma Realm Buddhist University/City of Ten Thousand Buddhas – Donna Farmer, FNP
Long Valley Health Center – Rod Grainger
Mendocino Coast Clinics – Lucresha Renteria
Mendocino Community Health Clinic – Stephanie Ouellette
Round Valley Indian Health Center – Julia Russ

Health & Human Services

Cancer Resource Centers of Mendocino County – Karen Oslund
Ford Street Project, Continuum of Care, Homeless – Jacque Williams
Manzanita Services – Wynd Novotny
Mendocino County Health & Human Services Agency – Dr. Gary Pace, County Health Officer
Mendocino County Health & Human Services Agency – Tammy Moss Chandler

Law Enforcement

Ukiah Police Department – Justin Wyatt

Nonprofits & Community-Based-Organizations

Action Network – Javier Chavez
Community Foundation of Mendocino County – Michelle Rich
Economic Development Finance Corp. – Heather Guerwitz
Fort Bragg Latino Coalition – Bob Rodriguez
Laytonville Healthy Start Family Resource Center – Jayma Spence
Leadership Mendocino – Heidi Dickerson
Plowshares Peace & Justice Center – Traci Boyl
Round Valley Family Resource Center – Joel Merrifield
Redwood Quality Management – Tim Schrader
Spanish Language HEP Mendo – Jackeline Gonzalez de Orozco

Private Business & Agriculture

Flow Kana – Amanda Reiman
Live Power Farm – Gloria Decater
Magruder Ranch – Grace Magruder
Nelson Family Vineyards – Tyler Nelson

ADDENDUM C

2019 Key Leader Survey Questions

1. How would you rate Mendocino County as **a healthy community** to live in? Select 1.

1	2	3	4	5
Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy

2. How would you rate your **own personal health**? Select 1.

1	2	3	4	5
Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy

3. How would you rate Mendocino County as **a safe place** to grow up or raise children? Select 1.

1	2	3	4	5
Very Unsafe	Unsafe	Somewhat Safe	Safe	Very Safe

4. In the list below, what do you think are the **three** most important **factors** that make this county a **good place to live**? Please choose 3.

a. Community involvement
b. Low crime/safe neighborhoods
c. Low level of child abuse
d. Good schools
e. Access to health care and other services
f. Parks and recreation
g. Strong family life
h. Clean environment
i. Affordable housing
j. Acceptance of diversity
k. Nature/environment
l. Good jobs and healthy economy
m. Healthy behaviors and lifestyles
n. Low death and disease rates
o. Religious or spiritual values
p. Arts and cultural events
q. Other: _____

5. In the list below, what do you think are the **three** most important **health problems** in Mendocino County? The most important health problems are those that have the greatest impact on overall community health in Mendocino County. Please choose 3.

a. Motor vehicle crashes
b. Firearm-related injuries
c. Mental health issues
d. Sexually transmitted diseases (HIV, HPV, etc.)
e. Teenage pregnancy
f. Childhood obesity
g. Lack of access to health care
h. Suicide
i. Water quality / water conservation
j. Hunger
k. Health food access / Poor diet
l. Inactivity / Lack of exercise
m. Homelessness
n. Economic issues
o. Tobacco use
p. Marijuana use
q. Alcohol and drug abuse
r. Agricultural pesticides
s. Air quality
t. Chronic diseases (obesity, high blood pressure, diabetes, etc.)
u. Infectious diseases (hepatitis, TB, influenza, etc.)
v. Aging health issues (arthritis, hearing loss, isolation, etc.)
w. Oral health access
x. Cancers
y. Other:_____

ADDENDUM D

2019 Key Leader Survey Results (n=90).

February 2019

	Very Unhealthy		Unhealthy		Somewhat Healthy		Healthy		Very Healthy		FREQ	%	Avg.
1. How would you rate Mendocino County as a healthy community to live in?	1	1.1%	3	3.3%	**50**	**55.6%**	33	36.7%	3	3.3%	**90**	**100.0%**	3.4
2. How would you rate your own personal health?	0	0.0%	6	6.7%	25	27.8%	**41**	**45.6%**	18	20.0%	**90**	**100.0%**	3.8

	Very Unsafe		Unsafe		Somewhat Safe		Safe		Very Safe				
3. How would you rate Mendocino County as a safe place to grow up or raise children?	1	1.1%	2	2.2%	32	35.6%	42	46.7%	13	14.4%	**90**	**100.0%**	3.7

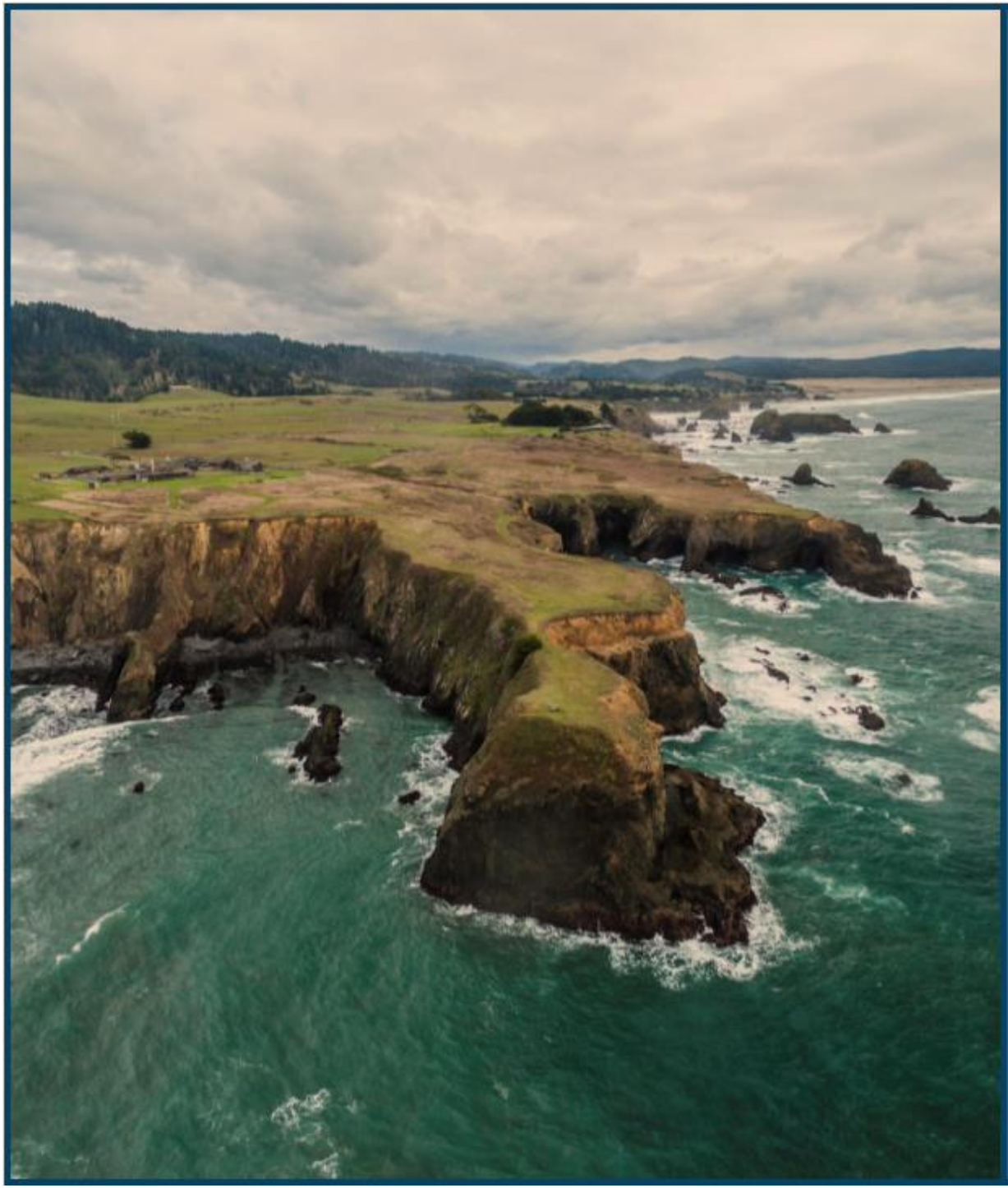
4. In the list below, what do you think are the three most important factors that make this county a good place to live? Please choose 3.

a. Community involvement	**50**	**55.6%**
b. Low crime/safe neighborhoods	15	16.7%
c. Low level of child abuse	0	0.0%
d. Good schools	7	7.8%
e. Access to health care and other services	14	15.6%
f. Parks and recreation	18	20.0%
g. Strong family life	15	16.7%
h. Clean environment	**27**	**30.0%**
i. Affordable housing	4	4.4%
j. Acceptance of diversity	15	16.7%
k. Nature/environment	**70**	**77.8%**
l. Good jobs and healthy economy	2	2.2%
m. Healthy behaviors and lifestyles	12	13.3%
n. Low death and disease rates	0	0.0%
o. Religious or spiritual values	3	3.3%
p. Arts and cultural events	14	15.6%
q. Other	4	4.4%
Total (n=90)	**270**	

5. In the list below, what do you think are the three most important health problems in Mendocino County? The most important health problems are those that have the greatest impact on overall community health in Mendocino County. Please choose 3.

a. Motor vehicle crashes	0	0.0%
b. Firearm-related injuries	0	0.0%
c. Mental health issues	**67**	**74.4%**
d. Sexually transmitted diseases (HIV, HPV, etc.)	0	0.0%
e. Teenage pregnancy	2	2.2%

	FREQ	%
f. Childhood obesity	10	11.1%
g. Lack of access to health care	15	16.7%
h. Suicide	1	1.1%
i. Water quality / water conservation	0	0.0%
j. Hunger	0	0.0%
k. Health food access / Poor diet	8	8.9%
l. Inactivity / Lack of exercise	6	6.7%
m. Homelessness	**37**	**41.1%**
n. Economic issues	**33**	**36.7%**
o. Tobacco use	2	2.2%
p. Marijuana use	13	14.4%
q. Alcohol and drug abuse	**40**	**44.4%**
r. Agricultural pesticides	2	2.2%
s. Air quality	1	1.1%
t. Chronic diseases (obesity, high blood pressure, diabetes, etc.)	17	18.9%
u. Infectious diseases (hepatitis, TB, influenza, etc.)	0	0.0%
v. Aging health issues (arthritis, hearing loss, isolation, etc.)	8	8.9%
w. Oral health access	1	1.1%
x. Cancers	1	1.1%
y. Lack of low income and affordable housing	3	3.3%
z. Other	3	3.3%
Total (n=90)	**270**	



2019 Mendocino County Community Health Needs Assessment

APPENDIX C

Community Health Status Assessment

October 2019

TABLE OF CONTENTS

Community Health Status Assessment

Results

Sources

Addendum

Cover Photo credit Brendan McGuigan

COMMUNITY HEALTH STATUS ASSESSMENT

Introduction

The Community Health Status Assessment (CHSA) is a method of reviewing key data indicators that answer the questions, "How healthy are our residents?" and "What does the health status of our community look like?" The CHSA is one data-gathering component of the 2019 Mendocino County Community Health Needs Assessment (CHNA).

The 2019 CHNA is sponsored by a coalition of local organizations and agencies: Adventist Health Howard Memorial, Adventist Health Ukiah Valley, Alliance for Rural Community Health & Community Health Resource Network, Community Foundation of Mendocino County, FIRST 5 Mendocino, Healthy Mendocino, Mendocino Community Health Clinics, Mendocino County Health & Human Services Agency, Public Health Branch, Mendocino County Office of Education, North Coast Opportunities, Partnership HealthPlan of California, Redwood Community Services, Inc., Redwood Quality Management Company, and United Way of the Wine Country. The CHNA is a project of Healthy Mendocino, which facilitated the Planning Group.

The CHSA report highlights key data indicators organized into broad-based categories related to health and well-being.

The data categories included in this CHSA are as follows:

- Socioeconomic Characteristics
- Social Determinants of Health
- Behavioral Risk Factors
- Maternal Child and Adolescent Health
- Healthcare and Preventive Services
- Hospitalization and Emergency Room Utilization
- Dental Health
- Illness, Injury and Deaths

The remaining indicators are displayed in a data book as an addendum to this report.

Methodology and Limitations

The findings presented in this report highlight issues that impact the health status of the people of Mendocino County. The information comes from a variety of sources and is organized on the Healthy Mendocino website http://www.healthymendocino.org/.

The Healthy Mendocino website is produced in partnership between Mendocino County and the Conduent Healthy Communities Institute (HCI). Conduent HCI is a network of researchers, public health technology specialists, epidemiologists and public administrators, working to provide communities with easy to understand data, best practices, and funding source information to

drive community health improvement. The Healthy Mendocino website provides statistical indicators for 203 key subjects that describe aspects of the population used to measure health, environmental quality and quality of life. Indicators may include measurements of illness and disease, environmental and economic indicators, as well as behaviors and actions related to health.

Data found on the site comes from a variety of sources, including the National Cancer Institute, the Centers for Disease Control, the American Community Survey, the Census Bureau, Department of Justice, and other state-specific sources listed on the Healthy Mendocino website. (http://www.healthymendocino.org*)* Data is presented with comparisons to other California counties, along with averages for local or national values, changes over time and target goals for health outcomes from Healthy People 2020. (http://www.healthypeople.gov*)*

Reviewing key indicators on the Healthy Mendocino website that are highlighted in red, allows us to see at a glance areas of possible improvement to the health of the community. This report focuses on key subjects with values less than the state averages, or ones that fail to meet the Healthy People 2020 objectives. These are areas where there are disparities in obtaining health care, increased incidence of illness, behavioral practices that negatively affect one's health, and/or societal determinants such as low employment or lack of transportation that adversely affect the health of a community.

The aim of statistical testing is to uncover significant differences. When using statistical measures, the larger the sample size the more certain researchers can be that the sample reliably reflects the population mean. However, smaller sample sizes can still detect differences across populations. In cases where the data reflects smaller sample sizes, we have added the notation that values may be statistically unstable and should be interpreted with caution. At the end of this report is a table of indicators that contains the statistics for Mendocino County and the corresponding values for the State and the U.S.

RESULTS

Demographic Information

Mendocino County Demographic Profile	Mendocino	California
Population, 2018	87,580	39,964,848
Population, 2010 (April 1 estimates)	87,841	37,254,503
Population, percent change - 2010 to 2019	>1%	7%
Persons under 5 years, percent	5.9%	6.2%
Persons under 17 years, percent	15.6%	16.6%
Persons 65 years and over, percent	21.7%	14.5%
Female persons, percent	50.3%	50.3%
Ethnicity, percent, 2019		
White alone, percent (a)	73.2%	54.7%
Black or African American alone (a)	0.8%	5.8%
American Indian and Alaska Native alone (a)	5.1%	0.97%
Asian alone (a)	2.0%	14.8%
Native Hawaiian and Other Pacific Islander alone (a)	0.2%	0.4%
Persons reporting two or more Races	22.9%	23.18%
Hispanic or Latino, percent (b)	26.1%	39.5%
Foreign born persons, percent, 2017	13.0%	27.00%
Language other than English spoken at home, percent of persons age 5+, 2010-2017	21.20%	44.00%
High school graduate or higher, percent of persons age 25+, 2010-2017	85.50%	86.90%
Bachelor's degree or higher, percent of persons age 25+, 2010-2017	32.60%	24.80%
Veterans, 2010-2017	6,357	1,661,433
Mean travel time to work (minutes), workers age 16+, 2010-2017	18.6	27.2

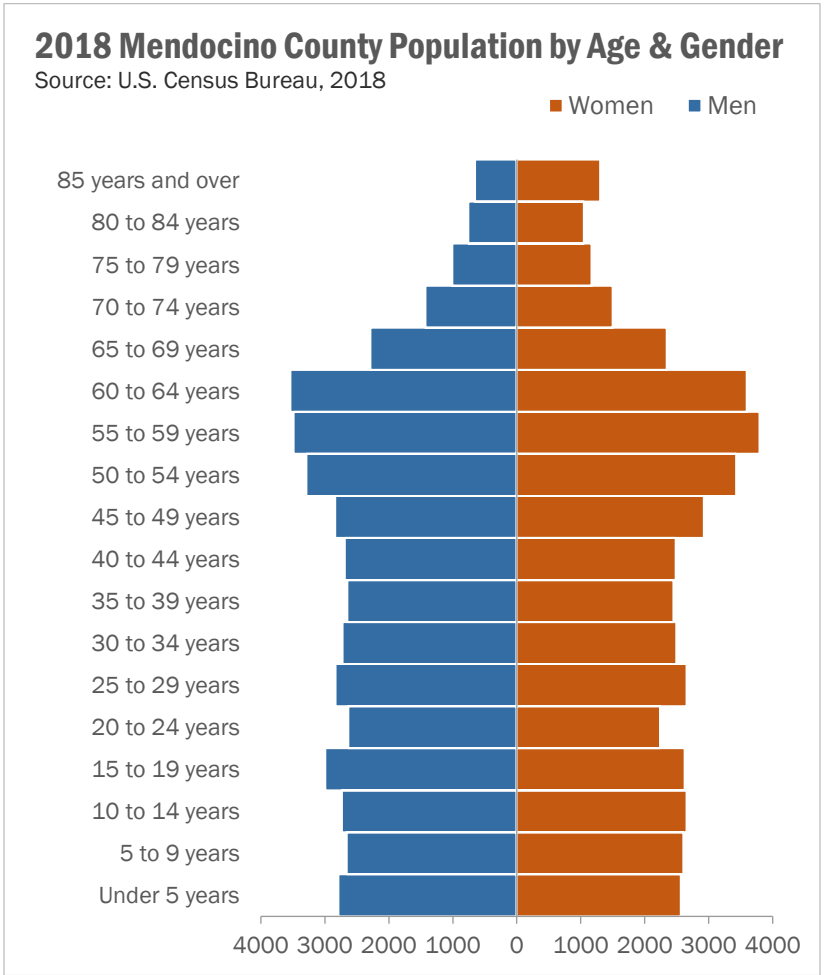
Mendocino County Demographic Profile	Mendocino	California
Housing units, 2017	41,107	14,176,670
Homeownership rate, 2009-2013	54.50%	59.20%
Housing units in multi-unit structures, percent, 2009-2013	12.50%	31.00%
Median value of owner-occupied housing units, 2013-2017	$338,000	$443,400
Households, 2013-2017	34,182	12,888,128
Persons per household, 2013-2017	2.50	2.96
Per capita money income in past 12 months (2017 dollars), 2013-2017	$27,093	$33,128
Median household income, 2009-2013	$46,528	$67,169
Persons below poverty level, percent, 2013-2017	16.3%	13.3%
Land area in square miles, 2010	3,506.34	155,779.22
Persons per square mile, 2010	25.1	239.1

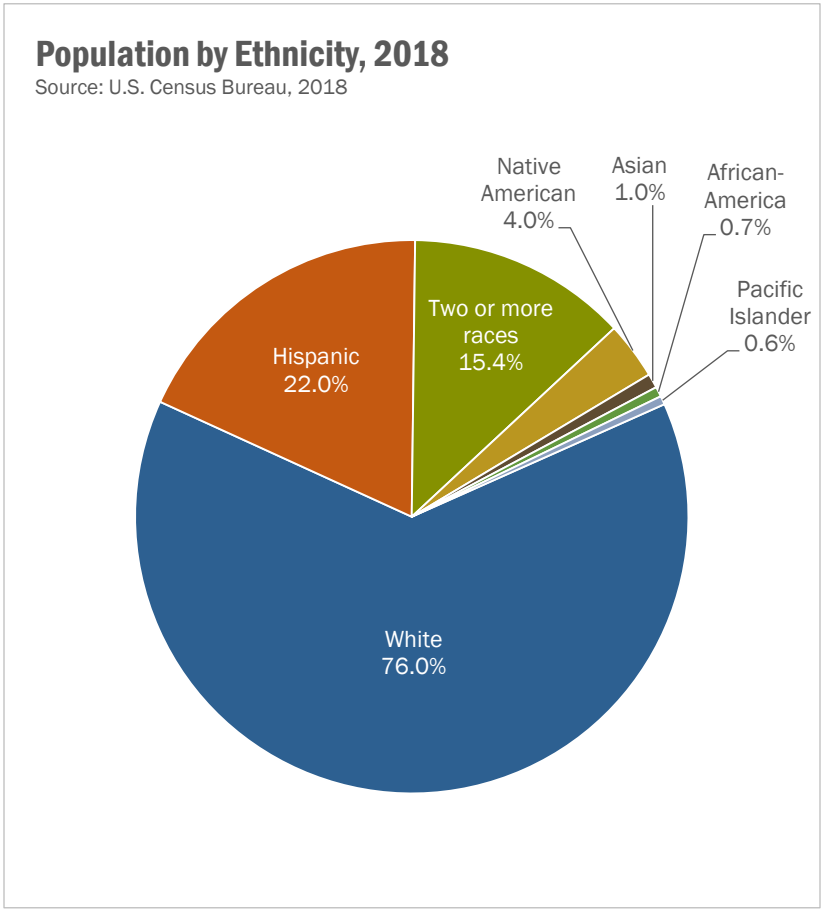
Data Source: Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits(a) Includes persons reporting only one race. (b) Hispanics may be of any race, so also are included in applicable race categories.

Socioeconomic Characteristics

Mendocino County is a rural county in Northern California with a land area of 3,509 square miles. The estimated population in 2018 was 87,580. Slightly over one-half (55%) of the population live in urban areas, while 45% live in rural communities, farms or ranches.

The population pyramid clearly shows the "Baby Boomer" demographic aging into their 50's to 60's. Mendocino County has a slightly older median age of 42.3 years, compared with California's median age of 36.4 years.





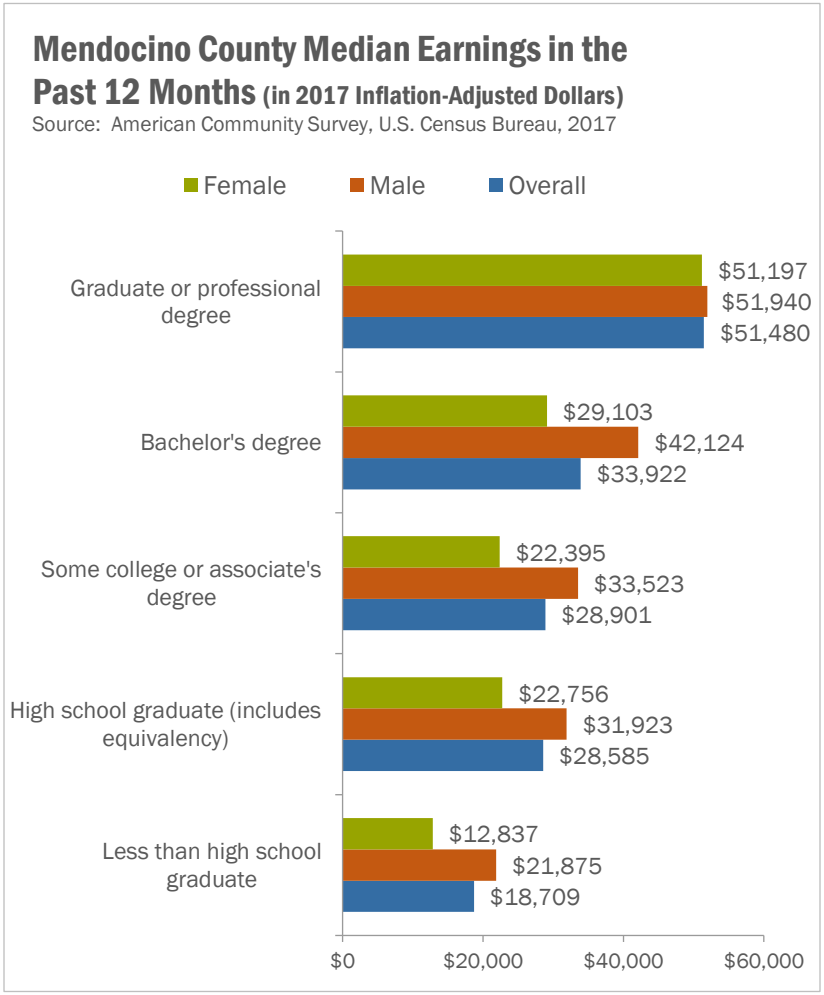
Population of Mendocino County below Federal Poverty Level, 2018*

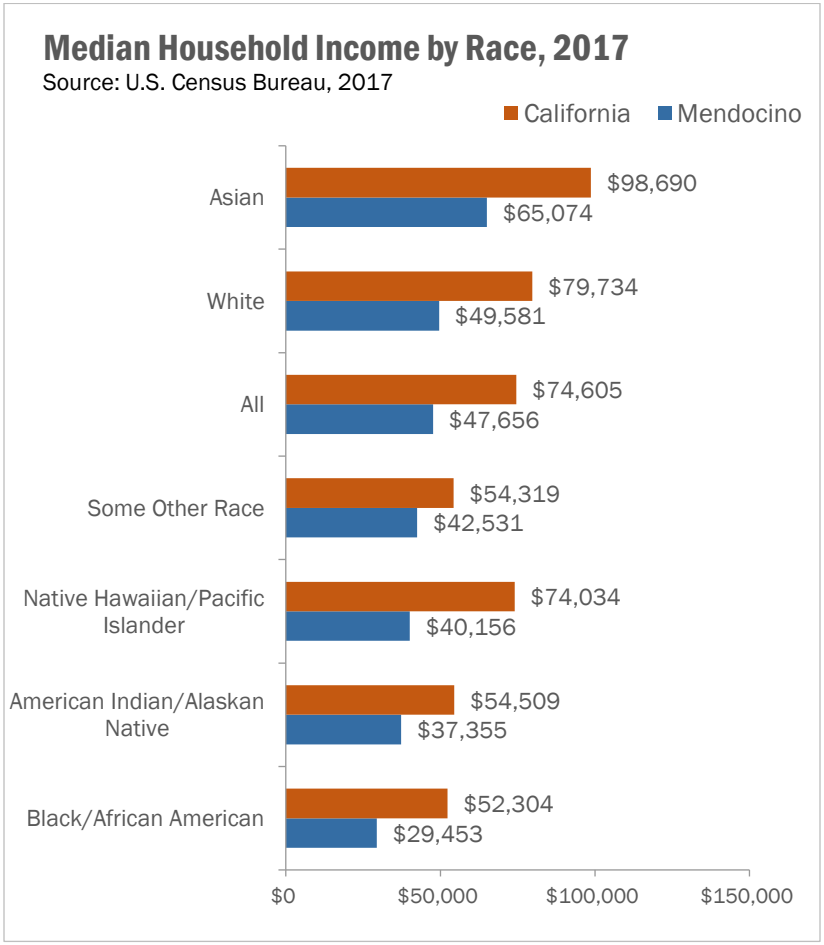
*(In 2018, the Federal Poverty Level for individuals was calculated as a single person living on less than $12,140 per year, and a family of four with income less than $25,100.)
Data Source: U.S. Census Bureau, 2013-2018 American Community Survey 5-Year Estimates

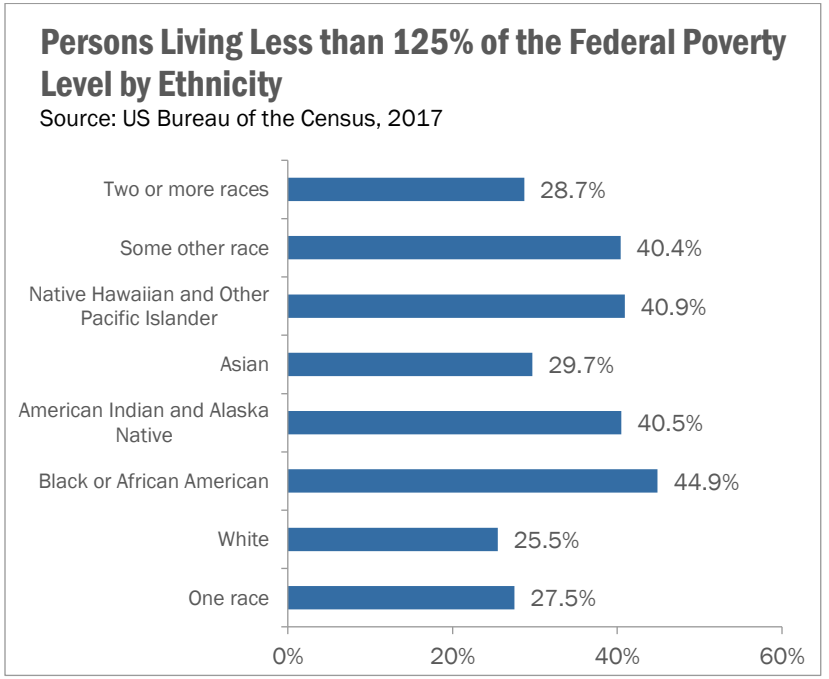
Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. The percentage of the population with incomes below 200% of the Federal Poverty Level (FPL) in 2018 was about 17% for men, and 21% for women. When categorized by race/ethnicity, 42% of African Americans living in Mendocino County in 2018 had incomes below 200% of the FPL, followed by Hispanic or Latinx 27%, Native Americans 25%, Caucasians 15%, Asians 14%, and Pacific Islanders 14%. For the years 2012 to 2016, 9% of people over 65 years were living below the FPL; 15% of families, and 24% of children.

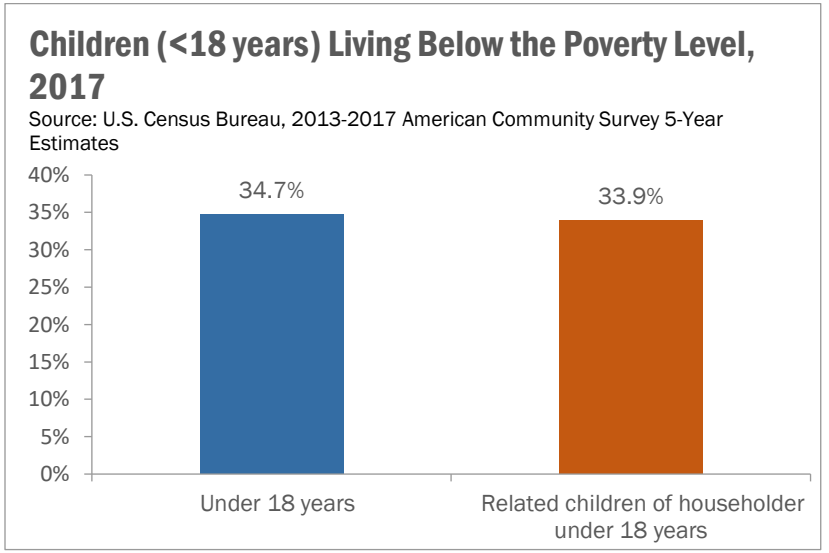
People living in poverty have poorer health outcomes. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival. Nineteen percent of those whose income fell below the FPL worked either full or part-time during the 12 months of 2017. Educational achievement is closely associated with higher earning power. Twenty-five percent of those whose incomes fell below the FPL had less than a high school education in 2017.

The previous CHNA identified the issue of poverty as an area for improvement in Mendocino County. A CHIP group was formed to understand the underlying issues. The Poverty Action Team is working to create strategies to help people gain access to capital and markets, promote micro-enterprise within communities, offer classes to improve financial literacy including tax help and business planning, and promote education to learn new vocational skills.



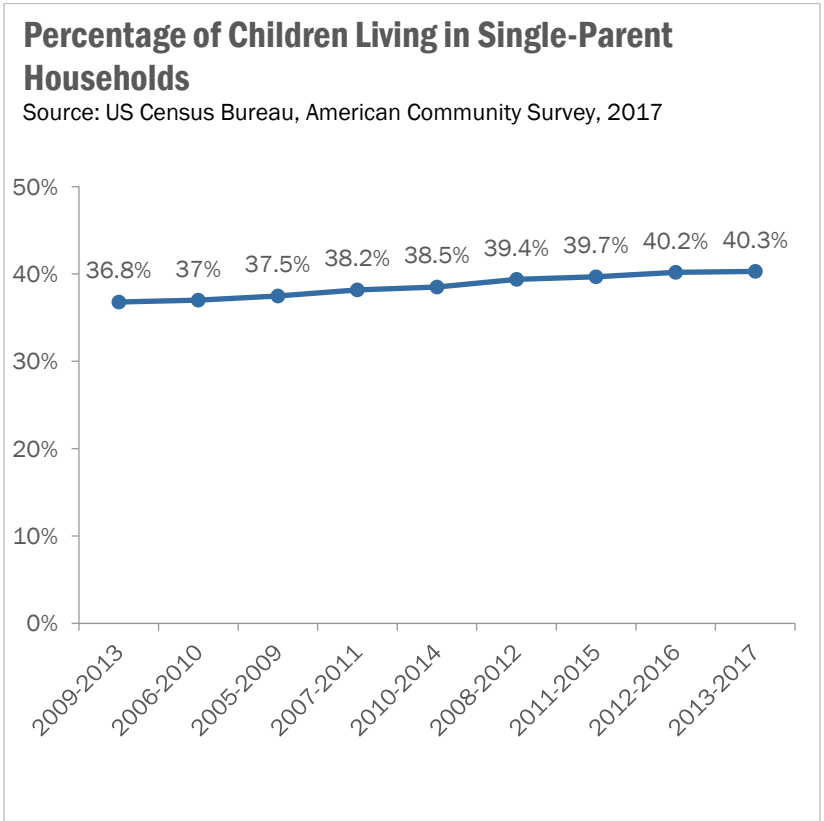


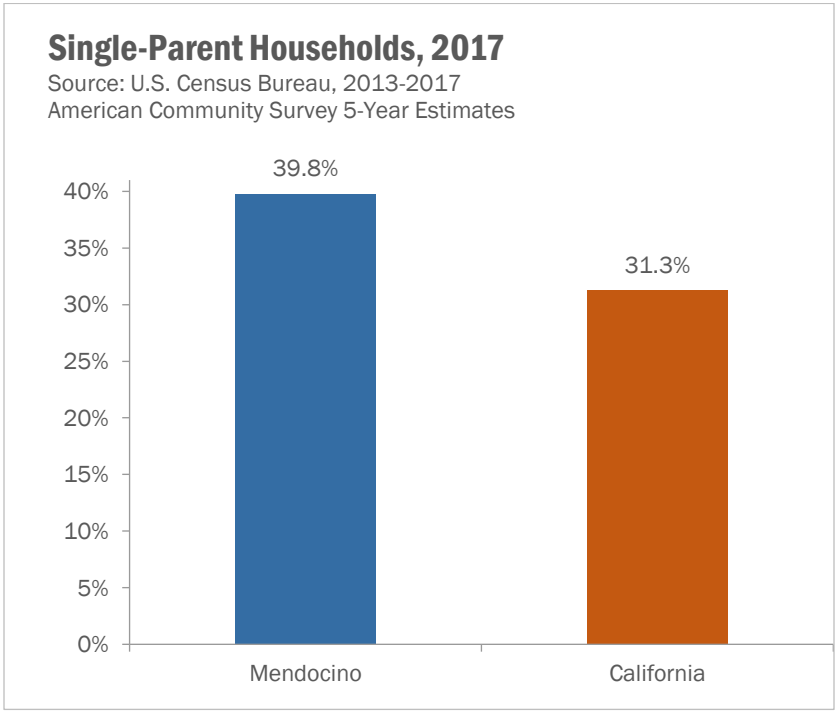




Family income has been shown to affect a child's well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems such as low birth weight or lead poisoning and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.

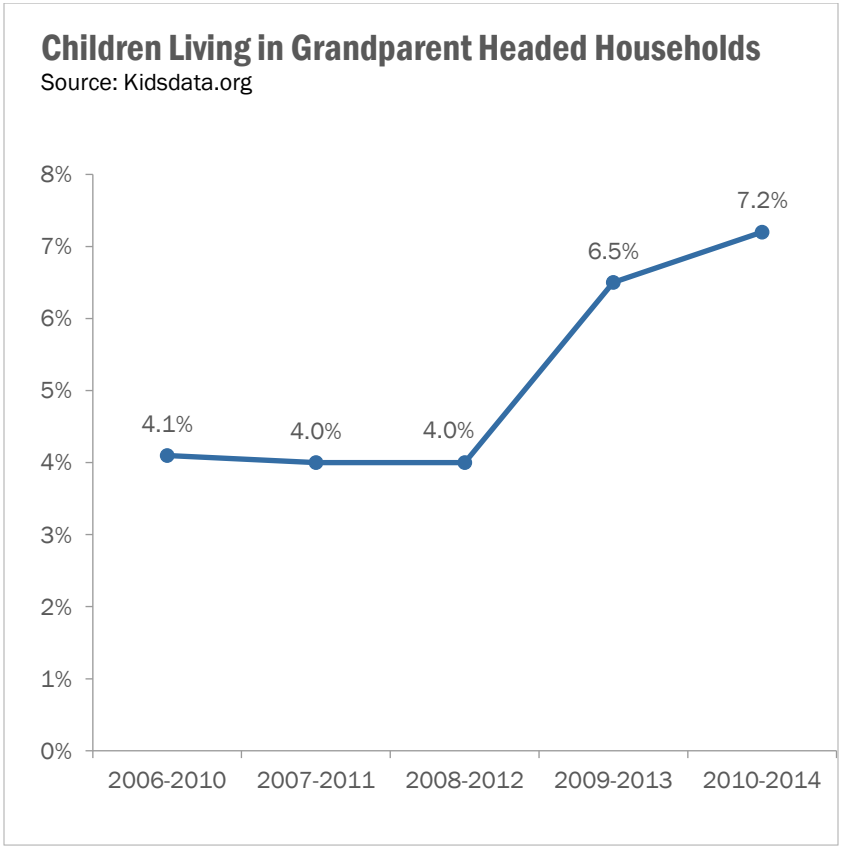
Single Parent Households, 2017





During 2017, 40% of Mendocino County households with children were headed by a single parent, compared to 31% for the State of California. Of these, 51% of single parent households in the county earned less than 125% of the FPL. Adults and children in single-parent households are at a higher risk for adverse health effects, such as emotional or behavioral problems, compared to their peers. Children in such households are more likely to develop depression, smoke, and abuse alcohol and other substances. Consequently, these children experience increased risk of morbidity and mortality of all causes. Similarly, single parents suffer from lower perceived health and higher risk of mortality.

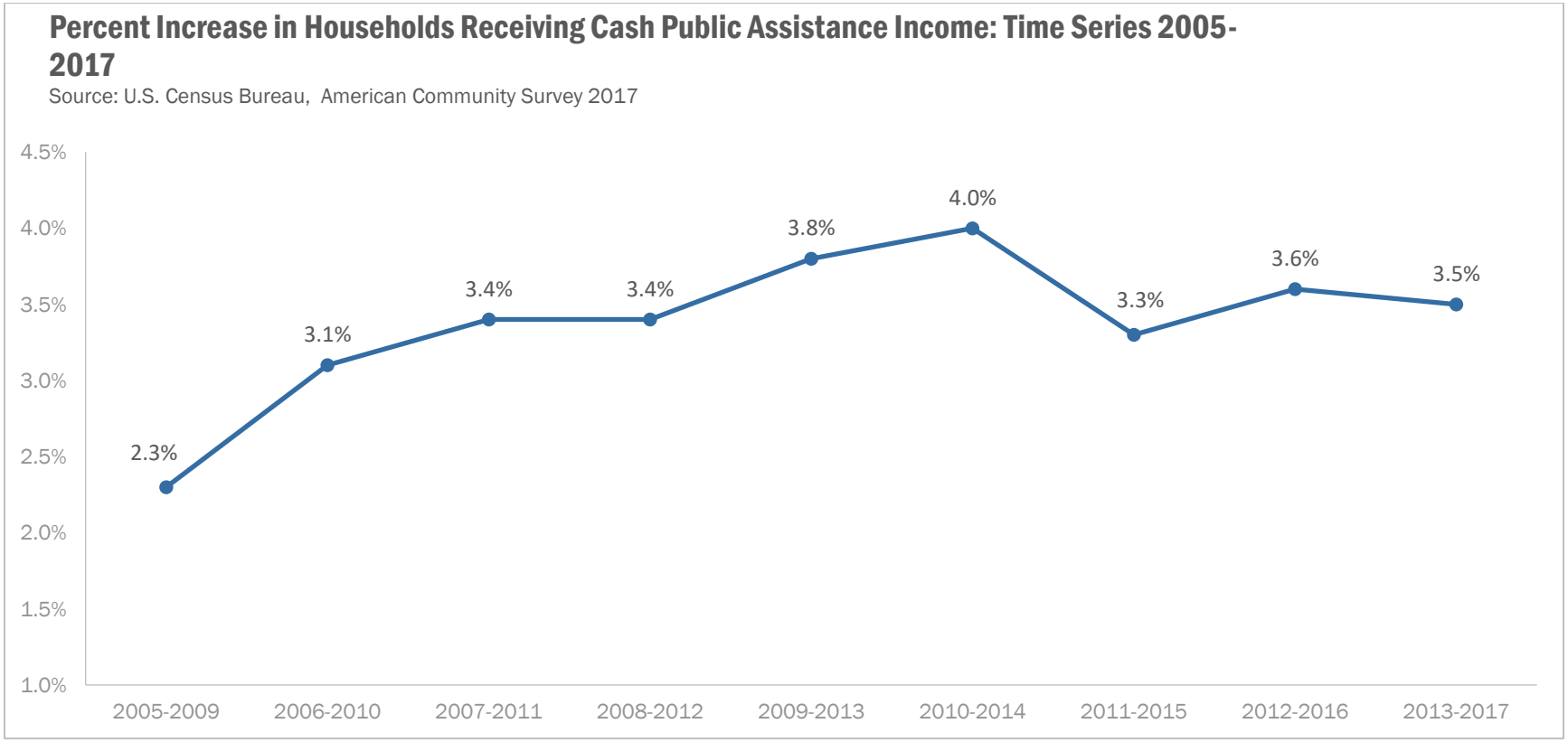
Grandparent-Headed Households Responsible for Grandchildren under 18 Years



Grandparent-headed households have disproportionately high rates of poverty. Single, older women of racial and ethnic minority groups with low educational attainment disproportionately head grandparent-headed households. Children in grandparent-headed households are especially likely to display behavioral and emotional problems because of the events leading up to the move into the grandparent's home, including economic crises, family conflict, neglect or abuse, and separation from one or both parents. High rates of attention deficit/hyperactivity disorder, depression, and anxiety have been observed in this population along with developmental, emotional, and behavioral problems often due to high rates of prenatal exposure to alcohol and other drugs in utero. Due to age and their own health status, grandparents may be less able than parents to adjust to the changing financial needs of co-resident children. Income meant to support one or two older adults suddenly must fulfill the needs of co-resident grandchildren and, in some cases, adult children. This is particularly true for those grandparents who previously exited the labor force through retirement and who rely on fixed incomes. Further, grandparents may be less able than parents to either return to work or to make adjustments in current work hours because of a greater likelihood of health limitations and disability than for parents. Such factors may inhibit the ability of caregivers in grandparent-headed households to adapt financially to the needs of co-resident children.

In Mendocino County, the number of grandparent-headed households has increased by more than 1,000 households in the five-year period between 2010 and 2014 (a 57% increase of 1,000 to 1,750).

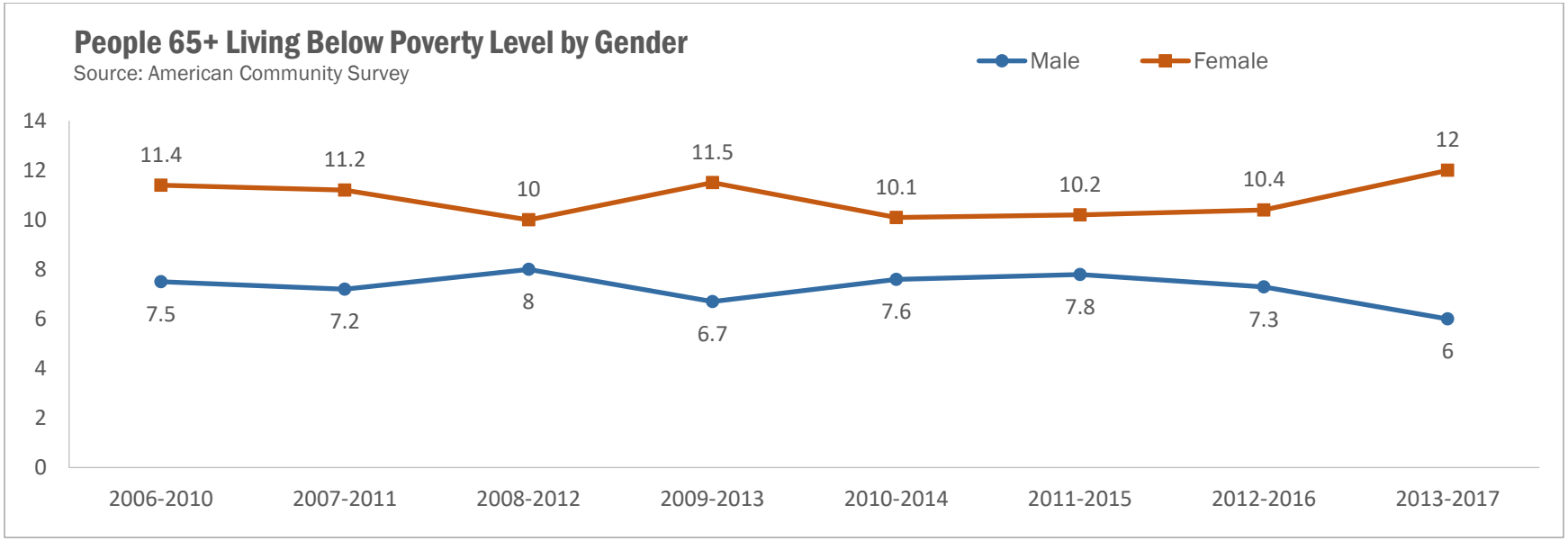
Households Receiving Cash Public Assistance



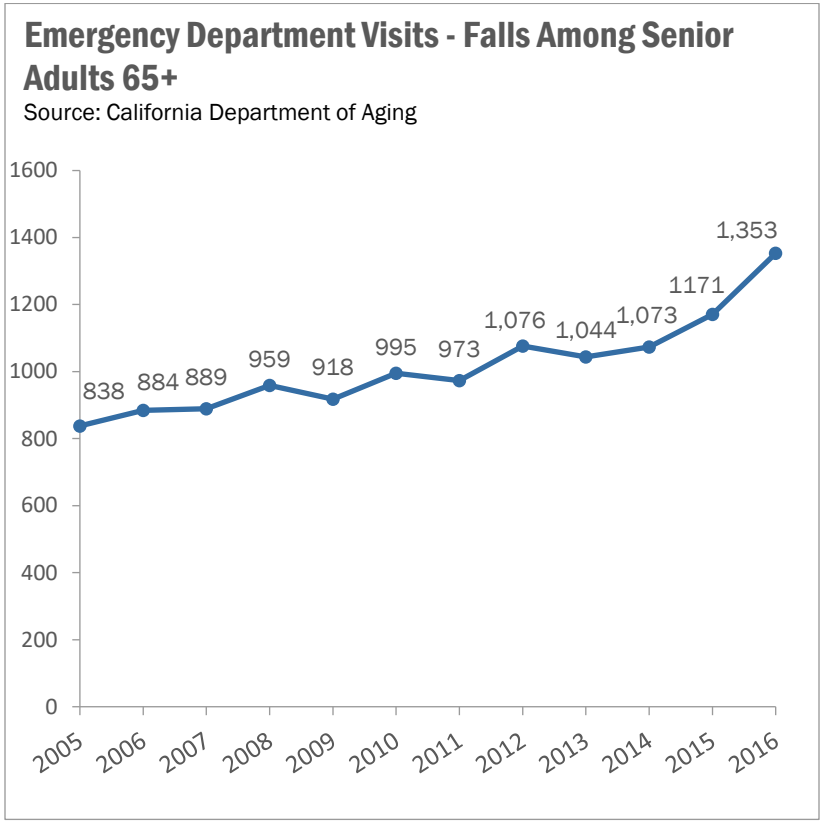
Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). It does not include Supplemental Security Income (SSI) or noncash benefits such as Food Stamps. Areas with more households on public assistance programs have higher poverty rates.

Estimates for 2013-2017 are that 3.5% of households in Mendocino County are receiving cash public assistance income, compared to the state rate of 3.6%.

Seniors



The population of people over 80 years old will increase by 206% between 2010 and 2060 making it the fastest growing demographic in Mendocino County. The American Community Survey estimates for the years 2012 to 2016, 9% of people over 65 years old in our county were living at or below the FPL for a single person. Older adults on fixed incomes struggle with rising housing costs, health care bills, inadequate nutrition, lack of transportation and isolation, diminished savings and job loss. For many older adults who are above the Federal Poverty Level, just one major adverse event can be catastrophic. Women are impacted at greater numbers because on average, they live longer than men, and women of color disproportionately feel the effects of poverty. Seniors need increasing assistance with every-day tasks, and care for the elderly falls either on family members, or on supportive care aides, responsible for an estimated 70-80% of the paid hands-on care for older adults. These are some of the lowest paid of all U.S. workers. The role of caregiver is most often held by women, and frequently creates a pathway to financial hardship later in life. The majority of caregiving is provided informally by family or friends who take extended periods of time away from work to raise children or to care for an ailing loved one. The breaks in service and limited supports available to informal caregivers produces financial strain and reduces the individual's lifetime social security earnings as well as their ability to save.



Statistics show that:

- More than 40% of people hospitalized from hip fractures do not return home and are not capable of living independently again;
- 25% of those who have fallen pass away each year;
- On average, two older adults die from fall-related injuries every day in California.

Falls can result in hip fractures, head injuries or even death. In many cases, those who have experienced a fall have a hard time recovering and their overall health deteriorates.

In California alone, 1.3 million older adults experience an injury due to falling. A person is more likely to fall if s/he is age 80 or older or if s/he has previously fallen. Over time people may feel unsteady when walking due to changes in physical abilities such as vision, hearing, sensation, and balance. People who become fearful of falling may reduce their involvement in activities. Also, the environment may be designed or arranged in a way that makes a person feel unsafe.

Studies show that balance, flexibility, and strength training not only improve mobility, but also reduce the risk of falling. Statistics show that many older adults do not exercise regularly, and 35% of people over the age of 65 do not participate in any leisure physical activity. This lack of exercise only makes it harder for individuals to recover after a fall. Many people are afraid of falling again and reduce their physical activity even more. There are many creative and low-impact forms of physical activity for fall prevention, such as tai chi.

The environment can present many hazards. At home older adults are commonly concerned about falling in the bathtub or on steps. In the community there can be trip hazards such as uneven or cracked sidewalks. By making changes to the home and community environment a person can feel safer and less at risk of falling. For example, the bathroom can be modified by installing grab bars as in the shower or tub, having a place to sit, and having non-slip surfaces. Steps can have handrails, adequate lighting, and contrast between steps. Community sidewalks in disrepair can be reported to city officials for repair.[i]

Elder Abuse and Abuse of a Dependent Adult

Abuse of an elder or a dependent adult is abuse of:

- Someone 65 years old or older; or
- A dependent adult, who is someone between 18 and 64 that has certain mental or physical disabilities that keep him or her from being able to do normal activities or protect himself or herself.

Abuse is the physical, sexual, psychological, or financial harm or neglect of older people or dependent adults who may be unable to defend or fend for themselves. The incidence of elder abuse is expected to increase as the size of the older population grows, further straining the social service and criminal justice systems charged with protecting that population. As the majority of the older adult population, women are also the most frequent targets of elder abuse and exploitation. Women are more likely to spend their last years at home as widows, if they ever married, and later will make up the majority of residents in skilled nursing or residential care. The loss of independence and autonomy that can come with diminished health or mental capacity heighten an elder's vulnerability to abuse.

In California, as well as nationally, the estimate is that one out of ten older adults living at home suffers some form of abuse, neglect or exploitation. In Mendocino County, there are approximately 17,200 residents who were 65 years or older in 2018. During FY 2014-2015 there were 637 cases of elder abuse opened by Adult Protective Services. During FY 2017-2018 there were 1,029 cases of elder abuse opened, with 129 confirmed cases of abuse of an elder, and 42 confirmed cases of abuse of a dependent adult. In 2016, the District Attorney's Office prosecuted 27 elder or dependent adult abuse cases. [ii]

Social Determinants of Health

Understanding what affects our health

Social Determinants of Health (SDOH) are social, economic, and physical conditions in the environments in which people are born, live, learn, work, play, worship and age, that affect a wide range of health, functioning, quality-of-life outcomes and risks. Resources that enhance the quality of life can have a significant influence on population health outcomes, such as safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. In addition to the material attributes of the environment, patterns of social engagement and a sense of security and well-being are affected by where people live.

Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety

- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

Examples of physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)

Differences in the health of a population are striking in communities with poor SDOH, such as unstable housing, low income, unsafe neighborhoods, or substandard education. By applying what we know about SDOH, we can not only improve individual and population health but also advance health equity. The website Healthy People 2030 (https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030) highlights the importance of addressing SDOH by including "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.

Healthy People 2030

Healthy People 2030 is a collaborative project developed under the leadership of the Federal Interagency Workgroup by the U. S. Department of Health and Human Services and other federal agencies, public stakeholders and an advisory committee. Its goals are to identify national health priorities, increase awareness of the determinants of health, provide measurable objectives and goals that are applicable to local levels in order to achieve health equity, eliminate disparities, promote healthy behaviors and improve the health of all groups.

Every decade, the Healthy People initiative develops a new set of science-based, 10-year national objectives with the goal of improving the health of all Americans. The development of Healthy People 2030 includes establishing a framework for the initiative—the vision, mission, foundational principles, plan of action, and overarching goals—and identifying new objectives.

Educational Achievement

High Quality Childcare and Early Childhood Education in Mendocino County

Research indicates that high quality childcare and early education have lasting positive effects including increased IQ scores, higher levels of behavioral and emotional functioning, school readiness, academic achievement, educational achievement including high

school graduation and higher earnings later in life. The gains are particularly pronounced for children from low-income families and those at risk for academic failure. In Mendocino County, there is an unmet demand for quality childcare. The California Child Care Resource & Referral Network estimates that in 2017, approximately 76% of the county's children ages 3-5 years old did not attend a preschool, a nursery school or Head Start program for at least 10 hours a week. In California, 77% of children did not have high quality childcare available.

The annual costs for childcare by age group and facility type, 2016

California	Amount	
	Infant	Preschooler
Child Care Center	$16,452	$11,202
Family Child Care Home	$10,609	$9,984

Mendocino County	Amount	
	Infant	Preschooler
Child Care Center	$12,508	$8,483
Family Child Care Home	$8,540	$8,043

Kindergartners with All Required Immunizations, 2016

Locations	Percent
California	92.8%
Mendocino County	87.4%

Educational Attainment Mendocino County, 2017

Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime.

Mendocino County, 2017	
Percent with an associate degree	9.20%
College Graduation Rate	22.00%
Percent with a graduate or professional degree	8.40%
High School Graduation Rate	85.20%
Percent who did not finish the 9th grade	6.90%
California, 2017	
Percent with an associate degree	7.80%
College Graduation Rate	30.70%
Percent with a graduate or professional degree	11.20%
High School Graduation Rate	81.20%
Percent who did not finish the 9th grade	10.20%

Housing and Homelessness

Housing

Mendocino County has been experiencing a housing crisis for many years, and it is being exacerbated by several factors. The Bay Area counties now have the highest housing costs in the United States, surpassing even Manhattan, NY. As rents are raised, families are being forced out and are moving to neighboring counties such as Mendocino. In 2016-2017, a series of wildfires destroyed thousands of homes across the State and in Mendocino County. Much of Mendocino is agricultural land, and either not suitable for or zoned for development. The U.S. Census Bureau estimates that over one-half of residents (52%) who rent in Mendocino County pay over a third (35%) of their total income for rent. Spending such a high percentage of household income on rent can create financial hardship and may not leave enough money for food, transportation or medical expenses. High rent also makes it difficult or impossible for families to save any of their income for future needs.

Safe and affordable housing is an essential component of healthy communities, and the effects of housing problems are widespread. Residents who do not have a kitchen in their home are more likely to depend on unhealthy convenience foods, and a lack of plumbing facilities increases the risk of infectious disease. Research has found that young children who live in crowded housing conditions are at increased risk of food insecurity, which may impede their academic performance. In areas where housing costs are high, low-income residents may be forced into substandard living conditions with an increased exposure to mold and mildew growth, pest infestation, and lead or other environmental hazards.

The CHIP Housing Action Team, which was formed as a response to the lack of housing, has been working with developers, city and county officials, and members of the community to identify solutions to this crisis. As a result of these efforts, new housing developments for both low- and middle-income families and farm labor families are being constructed across the county. Some of the cities have adopted ordinances to allow for additional units to be built in existing homes. In addition, a new housing development for people with mental or physical disabilities has opened in Ukiah.

Homelessness

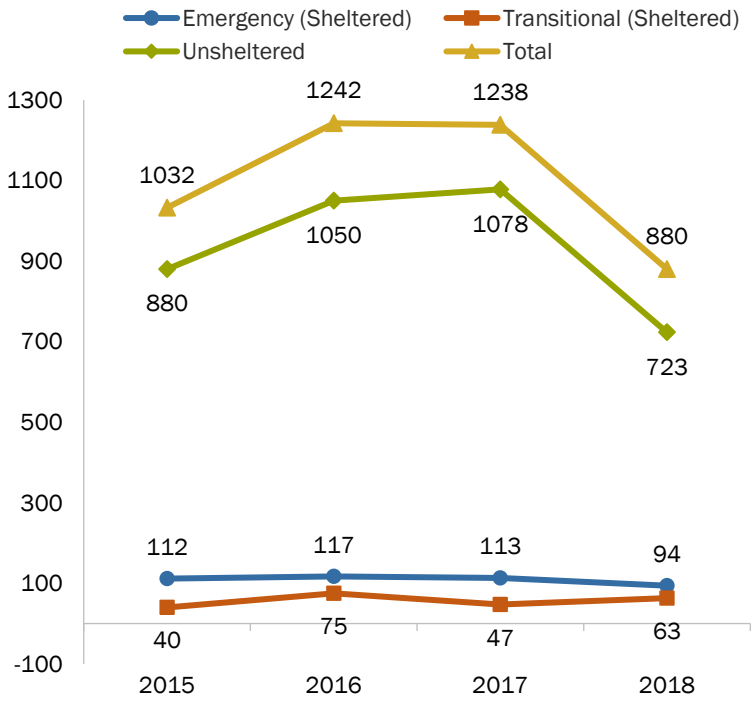
Lack of affordable housing is not the only component of homelessness. Many people experiencing homelessness face serious challenges such as mental illness, substance abuse, disabilities, and/or lack of education. Combining housing assistance with other social services such as employment training, substance abuse treatment, childcare and coordinated case management have been shown to be effective in helping people live more stable and productive lives.

Addressing the issues around people experiencing homelessness takes a coordinated, community effort. The Mendocino County Homeless Services Continuum of Care (MCHSCoC) is a collaborative of multiple agencies throughout the county. Their activities include the “Point in Time Census and Survey” of individuals and families experiencing homelessness; “Coordinated Entry” which assesses the needs of those who are homeless and matches appropriate services to those individuals; ongoing cooperation focused on securing and maintaining funding resources to address homelessness and provide permanent housing.

The U.S. Department of Housing & Development (HUD) requires cities across the country to conduct "Point in Time" (PIT) counts. The unsheltered count of the homeless in Mendocino County occurs annually within the last 10 days of January. The count takes place at the same time across the county, so that a homeless person cannot be counted twice if they move their location during the day. The PIT count in 2017 estimated there were approximately 1,200 persons either in emergency or transitional housing, or "unsheltered".

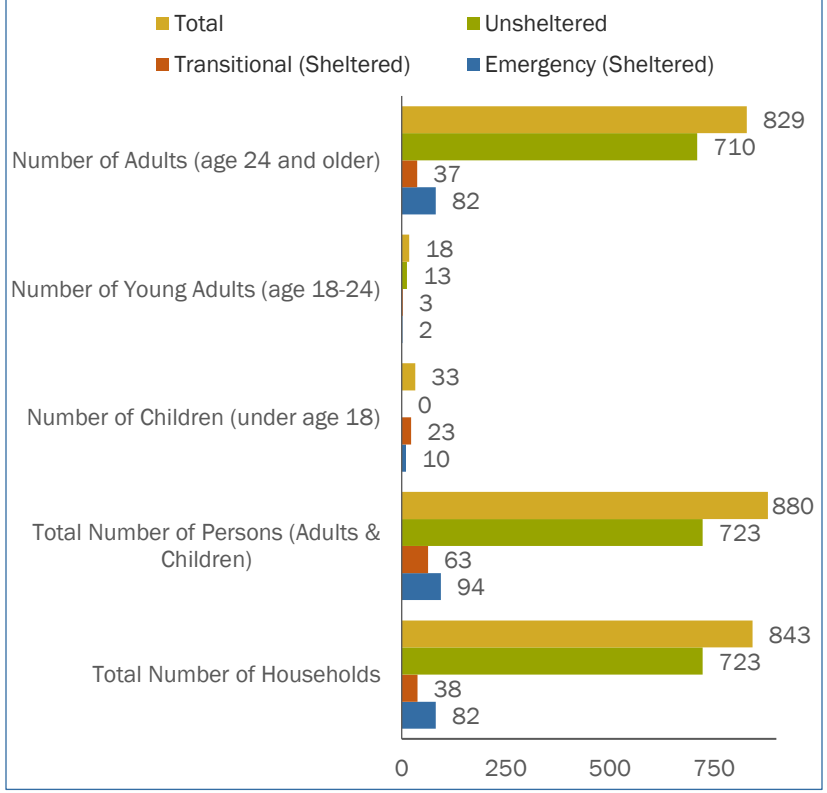
Total Number of Homeless Persons (Adults & Children)

Source: Mendocino County Continuum of Care for the Homeless Reports, 2015 through 2018



Homelessness Count, Mendocino County, January 2018

Source: Mendocino County Continuum of Care for the Homeless Report, 2018.



To better understand the dynamics of the homeless population Mendocino County Health and Human Services Agency contracted with Marbut Consulting in 2017 to conduct a Homeless Services Needs Assessment and to develop Strategic Action Recommendations to help the county improve its methods for decreasing homelessness. Dr. Robert Marbut, a well-known expert

on homelessness across the country, determined that the Mendocino County PIT data from the past few years seemed to overestimate the numbers of people experiencing homelessness. He stated that this was due to four different sub-groups of "street people" being categorized as one broad homeless population, including many individuals who are not actually experiencing homelessness as defined by HUD. These sub-groups are different in their homelessness origins and characteristics, needing customized actions specific to each group in order to address their needs. Three of the four groups met the definition of homelessness as per federal guidelines.

Marbut defined the four distinct groups as follows:

- Very-home grown (39%): year-round homeless who have deep family connections in the community and most attended local high schools;
- Somewhat home grown (23%): year-round homeless who followed their family to the county, but most attended high school elsewhere;
- Not from Mendocino County (38%): mostly year-round, homeless before arriving in the county,
- No family connections to the community. This 4th group is defined as "North-South Travelers" people NOT experiencing federally defined homelessness, but rather passing through, often on a seasonal basis.

Some interesting takeaways from Dr. Marbut's data analyses of the street-level community indicate that the homeless situation in Mendocino County is similar to peer communities in some respects, but also revealed some significant differences.

- Males represented 61% and females represented 39%, which is 8-12% higher for females than expected.
- The average age was 44.4 years and the median was 46.0. Both are slightly younger than would be expected by 3-4 years. The average age an individual was first homeless, either in the county or before they moved here, was 39.6 years and the median age 41.0, both of which are younger than expected.
- Individuals experiencing street-level homelessness have lived in Mendocino County for 18.6 years on average, with a median of 14.5, which is once again uncommon. 60.5% of all individuals were already living in Mendocino County when they started to experience homelessness. Local family connectivity, compared to similar communities, was higher than expected with 51.4% of homeless individuals having family members living in Mendocino County. If deceased family members from the county were included the percentage increased to 61.9%.
- Chronic homelessness is defined by HUD as living on the streets for more than one year. 78% of the individuals surveyed by Dr. Marbut have been experiencing chronic homelessness. Of the 78%, 51.4% have been on the street for 1-4.99 years, and 26.7% for five or more years. 9.5% revealed that they have been living on the street for 10 or more years. This level of chronic homelessness, especially within the 1-5-year range, is uncharacteristic compared to peer communities.
- The street-level population of the county exhibits low mobility between cities and engages in only a limited amount of activities. 69.5% reported going to or utilizing 5 or fewer activities from a list of 20 places, programs, and activities. Individuals spend the majority of time at their "home-base"

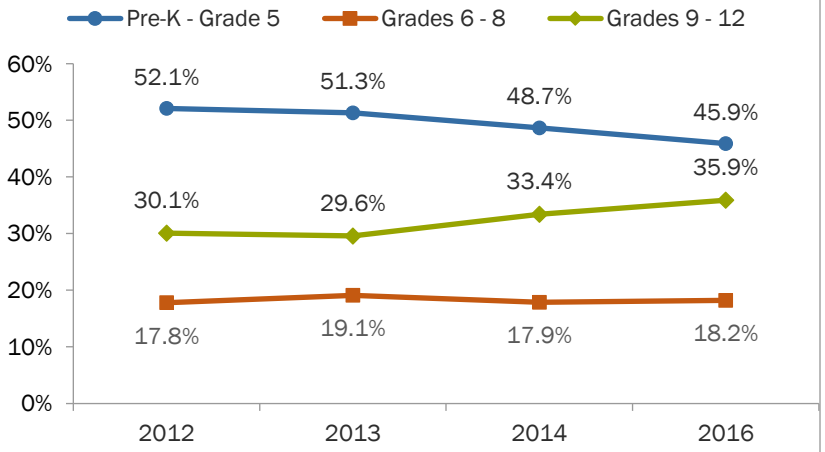
and also venture away to get a meal. The only two activities that exceeded 50% utilization was partaking in at least one medical service during the last month (57.1%) and going to the library (51.4%). Of the 20 most chronic individuals (inbound or homegrown) only 5 were active in structured programming.

- 53.3% of all the individuals surveyed did not have a job in Mendocino County before experiencing homelessness, and 81.9% did not have a job when surveyed.
- The number of people living in vehicles was relatively low but indicated trends that could be useful for policy making. In general car-campers had family in the county (50%), would eat at community meals, and do not want to sleep in group settings. Van-Campers were mostly from outside Mendocino County and lived in groups of two or more.

Dr. Marbut's report did note that many positives were already occurring in the county to address the homeless situation. As part of the scope of work, however, he provided multiple action items and suggestions for the county to consider and implement to improve the county's ongoing homeless situation. He determined that many county agencies and service providers have been counting the different sub-groups as one large homeless population and have been treating them as such. Commingling of very different groups, under one designation blurs the real problems and thus the solutions. Many individuals included are not actually experiencing homelessness as defined by HUD. The homelessness situation in the county will not improve unless the policy makers, service providers, and community in general have a clear understanding of who is actually experiencing homelessness and who is not. Only then can different strategies be used to address the needs of the different groups. There has also been wide-ranging duplication of services and efforts by multiple agencies within the county, without a more strategic overall system-wide plan to address homelessness issues. For the complete data analyses and recommendations provided by "Marbut Consulting" to the Board of Supervisors please refer to the final written report titled "Homelessness Needs Assessment and Action Steps for Mendocino County, March 19, 2018".

Percentage of Public School Students Recorded as Homeless

Source: California Department of Education, 2017



(Data for 2015 not available) Definition: Percentage of public school students recorded as being homeless at any point during a school year, by grade level (e.g., among California students recorded as being homeless at some point during the 2016 school year, 52.3% were in grades Pre-K through 5). Footnote: Years presented are the final year of a school year (e.g., 2015-2016 is shown as 2016). Students are recorded as homeless if their nighttime residence is (i) shared housing with others due to loss of housing, economic hardship, or similar reason, (ii) a hotel or motel, (iii) a temporary shelter, or

(iv) unsheltered. These data may include duplicate counts of homeless students; as homeless students move frequently; it is possible that the same student will be recorded by multiple school districts. Data for 2015 are not available due to changes in reporting. Note that percentages for county offices of education are less reliable than percentages for other school districts due to fluctuations in official enrollment.

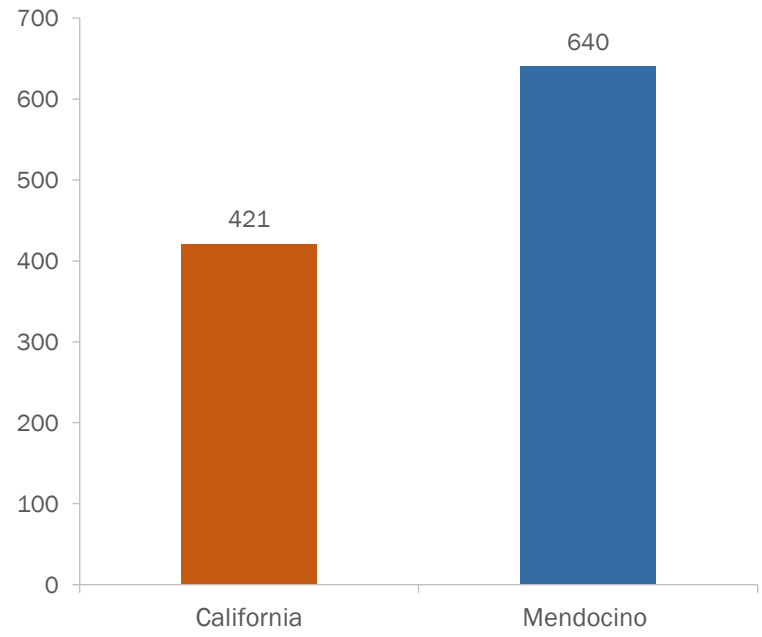
Homelessness can mean sleeping on a relative's couch, a vehicle or trailer or in a shelter. Homelessness is associated with a myriad of poor health outcomes, especially for children. Homeless pregnant women are less likely to receive adequate prenatal care, are at greater risk for substance abuse, and their infants at greater risk of being prenatally exposed to alcohol and/or drugs. Homelessness causes severe trauma to children and youth, disrupting their relationships, putting their health and safety at risk, and hampering their development. Homeless children are more likely than other children to have physical and mental health problems, and experience hunger and malnutrition. Emotional distress, developmental delays, and decreased academic achievement are also more common in this population. Many of these children and youth experience deep poverty, instability and exposure to domestic violence before becoming homeless, and homelessness increases their vulnerability to additional trauma. In addition to the risks faced by homeless children, including increased vulnerability to sexual exploitation, youth without homes are far more likely than their peers to be infected with HIV and have other serious health problems.

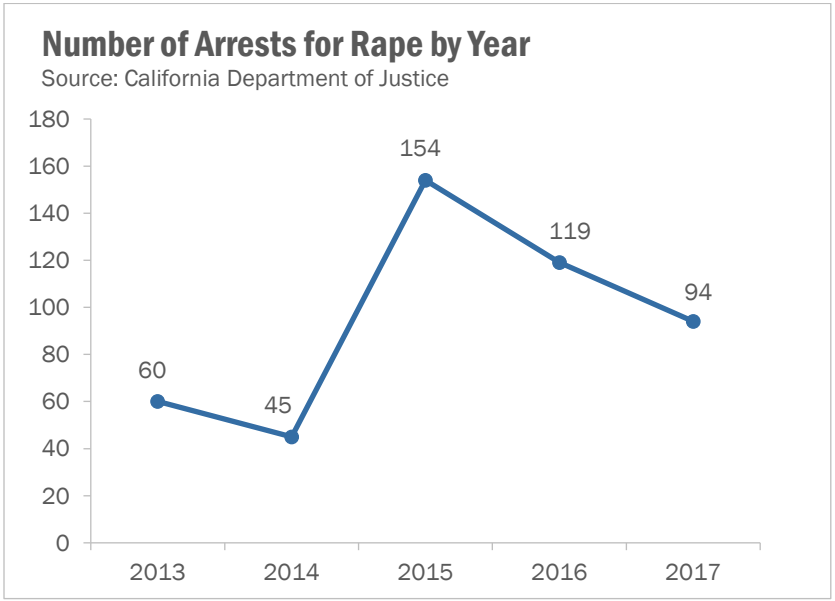
Adult Arrests

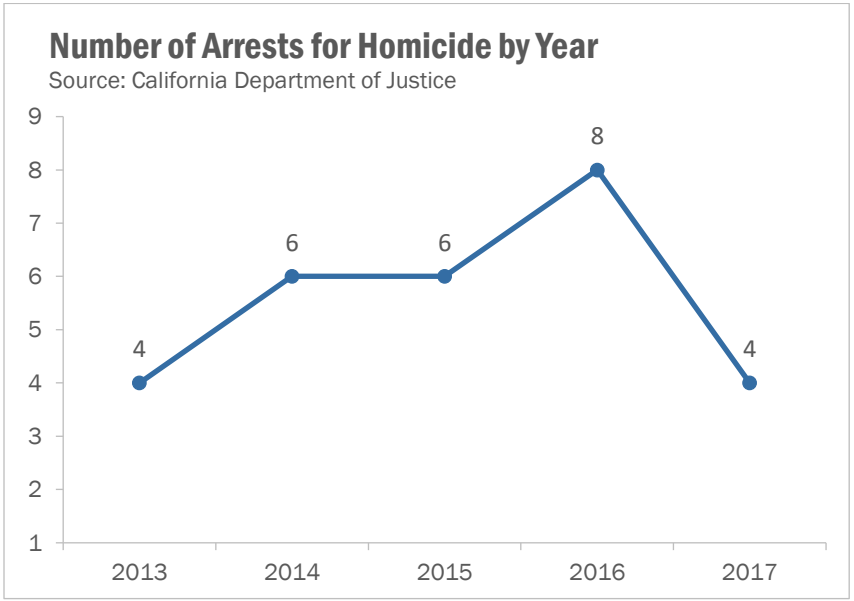
Crimes affect almost everyone in a community, including victims, offenders, their friends and families, and neighbors. Crimes diminish community productivity and undermine social functioning. Residents of areas with high criminal activity feel less safe in their neighborhoods and may encounter obstacles to completing routine tasks. High crime rates can further lead to social factions and impede economic growth. Local governments may need to spend significant public funds for expanded police departments, prisons/jails, courts, and treatment programs.

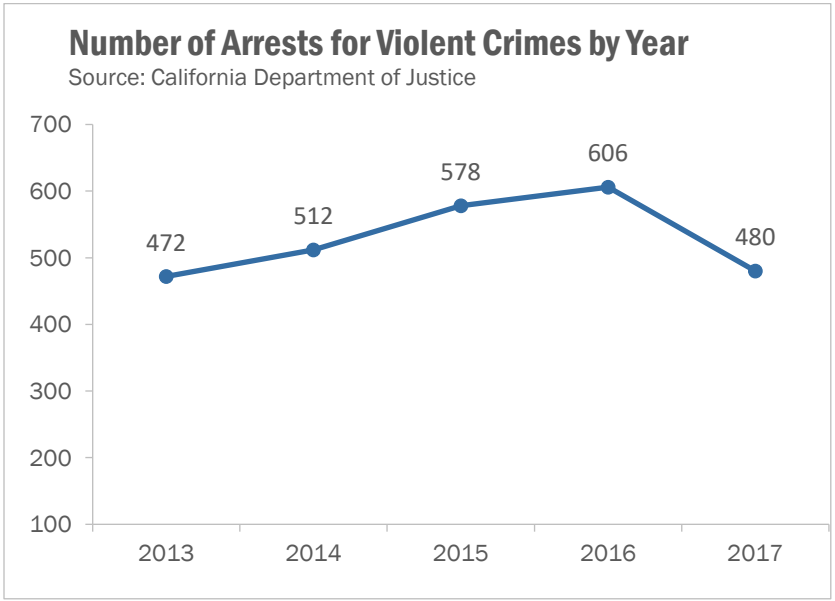
Rate of Violent Crime Offenses in Mendocino County, 2017

Source: California Department of Justice









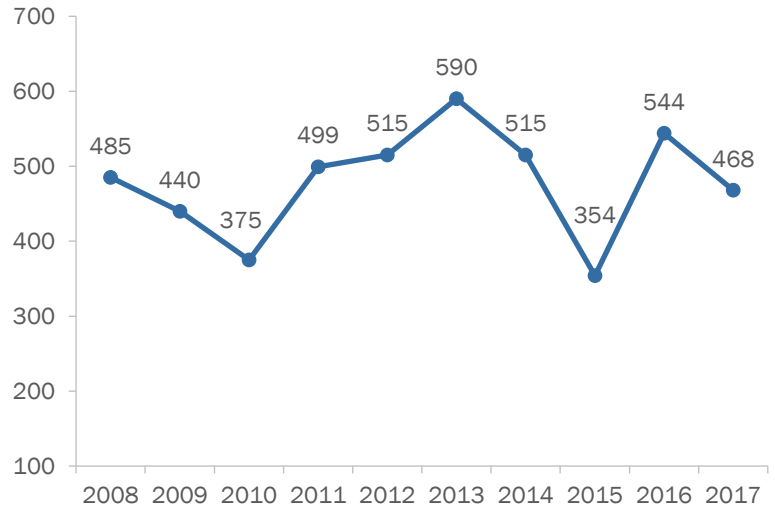
Domestic Violence

Domestic violence may include physical, emotional, verbal, sexual, spiritual, and/or financial abuse. The impact of domestic violence affects everyone around it including family members, neighbors and the larger community. Children exposed to domestic violence can experience physical, emotional and behavioral responses which include feeling afraid, guilty and sad, having sleep disturbances, stomach aches and headaches, bedwetting, and inability to concentrate, among other problems. Studies have found a correlation between Adverse Childhood Experiences (ACEs) (including all types of domestic violence described above) and the increased incidence of chronic diseases including heart disease, lung

cancer, and diabetes, as well as depression and suicide amongst those individuals. In addition to their severe and lasting impact on the victims of domestic violence, these problems can affect both the health and wellness of our community, as well as the local economy.

Total Calls for Domestic Violence

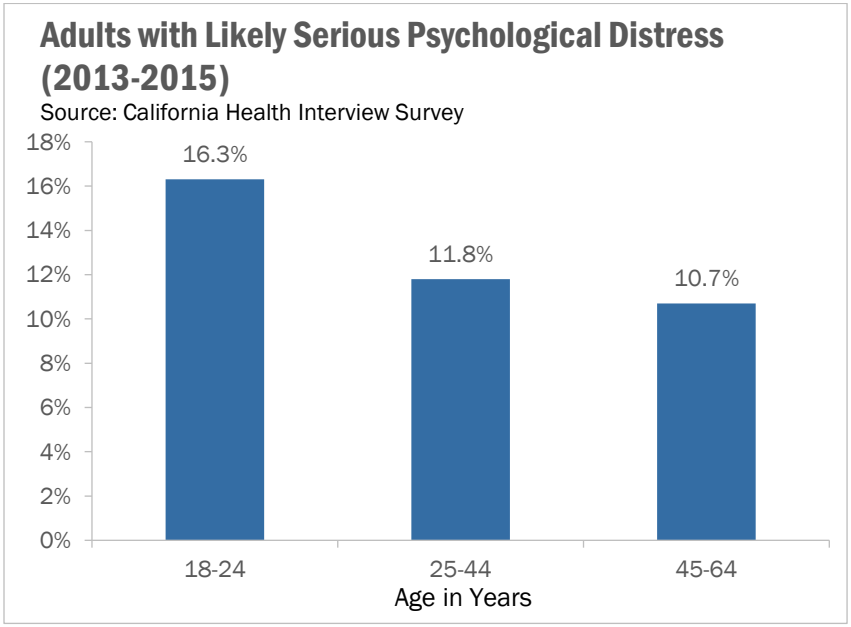
Source: California Department of Justice, 2017

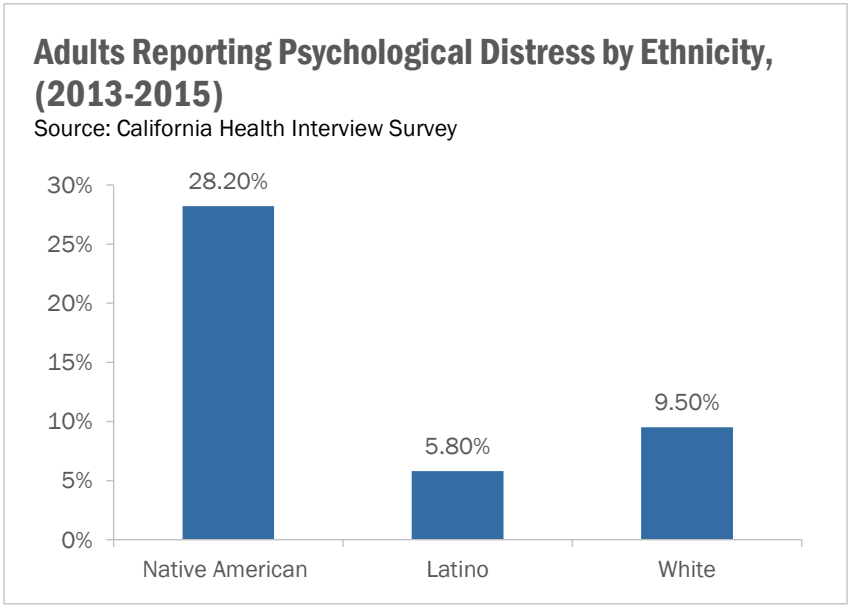


Behavioral Risk Factors

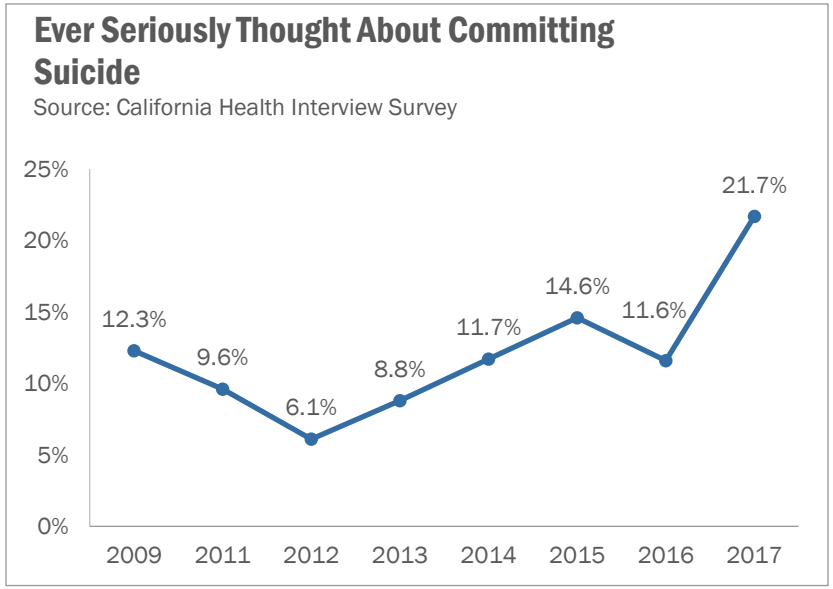
The 2015 Community Health Needs Assessment identified unmet mental health needs as a serious public health problem in Mendocino County. The Mental Health Services Act (MHSA) of 2005, provides funding for the delivery of mental health services, and the county has a Community Program Planning (CPP) process for the development of mental health services. Stakeholders in the CPP include: individuals with mental illness, including children, youth, adults, and seniors; family members of consumers with mental illness; service providers; educators; law enforcement officials; veterans; substance use treatment providers; health care providers; community based organizations; and other concerned community members. The stakeholder list is updated regularly and based on community members, providers, and consumers' interest in participating. The CPP holds regularly scheduled meetings to allow for input and planning in the on-going management and development of programs and services to meet the mental health needs of the community. Service delivery is coordinated through an Integrated Care Coordination Model of mental health services.

As services are increasingly integrated, more programs move from serving targeted populations, such as an age specific program, to a program that has the ability to serve consumers of all ages and needs, with a "no wrong door" approach. Outpatient care for individuals with emotional distress, substance abuse treatment needs or a severe mental illness is generally available in Mendocino County. There is currently no inpatient facility in the county, the previous inpatient psychiatric facility was closed in 1999. Individuals experiencing a mental health crisis are held either in the local jail or at a hospital emergency department until they can be transferred to a psychiatric inpatient facility out-of-county. In 2017, the voters approved Measure B, an initiative calling for a half-cent sales tax increase to fund inpatient mental health facilities. These facilities are in the planning stage.



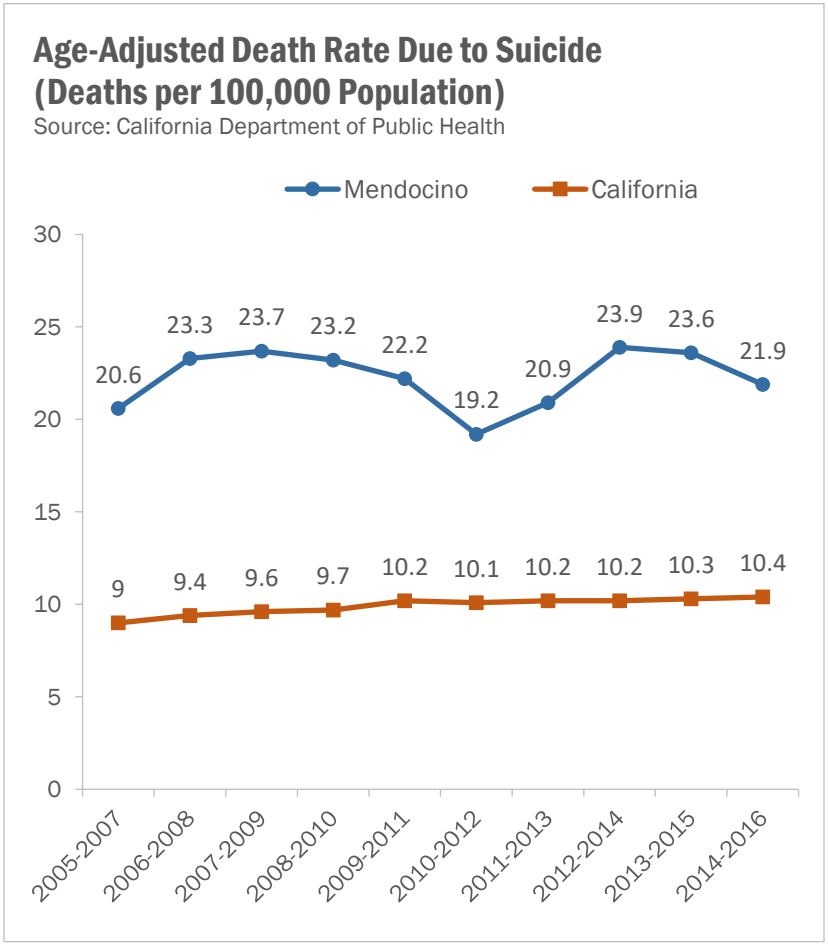


The California Health Interview Survey for 2017 found that 22% of all Mendocino County residents who responded to the survey said they had thought about suicide at some point.

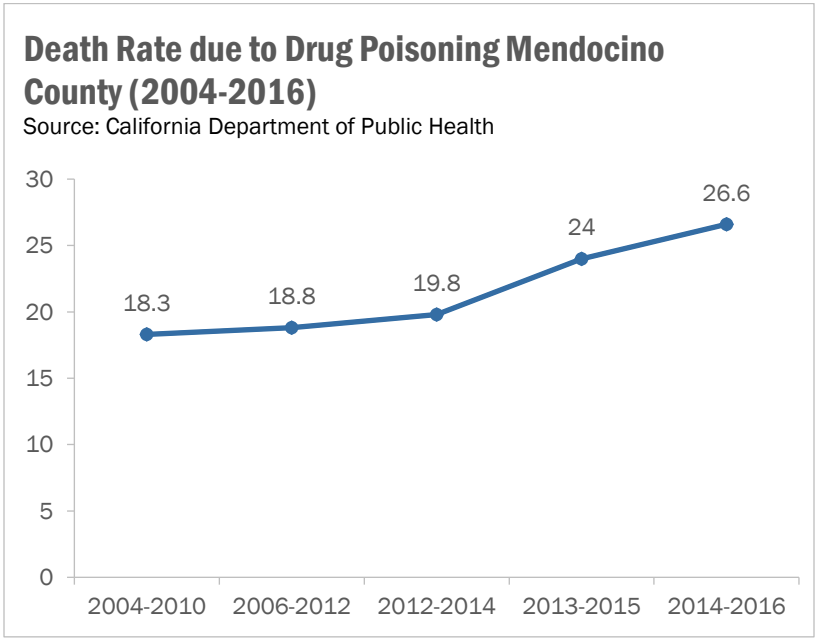


The age-adjusted death rate due to suicide in Mendocino County is twice that of the state.[iii] Comparing all other counties in California, Mendocino County ranks 6th overall in the rate of suicides.[iv] In response to this problem, Mendocino County in partnership with Adventist Health Ukiah Valley (AHUV), and lead by Marvel Harrison, PhD, has brought extensive County-wide education sessions of the suicide prevention program QPR: Question, Persuade, Refer. QPR is a national, evidence-based suicide prevention program. The program is designed to teach community members to recognize the warning signs of suicide, have the capacity to offer hope and understand the interventions available to a person considering suicide. Similar to CPR, QPR trains people to identify crisis and direct to proper care.

Like medical “herd immunity” the program aims for behavioral “community immunity”. Said Ms. Harrison, “There truly is safety in numbers. The more people we get trained in QPR, the more deaths by suicide we can prevent. By training as many community members as possible, we will be able to put far more people on the front line of suicide prevention. It takes what Mendocino County has for each other, courage, compassion and commitment."



Drug Abuse



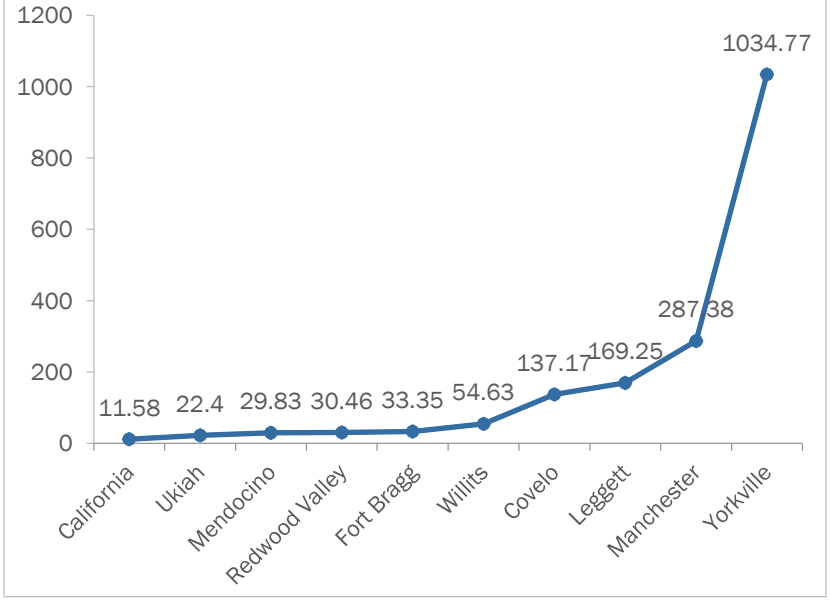
The death rate due to drug poisoning is rising. Mendocino County averages two deaths a month from unintentional prescription opioid overdose, per capita, twice the state average.[v]

In response to this crisis, Mendocino County has formed the Safe Rx Mendocino Coalition promoting all efforts to build a healthy community that is free of opioid abuse and related stigma. In addition, the coalition is promoting the distribution of Narcan, (generic name Naloxone), a nasal spray that can help reverse opioid overdose. The Safe Rx Mendocino Coalition is composed of partners from local hospitals, clinics, first responders, tribes, family service agencies, addiction treatment facilities, and others, to educate the community about safe prescribing guidelines, alternative pain

management, encouraging chronic opioid users to participate in Medically Assisted Treatment (MAT) for addiction, proper disposal of medication and/or syringes and more. The Safe Rx Coalition has identified specific areas for needle disposal boxes, holds regular events where medications can be turned in for disposal, and offers drug lock-bags so family members can safely keep medications out of the hands of children or other family members.

All Drug Overdoses: Age-Adjusted Rate per 100,000 Residents, 2017

Source: California Department of Public Health



This graph shows acute poisoning deaths involving opioids such as prescription opioid pain relievers (i.e. hydrocodone, oxycodone, and morphine) and heroin and opium.

Binge Drinking

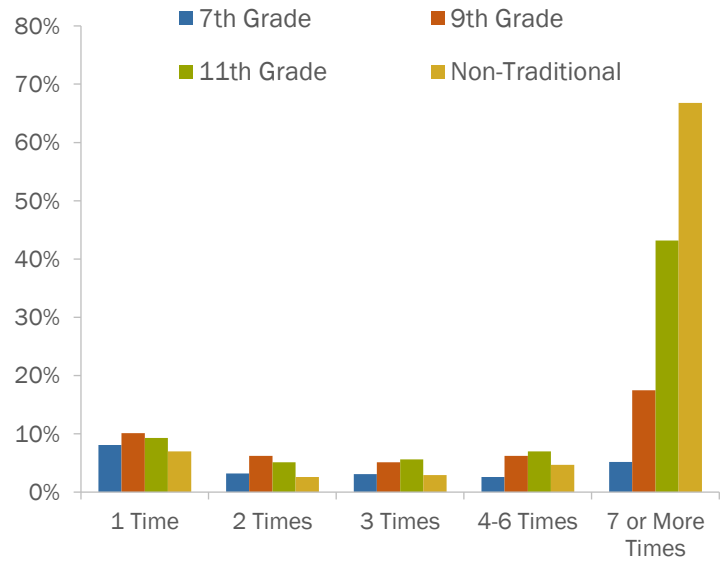
Binge drinking is a common form of excessive alcohol use in the United States. Binge drinking can be dangerous and may result in vomiting, loss of sensory perception, and blackouts. The prevalence of binge drinking among men is twice that of women. In addition, it was found that binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers. Alcohol abuse is associated with a variety of negative health and safety outcomes including alcohol-related traffic accidents and other injuries, other types of drug use, sexual assault, employment problems, legal difficulties, financial loss, family disputes and other interpersonal problems.

The percentage of adults in Mendocino County who admit to binge drinking over the past year has remained about the same between 30% to 45% from 2010 to 2017.

Alcohol is the most widely used substance among the nation's young people and binge drinking, in particular, has been linked to risky health behaviors (e.g., unprotected sex, smoking), injuries, motor vehicle accidents, impaired cognitive functioning, poor academic performance, physical violence, and suicide attempts. Drinking during adolescence increases the likelihood of alcohol dependence in adulthood, and excessive alcohol consumption can have long-term health consequences, including liver disease, cancer, and cardiovascular disease.

Alcohol Use in Lifetime by Grade Level, Mendocino County (2013-2016)

Source: California Department of Education

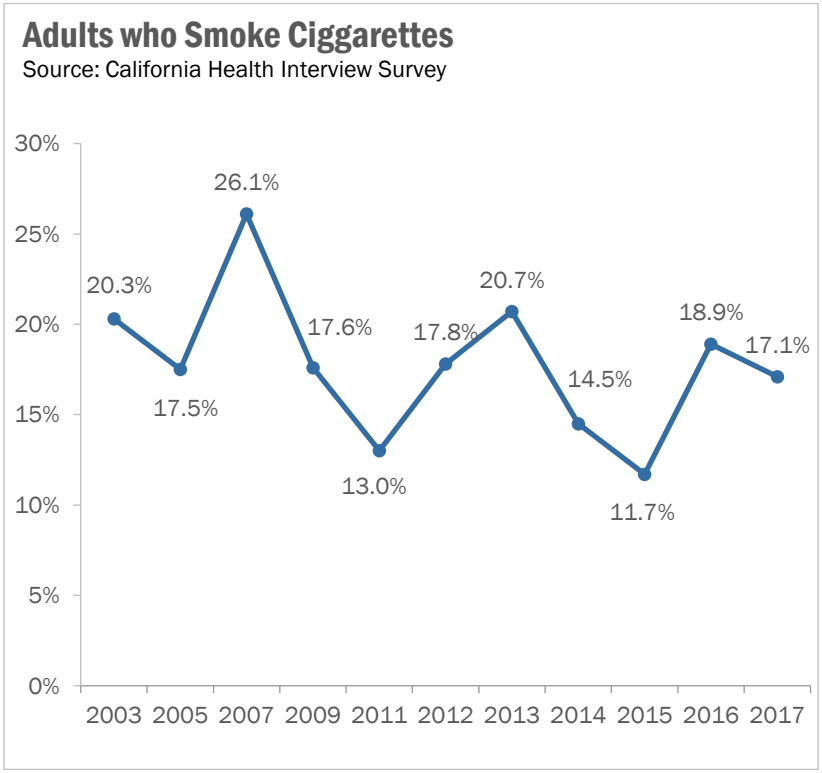


Smoking and Vaping

Tobacco is the agent most responsible for avoidable illness and death in America today. Tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers, which can cause or exacerbate a wide range of adverse health effects including cancer, respiratory infections, and asthma. Health behavior patterns formed in adolescence play a crucial role in health throughout life. Those who start smoking young are more likely to have a long-term addiction to nicotine than people who start smoking later in life, putting them at greater risk for smoking-related illness and death. Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States. If smoking prevalence among adolescents persists, it is estimated that in the U.S., 5 million persons who are currently under the age of 18 will die prematurely from smoking-related diseases.

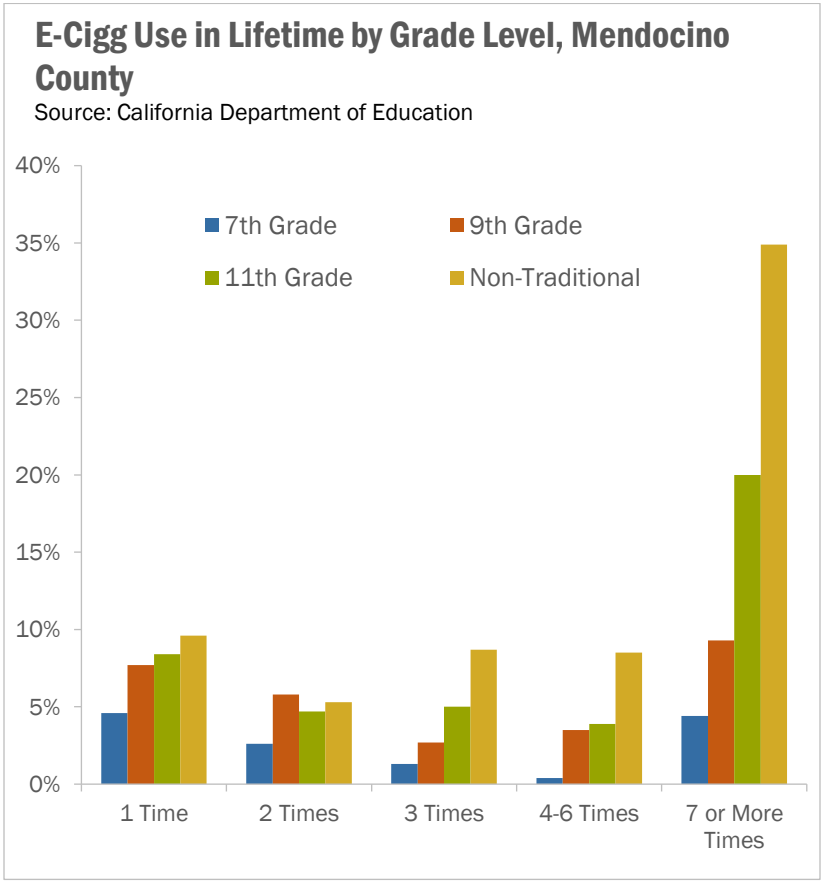
Tobacco use is considered a risk factor for numerous chronic diseases, including but not limited to cancer, cardiovascular disease, emphysema, chronic obstructive pulmonary disease, pneumonia, diabetes, and rheumatoid arthritis.[vi] Exposure to tobacco smoke is a risk factor for chronic diseases and is considered a human carcinogen.[vii] Acute effects of secondhand smoke are serious and include increased frequency and severity of asthma attacks, respiratory symptoms such as coughing and shortness of breath, and respiratory infections such as bronchitis and pneumonia. In addition, using tobacco or being exposed to tobacco smoke during pregnancy is detrimental in fetal development and increases the risk of sudden infant death syndrome. [viii]

The State of California has led the way in legislating prohibitions for smoking. Smoking is no longer permitted in public buildings, farmer's markets, foster and group homes, multi-unit housing, personal vehicles when a minor (<18 years of age) is present, public transportation, workplaces, correctional facilities, playgrounds, and schools.



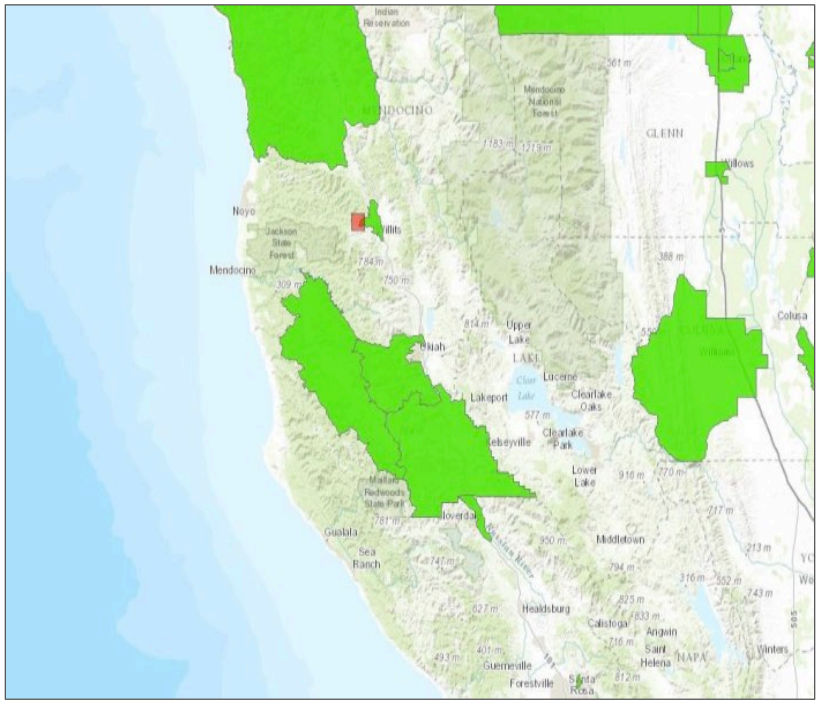
When it comes to tobacco use, cigarettes are considered a combusted or burned product. The cigarette has to be lit, the tobacco burned, and the smoke inhaled. Vaping, and E-Cigarettes on the other hand, involves no combustion or burning. Instead, these products release an aerosol that is inhaled.

Use of e-cigarettes increased dramatically over the past decade, making them the most common tobacco product used among youth. While many people make the mistake of assuming this aerosol is as harmless as water vapor, it actually consists of fine particles containing toxic chemicals, many of which have been linked to cancer, as well as respiratory and heart diseases. Components of e-cigarette solutions generally include nicotine, flavoring chemicals, and other additives (including those unknown and/or unadvertised to the user). Currently, there are no federal quality standards to ensure the accuracy of e-cigarette constituents as advertised or labeled. Refillable cartridges allow the user to deliver other psychoactive substances, including marijuana. Numerous toxicants and carcinogens have been found in e-cigarette solutions, including aldehydes, tobacco-specific nitrosamines, metals, tobacco alkaloids, and polycyclic aromatic hydrocarbons. E-cigarette solution has also been shown to be cytotoxic to human embryonic stem cells. Nicotine is the major psychoactive component of e-cigarette solution. There are often wide discrepancies between the labeled amount and actual nicotine content within the solution. Reported nicotine concentration in e-cigarette solution ranges widely and, depending on how the product is used, can be comparable to or exceed the amount of nicotine in a single conventional cigarette. Nicotine is a highly addictive drug that can have lasting damaging effects on adolescent brain development and has been linked to a variety of adverse health outcomes, especially for the developing fetus. Nicotine has neurotoxic effects on the developing brain. In early adolescence, executive function and neurocognitive processes in the brain have not fully developed or matured. Adolescents are more likely to engage in experimentation with substances such as cigarettes, and they are also physiologically more vulnerable to addiction. The earlier in childhood an individual uses nicotine-containing products, the stronger the addiction and the more difficult it is to quit. The vast majority of adult smokers initiated tobacco use by 18 years of age.



This chart (2012-2015) shows the estimated percentage of public school students in grades 7, 9, 11, and non-traditional programs who have ever used electronic cigarettes or other vaping devices, by grade level and number of occasions.

Healthy Weight

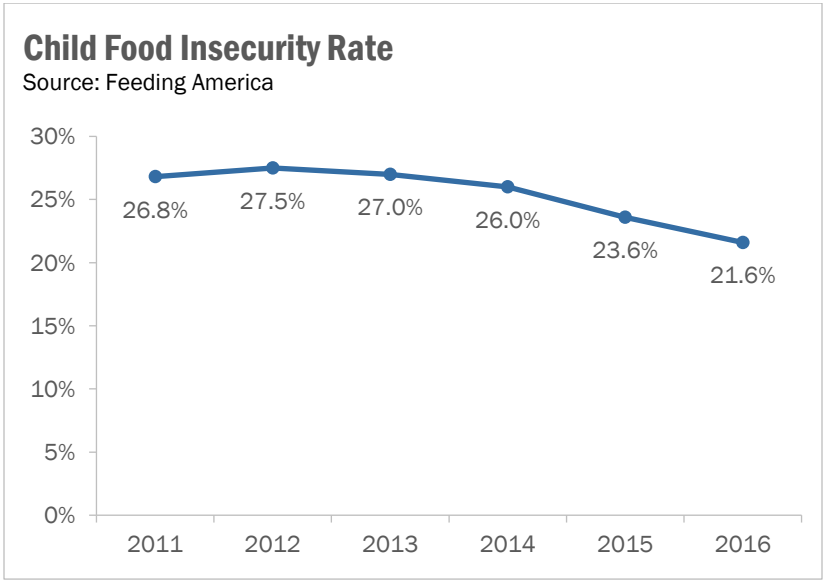


Data Source: U.S. Department of Agriculture

Mendocino County has large geographic areas that the U.S. Department of Agriculture (USDA) considers "food deserts." These are census tracts with a high proportion of low-income residents who are 10 or more miles away from a supermarket. Limited access to supermarkets or grocery stores may make it harder for low income residents to eat a healthy diet. There is strong evidence that food deserts are correlated with high prevalence of overweight, obesity, and premature death as supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

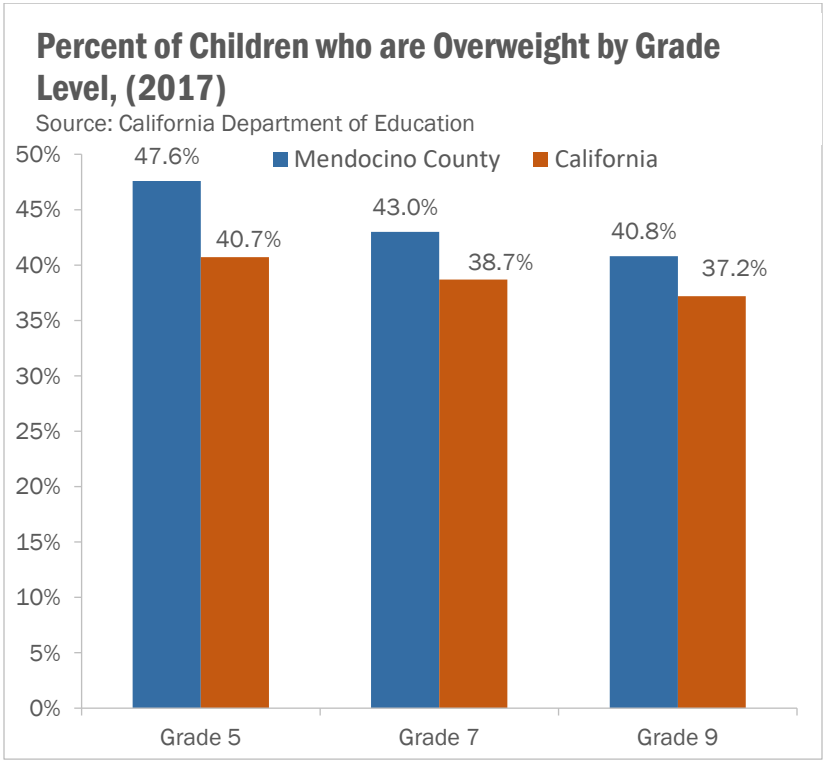
Additionally, those with low incomes may face barriers to accessing a consistent source of healthy food. Lacking constant access to food is related to negative health outcomes such as weight gain and premature mortality.

The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Children exposed to food insecurity are of particular concern given the potential impacts of scarce food resources on their health and development. Children who are food insecure are more likely to be hospitalized and may be at higher risk for developing obesity and asthma. Children who experience food insecurity also may be at higher risk for behavioral and social issues including fighting, hyperactivity, anxiety, and bullying. In Mendocino County, the rate of food insecurity for children has been steadily declining.



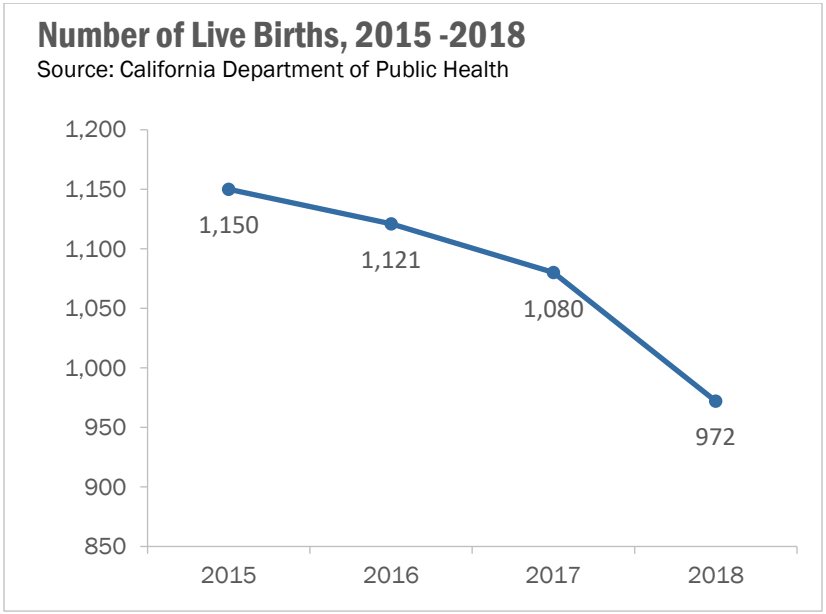
Obesity

Children who are overweight or obese are at higher risk for a range of health problems, including asthma, heart disease, stroke, and some types of cancer; they also are more likely to stay overweight or obese as adults.[ix] Some obese children are diagnosed with illnesses previously considered "adult" conditions, such as high blood pressure and type-2 diabetes.[x] In addition, children with obesity are at increased risk for joint and bone problems, sleep apnea, and social and emotional difficulties, such as stigmatization and low self-esteem.



Maternal Child Adolescent Health

The number of live births in Mendocino County shows a steady decline.



The Infant Mortality Rate for Mendocino County

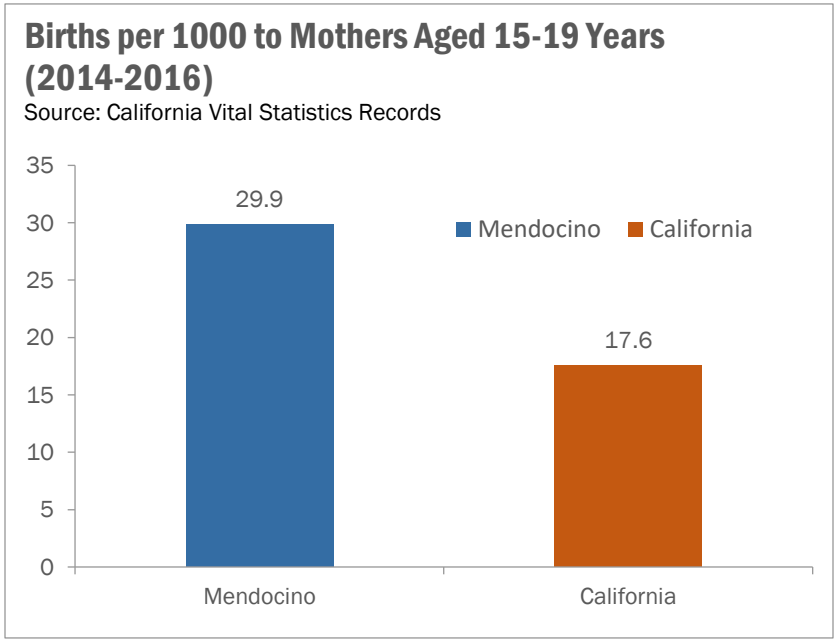
In 2018 the infant mortality rate was 7.4 per 1,000 infants. The California rate was 4.6 per 1,000 infants.

Age-Adjusted Child Death Rate

Between the years 2013-2015, the age-adjusted child death rate was 51.3 per 100,000 children under age 24 years, compared with California's rate of 30.0 per 100,000. But by 2018, the age-adjusted child death rate in Mendocino County had fallen to 32.4 per 100,000.

Low-Birth Weight Infants (2014-2016)

Percent of low-birth rate infants in Mendocino County, 6.4%. California percentage 6.8%



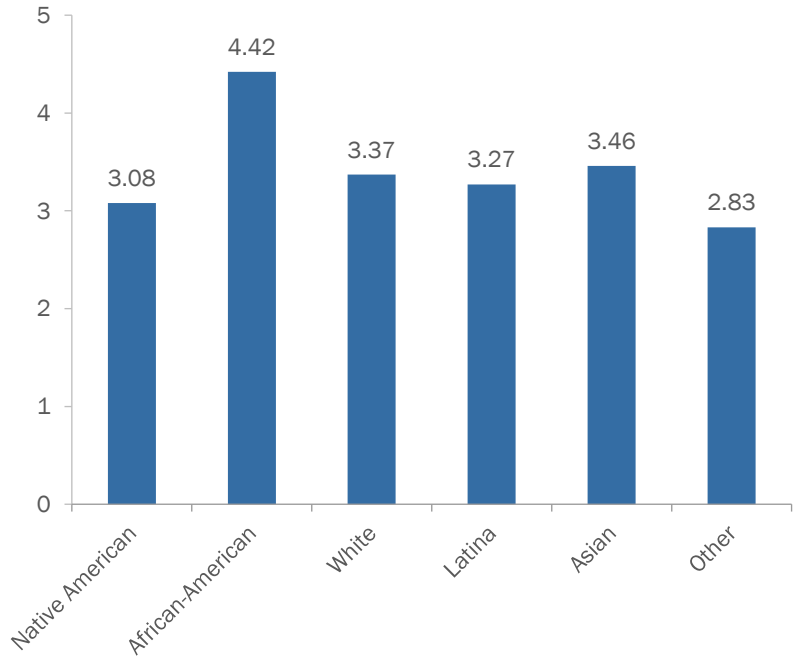
The age-specific rate of teen pregnancy was 29.9 per 1,000. Compared with the California rate of 17.6 per 1,000

Breast-feeding Initiation (2014-2016)

Mendocino County percent of mothers initiating breastfeeding was 96.3%, up from the previous percentage of 95.2%. The California percentage was 93.8%

Average Month Prenatal Care was Begun by Ethnicity (2015-2018)

Source: Calirfornia Department of Public Health



Pregnant women, substance use, and its effects

Since 2010 the number of pregnant females, aged 15 to 44 years, with any diagnosis of substance abuse has been increasing at an alarming rate in Mendocino County. Data show that drug and alcohol use among pregnant women in Mendocino County was more than twice the state level by 2015. Alcohol, tobacco, cannabis, and other drug exposures during pregnancy pose serious health risks for pregnant women and their unborn children.

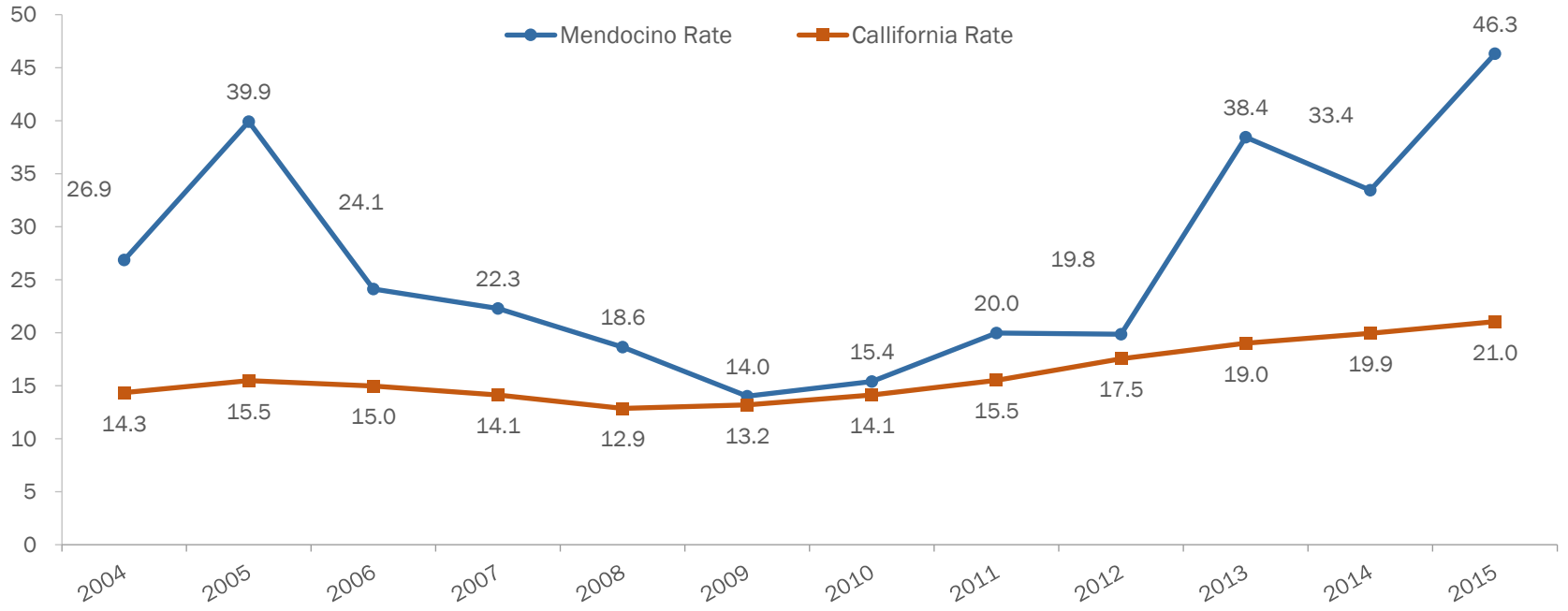
The adverse effects to the developing fetus and long-term effects on the child include: increased risk of miscarriage or fetal death, premature birth, low birth weight, birth defects, physical deformities, respiratory problems, heart defects, developmental disabilities, learning disabilities, and infant mortality. Repetitive use of certain drugs can cause neonatal abstinence syndrome (NAS) in which the baby goes through withdrawal symptoms after birth.

The most frequently used substance during pregnancy is tobacco, followed by alcohol, cannabis, and illegal substances. Misuse of prescription medications is also a problem. Many substance abusers use more than one drug or use a combination of substances, which increases the dangerous effects to both mother and fetus.

In the United States women comprise 40% of those with a lifetime drug use disorder and 26% of those who meet criteria for both an alcohol and drug use disorder during the prior 12-month period. Furthermore, women are at highest risk for developing a substance use disorder during their reproductive years, especially ages 18-29. This means that women who are pregnant or soon to become pregnant are at increased risk for substance abuse. Many women with substance use disorders are also diagnosed with mental disorders. Patients who exhibit both are often more resistant to treatment and may have more severe or persistent symptoms.

Any Diagnosis of Substance Abuse of Pregnant Females, Aged 15 to 44 years, rate per 1,000 Hospitalizations

Source: California Office of Statewide Health Planning and Development

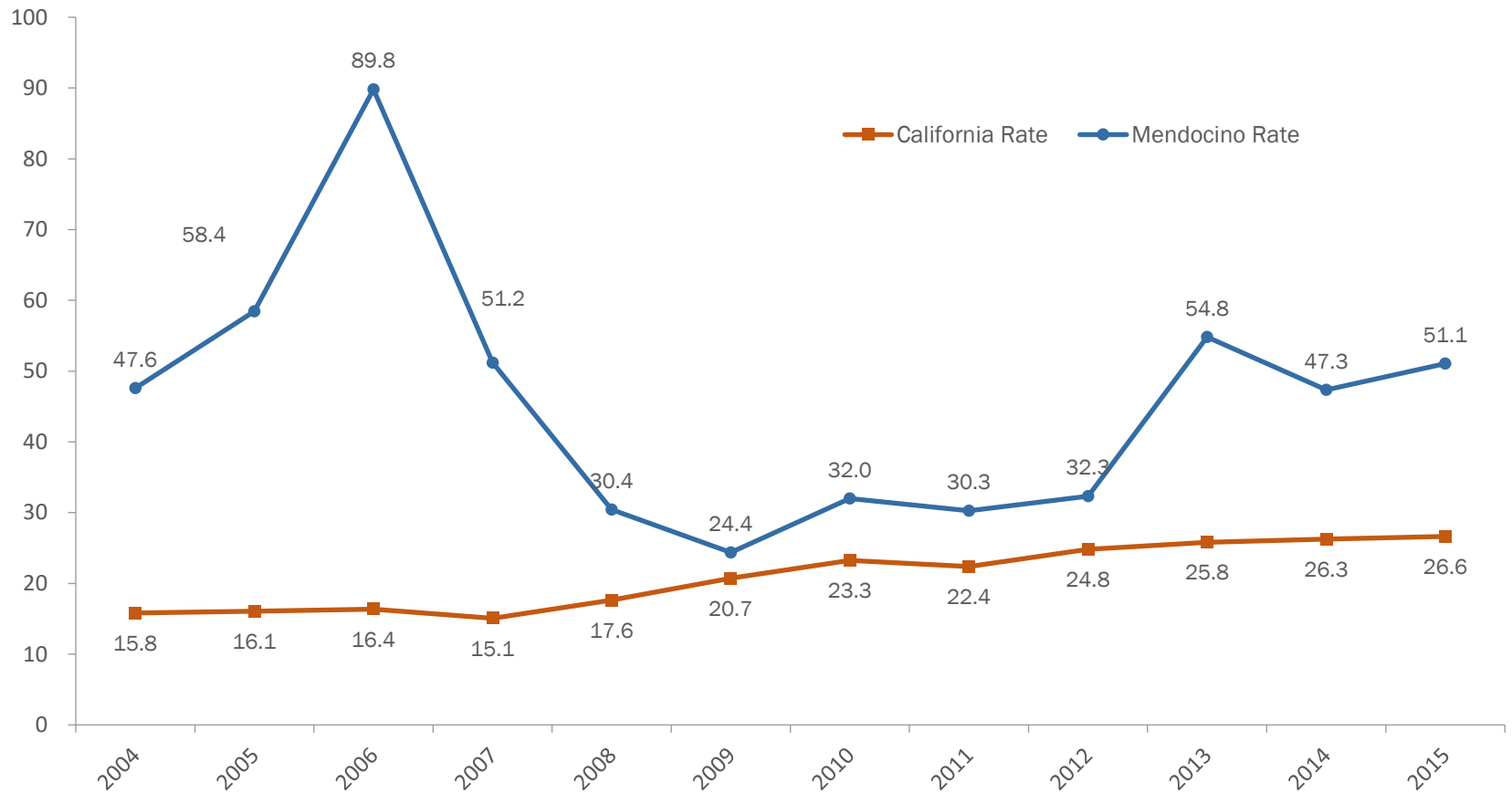


While most women attempt to discontinue substance use after learning that they are pregnant, approximately half of all pregnancies are unplanned, and women often do not realize that they are pregnant until 4 to 6 weeks after conception. This period of continued consumption of alcohol and other harmful substances puts the developing embryo or fetus at risk. Once the fact of pregnancy was known, however, most women reduced or stopped drug and alcohol use.

There are few existing treatments for pregnant women diagnosed with substance abuse. These mainly focus on behavioral counseling and psychosocial interventions. Education on the dangers and effects of drug use while pregnant needs to be implemented in the pre-teen years and needs to continue through public health outreach to all women of childbearing age, and to those in the most susceptible communities.

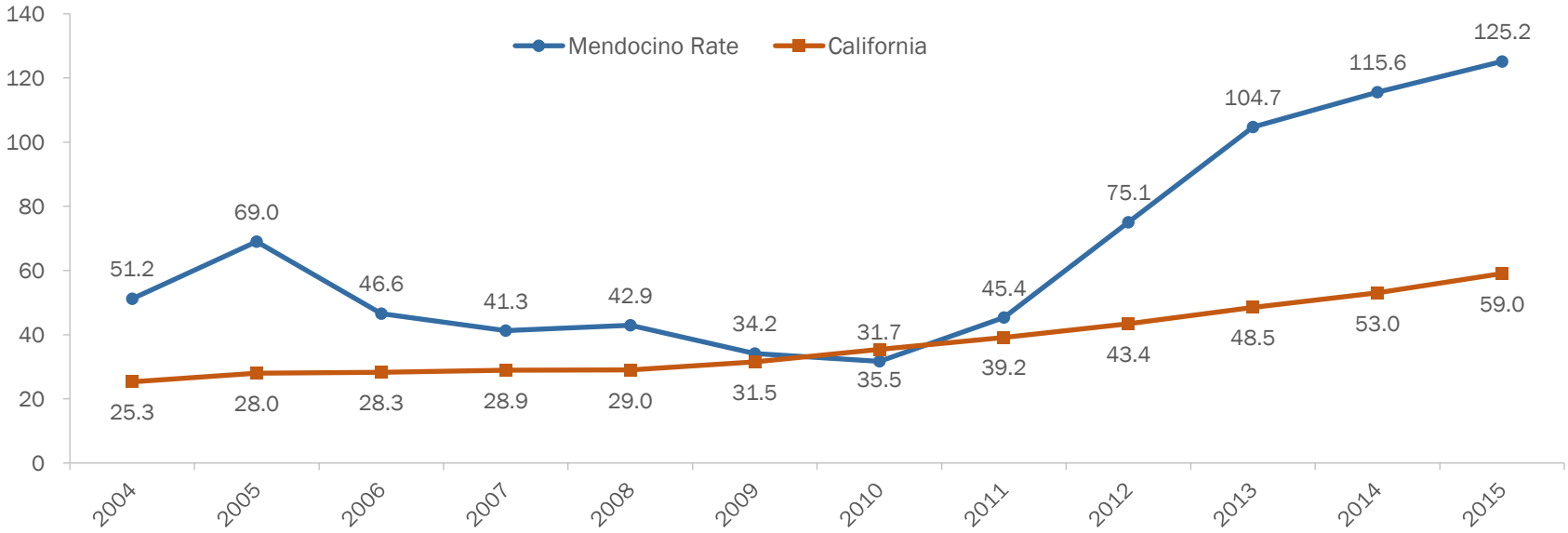
Infants (0 to 89 days old) with a Diagnosis of Substance Abuse, rate per 1,000 Hospitalizations

Source: California Department of Public Health



Any Mental Health Diagnosis of Pregnant Females, Ages 15 to 44 years, rate per 1,000 Hospitalizations

Source: California Department of Public Health



Many pregnant women experience psychiatric disorders in their childbearing years. Mental illness not only affects the mother's well-being but may also have significant effects on fetal outcomes. In California, 1 out of every 5 pregnant women or new mothers suffers from a pregnancy-related mental health issue such as depression, anxiety, or even psychosis. A mother's suffering can be so severe they may not be able to function properly or care for their infant, and in some cases if untreated, can lead to a mother's suicide or harming the newborn. Fortunately, these conditions are treatable and early detection by healthcare providers, family or friends can make a positive impact. Programs such as Care for Her offered by the Mendocino Community Health Center, The Blue Dot Project Maternal Mental Health Awareness campaign, and the Family Birth Center at Adventist Health all offer support and education about maternal mental health issues. In addition, Healthy Families Mendocino is a free of charge, nationally recognized home visiting program for women who are pregnant or up to two-weeks postpartum, low-income and/or Medi-Cal eligible, and whose babies are at risk of *adverse childhood experiences* resulting from maltreatment, domestic violence, homelessness, or parental substance abuse, untreated mental illness, or trauma history. Enrolled families may continue receiving home visiting services until the child reaches three years of age. Community clinics, hospitals, family resource centers can refer clients to the program, but women may also self-refer by contacting the program directly.

Immunizations

(Source: EdSource: Highlighting Strategies for Student Success
https://edsource.org/2019/vaccination-rates-by-school-in-california-2017-18/610790)

School	2017-2018 Students	2017-2018 Up to date	2016-2017 Up to date	2017-2018 Medical	2016-2017 Medical	2017-2018 Belief	2016-2017 Belief	2017-2018 Other	2017-2018 Overdue
The Waldorf School of Mendocino County	27	44.44%	*	37.04%	*	0%	*	0%	0%
Laytonville Elementary	36	86.11%	89.66%	11.11%	0%	0%	3.45%	0%	0%
Mendocino K-8 Mendocino Unified	27	70.37%	70.37%	11.11%	0%	0%	0%	0%	0%
Anderson Valley Elementary	39	> 95%	90%	< 5%	0%	< 5%	0%	< 5%	< 5%
St. Mary of the Angels	27	> 95%	> 95%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%
Arena Elementary Point Arena Unified	25	> 95%	> 95%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%
Potter Valley Elementary	22	> 95%	> 95%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%
River Oak Charter Ukiah Unified	42	76.19%	59.52%	9.52%	2.38%	0%	11.90%	0%	0%
Willits Elementary Charter	23	82.61%	68.18%	8.70%	0%	0%	0%	0%	0%
Tree of Life Charter Ukiah Unified	23	82.61%	> 95%	4.35%	< 5%	0%	< 5%	0%	0%
Frank Zeek Elementary Ukiah Unified	> 99	> 98%	94.74%	< 2%	0%	< 2%	0%	< 2%	< 2%
Nokomis Elementary Ukiah Unified	82	> 98%	97.22%	< 2%	0%	< 2%	0%	< 2%	< 2%
Redwood Elementary Fort Bragg Unified	134	74.63%	69.92%	0%	0%	0%	1.63%	0%	25.37%
Round Valley Elementary	42	83.33%	94.29%	0%	2.86%	0%	2.86%	0%	14.29%
Calpella Elementary Ukiah Unified	126	97.62%	94.44%	0%	0%	0%	0%	0%	0%

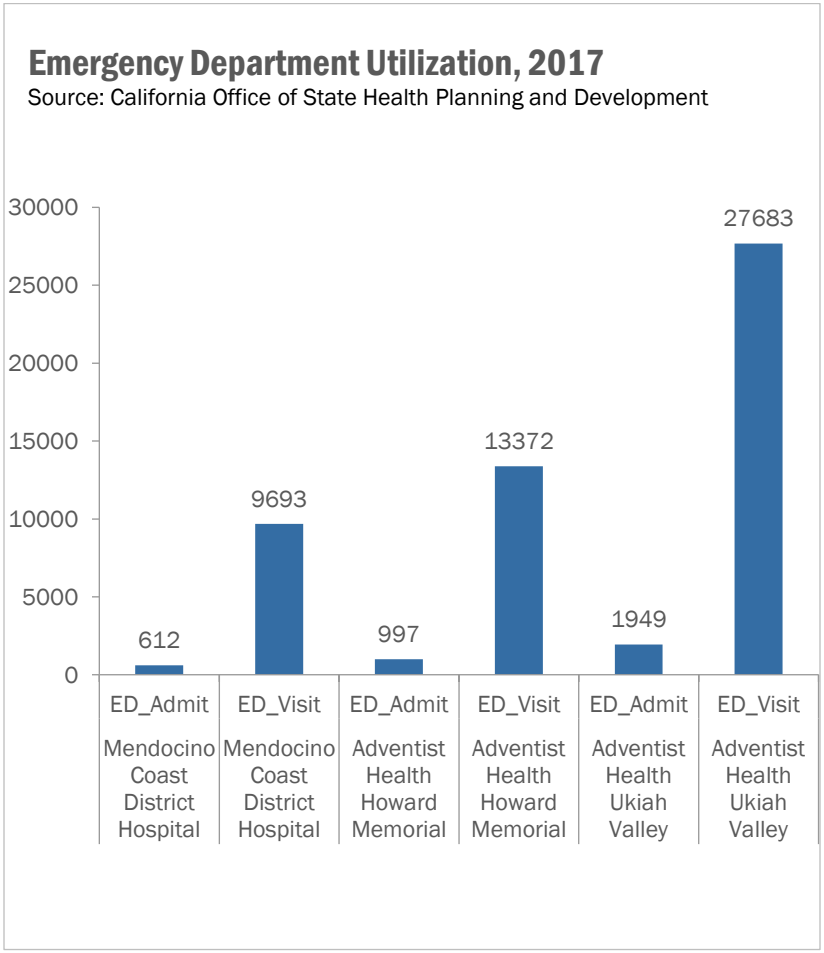
Grace Hudson Elementary Ukiah Unified	> 98	88.78%	94.74%	0%	0%	0%	0%	0%	0%
Oak Manor Elementary Ukiah Unified	96	91.67%	95.92%	0%	0%	0%	0%	0%	8.33%
Yokayo Elementary Ukiah Unified	83	95.18%	> 98%	0%	< 2%	0%	< 2%	2.41%	0%
Brookside Elementary Willits Unified	155	82.58%	90.73%	0%	0.66%	0%	1.32%	0%	17.42%

Definitions of column headers:

- School: School name, district (if available), and county.
- 2017-18 Students: Number of incoming kindergarten students in the 2017-18 school year.
- 2017-18 Up to date: Percentage of incoming kindergartners up to date on their vaccinations in the 2017-18 school year.
- 2016-17 Up to date: Percentage of incoming kindergartners up to date on their vaccinations in the 2016-17 school year.
- 2017-18 Medical: Percentage of incoming kindergartners claiming a Permanent Medical Exemption in the 2017-18 school year.
- 2016-17 Medical: Percentage of incoming kindergartners claiming a Permanent Medical Exemption in the 2016-17 school year.
- 2017-18 Belief: Percentage of incoming kindergartners claiming a Personal Belief Exemption in the 2017-18 school year.
- 2016-17 Belief: Percentage of incoming kindergartners claiming a Personal Belief Exemption in the 2016-17 school year.
- 2017-18 Overdue: Percentage of children who are overdue for one or more required immunizations in the 2017-18 school year.
- 2017-18 Other: Percentage of children who are not required to have immunizations because they attend a home school or an independent study program or receive special education services in the 2017-18 school year.
- An asterisk indicates that no data is available because the school did not submit its statistics.
- Percentages may not add up to 100 percent because one category, conditional exemptions, is not shown.
- A conditional exemption refers to students who have received some vaccines, but under immunization schedules must wait before their next vaccinations. They are admitted on the condition that they become up to date.

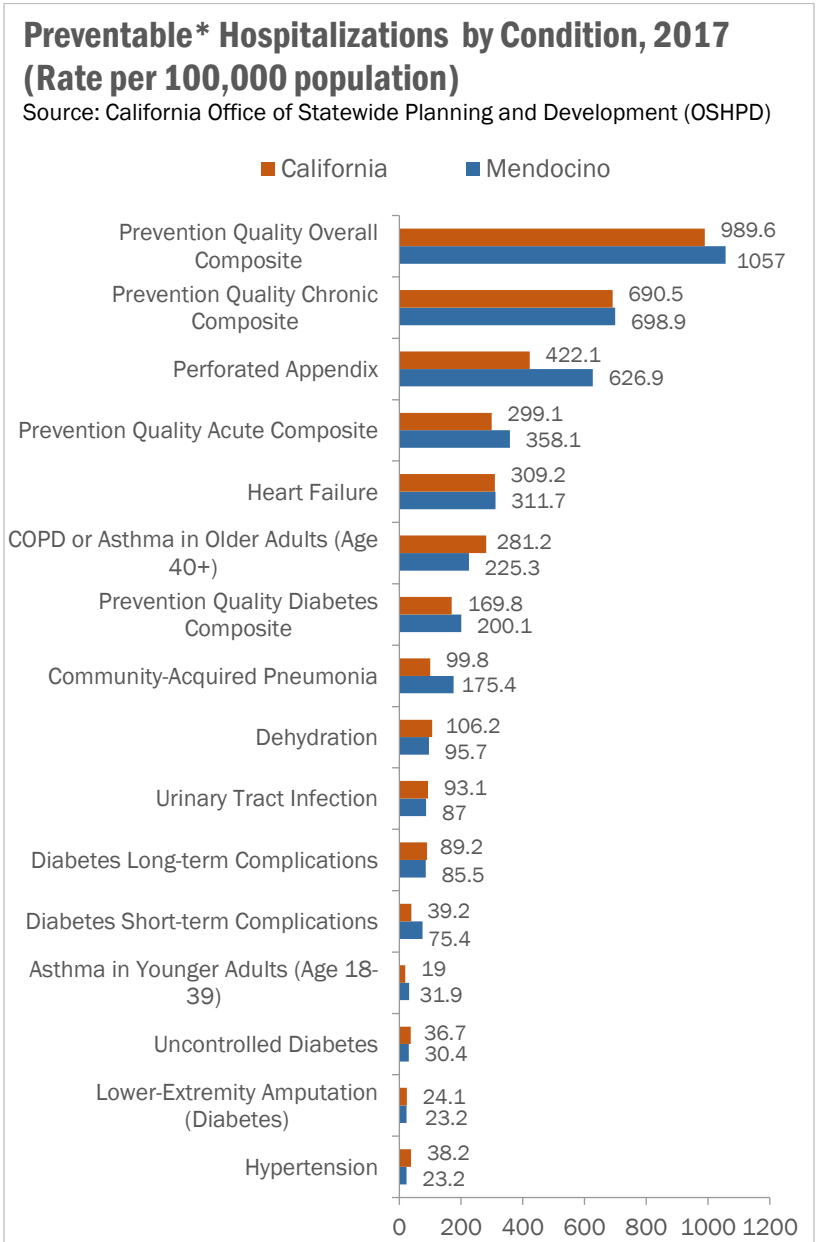
Healthcare and Preventative Services

Hospitalization and Emergency Room Utilization



Safe Haven Wellness Center (SHWC)

Individuals admitted into Emergency Departments or Inpatient care for treatment and then released, may find themselves with limited options for post-hospital care. Patients are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning, so California Senate Bill 1152 requires each hospital to include a written patient discharge planning policy and process for homeless patients, and/or those with substance abuse issues. Prior to discharge the hospital shall determine that the patient has been fed, has adequate clothing, medications, disease screening and vaccinations, identified any mental health or behavioral health care services needed, and provides a "warm hand-off" from the hospital to the Safe Haven Wellness Center. SHWC is intended to address the intersection of homelessness and opioid addiction for individuals residing in Mendocino County.



The Agency for Healthcare Research and Quality uses *Prevention Quality Indicators (PQIs) to measure adult hospital admissions for "ambulatory care-sensitive conditions", hospitalizations that evidence suggest may have been avoided through access to high-quality outpatient care. The Prevention Quality *Composite* Indicators are those that include multiple conditions, such as a patient presenting with COPD, diabetes and hypertension.

Medical Insurance and Uninsured Rates

The measurement of the uninsured is the percentage of the population under age 65 without health insurance coverage. Lack of health insurance coverage is a significant barrier to accessing needed health care and to maintaining financial security. It can contribute to delays in seeking medical care when a condition is treatable or controllable, for example in an out-patient setting, leading to higher levels of care and greater expense to treat more serious conditions at the Emergency Department or as an inpatient. Being uninsured can lead to dire financial consequences when patients are uninsured and are unable to pay their medical bills.

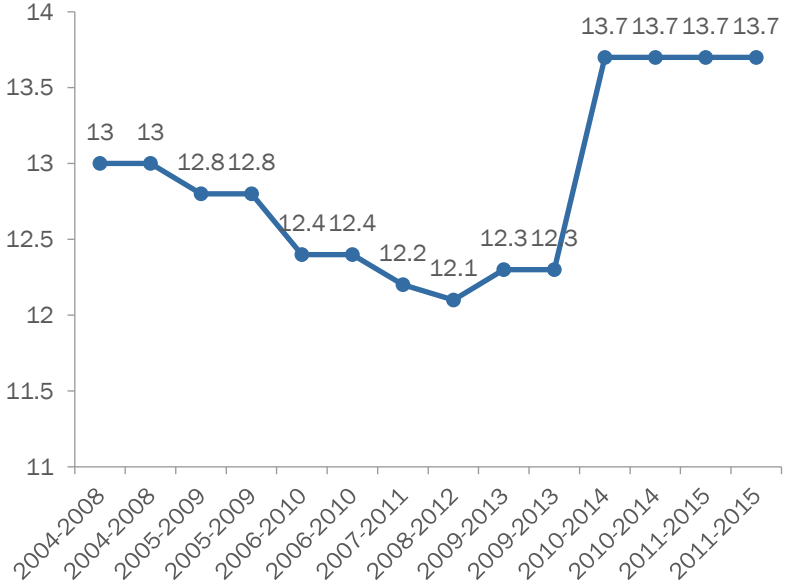
In Mendocino County estimates are that 10% of the population is uninsured, compared with California at 8%.

Dental Health

Oral health impacts overall health and well-being. Tooth-decay is one of the most prevalent chronic infectious diseases in the United States.

Oral Cavity and Pharynx Cancer Incidence Rate, cases per 100,000 population

Source: California Department of Public Health



Individuals with poor oral health have higher rates of cardiovascular problems such as heart attack and stroke than people with good oral health. There are a number of theories about why this seems to be true[xi] but it appears that the bacteria involved in periodontal disease may contribute to inflammation that worsens hypertension and atherosclerosis. In addition to cardiovascular problems, periodic check-ups help detect oral cancers. The known risk factors for developing oral cancers are tobacco use and heavy alcohol consumption. The overall rate for oral cancers in California is 10.3 cases per 100,000, compared to Mendocino County at 13.7 cases per 100,000.

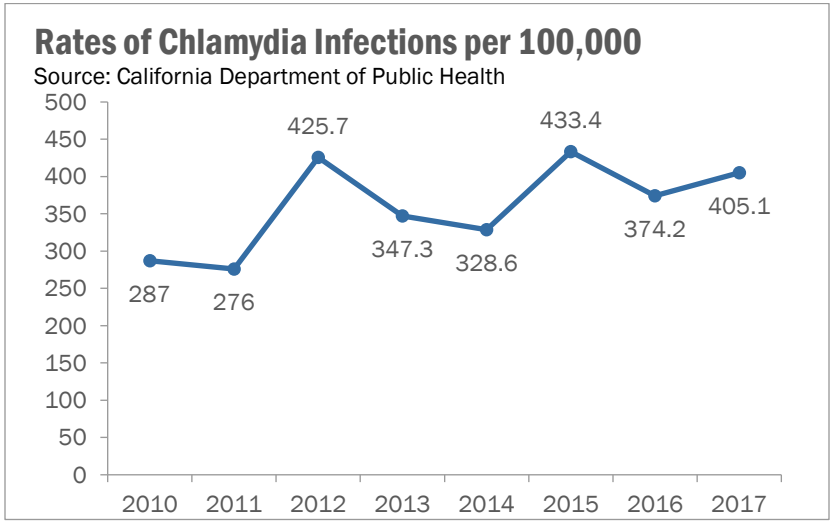
The ratio of dentists to the population of Mendocino County is 1,280:1, compared with the rate in California overall of 1,200:1. The rate in Mendocino County has declined from 2015, when it was 1,301:1. The populations most underserved are those individuals with no dental insurance or those with Medi-Cal dental insurance (Denti-Cal). Individuals with no dental insurance coverage are more likely to put off regular check-ups and seek care when dental caries become significantly infected and painful. Individuals with Denti-Cal insurance often have difficulty finding dentists who accept this coverage due to low reimbursement rates, and this insurance offers only limited treatment options. Of the estimated 19,000 children in Mendocino County, in 2016, only 39% of low-income children, ages 0 to 5, had visited a dentist in the past year.

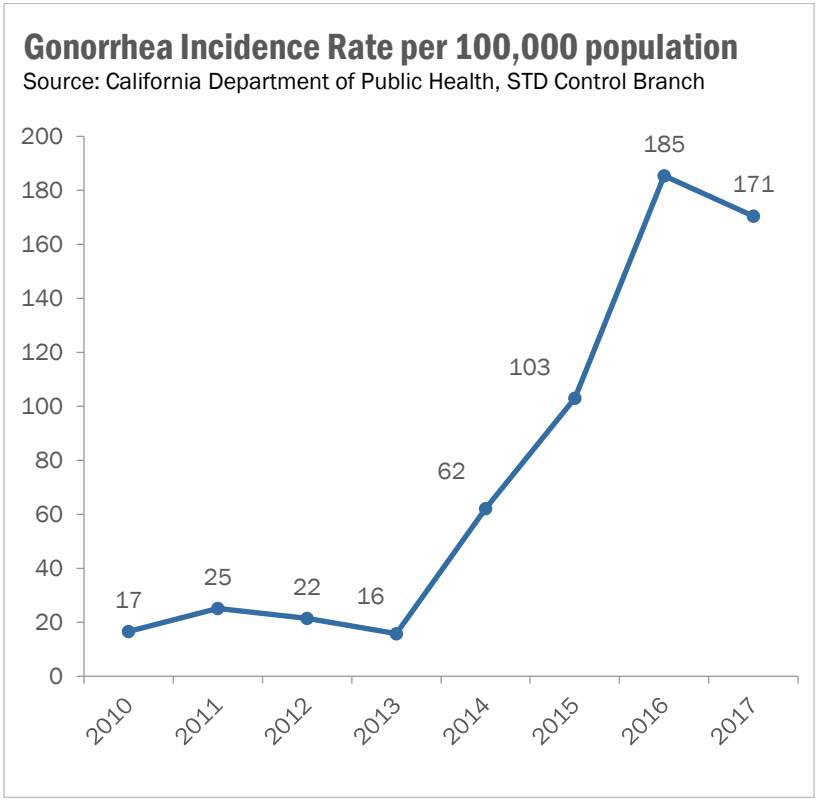
In an effort to increase the availability of dental care and educate the public about the importance of starting oral health care for children early in life, Mendocino County launched an Oral Health Advisory Committee in March 2018. The overarching goal is to partner with school districts around the county to provide school-based services; classroom education, oral screenings, fluoride varnish and dental sealants. School-based services will provide the need for our young populations to have early dental care which in turn will reduce the number of missed school days due to oral problems and increase their overall health. Early oral health care can prevent future problems.

Death, Disease and Chronic Conditions

Sexually Transmitted Infections

Chlamydia, the most frequently reported bacterial sexually transmitted infection (STI) in the United States, is caused by the bacterium, *Chlamydia trachomatis*. Although symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia can also cause discharge from the penis of an infected man. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Chlamydia infections, while also an indicator of non-safe sexual practices, make the individual more susceptible to infection by the HIV virus. In 2017, the overall rate for the State of California was 552.2 per 100,000 population.

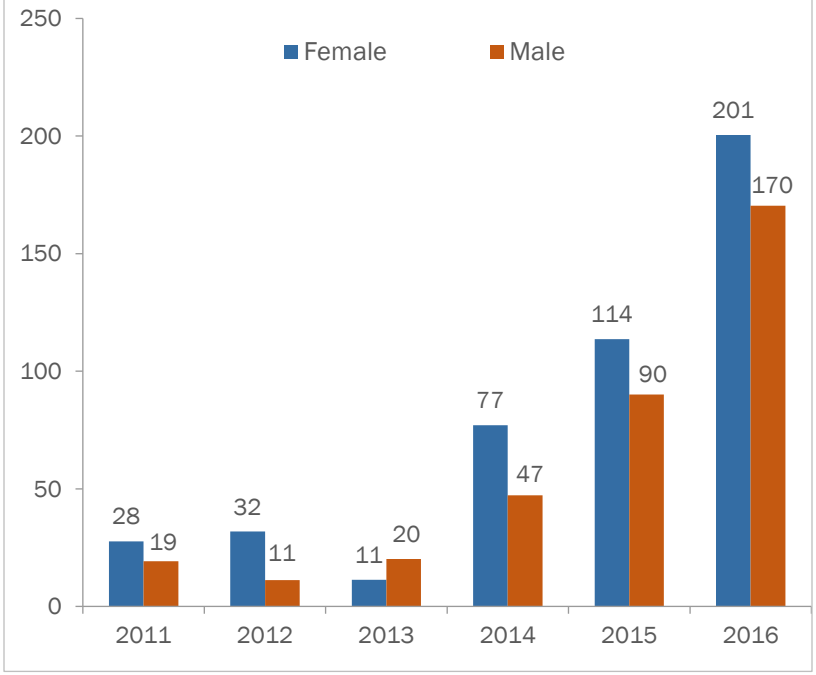




Gonorrhea is an STI caused by *Neisseria gonorrhoeae*. It is typically asymptomatic, but easy to treat. However, gonorrhea has developed resistance to antibiotics over the years, complicating treatment. Many people with gonorrhea don't have any symptoms, but they can still spread the infection to others. Gonorrhea has progressively developed resistance to the antibiotic drugs prescribed to treat it. Following the spread of gonococcal fluoroquinolone resistance, the cephalosporin antibiotics have been the foundation of recommended treatment for gonorrhea.

Gonorrhea Incidence Rate per 100,000 population by Gender

Source: California Department of Public Health, STD Control Branch



Gonorrhea that is not treated can cause serious health problem in men and women. Pelvic inflammatory disease occurs in women when the gonorrhea infection affects their uterus or fallopian tubes. The most serious complication associated with pelvic inflammatory disease is infertility. Complications in men with gonorrhea include epididymitis (an inflammation of the tube that carries sperm) and infertility. Mendocino County has higher rates of infections than California at 190 cases per 100,000 population.

Illness, Injury and Deaths

Cause of Death per 100,000 population Source: CDPH	Mendocino County	California
All causes	727.1	610.3
All cancers	157.2	137.4
Colorectal cancer	13.9	12.5
Lung cancer	34	27.5
Female breast cancer	19.9	18.9
Prostate cancer	27.9	19.4
Diabetes	18.8	21.2
Coronary heart disease	11.8	35.7
Alzheimer's disease	85	87.4
Stroke	37.2	36.3
Influenza / Pneumonia	14.8	14.2
Chronic lower respiratory disease	40.1	32
Liver disease and cirrhosis	9.3	12.2
Accidents (Unintentional injury)	67.1	32.2
Motor vehicle traffic crashes	15.5	9.5
Suicide	21.3	10.4
Homicide	6	5.2
Firearm related deaths	14.3	7.9
Drug induced deaths	26.2	12.7

Life Expectancy

Most people are nowadays expected to live to about 75 years, (this is the accepted figure for the United States), so anyone who dies before this is considered to have died prematurely.

We measure premature mortality by estimating the average years a person would have lived, if he or she had not died prematurely. A person who dies at 65 has lost 10 years of potential life while a person who dies at age 1 has lost 74 years of potential life.

This measure is different from overall mortality, because premature mortality focuses on deaths that could have been prevented. This measure is called Years of Potential Life Lost (YPLL). YPLL emphasizes deaths of younger persons, whereas statistics that include all deaths are going to have more deaths of elderly people, and therefore not tell us about the rates of premature deaths. In order to be able to compare with other populations we use a rate per 100,000 people. By examining deaths in a community and using the YPLL, we can determine and rank the causes of premature death.

Most premature deaths may be preventable through lifestyle modifications such as smoking cessation or healthy eating and exercise.

Years of Potential Life Lost (YPLL)
Source: California Vital Statistics

2018	Rate per 100,000
California	5,734
Mendocino	7,606
2017	**Rate per 100,000**
California	5,674
Mendocino	7,922
2016	**Rate per 100,000**
California	5,528
Mendocino	7,619
2015	**Rate per 100,000**
California	5,609
Mendocino	7,323
2014	**Rate per 100,000**
California	5,590
Mendocino	8,390

Causes of Death by Year and Gender

Source: California Vital Statistics

2013	Number 1 Cause of Premature Death	Number 2 Cause of Premature Death
Females	Lung Cancer	Breast Cancer
Males	Lung Cancer	Atherosclerotic heart disease of native coronary artery
2014	**Number 1 Cause of Premature Death**	**Number 2 Cause of Premature Death**
Females	Lung Cancer	Chronic obstructive pulmonary disease
Males	Lung Cancer	Atherosclerotic heart disease of native coronary artery
2015	**Number 1 Cause of Premature Death**	**Number 2 Cause of Premature Death**
Females	Breast Cancer	Lung Cancer
Males	Lung Cancer	Atherosclerotic heart disease of native coronary artery
2016	**Number 1 Cause of Premature Death**	**Number 2 Cause of Premature Death**
Females	Lung Cancer	Chronic obstructive pulmonary disease
Males	Lung Cancer	Acute myocardial infarction
2017	**Number 1 Cause of Premature Death**	**Number 2 Cause of Premature Death**
Females	Lung Cancer	Breast Cancer
Males	Atherosclerotic heart disease of native coronary artery	Lung Cancer

Mendocino County Ranking

The Robert Woods Johnson Foundation evaluates California counties based on a series of indicators. The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

Mendocino ranks 41 out of 55 in overall health ranking. Marin County is number 1.

SOURCES

Annie E. Casey Foundation https://www.aecf.org/
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California Center for Rural Policy http://www2.humboldt.edu/ccrp/
California Child Welfare Indicators Project http://cssr.berkeley.edu/ucb_childwelfare/
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FBI Uniform Crime Reports https://www.fbi.gov/services/cjis/ucr
Feeding America https://www.feedingamerica.org/
Healthy Mendocino http://www.healthymendocino.org/
Parents and the High Cost of Child Care: A Report http://usa.childcareaware.org/advocacy-public-policy/resources/reports-and-research/parents-and-the-high-cost-of-child-care
Child Welfare Services/Case Management System https://www.hwcws.cahwnet.gov/
Institute for Health Metrics and Evaluation http://www.healthdata.org/Kidsdata.org
Massachusetts Institute of Technology (MIT) http://www.mit.edu/
Mendocino County Continuum of Care for the Homeless Report http://www.co.mendocino.ca.us/hhsa/adult/coc.htm
National Cancer Institute (NCI) https://www.cancer.gov/
National Center for Education Statistics https://nces.ed.gov/
National Center for Health Outcomes Development https://www.cdc.gov/nchs/about/factsheets/factsheet_overview.htm
The Dartmouth Institute for Health Policy and Clinical Practice (TDI) https://tdi.dartmouth.edu/
U.S. Census Bureau http://www.census.gov/
U.S. Census Bureau, American Community Survey (ACS) https://www.census.gov/programs-surveys/acs/data.html
U.S. Department of Agriculture (USDA) http://www.usda.gov/wps/portal/usda/usdahome
U.S. Department of Health and Human Services (DHHS) https://www.hhs.gov/
US Department of Justice https://www.justice.gov/
US Department of Labor https://www.dol.gov/

ADDENDUM

Data Dictionary

The following indicators are from the previous Community Health Needs Assessment of 2015-2016 and the most updated values as of 2019. The previous values are in black, and the most recent values are in red for comparison.

Overall, 48% of the indicators show a positive trend, 7% are the same, and 45% show a negative trend.

Indicator #	Socioeconomics	Mendocino County	CA	US	HP 2020	Sources
1	People Living Below Federal Poverty Level	21.00% (2011-2013) 20.20% (2012-2017)	16.80% (2011-2013) 15.80% (2012-2017)	15.90% (2011-2013) 15.10% (2012-2017)	NA	ACS
2	Families Living Below Federal Poverty Level	14.50% (2011-2013) 14.70% (2012-2016)	12.70% (2011-2013) 11.80% (2012-2016)	11.70% (2011-2013) 11.00% (2012-2016)	NA	ACS
3	People 65+ Living Below the Federal Poverty Level	9.60% (2011-2013) 9.20% (2012-2016)	10.30% (2011-2013) 10.30% (2012-2016)	9.50% (2011-2013) 9.30% (2012-2016)	NA	ACS
4	Children Living Below Federal Poverty Level	30.08% (2011-2013) 24.40% 2017	23.30% (2011-2013) 21.90% (2012-2016)	22.40% (2011-2013) 21.20% (2012-2016)	NA	ACS
5	Unemployment Rate	6.60% -2014 4.50% 2018	7.20% -2014 4.20% 2018	6.00% -2014 3.90% 2018	NA	US Dep Labor

6	Median Household Income	$42,111 (2011-2013) $43,510 (2012-2016)	$59,645 (2011-2013) $63,783 (2012-2016)	$63,784 (2011-2013) $55,322 (2012-2016)	NA	ACS
7	Per Capita Income	$23,880 (2011-2013) $25,278 (2012-2016)	$29,103 (2011-2013) $31,485 (2012-2016)	$27, 884 (2011-2013) $29,829 (2012-2016)	NA	ACS
8	Living Wage- Annual income required to support household with one adult	$19,132 -2014 $22,425 2018	$23,295 -2014 $26,899 2018	NA	NA	MIT
9	Living Wage- Annual income required to support household with one adult and one child	$42,052 -2014 $49,670 2018	$47,212 -2014 $56,985 2018	NA	NA	MIT
10	Living Wage-Annual income required to support household with two adults and two children	$40,885 -2014 $50,438 2018	$46,063 -2014 $57,676 2018	NA	NA	MIT
11	Homeownership (percentage of housing units that are occupied by homeowners)	48.40% (2011-2013) 48.60% (2012-2016)	49.90% (2011-2013) 49.80% (2012-2016)	56.00% (2011-2013) 55.90% (2012-2016)	NA	ACS
12	Proportion of housing tenure who are renters	43.30% (2011-2013) 42.90% (2012-2016)	45.80% (2011-2013) 45.90% (2012-2016)	36.00% (2011-2013) 36.40% (2012-2016)	NA	ACS
13	Proportion of renters spending 30% or more of household income on rent	59.60% (2011-2013) 54.40% (2012-2016)	57.40% (2011-2013) 56.50% (2012-2016)	52.30% (2011-2013) 47.30% (2012-2016)	NA	ACS

14	Households with Cash Public Assistance Income	36.00% (2011-2013) 3.60% (2012-2016)	4.10% (2011-2013) 3.80% (2012-2016)	2.90% (2011-2013) 2.70% (2012-2016)	NA	ACS
15	Low-Income Persons who are Food Stamp/SNAP Participants	11.40% (2011-2013) 12.20% (2012-2016)	9.00% (2011-2013) 8.90% (2012-2016)	13.40% (2011-2013) 11.70% (2012-2016)	NA	ACS
16	Percentage of the population that experienced food insecurity at some point during the year	16.2% -2012 14.50% 2016	16.20% -2012 12.90% 2016	15.90% -2012 15.20% 2016	NA	CHIS/ BRFSS
17	Percentage of children (<18 years of age) living in households that experienced food insecurity at some point during the year	27.50% -2012 21.60% 2016	26.30% -2012 19.00% 2016	21.60% -2012 17.90% 2016	NA	Feeding America
18	Percent of the population that speak English less than "very well" (Language Spoken at home-Spanish)	8.80% (2011-2013) 10.10% (2012-2016)	19.10% (2011-2013) 10.80% (2012-2016)	8.60% (2011-2013) 5.70% (2012-2016)	NA	ACS
19	Children receiving free or reduced-price meals at schools per 100 students	63.6 -2012 73.20% 2015	57.5 -2012 58.60% 2015	51.9 -2012 73.60% 2017	NA	USDA
20	Percent of adults age 25+ without high school diploma	13.80% (2011-2013) 12.48% 2017	18.50% (2011-2013) 17.90% 2017	13.70% (2011-2013) 12.00% 2017	NA	ACS
21	High School Graduation Rate	84.10% (2011-2012) 85.20% 2017	83.80% (2011-2012) 83.20% 2017	82.20% (2011-2012) 84.00% 2017	NA	EDFacts

22	People 25+ with a bachelor's degree	14.30% (2011-2013) 17.66% 2018	19.50% (2011-2013) 17.90% 2018	18.20% (2011-2013) 18.80% 2018	NA	ACS
Indicator #	Social Determinants of Health	Mendocino County	CA	US	HP 2020	Sources
23	Voter Turnout (percentage of registered voters who voted in the last presidential election)	72.50% -2012 75.90% 2016	72.40% -2012 75.30% 2016	54.90% -2012 57.50% 2016	NA	CA Secretary of State
24	Proportion of renter occupied households living in overcrowded environments (>1.5 persons/room)	1.50% (2011-2013) 1.80% 2017	2.80% (2011-2013) 8.3% 2017	1.00% (2011-2013) 1.10% 2017	NA	ACS
25	Householder living alone 65 years and over	12.80% (2009-2013) 30.20% (2012-2016)	8.50% (2009-2013) 23.10% (2012-2016)	9.80% (2009-2013) 26.40% (2012-2016)	NA	ACS
26	Student-to-Teacher Ratio	18.9: 1 (2011-2012) 19:01 (2015-2016)	23.4:1 (2011-2012) 23.7:1 (2015-2016)	16.0:1 (2011-2012) 17.7:1 (2015-2016)	NA	National Center for Education Statistics
27	Percent of fourth grade students who are proficient and above in English Language Arts (ELA) and Math	51% (ELA) 56% (Math) -2013 33% (ELA) 26% (Math) 2017	65% (ELA) 72% (Math) -2013 45.06% (ELA) 40.45% (Math) 2017	67% (ELA) 82% (Math) -2013 48.56% (ELA) 37.56% (Math) 2017	NA	CDE
29	Percent of English language learners (K-12) who met California English Language Development Test (CELDT) criteria for proficiency	35% -2014 34% (2016-2017)	39% -2014 39% (2016-2017)	NA	NA	CDE

32	Percentage of 11th grade students reporting current gang involvement	5.50% (2011-2013) 6.10% (2013-2015)	7.50% (2011-2013) 5.40% (2013-2015)	7.90% (2011-2013) 9% (2013-2015)	NA	Kidsdata
33	Juvenile Arrest Rate (the number of felony and misdemeanor arrests per 1,000 adults ages 17 and under)	16.3 -2013 5.3 2015	9.3 -2013 9.6 2015	3.3 -2013 NA 2015	NA	CA DOJ
34	Number of domestic violence calls for assistance and rate per 1,000 population	6.8 -2013 8.6 2014	3.9 -2013 6 2014	5.6 -2013 NA	NA	CA DOJ
36	Arrest Rate (the number of felony and misdemeanor arrests per 1,000 youth ages 18+)	66.2 -2013 57.4 2016	38.3 -2013 35.1 2016	38.8 -2013 NA	NA	FBI Uniform Crime Reports
37	Fast Food Restaurant Density: Number of fast food restaurants per 100,000 population	59.2 -2013 59.2 2014	74.92 -2013 72 2014	72.74 -2013 73 2014	NA	USDA
38	WIC Authorized Grocery Stores per 100,000 population	22.84 -2011 14.7 2017	15.8 -2011 15.5 2017	15.6 -2011 15.8 2017	NA	USDA
39	Food Environment Index Score	15.88% -2011 7.40% 2018	3.29% -2011 8.80% 2018	5.02% -2011 7.70% 2018	NA	County Health Rankings
40	Grocery Stores and Supermarkets, Rate (Per 100,000 Pop.)	54.65 -2013 53 2015	21.7 -2013 24 2015	21.2 -2013 19 2015	NA	Census

41	Liquor Stores per 100,000 population (see comment)	13.66 -2013 11.4 2015	10.25 -2013 10.1 2015	10.44 -2013 10.5 2015	NA	Census
42	Recreation and Fitness Facilities, Rate (Per 100,000 Pop.)	0.17 facilities/per 100,000 -2013 0.16 facilities / per 100,000 2014	3 to 29 facilities /per 100,000 -2013 0.06 facilities per / 100,000 2014	NA -2013 NA	NA	Census
43	Percent of population living within 1/2 mile of a park	20.00% -2010 NA NA	27.60% -2010 NA NA	14% -2010 NA NA	NA	Census, ESRI
44	Workers Commuting by Public Transportation	0.70% (2011-2013) 0.50% 2016	5.20% (2011-2013) 5.10% 2016	5.10% (2011-2013) 5.10% 2016	NA	ACS
45	Workers who Drive Alone to Work	72.20% (2011-2013) 74.30% 2016	73.30% (2011-2013) 73.60% 2016	76.40% (2011-2013) 76.40% 2016	NA	ACS
46	Mean Travel Time to Work	18.3 minutes (2011-2013) 17.6 minutes 2016	27.5 minutes (2011-2013) 26.9 minutes 2016	25.7 minutes (2011-2013) 25 minutes 2016	NA	ACS
47	Percentage of days exceeding emissions standards (particulate matter 2.5 level)	7.80% -2008 9.40% 2017	4.20% -2008 NA NA	1.20% -2008 NA NA	NA	CDC NEPHTN

Indicator #	Social and Mental Health	Mendocino County	CA	US	HP 2020	Sources
48	Ratio of population to mental health providers	468 to 1 -2013 180 to 1 2018	623 to 1 -2013 320 to 1 2017	753 to 1 -2013 330 to 1 2017	NA	County Health Rankings
49	Percent of adults with a physical, mental or emotional disability	31.10% (2011-2012) 28.90% 2016	29.90% (2011-2012) 29.70% 2016	22.40% (2011-2012) 20.60% 2015	NA	CHIS/CDC
50	Percent of adults age 65+ with a physical, mental or emotional disability	50.30% (2011-2012) 38.90% (2012-2016)	51.30% (2011-2012) 36.00% (2012-2016)	36% (2011-2012) 35.80% (2012-2016)	NA	CHIS/CDC
51	Child Abuse Rate (the number of children under 18 years of age that experienced abuse or neglect in cases per 1,000 children)	19.4 -2012 19.3 2017	9.3 -2012 7.7 2017	9.2 -2012 9 2017	NA	Child Welfare Dynamic Report System
52	Substantiated allegations of child maltreatment per 1,000 children ages 0-17	17.1 -2013 19.2 2017	9.2 -2013 7.5 2017	9.2 -2013 9.1 2016	≤8.5	CDSS-UCB
53	Children with Entries to Foster Care per 1,000 children ages 0-17	8.4 -2013 12.3 2015	3.4 -2013 5.8 2015	5.1 -2013 NA NA	NA	CDSS-UCB/DHHS
54	Percent of people who report being divorced	14.70% (2011-2013) 17% 2017	8.20% (2011-2013) 10% 2017	9.70% (2011-2013) 11% 22017	NA	ACS

55	Non-fatal emergency department visits for self-inflicted injuries among youth age 5-19 per 100,000 population	180.4 -2014 267 2015	103.8 -2014 147.4 2015	153.2 -2013 210.01 2015	NA	OSHPD/ CDC WISQARS/Kidsdata.org
Indicator #	Maternal, Child and Adolescent Health	Mendocino County	CA	US	HP 2020	Sources
56	Percent of mothers exclusively breastfeeding in the hospital	75.60% -2013 73.50% 2015	64.80% -2013 68.80% 2015	77% -2013 81% 2015	≥81.9%	CDPH/ NVSS/CDC
57	Percent of WIC mothers exclusively breastfeeding at 6 months	31.50% -2013 48.80% 2017-18	17.40% -2013 26.30% 2015	45% -2013 24.90% 2015	≥25.5%	Mendocino WIC/CDC
58	The number of live births per 1,000 females	76.7 -2012 71 2015	63.6 -2012 62 2015	62 -2010 62.5 2015	NA	FHOP
59	Percent of newborns with Low Birth Weight (less than 2,500 grams)	5.70% -2012 6.10% 2015	6.70% -2012 6.80% 2015	8.00% -2012 8.00% 2015	≤7.8%	FHOP
60	Percent of newborns with very low birth rates (less than 1,500 grams)	0.70% -2012 1% 2015	1.10% -2012 1% 2015	1.40% -2012 1.50% 2015	≤1.4%	FHOP
61	Percent of newborns with very heavy birth weights (more than 4,000 grams)	9.80% -2012 11.30% 2017	8.30% -2012 8.00% 2017	8.10% -2102 8% 2017	NA	FHOP

62	Percent of female who received prenatal care in first trimester	68.20% -2011 67.10% 2015	83.6 -2011 83.20% 2015	73.70% -2011 75% 2015	≥77.9%	FHOP
63	Percent of women no prenatal care or prenatal care not starting until 3rd trimester	5.80% -2011 7.50% 2015	3.20% -2011 3.9 2015	6.00% -2011 6.20% 2015	NA	FHOP
64	Prenatal care covered by Medi-Cal insurance per 100 live births	66.6 -2012 NA	45.9 -2012 NA	NA	≤23.9%	CDPH IPODR/ NVSS
65	Percent of unmarried women who had birth in the past 12 months (15 to 50 years old)	39.20% (2011-2013) 48% 2015	33.90% (2011-2013) 39.00% 2015	35.90% (2011-2013) 40.30% 2015	NA	ACS
66	Teen Birth Rate (birth rate in live births per 1,000 females aged 15-19 years)	27.50% 2013 - 2015 24.90% 2014-2016	21.00% 2013 - 2015 17.60% 2014-2016	24.30% 2013 - 2015 22% 2014-2016	≤36.2	FHOP
67	Teen Birth Rate (birth rate in live births per 1,000 females aged 18-19 years)	60.8 -2011 46.1 2015	46.7 -2011 33.3 2015	47.1 -2011 40.70% 2015	≤105.9	FHOP
68	Percent of pre-term births (< 37 weeks gestation)	8.4 -2013 7.8 2015	9.5 -2013 8.5 2015	3.4 -2013 9.6 2015	≤11.4%	CDPH
69	Percent of births by C-section to low risk women giving birth for the first time	21.40% (2009-2011) 21.15% 2016	26.30% (2009-2011) 26% 2016	32.70% (2009-2011) 26% 2016	≤23.9%	CDPH IPODR/ NVSS

70	Delivery with MediCal insurance as anticipated payer per 100 live births	67.4 -2012 NA	46.4 -2012 59% 2013	44.9 -2010 NA	NA	CDPH IPODR/ NVSS
71	Infant deaths per 1,000 live births (within 1 year)	4.3 -2012 8.1 2015	4.7 -2012 4.5 2015	5.96 -2012 5.7 2015	≤6.0	CDPH
72	Young adult mortality, 20-24 years per 100,000	134.2 (2011-2012) Suppressed 2013-2015	68.2 (2011-2012) 66.5 2013-2015	84.6 -2012 NA NA	≤88.3	CDPH/CDC
73	Female mortality, 15-44 years per 100,000	583.2 (2011-2012) 648.7 2014	119.1 (2011-2012) 667.8 2014	776.1 -2012 777 2014	NA	CDPH/CDC
Indicator #	Healthcare and Preventative Services	Mendocino County	CA	US	HP 2020	Sources
74	Percent of people with Health Insurance	81.80% (2011-2013) 90.10% 2017	82.30% (2011-2013) 93.20% 2017	85.20% (2011-2013) 91.20% 2017	NA	ACS
75	Percent of with Private Health Insurance	48.10% (2011-2013) 33.30% 2017	60.10% (2011-2013) 54.40% 2017	65.20% (2011-2013) 65.40% 2017	NA	ACS
76	Children with Health Insurance	91.50% (2011-2013) 98.10% 2017	92.20% (2011-2013) 97.50% 2017	92.70% (2011-2013) 95.20% 2017	NA	ACS
77	Percent of population without health insurance	18.20% (2011-2013) 10.30% 2017	17.70% (2011-2013) 7.20% 2017	14.80% (2011-2013) 8.70% 2017	0.00%	ACS

78	Access to Primary Care Physicians Rate per 100,000	96.1 -2012 90 2017	85.1 -2012 78 2017	86.6 -2012 75 2017	NA	Dept HHS
79	Ratio of population to primary care physicians	1,042:1 -2011 1,070:1 2017	1,057:1 -2011 1,280:1 2017	1,355:1 -2011 1,040:1 2017	NA	County Health Rankings
80	Ambulatory Care Sensitive Conditions, Rate (Per 1,000 Medicare Enrollees)	35.97 -2012 NA 2015	45.3 -2012 36.2 2015	59.2 -2012 49.4 2015	NA	Dartmouth Atlas of Health Care
81	Annual Pneumonia Vaccination, Percent of Adults Age 65 +	58.70% (2006-2012) NA 2017	63.40% (2006-2012) 76.80% 2017	67.50% (2006-2012) 74.70% 2017	NA	BRFSS
82	Percent of kindergarteners with all required immunizations	75.40% -2013 86.80% 2017	90.20% -2013 95.10% 2017	>90% -2013 >90% 2017	NA	CDPH/CDC
83	Percent of adults age 50+ who have ever had a sigmoidoscopy /colonoscopy	46.40% (2006-2012) 68.40% 2016	57.90% (2006-2012) 67% 2016	61.30% (2006-2012) 69.80% 2016	≥70.5%	CHIS/NHIS
84	Cervical Cancer Screening (Past 3 Years), Percent of Women Age 18+	75.70% (2006-2012) 72.10% 2015	78.30% (2006-2012) 81.50% 2015	78.50% (2006-2012) 79.90% 2015	≥93.0%	BRFSS
85	Mammogram (Past 2 Years), Percent of Female Medicare Enrollees, Age 67-69	58.40% -2012 56.20% 2015	59.30% -2012 59.50% 2015	63.00% -2012 63.20% 2015	NA	Dartmouth Atlas of Health Care

86	Access to Dentists, Rate per 100,000	76.84 -2013 78 2016	77.45 -2013 82 2016	63.18 -2013 67 2016	NA	Dept HHS
87	Percent of Denti-Cal Recipients Without Dental Exam in Past 12 Months	27.70% (2006-2012) 49.20% 2015	30.50% (2006-2012) 49% 2015	30.20% (2006-2012) 34% 2015	NA	Anne E Casey Foundation
Indicator #	Behavioral Risk Factors	Mendocino County	CA	US	HP 2020	Sources
88	Children Consuming 2+ Servings of Fruits/Vegetables per Day	72% (2011-2012) 66.00% 2017	50.50% (2011-2012) 64.30% 2017	NA	NA	CHIS
89	Children and Adolescents who Watch 3+ Hours of Television (percentage of children 3-18 who watch television or play videogames for three or more hours on weekends) (2018 - figures only available for 2 to <3 hours)	48.70% -2009 NA NA	52.70% -2009 NA NA	NA	NA	CHIS
90	Percent of 5th, 7th and 9th graders who are physically fit	56.5% ** -2014 65.10% 2016-17	61.70% -2014 72.40% 2016-17	NA	NA	CDE
91	Percentage of Adults consuming fast food at least once in the past week	52.80% -2014 54.00% 2016	64.80% -2014 65.60% 2016	44% -2014 37.50% 2016	NA	CHIS/CDC
92	Percentage of Children under 18 consuming fast food at least once in the past week	16.90% -2014 12.60% 2017	56.30% -2014 37% 2016	34% -2014 34% 2015	NA	CHIS/CDC

93	Percent of adults binge drinking at least once in month prior.	22.90% (2006-2012) 38.70% 2015	17.20% (2006-2012) 24.70% 2015	16.90% (2006-2012) 17% 2015	≤24.4%	BRFSS
94	Percent of 11th grade students drinking at least once in month prior	49.40% (2011-2013) 37% (2014-2015)	31.30% (2011-2013) 29.10% (2014-2015)	35.10% (2011-2013) 38% (2014-2015)	NA	CA Healthy Kids Survey
95	Percent of adults smoking cigarettes some days or every day	18.60% (2006-2012) 15% (2015-2016)	12.80% (2006-2012) 11% (2015-2016)	18.10% (2006-2012) 17% (2015-2016)	≤12.0%	BRFSS
Indicator #	Illness and Injury	Mendocino County	CA	US	HP 2020	Sources
96	Life Expectancy for Females in years	80.9 -2013 81.2 2014	83.1 -2013 78.6 2014	81.2 -2013 76.7 2014	NA	CDC
97	Life Expectancy for Males in years	75.6 -2013 76 2014	78.3 -2013 78.6 2014	76.4 -2013 76.7 2014	NA	CDC
98	Percent of adults (20+ years) who are overweight (BMI >25 and < 30)	58.70% -2014 46.70% 2017	59.70% -2014 34.50% 2017	69.00% -2014 71.60% 2017	NA	CHIS
99	Percent of adults (20+ years) who are obese (BMI > 30)	22.20% -2014 21.00% 2017	27.30% -2012 26.90% 2017	27.10% -2012 39.80% 2017	NA	CHIS
100	Percent of 5th, 7th and 9th graders who are overweight or obese	43.50% -2014 43.80% 2017	38.30% -2014 38.80% 2017	17.70% -2014 20% 2017	NA	CDE

101	Percentage of Adults with Asthma (Lifetime Asthma Prevalence Percent)	13.22% (2011-2012) 18.00% 2015-2016	14.21% (2011-2012) 14.90% 2015-2016	13.36% (2011-2012) 14.00% 2015-2016	NA	CDC
102	Percent of children with Asthma (Lifetime Asthma Prevalence Percent)	7.00% (2011-2012) 21.10% 2016	15.40% (2011-2012) 13.70% 2016	12.70% -2013 10% 2016	NA	CHIS
103	Percentage of Adults with Diabetes (20+ years of age)	7.20% -2012 6.70% 2014	8.10% -2012 8.70% 2014	9.10% -2012 9.70% 2014	NA	CHIS/CDC
104	Percent of adults who have coronary heart disease	3.81% (2011-2012) 7.80% 2014	3.45% (2011-2012) 5.90% 2014	4.40% (2011-2012) NA NA	NA	CHIS/ NHANES
105	Prevalence of chronic obstructive pulmonary disease among adults	4.10% -2012 4.10% 2017	4.60% -2012 3.40% 2017	5.70% -2012 6.30% 2017	NA	American Lung Association/CDC
106	Percent of adults who have ever been diagnosed with high blood pressure	23.50% (2006-2012) 31.50% 2016	26.20% (2006-2012) 28.40% 2016	28.20% (2006-2012) 30.90% 2016	≤26.9%	CHIS
107	Breast Cancer Incidence Rate (per 100,000 females)	125 (2007-2011) 105.8 (2011-2015)	122.4 (2007-2011) 121.5 (2011-2015)	122.7 (2007-2011) 124.7 (2011-2015)	≤40.9	NCI
108	Cervical Cancer Incidence Rate (per 100,000 females)	12.1 (2007-2011) 10.9 (2011-2015)	7.8 (2007-2011) 7.2 (2011-2015)	7.8 (2007-2011) 7.5 (2011-2015)	≤ 7.1	NCI
109	Colorectal Cancer Incidence Rate per 100,000	41.6 (2007-2011) 31.7 (2011-2015)	41.5 (2007-2011) 36.2 (2011-2015)	43.3 (2007-2011) 39.2 (2011-2015)	≤38.7	NCI

110	Lung and Bronchus Cancer Incidence Rate per 100,000	59.1 (2007-2011) 49.2 (2011-2015)	49.5 (2007-2011) 43.3 (2011-2015)	64.9 (2007-2011) 60.2 (2011-2015)	NA	NCI
111	Prostate Cancer Incidence Rate (per 100,000 males)	131.5 (2007-2011) 87 (2011-2015)	136.4 (2007-2011) 101.2 (2011-2015)	142.3 (2007-2011) 109 (2011-2015)	NA	NCI
112	Gonorrhea Incidence Rate (per 100,000 population)	150.8 -2013 170.5 2017	100.4 -2013 190.3 2017	106.1 -2013 126.6 2017	NA	CDPH/CDC
113	Syphilis Incidence Rate (Primary & Secondary)	3.4 -2013 4.5 2017	9.3 -2013 16.8 2017	5.5 -2013 8.7 2017	NA	CDPH/CDC
114	Chlamydia Incidence Rate	347.3 -2013 405.1 2017	439.9 -2013 552.2 2017	446.6 -2013 476.1 (2014-2016)	NA	CDPH/CDC
115	Chronic Hepatitis C Prevalence Rate per 100,000 population	140.8 -2013 119.9 2015	81.9 -2013 86.4 2015	0.6 -2013 1.1 2015	NA	CDPH/CDC
116	HIV Prevalence Rate	27.1 -2012 28.4 2013	13.3 -2012 119.7 2013	15.3 -2012 13.5 2013	NA	CDPH/CDC
117	HIV Incidence (newly diagnosed cases) rates per 100,000 population	2.3 -2013 3.4 2016	12.3 -2013 12.9 2016	19.6/100,000 -2013 12.3 2016	≤ 13	Mendocino PH/CDPH/ CDC

118	Non-fatal emergency department visits for fall related injuries among adults 65 to 106 years (Age-Adjusted Rate per 1,000)	5.7 -2012 3.2 2014	4.1 -2012 1.9 2014	4.3 -2012 NA NA	≤ 4.7	CDPH EpiCenter/ CDC NCHS
119	Non-fatal emergency department visits for motor vehicle crash injuries (occupants) per 100,000	628 -2012 511.1 2014	483 -2012 506.6 2014	806 -2012 905 2014	NA	CDPH EpiCenter/ CDC WISQARS
120	Non-fatal emergency department visits for unintentional MVT collision with bicyclist per 100,000	11.3 -2013 17 2015	25 -2013 32.7 2015	147.9 -2013 140 2015	NA	140
Indicator #	Healthcare Cost/ Medicare Beneficiaries	Mendocino County	CA	US	HP 2020	Sources
121	Standardized Cost Breakdown of Medicare beneficiaries who were treated for inpatient care	$1,796 -2012 $2,134 2016	$2,459 -2012 $2,610 2016	$2,595 -2012 $2,689 2016	NA	CMS
122	Standardized Cost Breakdown of Medicare beneficiaries who were treated for post-acute care	$758 -2012 $866 2016	$1,477 -2012 $1,553 2016	$1,648 -2012 $1,664 2016	NA	CMS
123	Standardized Cost Breakdown of Medicare beneficiaries who were treated for hospice care	$75 -2012 $110 2016	$231 -2012 $293 2016	$317 -2012 $329 2016	NA	CMS
124	Standardized Cost Breakdown of Medicare beneficiaries who were treated for physician /OPD /Tests /Imaging	$2,423 -2012 $3,042 2016	$3,219 -2012 $3,580 2016	$3,329 -2012 $3,711 2016	NA	CMS

125	Standardized Cost Breakdown of Medicare beneficiaries who were treated for durable medical equipment	$165 -2012 $124 2016	$205 -2012 $160 2016	$236 -2012 $181 2016	NA	CMS
126	Standardized Cost Breakdown of Medicare beneficiaries who were treated for Part B Drug	$220 -2012 $200 2016	$353 -2012 $443 2016	$318 -2012 $429 2016	NA	CMS
127	Standardized Cost Breakdown of Medicare beneficiaries who were treated for outpatient dialysis facility	$160 -2012 NA	$301 -2012 NA	$245 -2012 $260 2016	NA	CMS
128	Actual per capita Medicare costs	$5,957 -2012 $6,853 2016	$8,889 -2012 $9,164 2016	$9,221 -2012 $9,533 2016	NA	CMS
129	Percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia	6.10% -2012 6.40% 2015	9.40% -2012 9.30% 2015	9.80% -2012 9.90% 2015	NA	CMS
130	Percentage of Medicare beneficiaries who were treated for asthma	4.10% -2012 6.50% 2015	5.20% -2012 7.50% 2015	4.90% -2012 8.20% 2015	NA	CMS
131	Percentage of Medicare beneficiaries who were treated for atrial fibrillation	6.90% -2012 7.00% 2015	7.20% -2012 7.30% 2015	7.60% -2012 6.90% 2015	NA	CMS
132	Percentage of Medicare beneficiaries who were treated for kidney disease	10.90% -2012 11.90% 2015	15.60% -2012 17.90% 2015	15.50% -2012 18.10% 2015	NA	CMS
133	Percentage of Medicare beneficiaries who were treated for high cholesterol	33.50% -2012 31.80% 2015	42.10% -2012 41.50% 2015	44.80% -2012 44.60% 2015	NA	CMS

134	Percentage of Medicare beneficiaries who were treated for chronic kidney disease	10.90% -2012 11.90% 2015	15.60% -2012 17.90% 2015	15.50% -2012 18.10% 2015	NA	CMS
135	Percentage of Medicare beneficiaries who were treated for chronic obstructive pulmonary disease (COPD)	8.70% -2012 8.70% 2015	9.40% -2012 8.90% 2015	11.30% -2012 11.20% 2015	NA	CMS
136	Percentage of Medicare beneficiaries who were treated for depression	15.20% -2012 15.60% 2015	13.40% -2012 14.30% 2015	15.50% -2012 16.70% 2015	NA	CMS
137	Percentage of Medicare beneficiaries who were treated for diabetes	19% -2012 18.60% 2015	26.60% -2012 25.30% 2015	27.00% -2012 16.50% 2015	NA	CMS
138	Percentage of Medicare beneficiaries who were treated for heart failure	9.70% -2012 9.30% 2015	14.30% -2012 12.90% 2015	14.60% -2012 13.50% 2015	NA	CMS
139	Percentage of Medicare beneficiaries who were treated for hypertension	43.80% -2012 42.90% 2015	51.20% -2012 49.60% 2015	55.50% -2012 55.00% 2015	NA	CMS
140	Percentage of Medicare beneficiaries who were treated for ischemic heart disease	17.80% -2012 15.90% 2015	26.10% -2012 23.60% 2015	28.60% -2012 26.50% 2015	NA	CMS
141	Percentage of Medicare beneficiaries who were treated for osteoporosis	4.70% -2012 3.70% 2015	7.40% -2012 6.70% 2015	6.40% -2012 6.00% 2015	NA	CMS
142	Percentage of Medicare beneficiaries who were treated for rheumatoid arthritis	20.50% -2012 22.90% 2015	27.40% -2012 27.60% 2015	29.00% -2012 30.00% 2015	NA	CMS

143	Percentage of Medicare beneficiaries who were treated for stroke	2.50% -2012 3.10% 2015	3.60% -2012 3.70% 2015	3.80% -2012 4.00% 2015	NA	CMS
Indicator #	Causes of Death	Mendocino County	CA	US	HP 2020	Sources
144	Age adjusted death rate; all causes per 100,000	724.4 2010-2012 734.8 2018	641.5 2010-2012 608.5 2018	732.8 -2012 728.8 2016	NA	CDPH
145	Alzheimer's disease age adjusted mortality rate per 100,000	17.4 2010-2012 12.6 2018	30 2010-2012 34.3 2018	23.8 -2012 34.4 2015	NA	CDPH
146	All cancers age adjusted mortality rate per 100,000	164.4 2010-2012 159.9 2015	153.3 2010-2012 140.2 2015	166.5 -2012 163.5 2015	≤ 161.4	CDPH/NCI
147	Breast cancer age adjusted mortality rate per 100,000	20.6 2010-2012 18.9 2015	20.9 2010-2012 19.1 2015	21.5 -2011 20.9 2015	≤ 20.7	CDPH/NCI
148	Colorectal cancer age adjusted mortality rate per 100,000	15.6 2010-2012 17.3 2015	14.2 2010-2012 12.8 2015	15.1 -2011 14.5 2015	≤ 14.5	CDPH/NCI
149	Lung cancer age adjusted mortality rate per 100,000	42.2 (2010-2012) 35.8 2015	34.8 (2010-2012) 28.9 2015	46 -2011 43.4 2015	≤ 45.5	CDPH/NCI
150	Prostate cancer age adjusted mortality rate per 100,000	15.2 2010-2012 29.2 2015	19.8 2010-2012 19.6 2015	20.8 -2011 19.5 2015	≤ 21.8	CDPH/NCI

151	Stroke age adjusted mortality rate per 100,000	33.5	36.6	36.9	≤ 34.8	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		36.7	35.3	37.2		
		2015	2015	2015		
152	Heart disease age adjusted mortality rate per 100,000	105.5	106.2	170.5	≤ 103.4	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		90.5	89.1	96.8		
		2015	2015	2015		
153	Diabetes age adjusted mortality rate per 100,000	17.0	19.9	21.2	≤ 66.6	CDPH/CDC
		2010-2012	2010-2012	-2012		
		17.3	25.3	26.5		
		2015	2015	2015		
154	Influenza mortality rate per 100,000	12.2	16.1	14.4	NA	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		13.7	14.3	14.6		
		2018	2018	2018		
155	Chronic Liver Disease and Cirrhosis per 100,000	13.9	11.5	9.9	≤ 8.2	CDPH/CDC
		2010-2012	2010-2012	-2012		
		12.9	12.2	12.8		
		2018	2018	2018		
156	Chronic Lower Respiratory Disease per 100,000	50	36.2	41.5	NA	CDPH/CDC
		2010-2012	2010-2012	-2012		
		40.2	32.1	40.9		
		2018	2015	2018		
157	Drug-Induced mortality rate per 100,000	14.4	10.8	10.2	≤ 11.3	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		26.2	12.2	20.90%		
		2018	2018	2016		
158	Homicide mortality rate per 100,000	5.8	5.2	5.4	≤ 5.5	CDPH/NVSS
		(2010-2012)	(2010-2012)	-2012		
		5.9	5	5		
		2018	2018	2016		

159	Firearm-Related mortality rate per 100,000	14.8 2016 12.2 2018	7.6 2016 7.6 2018	10.4 -2013 11.9 2016	≤ 9.2	CDPH/NVSS
160	Suicide death rate per 100,000	19.2 (2010-2012) 23.6 (2013-2015)	10.1 (2010-2012) 10.3 (2013-2015)	12.6 -2012 12.9 (2013-2015)	≤ 10.2	CDPH
161	Motor vehicle crash death rate per 100,000	16.5 (2010-2012) 15.3 (2014-2016)	7.3 (2010-2012) 8.8 (2014-2016)	7.55 (2008-2010) 11 (2014-2016)	≤ 12.4	CDPH/NVSS
162	Pedestrian motor vehicle death rate per 100,000	1.9 (2010-2012) NA	1.8 (2011-2013) NA	1.38 (2008-2010) NA	≤ 1.4	CDPH/NVSS
163	Alcohol Impaired Driving Deaths: Percentage of motor vehicle crash deaths with alcohol involvement	33.30% (2008-2012) 32% 2018	31.30% (2008-2012) 29% 2018	32.00% (2008-2012) 13% 2018	NA	County Health Rankings
164	Unintentional injury mortality rate (age adjusted) per 100,000	51.2 (2010-2012) 61.6 2018	27.3 (2010-2012) 30.3 2018	39.1 -2012 40 2018	≤ 36.0	CDPH/CDC
165	Years of Potential Life Lost Before Age 75, All Causes	7,947 (2008-2010) 8,000 (2014-2016)	5,594 (2008-2010) 5,200 (2014-2016)	6,851 (2008-2010) 5,300 (2014-2016)	NA	CDPH/CDC

Footnotes

[i] USC Leonard Davis School of Gerontology, Fall Prevention StopFalls.org

[ii]U.S. Government Accountability Office
http://www.gao.gov/key_issues/elder_abuse/issue_summary

U.S. Department of Justice https://www.justice.gov/

California Department of Social Services, Adult Protective Services
http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm

[iii] California Department of Public Health, Epicenter
http://epicenter.cdph.ca.gov/

[iv] California Department Public Health (2019). Preventing Violence in California: Data Brief 1: Overview of Homicide and Suicide Deaths in California. Sacramento, CA: California Department of Public Health

[v] California Department of Public Health, Epicenter
http://epicenter.cdph.ca.gov/

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[ix] American Heart Association. Oral hygiene and Cardiovascular Disease.
https://newsroom.heart.org/news/poor-oral-health-linked-to-higher-blood-pressure-worse-blood-pressure-control