MEMORIAL MEDICAL CENTER

2022 Community Health Needs Assessment

Mission

We enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in healthcare services.

Vision

Sutter Health leads the transformation of healthcare to achieve the highest levels of quality, access, and affordability.

Community Health Needs Assessment

The following report contains Memorial Medical Center 2022 Community Health Needs Assessment (CHNA), which is used to identify and prioritize the significant health needs of the communities we serve. CHNAs are conducted once every three years, in collaboration with other healthcare providers, public health departments and a variety of community organizations. This CHNA report guides our strategic investments in community health programs and partnerships that extend Sutter Health's not-for-profit mission beyond the walls of our hospitals, improving health and quality of life in the areas we serve.

2022 Community Health Needs Assessment

Conducted on behalf of

Memorial Medical Center
1700 Coffee Rd
Modesto, CA 95355

Conducted by

COMMUNITY HEALTH INSIGHTS

April 2022

Acknowledgments

We are deeply grateful to all those who contributed to the community health needs assessment conducted on behalf of Memorial Medical Center. Many dedicated community health experts and members of various social service organizations serving the most vulnerable members of the community gave their time and expertise as key informants to help guide and inform the findings of the assessment. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Memorial Medical Center. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. This joint report was authored by:

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the community served by Memorial Medical Center (MMC). The priorities identified in this report help to guide nonprofit hospitals' community health improvement programs and community benefit activities, as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com).

Community Definition

The definition of the community served was the county boundary of Stanislaus County. Stanislaus County includes the county hub which is the city of Modesto, California, and surrounding communities as defined by 26 ZIP codes. This is the designated service area because the majority of patients served by MMC resided in these ZIP Codes. Stanislaus County in located in the Central Valley of California and is a major agricultural producer for the state and the nation. The total population of the county was 548,679.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 12 community health experts, social service providers, and medical personnel. Furthermore, 17 community residents or community service provider organizations participated in 3 focus groups across the service area. Finally, 7 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the

[1] Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/.

quantitative data analysis and COVID-19 impact was collected during qualitative data collection. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as significant health needs. These significant health needs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs, if any, beyond those 12 PHNs identified in previous CHNAs.

List of Prioritized Significant Health Needs

The following significant health needs identified for the MMC service area are listed below in prioritized order.

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Increased Community Connections
5. Access to Functional Needs
6. Injury and Disease Prevention and Management
7. Active Living and Healthy Eating
8. System Navigation
9. Safe and Violence-Free Environment

Resources Potentially Available to Meet the Significant Health Needs

In all, 553 resources were identified in the service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2019 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

This CHNA details the process and findings of a comprehensive health assessment to guide decision-making for the implementation of community health improvement efforts using a health equity lens. The CHNA includes an overall health and social examination of the service area and highlights the needs of community members living in parts of the county where the residents experience more health disparities. This report also serves as a resource for community organizations in their effort to improve health and well-being in the communities they serve.

Introduction and Purpose

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the significant health needs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)" (p. 78963).[2]

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Memorial Medical Center (MMC), located at 1700 Coffee Rd, Modesto, CA 95355. MMC identified Stanislaus County as the primary service area. The total population of the county was 548,679.

MMC is an affiliate of Sutter Health, a nonprofit healthcare system. The CHNA was conducted over a period of approximately five months, beginning in December 2021 and concluding April 2022. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that nonprofit hospitals conduct a community health needs assessment at least once every three years.

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA on the behalf of MMC. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. In all, nine significant health needs were identified. Primary data were then used to prioritize these significant health needs.

Prioritization was based on three measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last measure was the percentage of community provider survey respondents that identified a health need as a top priority. Table 1 shows the value of these measures for each significant health need.

[2] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

Table 1: Health need prioritization inputs for MMC service area.

Prioritized Health Needs	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority
Access to Basic Needs Such as Housing, Jobs, and Food	92%	34%	67%
Access to Mental/Behavioral Health and Substance Use Services	100%	21%	67%
Access to Quality Primary Care Health Services	85%	15%	50%
Increased Community Connections	69%	1%	33%
Access to Functional Needs	77%	9%	~
Injury and Disease Prevention and Management	85%	6%	~
Active Living and Healthy Eating	62%	5%	17%
System Navigation	69%	1%	~
Safe and Violence-Free Environment	62%	2%	~

~ Health need not mentioned

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and were more frequently identified among the top priority needs.[3] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

[3] Further details regarding the creation of the prioritization index can be found in the technical report.

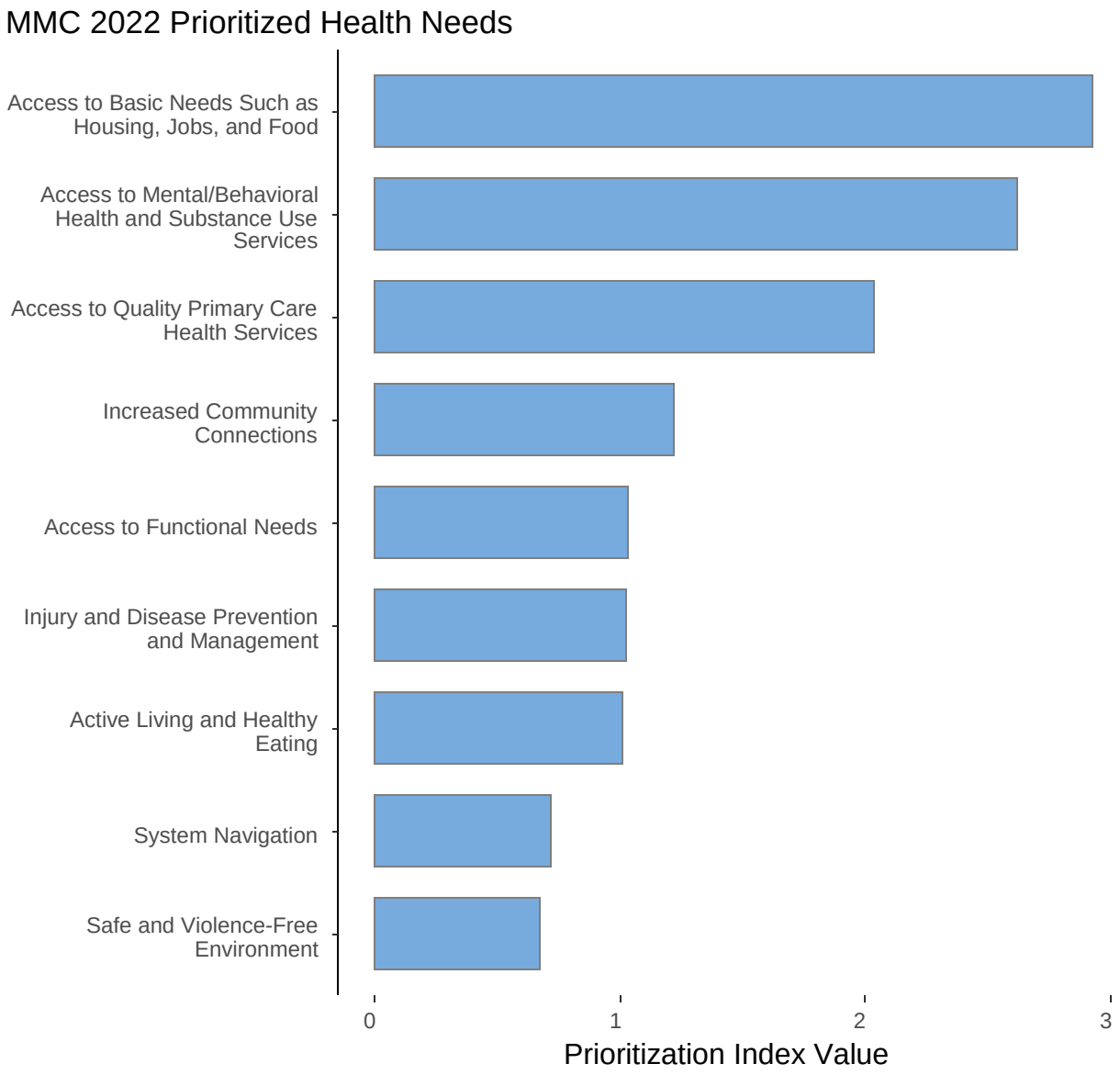


Figure 1: Prioritized significant health needs for MMC service area.

While COVID-19 was top of mind for many participating in the primary data collection process, feedback regarding the impact of COVID-19 confirmed that the pandemic exacerbated existing needs in the community.

The significant health needs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health ordered by their relationship to the conceptual model used to guide data collection for this report. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of this report).

1. Access to Basic Needs Such as Housing, Jobs, and Food

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[4] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.[5]

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Low wages do not cover basic living expenses for many in the area. • There is not enough affordable housing in the community. • Food insecurity is growing throughout the area. • Childcare is too expensive for many in the area. • Single family homes are now being used by multiple families due to high rent costs. • The community needs to focus on workforce development. • The area experiences higher than average unemployment. • The number of community residents experiencing homelessness is on the rise. • Economic development is needed to bring higher paying jobs to the area.	• Lack of affordable housing is a significant issue in the area. • Many people in the area do not make a living wage. • Services for homeless residents in the area are insufficient. • Educational attainment in the area is low. • Employment opportunities in the area are limited. • It is difficult to find affordable childcare. • Many residents struggle with food insecurity. • Poverty in the county is high. • The area needs additional low-income housing options.	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Hypertension Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • COVID-19 Cumulative Incidence • Asthma ED Rates • Asthma ED Rates for Children • Drug Induced Death • Adult Obesity • Limited Access to Healthy Foods

[4] McLeod, S. 2020. Maslow's Hierarchy of Needs. Retrieved 31 Jan 2022 from http://www.simplypsychology.org/maslow.html.

[5] Robert Wood Johnson Foundation, and University of Wisconsin, 2022. Research Articles. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
	• Services are inaccessible for Spanish-speaking and immigrant residents.	• Food Environment Index • Medically Underserved Area • COVID-19 Cumulative Full Vaccination Rate • Some College • High School Completion • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Unemployment • Children in Single-Parent Households • Social Associations • Children Eligible for Free Lunch • Children in Poverty • Median Household Income

2. Access to Mental/Behavioral Health and Substance Use Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• The community does not have enough mental health providers to meet the demand for services. • The community needs educated on when and how to seek mental health services.	• Additional services specifically for youth are needed (e.g., child psychologists, counselors and therapists in the schools). • There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Suicide Mortality • Poor Mental Health Days

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• There is a stigma for some when seeking mental health services. Quote: "In the Hispanic community, it is not okay to not be okay." • Youth in the community have an increased need for mental health services. • The community lacks adequate treatment facilities for substance use. • Attracting and retaining mental health workers in the community is a challenge. • The community needs more training programs for mental health workers. • Opioid and fentanyl use are top areas of concern for the community. • There is an excessive amount of vaping in schools. • Some youth in the community experience trauma in the home, and act out during school. • Some single parent homes struggle with financial and emotional difficulties. • There are limited treatment options for minors struggling with addiction. • ACES (Adverse Childhood Experiences) have impacted youth in the community. • Investing in telehealth can enhance the delivery of mental health services. • There are limited providers that take Medi-Cal.	• Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). • There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers). • Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. • It's difficult for people to navigate for mental/behavioral healthcare. • There are substance-use treatment services available here, but people do not know about them. • The stigma around seeking mental health treatment keeps people out of care. • Substance-use is an issue among youth in particular. • Mental/behavioral health services are available in the area, but people do not know about them. • Treatment options in the area for those with Medi-Cal are limited. • There aren't enough services here for those who are homeless and dealing with substance-use issues. • Awareness of mental health issues among community members is low. • The area lacks the infrastructure to support acute mental health crises. • The cost for mental/behavioral health treatment is too high. • The use of nicotine delivery products such as e-cigarettes and	• Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Adult Smoking • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Juvenile Arrest Rate • Disconnected Youth • Social Associations

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• There are no pediatric, inpatient mental health beds in the community. • The community needs more crisis stabilization options.	tobacco is a problem in the community.	

3. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• The community lacks an adequate supply of primary care providers. • There are excessive wait times for appointments for many in the community. • Prescription drugs are unaffordable for many in the community. • Members of the LGTBQ community often face discrimination when seeking healthcare services. • More clinics need to offer services outside of normal business hours, including weekends, to increase access. • Non-English speaking residents experience language barriers when trying to access healthcare services.	• Out-of-pocket costs are too high. • Quality health insurance is unaffordable. • Patients seeking primary care overwhelm local emergency departments. • Too few providers in the area accept Medi-Cal. • Wait-times for appointments are excessively long. • It is difficult to recruit and retain primary care providers in the region. • Patients have difficulty obtaining appointments outside of regular business hours. • Specific services are unavailable here (e.g., 24-	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Alzheimer's Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Low-income populations need more affordable health insurance options. • Access to healthcare is exceptionally limited for undocumented community residents. • There is a lack of healthcare resources for those experiencing homelessness. • More investment is needed in telehealth options to increase access in the community. • Medi-Cal coverage restrictions result in barriers for many needing healthcare services. • The community lacks providers that accept Medi-Cal insurance. • The community needs more training opportunities for healthcare workers.	hour pharmacies, urgent care, telemedicine). • The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). • There aren't enough primary care service providers in the area.	• Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Lung Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Primary Care Shortage Area • Medically Underserved Area • Primary Care Providers • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate

4. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[6] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Further, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

[6] Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved 31 Jan 2022 from https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• The community needs a better connection between law enforcement and mental health services. • The community needs to come together and work collectively to eliminate crime and solve other community-wide problems. • More collaboration and alignment between services will benefit the community. • Local funders should work together more on community programs and funding. • The community has no internships where youth learn how to engage in community work. • Local schools need to be better connected with healthcare services.	• Health and social-service providers operate in silos; cross-sector connections are needed. • The community needs to invest more in the local public schools. • Building community connections doesn't seem like a focus in the area. • City and county leaders need to work together. • People in the community face discrimination from local service providers. • Relations between law enforcement and the community need to be improved. • There isn't enough funding for social services in the county.	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Suicide Mortality • Unintentional Injuries Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Physical Inactivity • Access to Exercise Opportunities • Teen Birth Rate • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Specialty Care Providers • Primary Care Providers • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate • Violent Crime Rate • Juvenile Arrest Rate • Some College • High School Completion • Disconnected Youth

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
		• Unemployment • Children in Single-Parent Households • Social Associations • Access to Public Transit

5. Access to Functional Needs

Functional needs refer to needs related to adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Public transportation is inadequate for many relying on these services. • Many healthcare appointments are missed or avoided due to transportation issues. • There are those in the community that need training on the use of technology. • The bus schedules are insufficient for those with no other transportation options. • The community is difficult to get around in for those without a vehicle. • Access to technology is a challenge for some in the community. • Lower income populations struggle to afford functional internet services.	(No data reported)	• Disability • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Adult Obesity • COVID-19 Cumulative Full Vaccination Rate • Access to Public Transit

6. Injury and Disease Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focused on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Community Service Provider Survey Responses</td></tr>
<tr><td>• The community needs more after-school programs for youth.
• There is a lack of sex-education in schools; many only want to teach abstinence.
• Youth need more financial literacy training.
• The community needs more injury and disease prevention and management training.
• Nutrition classes are needed throughout the community.
• More investment is needed in early intervention services for families.
• The area needs more after school programs focused on art, music, and/or sports.
• More pre- and post-natal education programs are needed for expecting mothers and families.
• More promotores programs are warranted throughout the community.</td><td>(No data reported)</td><td>• Infant Mortality
• Child Mortality
• Chronic Lower Respiratory Disease Mortality
• Diabetes Mortality
• Heart Disease Mortality
• Hypertension Mortality
• Liver Disease Mortality
• Kidney Disease Mortality
• Suicide Mortality
• Unintentional Injuries Mortality
• COVID-19 Mortality
• COVID-19 Case Fatality
• Alzheimer's Disease Mortality
• Diabetes Prevalence
• Poor Mental Health Days
• Frequent Mental Distress
• Frequent Physical Distress
• Poor or Fair Health
• COVID-19 Cumulative Incidence
• Asthma ED Rates
• Asthma ED Rates for Children
• Excessive Drinking
• Drug Induced Death
• Adult Obesity
• Physical Inactivity
• Teen Birth Rate
• Adult Smoking</td></tr>
</table>

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
		• COVID-19 Cumulative Full Vaccination Rate • Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level

7. Active Living and Healthy Eating

Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas where unhealthy food is sold. Under resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• There is an excessive number of fast-food establishments in the community. • Healthier foods are not affordable for many in the community. • Families find it difficult to get outdoors in the community. • Some parts of the community lack sidewalks.	• Food insecurity is an issue here. • Fresh, unprocessed foods are unaffordable. • Homelessness in parks or other public spaces deters their use. • Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming). • Students need healthier food options in schools. • There are food deserts in the area where fresh, unprocessed foods are not available.	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Kidney Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• More farmer's markets are needed throughout the community. • The community should increase funding for parks and recreational activities. • Obesity is a concern for many in the community.		• Poor or Fair Health • Colorectal Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Adult Obesity • Physical Inactivity • Limited Access to Healthy Foods • Food Environment Index • Access to Exercise Opportunities • Access to Public Transit

8. System Navigation

System navigation refers to an individual's ability to traverse fragmented social-services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Further, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• It is difficult to understand and navigate the healthcare system, especially for non-English speaking residents. • Signing up for services can be overwhelming for some; it's a very complicated system.	(No data reported)	(No data reported)

[7] Natale-Pereira, A. et. al .2011. The Role of Patient Navigators in Eliminating Health Disparities. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Many struggle to understand how health insurance coverage works, and often do not get adequate coverage. • There are some resources in the community that people do not know about. • Medi-Cal restrictions make is hard for some people to get the care they need, especially the undocumented.		

9. Safe and Violence-Free Environment

Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Further, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[8]

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Many of the parks in the area are unsafe. • It is dangerous to walk in some parts of the community. • Safe outdoor activities for youth are needed throughout the area. • Violence is growing in parts of the community. • The community needs a better relationship with law enforcement.	(No data reported)	• Life Expectancy • Premature Death • Hypertension Mortality • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Physical Inactivity • Access to Exercise Opportunities • Violent Crime Rate

[8] Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
Some community members are scared to report crimes. • Some streets need better lighting to increase safety in neighborhoods. • Gang activity is growing in parts of the community. • Child abuse and neglect are issues for some parts of the community.		• Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth • Social Associations

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[9] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. MMC requested written comments from the public on its most recently conducted CHNA and adopted implementation strategy through SHCB@sutterhealth.org.

At the time of the development of this CHNA report, MMC had not received written comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, and the service provider survey. MMC will continue to use its website as a tool to solicit public comments and ensure that these comments are considered as community input in the development of future CHNAs.

[9] Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 10 interviews with 12 community health experts, 3 focus groups conducted with a total of 17 community residents or community service providers, and 6 responses to the Community Service Provider survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 86 different health-outcome and health factor indicators were collected for the CHNA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the service area. This included identifying 12 potential health needs (PHNs) that could exist these communities. These PHNs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA, including primary and secondary data collection, analysis, and results, see the technical section of this report.

Description of Community Served

The definition of the community served was Stanislaus County. This is the designated service area because the majority of patients served by MMC resided in this area. The total population of the area was 548,679. The service area is shown in Figure 2.

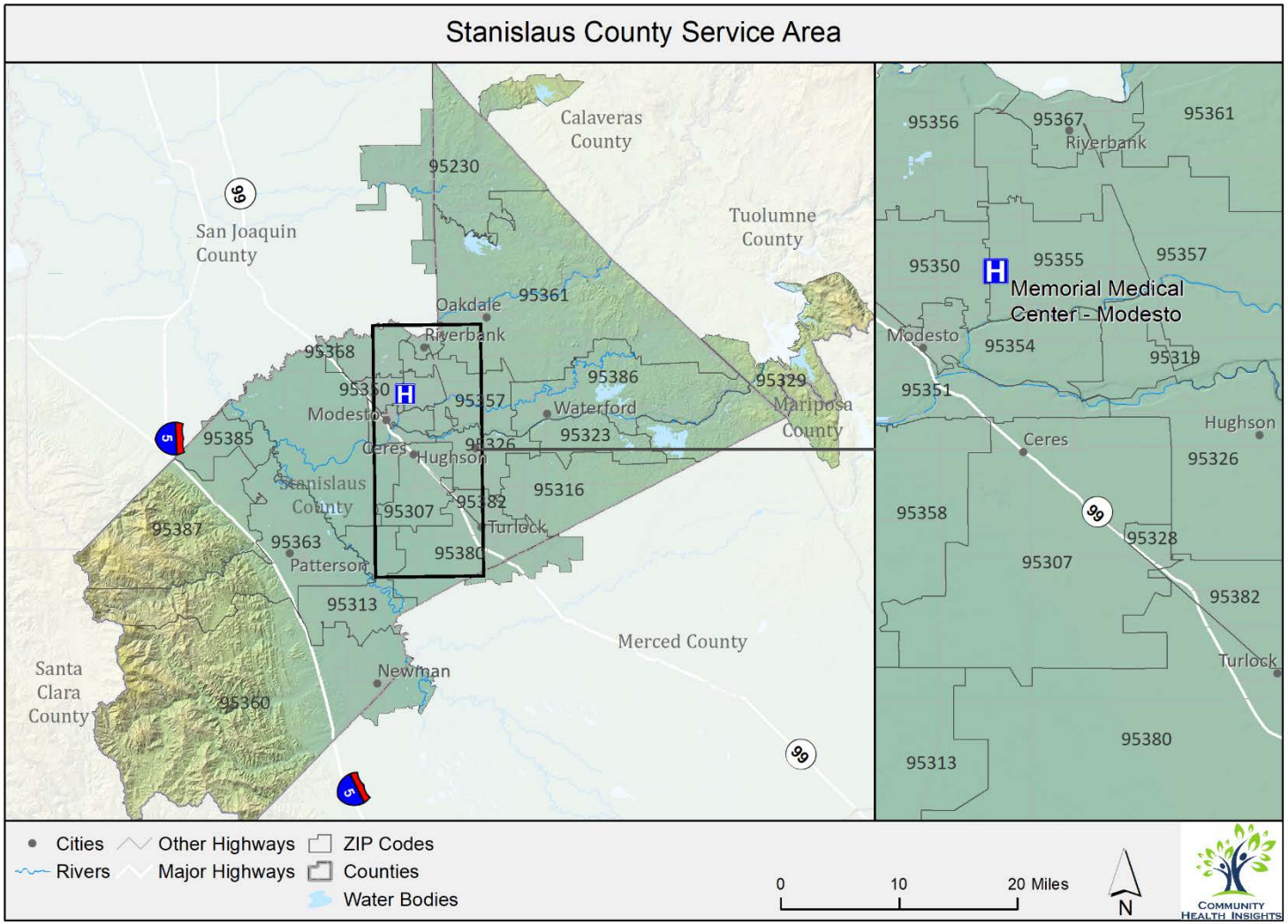


Figure 2: Community served by MMC

Population characteristics for each ZIP Code in the service area are presented in Table 2. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively to the state or county is highlighted.

Table 2: Population characteristics for each ZIP Code located in the MMC service area.

ZIP Code	Total Population	% Non-White or	Median Age (yrs.)	Median Income	% Poverty	% Unemployme	% Uninsured	% Without High School	% With High Housing Costs	% With Disability
95230	840	52.7	34.5	$89,016	27.1	0	0	19.9	11.5	3.7
95307	46,283	73.9	30.4	$58,827	17	11.6	5.8	27.8	35.7	13.1
95313	1,305	65.1	36.1	$52,105	14.9	5.1	10.3	25.1	24	17.2
95316	7,022	35.5	37.7	$70,907	15.6	10	3.8	17.2	32.2	11.5
95319	1,745	71.5	37.6	$31,966	29.1	7.1	6.4	36	31	30.7
95323	1,299	35.6	35.1	$71,667	12	7.8	7.8	21.3	23.9	15
95326	10,147	36.5	35.6	$79,386	8.8	5.4	3.2	13	28.5	13.4
95328	4,480	83.1	27.9	$53,112	14.7	11.5	5.8	32.9	34.3	10.5
95329	2,570	26.9	50.6	$55,407	14.6	10.4	3.7	13.1	34.7	18.6
95350	54,210	50.9	36.6	$53,604	16.2	8.2	5.2	16	40.4	17.4
95351	48,542	81.9	29.4	$41,309	27.2	14.1	8.2	39.4	48.9	13.5
95354	24,923	52.7	34.1	$50,226	18.5	11.9	7.4	21.3	40.6	15.6
95355	59,621	49.3	39.3	$66,719	10.7	7.7	4.9	10.4	37.4	15.6
95356	32,622	48.9	37.9	$70,699	11.2	5.8	5.1	10.8	36.4	12.3
95357	11,765	51.6	37.2	$73,304	12.2	6.1	5.3	22.3	28	10.1
95358	32,524	68.3	30.5	$60,987	17.6	12	8.7	30.2	35.9	11.1
95360	13,278	72.1	34	$62,679	8.3	12.3	4.4	22.7	27.5	10.7
95361	35,308	35.7	38.4	$72,313	11.1	9.7	4.6	13.5	34.1	11.9
95363	27,908	77.1	31.7	$71,934	11.5	8.4	6.2	27	40.2	8.4
95367	25,072	66.2	32.7	$71,934	10.8	6.7	5.2	25.7	28	8.8
95368	14,041	61.6	29.6	$82,928	8.8	7.2	3	20.1	33	9.9
95380	42,866	57.7	32	$46,580	20.6	9	6.1	25	42	14.5
95382	38,700	41.3	36.4	$72,206	10.7	5.8	4.2	13.4	38.9	11.6
95385	415	56.9	35.1	$68,542	3.9	7.4	7.7	24.9	10.8	12
95386	10,557	51.7	34.5	$60,895	17.9	7.7	4.7	30.4	29.7	14.2
95387	636	91.2	28.9	$39,919	7.4	40.7	0	51.2	27.9	19.7
Stanislaus	*543,194*	*58.1*	*34.1*	*$60,704*	*15.1*	*9.1*	*5.7*	*21.1*	*37.6*	*13.1*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

Health Equity

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a common understanding for the concept of health equity.

"*Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*"[10]

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[11]

In the US, and many parts of the world inequities are most apparent when comparing various racial and ethnic groups to one another. Using these comparisons between racial and ethnic populations, it's clear that health inequities persist across communities, including Stanislaus County.

This section of the report shows inequities in health outcomes, comparing these between race and ethnic groups. These differences inform better planning for more targeted interventions.

Health Outcomes - the Results of Inequity

The table below displays disparities among race and ethnic groups for the service area for life expectancy, mortality, and low birthweight.

Table 3: Health outcomes comparing race and ethnicity in the MMC service area.

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	~	~	~	4.8	4.8	4.9
Life Expectancy	Average number of years a person can expect to live.	73.7	82.9	73.1	82.6	76.5	78.2
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	~	36	59.7	38.6	43.4	41.2

[10] Robert Wood Johnsons Foundation. 2017. What is Health Equity? And What Difference Does a Definition Make? Health Equity Issue Brief #1. Retrieved 31 Jan 2022 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf .

[11] Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	569.4	250.1	607.1	275.5	430.1	369.8
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	14,214.7	5,118.1	12,206.5	5,538.9	8,407.5	7,117.3
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	6.5%	9.6%	9.1%	5.9%	6%	6.3%

~ Data Not Available
Data sources included in the technical section of the report.

When examining health outcomes across various race and ethnic groups, inequities are apparent. For example, life expectancy for American Indians/Alaska Natives and Blacks in the service area are notably lower than other groups. Also, low birthweight for Asians and Blacks was notably higher than other groups.

Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the service area, such as education attainment and income. These health factors are displayed in the table below and are compared across race and ethnic groups.

Table 4: Health factors comparing race and ethnicity in the MMC service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	48.3%	57.7%	58.4%	33%	60.9%	49.6%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	77.7%	79.8%	90.3%	64.2%	89.6%	78.9%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	3.1	2.5	2.5	3	2.7
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	2.9	2.1	2.4	2.8	2.5

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Children in Poverty	Percentage of people under age 18 in poverty.	27.9%	17%	22.9%	23.5%	14.2%	17.1%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$48,988	$72,225	$48,773	$54,190	$66,097	$62,761
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	5.2%	5.1%	2.5%	7.9%	3.6%	5.7%

~ Data Not Available

Unless otherwise noted, data sources included in the technical section of the report.

[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.

[b]From 2019 American Community Survey 5-year estimates table S2701.

Inequities are apparent when examining health factors across race and ethnic groups. For example, median household income varied significantly across groups, where American Indian/Alaska Natives and Blacks earned notably less than other groups, especially Asians and Whites. Furthermore, Hispanics had uninsured rates over twice that of Whites. Moreover, high school completion rates, a predictor of income, was notably lower in Hispanics than any other group.

Population Groups Experiencing Disparities

The figure below describes populations in the service area identified through qualitative data analysis that were identified as experiencing health disparities. Interview participants were asked, “What specific groups of community members experience health issues the most?” Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities. Figure 3 displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

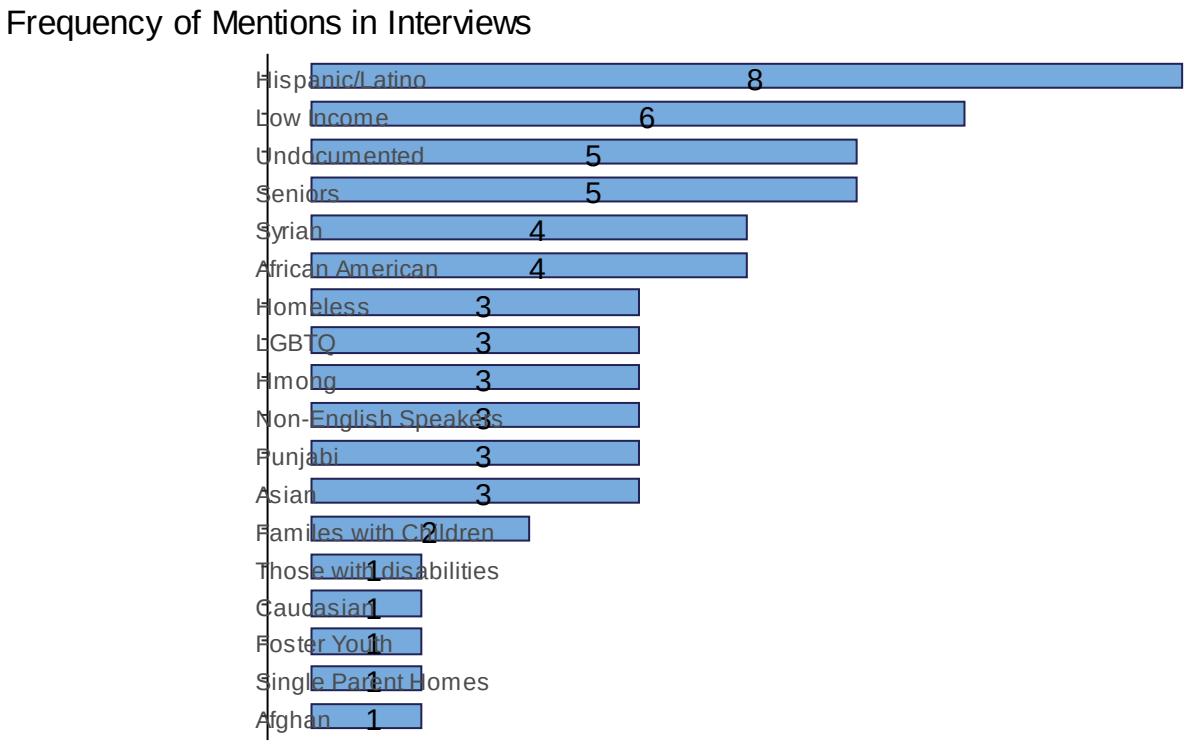


Figure 3: Populations experiencing disparities the MMC service area.

California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)[12] values for the service area. The HPI is an index based on 25 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

[12] Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from https://healthyplacesindex.org/about/.

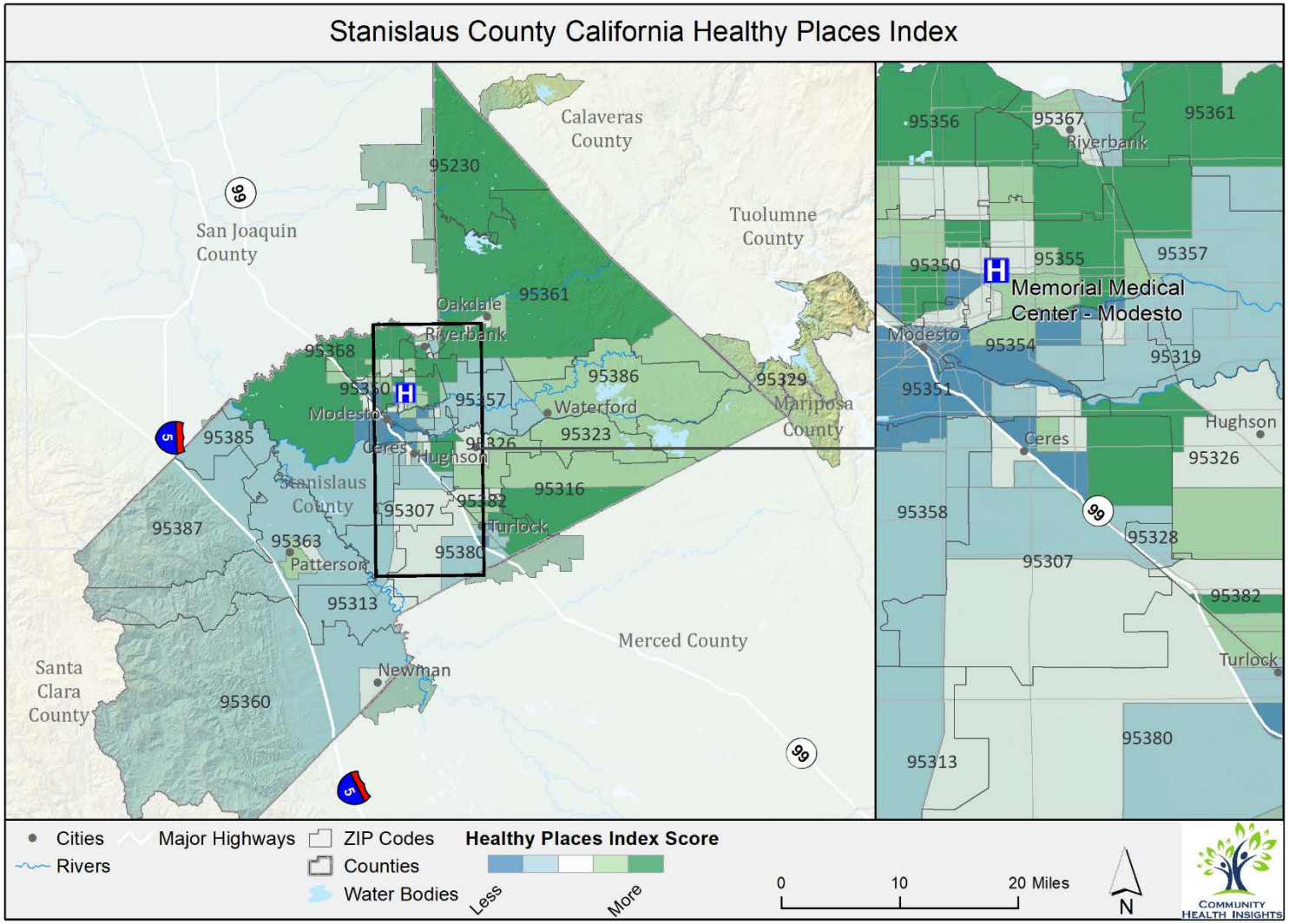


Figure 4: Healthy Places Index for MMC service area.

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. These areas are concentrated in and around Modesto, and follow the Highway 99 corridor south into Turlock. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Communities of Concern are geographic areas within the service area that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the service area likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. Analysis revealed seven (7) ZIP Codes that met the criteria to be classified as a Primary Community of Concern. These communities were those where all data sources, both quantitative and qualitative, confirmed health disparities in these areas. Data also revealed three (3) Secondary Communities of Concern. These communities were those identified primarily by qualitative data sources. (For a detailed description of Community of Concern identification, see the technical section of this report). Communities of Concern are noted in Table 5, with the census population provided for each, and are displayed in Figure 5.

Table 5: Identified Communities of Concern for the MMC service area.

ZIP Code	Community\Area	Population
	Primary Communities of Concern	
95307	Ceres, South Modesto	46,283
95319	Empire (East of Modesto)	1,745
95350	North Modesto	54,210
95351	Modesto	48,542
95354	Airport District (Modesto)	24,923
95357	Empire	11,765
95358	West Modesto	32,524
	Secondary Communities of Concern	
95361	Oakdale	35,308
95363	Patterson, Grayson, Westly	27,908
95380	Turlock	42,866
Total Population in Communities of Concern		*326,074*
Total Population in Hospital Service Area		*548,679*
Percentage of Service Area Population in Community of Concern		*59.4%*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

Figure 5 displays the ZIP Code Communities of Concern for the service area. Those in pink are considered Primary Communities of Concern, while those shown in blue are Secondary Communities of Concern. Figure 6 shows the distribution of population within Stanislaus County.

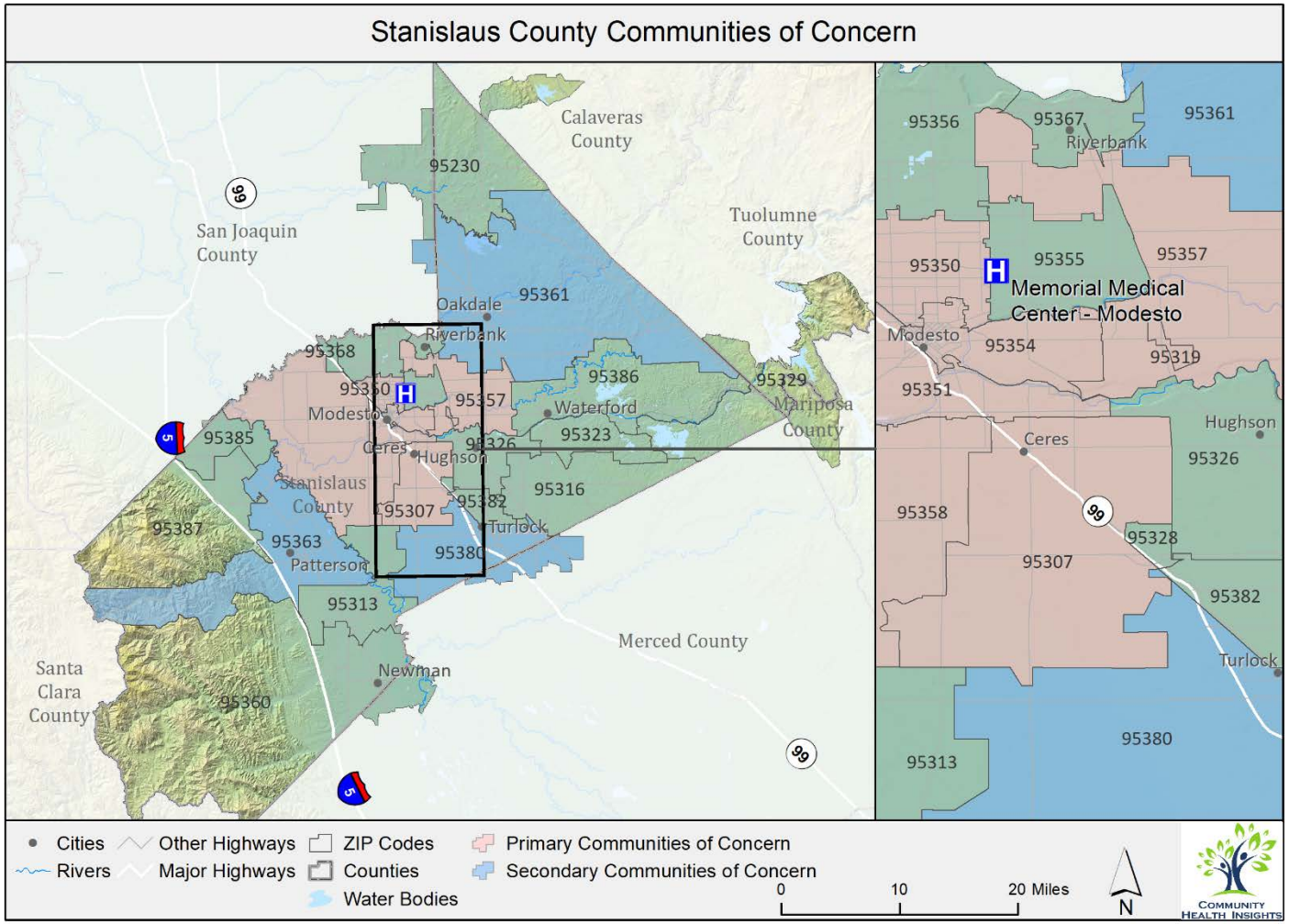


Figure 5: MMC Communities of Concern.

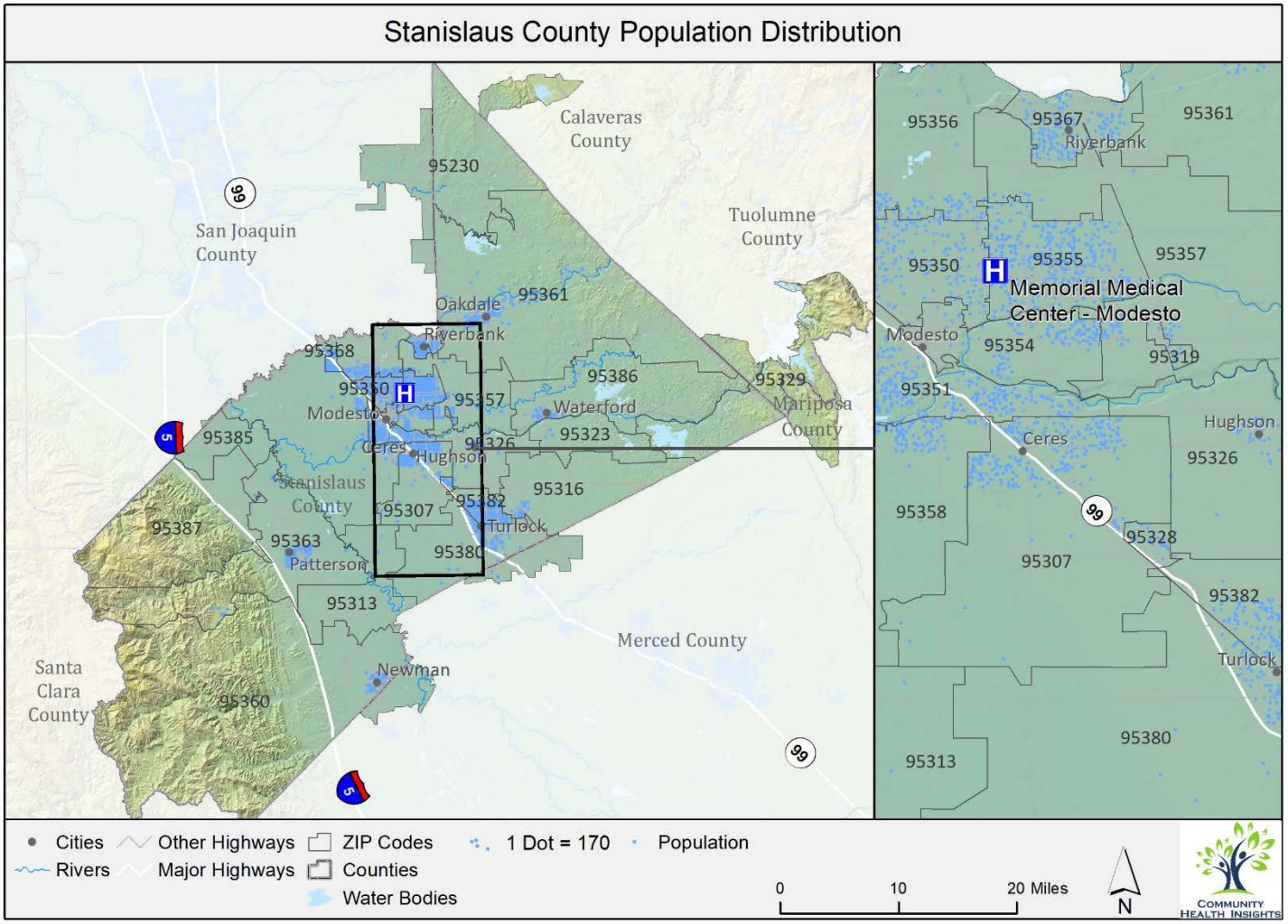


Figure 6: Stanislaus County population distribution

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators for the service are noted in Table 6.

Table 6: COVID-19-related rates for the MMC service area.

Indicators	Description	Stanislaus	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	289.4	223.0	Stanislaus: 289.4 California: 223
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.3%	1.0%	Stanislaus: 1.3% California: 1%
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	21,750.2	21,564.1	Stanislaus: 21,750.2 California: 21,564.1
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	57,140.2	70,357.8	Stanislaus: 57,140.2 California: 70,357.8

COVID-19 data collected on March 23, 2022.

Overall, Stanislaus County had higher rates of infection and mortality due to COVID-19, and lower vaccination rates, when compared to state benchmarks.

Key informants and focus group participants were asked how the COVID-19 pandemic had impacted the health needs they described during interviews. Community Survey Provider Survey respondents were also asked to identify ways in which COVID-19 impacted health needs in the communities they served. A summary of their responses is shown in Table 7.

Table 7: The impacts of COVID-19 on health need as identified in primary data sources.

Key Informant and Focus Group Responses	Community Service Provider Survey Responses
• The number of community residents experiencing homelessness has increased. • Many were afraid to seek healthcare services resulting in substantial delays in getting preventative care, as well as needed treatments for existing health issues. • The need for mental health services increased substantially, especially for youth. This has added even more strain to an already over-burdened mental health system. • Children were exposed to more abuse and neglect as they were not in school.	• Isolation is harming the mental health of community members. • Residents encounter economic hardships from lost or reduced employment. • Residents delay or forgo healthcare to limit their exposure to the virus. • Residents in the community are being evicted from their homes. • Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services).

Key Informant and Focus Group Responses	Community Service Provider Survey Responses
• Domestic violence has increased over the course of the pandemic. • Food insecurity increased, especially among those relying on free/reduced meals in schools. • Those already struggling to afford basic needs were impacted the most, adding greater challenges in meeting basic needs. • Many of those that contracted the virus are still dealing with lingering effects of the disease. • There is a great deal of misinformation being spread throughout the community about COVID-19. • Those that contracted the virus had to miss work, creating greater financial hardships for families. • Those families with limited technology in their homes saw their children fall further behind in school; they also were not able to use telehealth services. • Young children have experienced delays in social skills development. • COVID exacerbated an already existing "digital divide" that existed throughout the community. • Suicide rates among youth increased. • Obesity rates have increased over the course of the pandemic. • Hospitals saw an overwhelming surge during the pandemic, putting an enormous strain on these systems and healthcare workers.	

Resources Potentially Available to Meet the Significant Health Needs

In all, 553 resources were identified in the service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 169 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 MMC CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 8.

Table 8: Resources potentially available to meet significant health needs in priority order.

Significant Health Needs (in Priority Order)	Number of Resources
Access to Basic Needs Such as Housing, Jobs, and Food	91
Access to Mental/Behavioral Health and Substance Use Services	81
Access to Quality Primary Care Health Services	67
Increased Community Connections	72
Access to Functional Needs	14
Injury and Disease Prevention and Management	72
Active Living and Healthy Eating	64
System Navigation	74
Safe and Violence-Free Environment	18
Total Resources	**553**

For more specific examination of resources by significant health need and by geographic location, as well as the detailed method for identifying these, see the technical section of this report.

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s) (p. 78969)."[13] MMC invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

CHNAs play an important role in helping nonprofit hospitals and other community organizations determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in the CHNA report can help provide nonprofit hospitals and community service providers with content to work in collaboration to engage in meaningful community work.

Please send any feedback about this CHNA report to SHCB@sutterhealth.org with "CHNA Comments" in the subject line. Feedback received will be incorporate into the next CHNA.

[13] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Memorial Medical Center (MMC) service area (HSA).

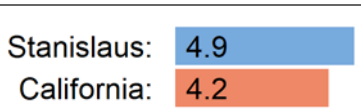
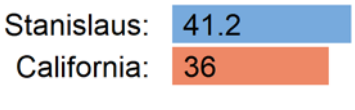
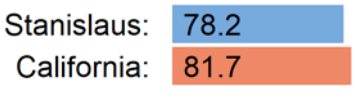
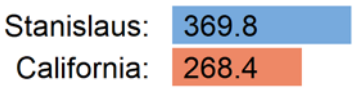
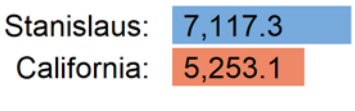
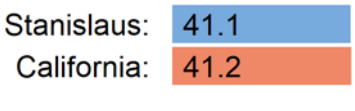
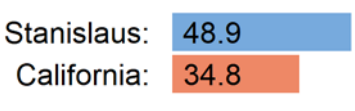
Results of Data Analysis

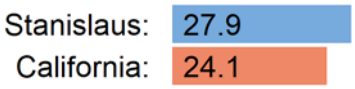
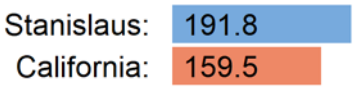
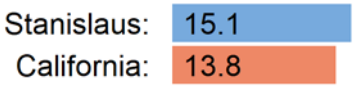
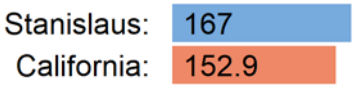
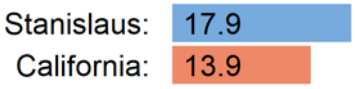
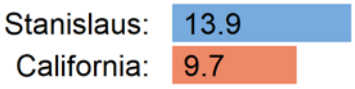
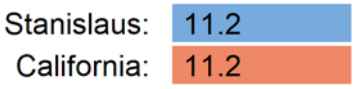
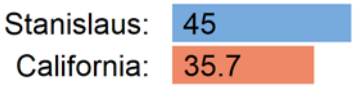
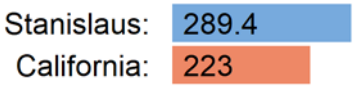
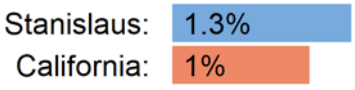
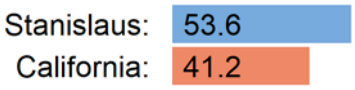
Compiled Secondary Data

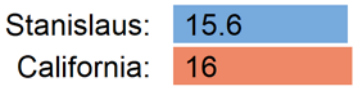
The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. Indicator values for Stanislaus County were compared to the California state benchmark and are highlighted below when performance was worse in the county than in the state. The associated figures show rates for the county compared to the California state rates.

Length of Life

Table 9: County length of life indicators compared to state benchmarks.

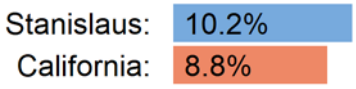
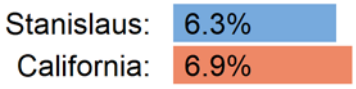
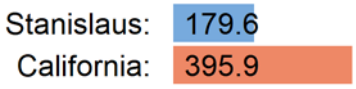
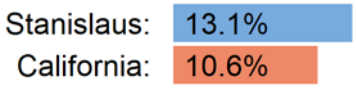
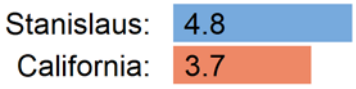
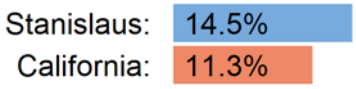
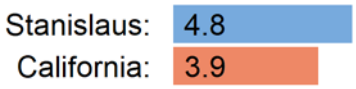
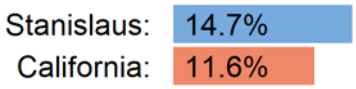
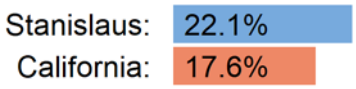
Indicators	Description	Stanislaus	California	
Early Life				
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	4.9	4.2	
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	41.2	36.0	
Life Expectancy	Average number of years a person can expect to live.	78.2	81.7	
Overall				
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	369.8	268.4	
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	7,117.3	5,253.1	
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	41.1	41.2	
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	48.9	34.8	

Indicators	Description	Stanislaus	California	
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	27.9	24.1	
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	191.8	159.5	
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	15.1	13.8	
Cancer, Liver, and Kidney Disease				
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	167.0	152.9	
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	17.9	13.9	
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	13.9	9.7	
Intentional and Unintentional Injuries				
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	11.2	11.2	
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	45.0	35.7	
COVID-19				
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	289.4	223.0	
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.3%	1.0%	
Other				
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	53.6	41.2	

Indicators	Description	Stanislaus	California	
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	15.6	16.0	

Quality of Life

Table 10: County quality of life indicators compared to state benchmarks.

Indicators	Description	Stanislaus	California	
Chronic Disease				
Diabetes Prevalence	Percentage of adults ages 20 and above with diagnosed diabetes.	10.2%	8.8%	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	6.3%	6.9%	
HIV Prevalence	Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	179.6	395.9	
Disability	Percentage of the total civilian noninstitutionalized population with a disability	13.1%	10.6%	
Mental Health				
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.8	3.7	
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	14.5%	11.3%	
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	4.8	3.9	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	14.7%	11.6%	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	22.1%	17.6%	
Cancer				

Indicators	Description	Stanislaus	California	
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	38.7	34.8	Stanislaus: 38.7 California: 34.8
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	23.3	27.9	Stanislaus: 23.3 California: 27.9
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	48.1	40.9	Stanislaus: 48.1 California: 40.9
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	81.4	91.2	Stanislaus: 81.4 California: 91.2
COVID-19				
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	21,750.2	21,564.1	Stanislaus: 21,750.2 California: 21,564.1
Other				
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	527.0	422.0	Stanislaus: 527 California: 422
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	722.0	601.0	Stanislaus: 722 California: 601

Health Behavior

Table 11: County health behavior indicators compared to state benchmarks.

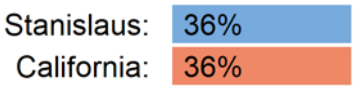
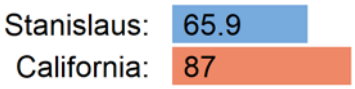
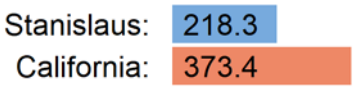
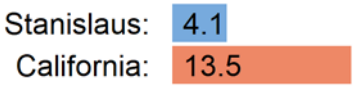
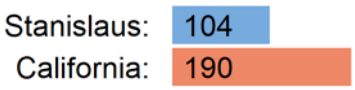
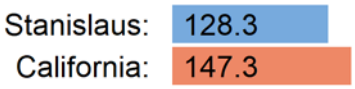
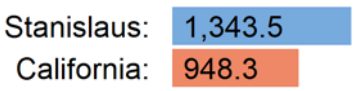
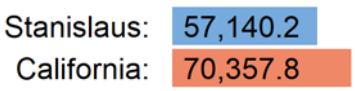
Indicators	Description	Stanislaus	California	
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	19.3%	18.1%	Stanislaus: 19.3% California: 18.1%
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	17.2	14.3	Stanislaus: 17.2 California: 14.3
Adult Obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	31.5%	24.3%	Stanislaus: 31.5% California: 24.3%

Indicators	Description	Stanislaus	California	
Physical Inactivity	Percentage of adults ages 20 and over reporting no leisure-time physical activity.	23.3%	17.7%	Stanislaus: 23.3% California: 17.7%
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	4.9%	3.3%	Stanislaus: 4.9% California: 3.3%
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.9	8.8	Stanislaus: 7.9 California: 8.8
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	91.0%	93.1%	Stanislaus: 91% California: 93.1%
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	531.5	585.3	Stanislaus: 531.5 California: 585.3
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	24.4	17.4	Stanislaus: 24.4 California: 17.4
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	15.8%	11.5%	Stanislaus: 15.8% California: 11.5%

Clinical Care

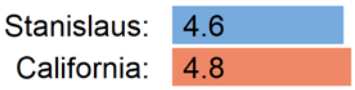
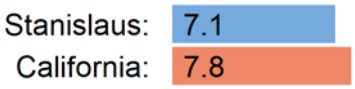
Table 12: County clinical care indicators compared to state benchmarks.

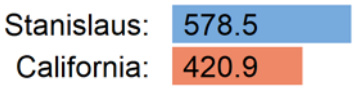
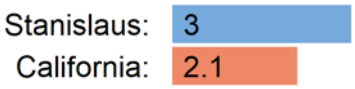
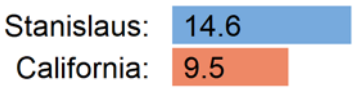
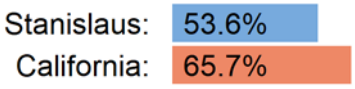
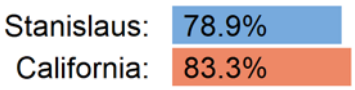
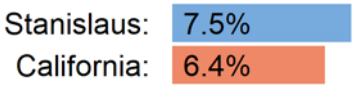
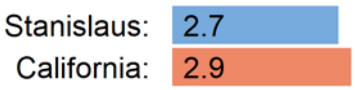
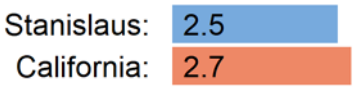
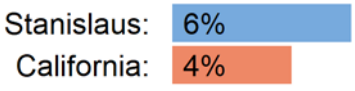
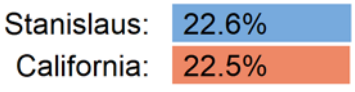
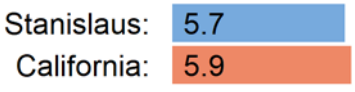
Indicators	Description	Stanislaus	California	
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	Yes		Stanislaus: Yes California:
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	No		Stanislaus: No California:
Mental Health Care Shortage Area	Presence of a mental health professional shortage area within the county.	Yes		Stanislaus: Yes California:
Medically Underserved Area	Presence of a medically underserved area within the county.	Yes		Stanislaus: Yes California:

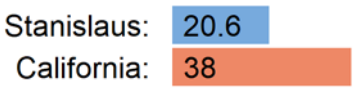
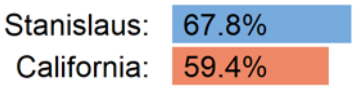
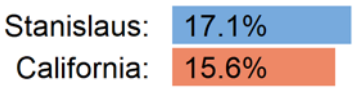
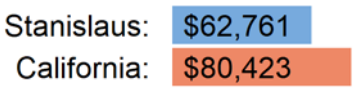
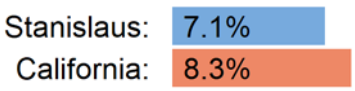
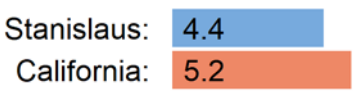
Indicators	Description	Stanislaus	California	
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	36.0%	36.0%	
Dentists	Dentists per 100,000 population.	65.9	87.0	
Mental Health Providers	Mental health providers per 100,000 population.	218.3	373.4	
Psychiatry Providers	Psychiatry providers per 100,000 population.	4.1	13.5	
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	104.0	190.0	
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	128.3	147.3	
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted)	1,343.5	948.3	
COVID-19				
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	57,140.2	70,357.8	

Socio-Economic and Demographic Factors

Table 13: County socio-economic and demographic factors indicators compared to state benchmarks.

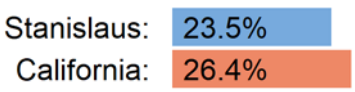
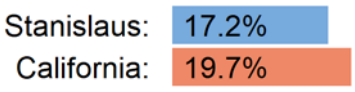
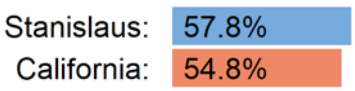
Indicators	Description	Stanislaus	California	
Community Safety				
Homicide Rate	Number of deaths due to homicide per 100,000 population.	4.6	4.8	
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	7.1	7.8	

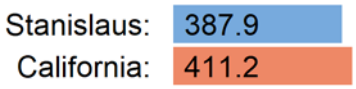
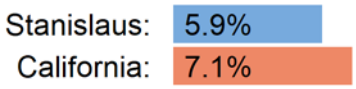
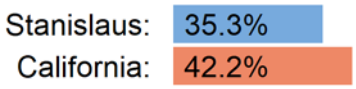
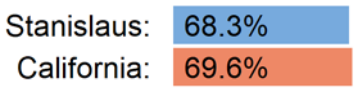
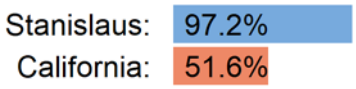
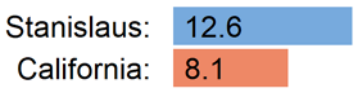
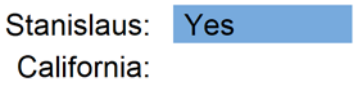
Indicators	Description	Stanislaus	California	
Violent Crime Rate	Number of reported violent crime offenses per 100,000 population.	578.5	420.9	
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	3.0	2.1	
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	14.6	9.5	
Education				
Some College	Percentage of adults ages 25-44 with some post-secondary education.	53.6%	65.7%	
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	78.9%	83.3%	
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	7.5%	6.4%	
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	2.7	2.9	
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	2.5	2.7	
Employment				
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	6.0%	4.0%	
Family and Social Support				
Children in Single-Parent Households	Percentage of children that live in a household headed by single parent.	22.6%	22.5%	
Social Associations	Number of membership associations per 10,000 population.	5.7	5.9	

Indicators	Description	Stanislaus	California	
Residential Segregation (Non-White/White)	Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.	20.6	38.0	
Income				
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	67.8%	59.4%	
Children in Poverty	Percentage of people under age 18 in poverty.	17.1%	15.6%	
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$62,761.0	$80,423.0	
Uninsured Population under 64	Percentage of population under age 65 without health insurance.	7.1%	8.3%	
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.4	5.2	

Physical Environment

Table 14: County physical environment indicators compared to state benchmarks.

Indicators	Description	Stanislaus	California	
Housing				
Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	23.5%	26.4%	
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	17.2%	19.7%	
Homeownership	Percentage of occupied housing units that are owned.	57.8%	54.8%	

Indicators	Description	Stanislaus	California	
Homelessness Rate	Number of homeless individuals per 100,000 population.	387.9	411.2	
Transit				
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	5.9%	7.1%	
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	35.3%	42.2%	
Access to Public Transit	Percentage of population living near a fixed public transportation stop	68.3%	69.6%	
Air and Water Quality				
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 3.0 pollution burden score percentile of 50 or greater	97.2%	51.6%	
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	12.6	8.1	
Drinking Water Violations	Presence of health-related drinking water violations in the county.	Yes		

Community Service Provider Survey Results

Table 15: Service provider survey results for Stanislaus County.

Service Provider Survey Snapshot | Stanislaus County (N=6)	
Health Needs	***% Reporting***
Most Frequently Reported	
Access to Dental Care and Preventive Services	*100.0*
Increased Community Connection	*100.0*
Access to Basic Needs Such as Housing, Jobs, and Food	*83.3*
Access to Quality Primary Care Health Services	*83.3*
Access to Mental/Behavioral Health and Substance-Abuse Services	*83.3*
Top 3/ Priority *(Most Frequently Reported Characteristics)*	
Access to Mental/Behavioral Health and Substance Abuse Services	*66.7*
• Additional services specifically for youth are needed (e.g., child psychologists, counselors and therapists in the schools). • Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). • There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers). • There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).	
Access to Basic Needs Such as Housing, Jobs, and Food	*66.7*
• Lack of affordable housing is a significant issue in the area. • Many people in the area do not make a living wage. • Services for homeless residents in the area are insufficient.	
Access to Quality Primary Care Health Services	*50.0*
• Quality health insurance is unaffordable. • Out-of-pocket costs are too high.	

CHNA Methods and Processes

Two related models were foundational in this CHNA. The first is a conceptual model that expresses the theoretical understanding of community health used in the analysis. This understanding is important because it provides the framework underpinning the collection of primary and secondary data. It is the tool used to ensure that the results are based on a rigorous understanding of those factors that influence the health of a community. The second model is a process model that describes the various stages of the analysis. It is the tool that ensures that the resulting analysis is based on a tight integration of community voice and secondary data and that the analysis meets federal regulations for conducting hospital CHNAs.

Conceptual Model

The conceptual model used in this needs assessment is shown in Figure 7. This model organizes populations' individual health-related characteristics in terms of how they relate to up- or downstream

health and health-disparities factors. In this model, health outcomes (quality and length of life) are understood to result from the influence of health factors describing interrelated individual, environmental, and community characteristics, which in turn are influenced by underlying policies and programs.

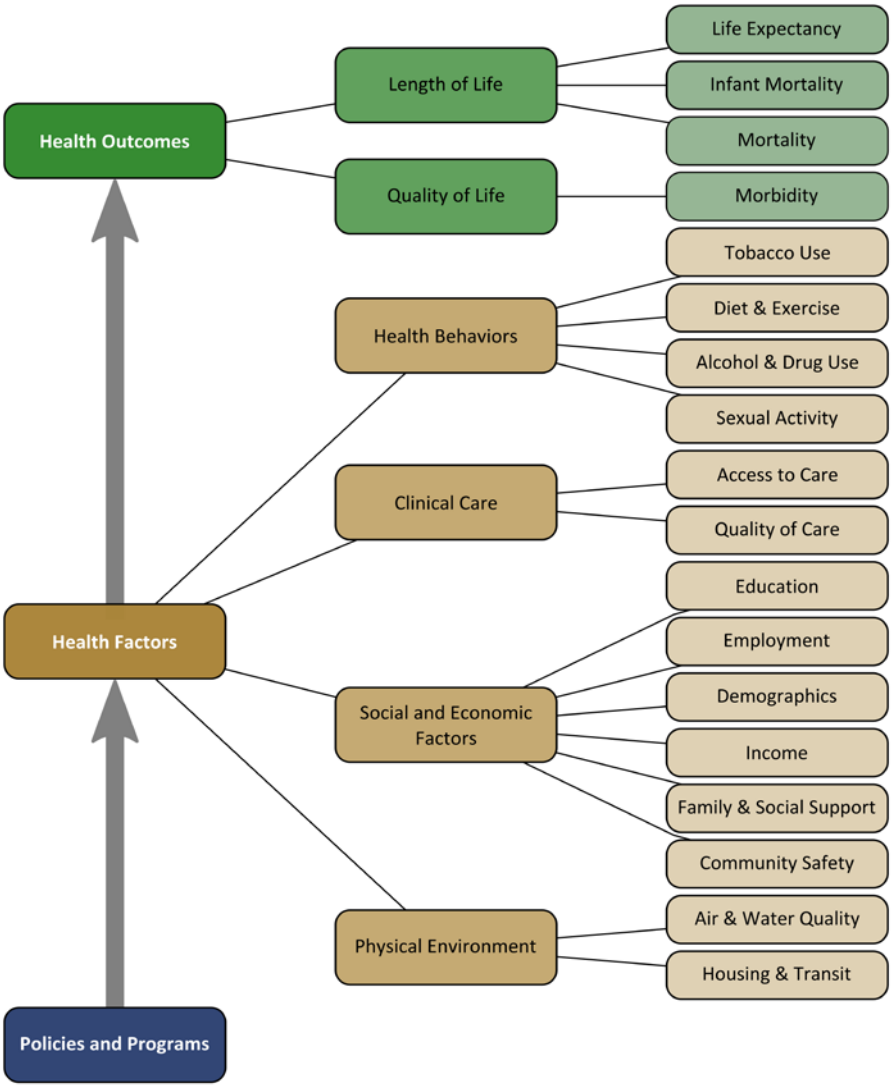


Figure 7: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

This model was used to guide the selection of secondary indicators in this analysis as well as to express in general how these upstream health factors lead to the downstream health outcomes. It also suggests that poor health outcomes within the service area can be improved through policies and programs that address the health factors contributing to them. This conceptual model is a slightly modified version of the County Health Rankings Model used by the Robert Wood Johnson Foundation. It was primarily altered by adding a "Demographics" category to the "Social and Economic Factors" in recognition of the influence of demographic characteristics on health outcomes.

To generate the list of secondary indicators used in the assessment, each conceptual model category was reviewed to identify potential indicators that could be used to fully represent the category. The results of this discussion were then used to guide secondary data collection.

Process Model

Figure 8 outlines the data collection and analysis stages of this process. The project began by confirming the HSA for MMC which the CHNA would be conducted. Primary data collection included key informant interviews and focus-groups with community health experts and residents as well as a community survey provider survey. Initial key informant interviews were used to identify Primary and Secondary Communities of Concern which are areas or population subgroups within the county experiencing health disparities.

Overall primary and secondary data were integrated to identify significant health needs for the HSA. Significant health needs were then prioritized based on analysis of the primary data. Finally, information was collected regarding the resources available within the community to meet the identified health needs. An evaluation of the impact of the hospital's prior efforts was obtained from hospital representatives and any written comments on the previous CHNA were gathered and included in the report.

Greater detail on the collection and processing of the secondary and primary data is given in the next two sections. This is followed by a more detailed description of the methodology utilized during the main analytical stages of the process.

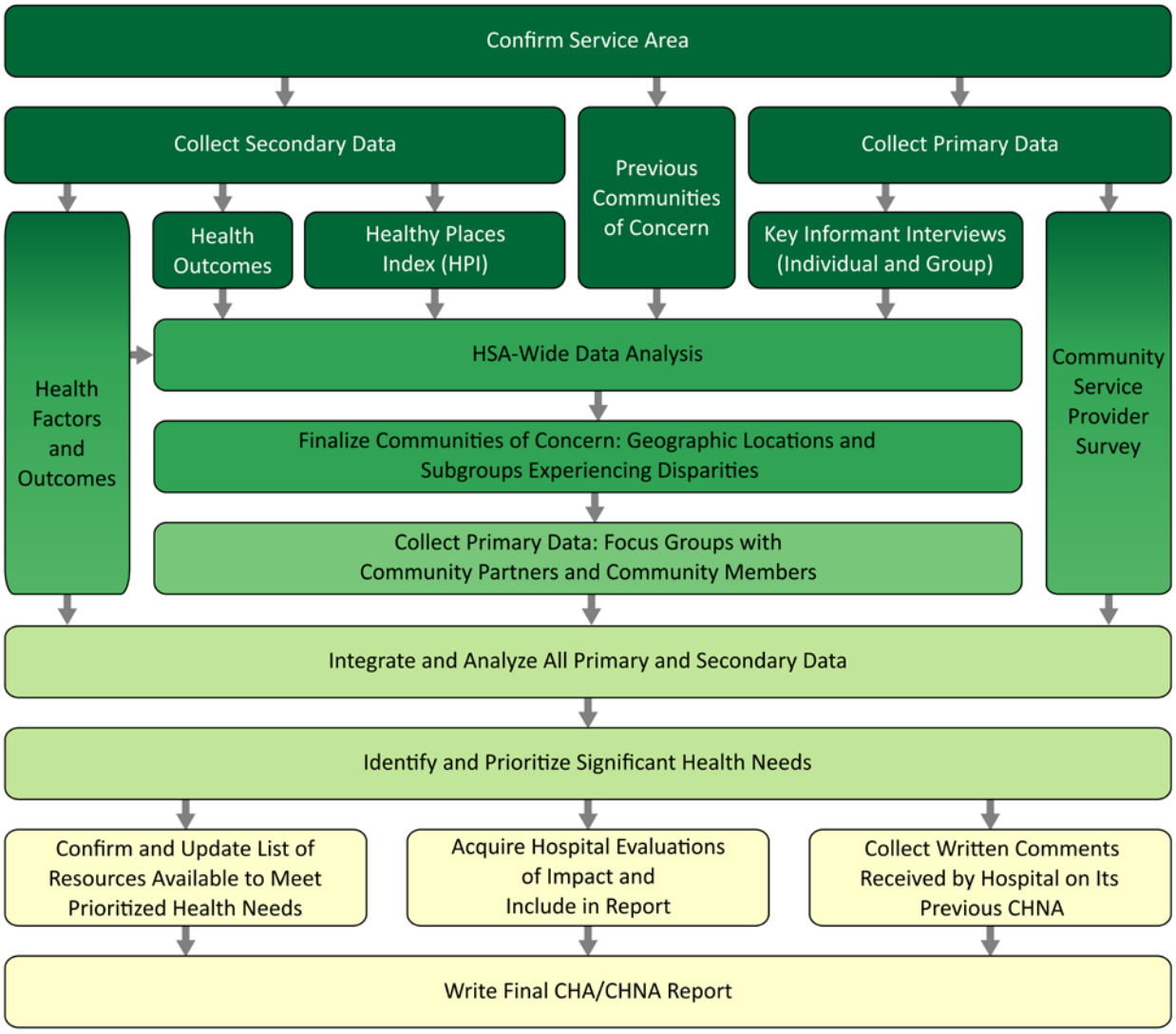


Figure 8: CHNA process model for MMC.

Primary Data Collection and Processing

Primary Data Collection

Input from the community served by MMC was collected through two main mechanisms. First, key informant interviews were conducted with community health experts and area service providers (i.e., members of social service nonprofit organizations and related healthcare organizations). These interviews occurred in both one-on-one and in group interview settings. Second, focus groups were conducted with community residents that were identified as populations experiencing disparities.

All participants were given an informed consent form prior to their participation, which provided information about the project, asked for permission to record the interview, and listed the potential benefits and risks for involvement in the interview. All interview data were collected through note taking and, in some instances, recording.

Key Informant Results

Primary data collection with key informants included two phases. First, phase one began by interviewing area-wide service providers with knowledge of the service area, including input from the designated Public Health Department. Data from these area-wide informants, coupled with socio-demographic data, was used to identify additional key informants for the assessment that were included in phase two.

As a part of the interview process, all key informants were asked to identify vulnerable populations. The interviewer asked each participant to verbally explain what vulnerable populations existed in the county. As needed for a visual aid, key informants were provided a map of the HSA to directly point to the geographic locations of these vulnerable communities. Additional key informant interviews were focused on the geographic locations and/or subgroups identified in the earlier phase.

Table 16 contains a listing of community health experts, or key informants, that contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

Table 16: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Stanislaus County Office of Education	01/14/2022	1	Education and Prevention	School aged youth
Sutter Medical Foundation South Valley	01/19/2022	1	Healthcare provider	Residents of Modesto
Memorial Medical Center Staff	01/20/2022	2	Acute care hospital	Residents of Stanislaus County
Golden Valley Health Centers	01/21/2022	2	Healthcare provider	Low income; homeless
Valley Children's Healthcare	01/28/2022	1	Healthcare provider	Children and families
First 5 Stanislaus County	01/28/2022	1	Early childhood development	Children 0-5 years and families
Stanislaus County Public Health	02/01/2022	1	Public Health	All residents of Stanislaus County
West Modesto Community Collaborative	02/08/2022	1	Health promotion and education	West and South Modesto; Low income; Hispanic; African American; Asian
Sierra Vista Child & Family Services	02/09/2022	1	Mental and behavioral health	Children and families
Center for Human Services	02/14/2022	1	Mental health, addiction, education, shelter	Low income; underserved

Key Informant Interview Guide

The following questions served as the interview guides for key informant interviews.

2022 CHNA Group/Key Informant Interview Protocol

1. **BACKGROUND**
    a) **Please tell me about your current role and the organization you work for?**
        i. Probe for:
            1. Public health (division or unit)
            2. Hospital health system
            3. Local non-profit
            4. Community member
    b. **How would you define the community (ies) you or your organization serves?**
        i. Probe for:
            1. Specific geographic areas?
            2. Specific populations served?
            3. *Who? Where? Racial/ethnic make-up, physical environment (urban/ rural, large/small)*
2. **CHARACTERISTICS OF A HEALTHY COMMUNITY**
    a. **In your view, what does a healthy community look like?**
        i. Probe for:
            1. Social factors
            2. Economic factors
            3. Clinical care
            4. Physical/built environment (food environment, green spaces)
            5. Neighborhood safety
3. **HEALTH ISSUES**
    a. **What would you say are the biggest health needs in the community?**
        i. Probe for:
            1. How has the presence of COVID-19 impacted these health needs?
    b. **INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live?**
        i. Probe for:
            1. What specific geographic locations struggle with health issues the most?
            2. What specific groups of community members experience health issues the most?
4. **CHALLENGES/BARRIERS**
    a. **Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?**
        i. **Do these inequities exist among certain population groups?**
        ii. Probe for:
            1. Health Behaviors (maladaptive, coping)
            2. Social factors (social connections, family connectedness, relationship with law enforcement)
            3. Economic factors (income, access to jobs, affordable housing, affordable food)

4. Clinical Care factors (access to primary care, secondary care, quality of care)
5. Physical (Built) environment (safe and healthy housing, walkable communities, safe parks)

5. **SOLUTIONS**
    a. **What solutions are needed to address the health needs and or challenges mentioned?**
        i. Probe for:
            1. Policies
            2. Care coordination
            3. Access to care
            4. Environmental change
6. **PRIORITY**
    a. **Which would you say are currently the most important or urgent health issues or challenges to address (at least 3 to 5) in order to improve the health of the community?**
7. **RESOURCES**
    a. **What resources exist in the community to help people live healthy lives?**
        i. Probe for:
            1. Barriers to accessing these resources.
            2. New resources that have been created since 2019
            3. New partnerships/projects/funding
8. **PARTICIPANT DRIVEN SAMPLING:**
    a. **What other people, groups or organizations would you recommend we speak to about the health of the community?**
        i. Name 3 types of service providers that you would suggest we include in this work?
        ii. Name 3 types of community members that you would recommend we speak to in this work?
9. **OPEN: Is there anything else you would like to share with our team about the health of the community?**

Focus Group Results

Focus group interviews were conducted with community members or service providers living or working in geographic areas of the service area identified as locations or populations experiencing a disparate amount of poor socioeconomic conditions and poor health outcomes. Recruitment consisted of referrals from designated service providers representing vulnerable populations, as well as direct outreach to special population groups.

Table 17 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table 17: Focus group list.

Hosting Organization	Date	Number of Participants	Populations Represented
Sierra Vista Child & Family Services	03/16/2022	7	Hispanic; undocumented; low income

Hosting Organization	Date	Number of Participants	Populations Represented
West Modesto Community Collaborative	03/17/2022	5	Children and families in West and South Modesto; Latino; African American, Asian
Golden Valley Health Centers	03/18/2022	5	Low income; homeless; seniors; undocumented; Hispanic; LGBTQ

Focus Group Interview Guide

The following questions served as the interview guides for focus group interviews.

2022 CHNA Focus Group Interview Protocol

1. Let's start by introducing ourselves. Please tell us your name, the town you live in, and one thing that you are proud of about your community.
2. We would like to hear about the community where you live. Tell us in a few words what you think of as "your community". What it is like to live in your community?
3. What do you think that a "healthy environment" is?
4. When thinking about your community based on the healthy environment you just described, what are the biggest health needs in your community?
5. Are needs more prevalent in a certain geographic area, or within a certain group of the community?
6. How has the presence of COVID-19 impacted these health needs?
7. What are the challenges or barriers to being healthy in your community?
8. What are some solutions that can help solve the barriers and challenges you talked about?
9. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address to improve the health of the community?
10. Are these needs that have recently come up or have they been around for a long time?
11. What are resources that exist in the community that help your community live healthy lives and address the health issues and inequity we have discussed?
12. Is there anything else you would like to share with our team about the health of the community?

Primary Data Processing

Key informant and focus group data were analyzed using qualitative analytic software. Content analysis included thematic coding to potential health need categories, the identification of special populations experiencing health issues, and the identification of resources. In some instances, data were coded in accordance to the interview question guide. Results were aggregated to inform the determination of prioritized significant health needs.

Community Service Provider Survey

A web-based survey was administered to community service providers (CSP) who delivered health and social services to community residents of the HSA. A list of CSPs affiliated with the hospitals included in this report was used as an initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey aims and inviting them to participate. Participants we also encouraged to forward the recruitment message to other CSPs in their networks. The survey was designed using Qualtrics, an

online survey platform, and was available for approximately two weeks. Six (6) respondents completed the survey. Survey respondents were also given the opportunity to be acknowledged for their participation in the report, and are listed as follows:

Benazir Ali, Virginia Carney, Charmaine Monte, and Al Rowlett.

After providing socio-demographic information including the county they served and their affiliated organization(s), survey respondents were shown a list of 12 potential health needs and asked to identify which were unmet health needs in their community. In order to reduce any confusion or ambiguity that could introduce bias, participants could scroll over each health need for a definition. Respondents were then asked to select which of the needs they identified as unmet in their community were the priority to address (up to three health needs). Upon selection of these priority unmet health needs, respondents were asked about the characteristics of each as it is expressed in their community. Depending upon the specific health need, respondents were shown a list of between 7-12 characteristics and could select all that apply. Respondents were also offered the opportunity to provide additional information about the health need in their community if it was not provided as a response option. Finally, a set of questions were included about how the COVID-19 pandemic impacted the health needs of the community.

When the survey period was over, incomplete and duplicate responses were removed from the dataset and the survey responses were double-checked for accuracy. Descriptive statistics and frequencies were used to summarize the health needs. This information was used along with other data sources to both identify and rank significant health needs in the community, and to describe how the health needs were expressed.

Secondary Data Collection and Processing

The term “secondary data” refers to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to 1) inform the identification of Communities of Concern, 2) support the identification of health needs within the MMC HSA. This section details the data sources and processing steps used to obtain the secondary data used in each of these steps and prepare them for analysis.

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),[14] derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),[15] health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2015-2019 due to each of the causes listed in Table 18.

[14] Public Health Alliance of Southern California. 2021. HPI_MasterFile_2021-04-22.zip. Data file. Retrieved 1 May 2021 from https://healthyplacesindex.org/wp-content/uploads/2021/04/HPI_MasterFile_2021-04-22.zip.
[15] State of California, Department of Public Health. 2021. California Comprehensive Master Death File (Static), 2015-2019.

Table 18: Mortality indicators used in Community of Concern Identification.

Cause of Death	ICD 10 Codes
Alzheimer's disease	G30
Malignant neoplasms (cancers)	C00-C97
Chronic lower respiratory disease (CLRD)	J40-J47
Diabetes mellitus	E10-E14
Diseases of heart	I00-I09, I11, I13, I20-I51
Essential hypertension and hypertensive renal disease	I10, I12, I15
Accidents (unintentional injuries)	V01-X59, Y85-Y86
Chronic liver disease and cirrhosis	K70, K73-K74
Nephritis, nephrotic syndrome and nephrosis	N00-N07, N17-N19, N25-N27
Pneumonia and influenza	J09-J18
Cerebrovascular disease (stroke)	I60-I69
Intentional self-harm (suicide)	*U03, X60-X84, Y87.0

While the HPI dataset was used as-is, additional processing was required to prepare the mortality data for analysis. This included two main steps. First, ZIP Codes associated with PO Boxes needed to be merged with the larger ZIP Codes in which they were located. Once this was completed, smoothed mortality rates were calculated for each resulting ZIP Code.

ZIP Code Consolidation

The mortality indicators used here included deaths reported for the ZIP Code at the decedent's place of residence. ZIP Codes are defined by the U.S. Postal Service as a single location (such as a PO Box), or a set of roads along which addresses are located. The roads that comprise such a ZIP Code may not form contiguous areas and do not match the areas used by the U.S. Census Bureau (the main source of population and demographic data in the United States) to report population. Instead of measuring the population along a collection of roads, the census reports population figures for distinct, largely contiguous areas. To support the analysis of ZIP Code data, the U.S. Census Bureau created ZIP Code Tabulation Areas (ZCTAs). ZCTAs are created by identifying the dominant ZIP Code for addresses in a given Census block (the smallest unit of census data available), and then grouping blocks with the same dominant ZIP Code into a corresponding ZCTA. The creation of ZCTAs allows us to identify population figures that make it possible to calculate mortality rates for each ZCTA. However, the difference in the definition between mailing ZIP Codes and ZCTAs has two important implications for analyses of ZIP Code level data.

First, ZCTAs are approximate representations of ZIP Codes rather than exact matches. While this is not ideal, it is nevertheless the nature of the data being analyzed. Second, not all ZIP Codes have corresponding ZCTAs. Some PO Box ZIP Codes or other unique ZIP Codes (such as a ZIP Code assigned to a single facility) may not have enough addressees residing in a given census block to ever result in the creation of a corresponding ZCTA. But residents whose mailing addresses are associated with these ZIP Codes will still show up in reported health-outcome data. This means that rates cannot be calculated for these ZIP Codes individually because there are no matching ZCTA population figures.

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California[16] were compared to ZCTA boundaries.[17] These unique ZIP Codes were then assigned to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

Rate Calculation and Smoothing

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical bayes smoothed rates (EBRs) were created for all indicators possible.[18] Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small-number problem. Empirical bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

Because the EBR were created for all ZCTAs in the state, ZCTAs with small populations that may have unstable high rates had their rates "shrunk" to more closely match the overall indicator rate for ZCTAs in the entire state. This adjustment can be substantial for ZCTAs with very small populations. The difference between raw rates and EBRs in ZCTAs with very large populations, on the other hand, is negligible. In this way, the stable rates in large-population ZIP Codes are preserved, and the unstable rates in smaller-population ZIP Codes are shrunk to more closely match the state norm. While this may not entirely resolve the small-number problem in all cases, it does make the comparison of the resulting rates more appropriate. Because the rate for each ZCTA is adjusted to some degree by the EBR process, this also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

EBRs were calculated for each mortality indicator using the total population figure reported for ZCTAs in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

Significant Health Need Identification Dataset

The second main set of data used in the CHNA includes the health factor and health outcome indicators used to identify significant health needs. The selection of these indicators was guided by the previously identified conceptual model. Table 19 lists these indicators, their sources, the years they were measured, and the health-related characteristics from the conceptual model they are primarily used to represent.

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[16] Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from http://www.Zip-Codes.com.
[17] US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from https://www.census.gov/cgi-bin/geo/shapefiles/index.php.
[18] Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

Table 19: Health factor and health outcome indicators used in health need identification.

Conceptual Model Alignment			Indicator	Data Source	Time Period
Health Outcomes	Length of Life	Infant Mortality	Infant Mortality	County Health Rankings	2013 - 2019
		Life Expectancy	Child Mortality	County Health Rankings	2016 - 2019
			Life Expectancy	County Health Rankings	2017 - 2019
			Premature Age-Adjusted Mortality	County Health Rankings	2017 - 2019
			Premature Death	County Health Rankings	2017 - 2019
			Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			COVID-19 Mortality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-03-23
			COVID-19 Case Fatality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-03-23
			Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Influenza and Pneumonia Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019

Conceptual Model Alignment			Indicator	Data Source	Time Period
	Quality of Life	Morbidity	Diabetes Prevalence	County Health Rankings	2017
			Low Birthweight	County Health Rankings	2013 - 2019
			HIV Prevalence	County Health Rankings	2018
			Disability	2019 American Community Survey 5 year estimate variable S1810_C03_001E	2015 - 2019
			Poor Mental Health Days	County Health Rankings	2018
			Frequent Mental Distress	County Health Rankings	2018
			Poor Physical Health Days	County Health Rankings	2018
			Frequent Physical Distress	County Health Rankings	2018
			Poor or Fair Health	County Health Rankings	2018
			Colorectal Cancer Prevalence	California Cancer Registry	2013 - 2017
			Breast Cancer Prevalence	California Cancer Registry	2013 - 2017
			Lung Cancer Prevalence	California Cancer Registry	2013 - 2017
			Prostate Cancer Prevalence	California Cancer Registry	2013 - 2017
			COVID-19 Cumulative Incidence	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-03-23
			Asthma ED Rates	Tracking California	2018
			Asthma ED Rates for Children	Tracking California	2018
Health Factors	Health Behavior	Alcohol and Drug Use	Excessive Drinking	County Health Rankings	2018
			Drug Induced Death	CDPH 2021 County Health Status Profiles	2017 - 2019
		Diet and Exercise	Adult Obesity	County Health Rankings	2017
			Physical Inactivity	County Health Rankings	2017
			Limited Access to Healthy Foods	County Health Rankings	2015
			Food Environment Index	County Health Rankings	2015 & 2018
			Access to Exercise Opportunities	County Health Rankings	2010 & 2019
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2018

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Teen Birth Rate	County Health Rankings	2013 - 2019
		Tobacco Use	Adult Smoking	County Health Rankings	2018
	Clinical Care	Access to Care	Primary Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Dental Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Mental Health Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Medically Underserved Area	U.S. Heath Resources and Services Administration	2021
			Mammography Screening	County Health Rankings	2018
			Dentists	County Health Rankings	2019
			Mental Health Providers	County Health Rankings	2020
			Psychiatry Providers	County Health Rankings	2020
			Specialty Care Providers	County Health Rankings	2020
			Primary Care Providers	County Health Rankings	2018; 2020
		Quality Care	Preventable Hospitalization	California Office of Statewide Health Planning and Development Prevention Quality Indicators for California	2019
			COVID-19 Cumulative Full Vaccination Rate	CDPH COVID-19 Vaccine Progress Dashboard Data	Collected on 2022-03-23
	Socio-Economic and Demographic Factors	Community Safety	Homicide Rate	County Health Rankings	2013 - 2019
			Firearm Fatalities Rate	County Health Rankings	2015 - 2019
			Violent Crime Rate	County Health Rankings	2014 & 2016
			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2015 - 2019
			Motor Vehicle Crash Death	County Health Rankings	2013 - 2019

Conceptual Model Alignment			Indicator	Data Source	Time Period
		Education	Some College	County Health Rankings	2015 - 2019
			High School Completion	County Health Rankings	2015 - 2019
			Disconnected Youth	County Health Rankings	2015 - 2019
			Third Grade Reading Level	County Health Rankings	2018
			Third Grade Math Level	County Health Rankings	2018
		Employment	Unemployment	County Health Rankings	2019
		Family and Social Support	Children in Single-Parent Households	County Health Rankings	2015 - 2019
			Social Associations	County Health Rankings	2018
			Residential Segregation (Non-White/White)	County Health Rankings	2015 - 2019
		Income	Children Eligible for Free Lunch	County Health Rankings	2018 - 2019
			Children in Poverty	County Health Rankings	2019
			Median Household Income	County Health Rankings	2019
			Uninsured Population under 64	County Health Rankings	2018
			Income Inequality	County Health Rankings	2015 - 2019
	Physical Environment	Housing and Transit	Severe Housing Problems	County Health Rankings	2013 - 2017
			Severe Housing Cost Burden	County Health Rankings	2015 - 2019
			Homeownership	County Health Rankings	2015 - 2019
			Homelessness Rate	US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report	2020
			Households with no Vehicle Available	2019 American Community Survey 5-year estimate variable DP04_0058PE	2015 - 2019
			Long Commute - Driving Alone	County Health Rankings	2015 - 2019

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Access to Public Transit	OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau	2021; 2020
		Air and Water Quality	Pollution Burden Percent	California Office of Environmental Health Hazard Assessment	2018
			Air Pollution - Particulate Matter	County Health Rankings	2016
			Drinking Water Violations	County Health Rankings	2019

The following sections give further details about the sources of these data and any processing applied to prepare them for use in the analysis.

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings[19] dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 20.

Table 20: Sources and time periods for indicators obtained from County Health Rankings.

CHR Indicator	Time Period	Data Source
Infant Mortality	2013 - 2019	National Center for Health Statistics - Mortality Files
Child Mortality	2016 - 2019	National Center for Health Statistics - Mortality Files
Life Expectancy	2017 - 2019	National Center for Health Statistics - Mortality Files
Premature Age-Adjusted Mortality	2017 - 2019	National Center for Health Statistics - Mortality Files
Premature Death	2017 - 2019	National Center for Health Statistics - Mortality Files
Diabetes Prevalence	2017	United States Diabetes Surveillance System

[19] University of Wisconsin Population Health Institute. 2021. County Health Rankings State Report 2021. Retrieved 6 May 2021 from https://www.countyhealthrankings.org/app/oregon/2021/downloads and https://www.countyhealthrankings.org/app/california/2021/downloads.

CHR Indicator	Time Period	Data Source
Low Birthweight	2013 - 2019	National Center for Health Statistics - Natality files
HIV Prevalence	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Poor Mental Health Days	2018	Behavioral Risk Factor Surveillance System
Frequent Mental Distress	2018	Behavioral Risk Factor Surveillance System
Poor Physical Health Days	2018	Behavioral Risk Factor Surveillance System
Frequent Physical Distress	2018	Behavioral Risk Factor Surveillance System
Poor or Fair Health	2018	Behavioral Risk Factor Surveillance System
Excessive Drinking	2018	Behavioral Risk Factor Surveillance System
Adult Obesity	2017	United States Diabetes Surveillance System
Physical Inactivity	2017	United States Diabetes Surveillance System
Limited Access to Healthy Foods	2015	USDA Food Environment Atlas
Food Environment Index	2015 & 2018	USDA Food Environment Atlas, Map the Meal Gap from Feeding America
Access to Exercise Opportunities	2010 & 2019	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
Chlamydia Incidence	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Teen Birth Rate	2013 - 2019	National Center for Health Statistics - Natality files
Adult Smoking	2018	Behavioral Risk Factor Surveillance System
Mammography Screening	2018	Mapping Medicare Disparities Tool
Dentists	2019	Area Health Resource File/National Provider Identification file
Mental Health Providers	2020	CMS, National Provider Identification
Psychiatry Providers	2020	Area Health Resource File
Specialty Care Providers	2020	Area Health Resource File
Primary Care Providers	2018; 2020	Area Health Resource File/American Medical Association; CMS, National Provider Identification
Homicide Rate	2013 - 2019	National Center for Health Statistics - Mortality Files
Firearm Fatalities Rate	2015 - 2019	National Center for Health Statistics - Mortality Files
Violent Crime Rate	2014 & 2016	Uniform Crime Reporting - FBI
Motor Vehicle Crash Death	2013 - 2019	National Center for Health Statistics - Mortality Files
Some College	2015 - 2019	American Community Survey, 5-year estimates
High School Completion	2015 - 2019	American Community Survey, 5-year estimates
Disconnected Youth	2015 - 2019	American Community Survey, 5-year estimates
Third Grade Reading Level	2018	Stanford Education Data Archive

CHR Indicator	Time Period	Data Source
Third Grade Math Level	2018	Stanford Education Data Archive
Unemployment	2019	Bureau of Labor Statistics
Children in Single-Parent Households	2015 - 2019	American Community Survey, 5-year estimates
Social Associations	2018	County Business Patterns
Residential Segregation (Non-White/White)	2015 - 2019	American Community Survey, 5-year estimates
Children Eligible for Free Lunch	2018 - 2019	National Center for Education Statistics
Children in Poverty	2019	Small Area Income and Poverty Estimates
Median Household Income	2019	Small Area Income and Poverty Estimates
Uninsured Population under 64	2018	Small Area Health Insurance Estimates
Income Inequality	2015 - 2019	American Community Survey, 5-year estimates
Severe Housing Problems	2013 - 2017	Comprehensive Housing Affordability Strategy (CHAS) data
Severe Housing Cost Burden	2015 - 2019	American Community Survey, 5-year estimates
Homeownership	2015 - 2019	American Community Survey, 5-year estimates
Long Commute - Driving Alone	2015 - 2019	American Community Survey, 5-year estimates
Air Pollution - Particulate Matter	2016	Environmental Public Health Tracking Network
Drinking Water Violations	2019	Safe Drinking Water Information System

The provider rates for the primary care physicians and other primary care providers indicators obtained from CHR were summed to create the final primary care provider indicator used in this analysis.

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa[20] online data query system for the years 2015-2019. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

[20] State of California, Department of Public Health. 2021. California Vital Data (Cal-ViDa), Death Query. Retrieved 1 Jun 2021 from https://cal-vida.cdph.ca.gov/.

CDPH masks the actual number of deaths that occur in a county for a given year and cause if there are between 1 and 10 total deaths recorded. Because of this, the following process was used to estimate the total number of deaths for counties whose actual values were masked. First, mortality rates for each cause and year were calculated for the state. The differences between the by-cause mortality for the state and the total by-cause mortality reported across all counties in the state for each cause and year were also calculated.

Next, we applied the state by-cause mortality rate for each cause and year to estimate mortality at the county level if the reported value was masked. This was done by multiplying the cause/year appropriate state-level mortality rate by the 2017 populations of counties with masked values. Resulting estimates that were less than 1 or greater than 10 were set to 1 and 10 respectively to match the known CDPH masking criteria.

The total number of deaths estimated for counties that had masked values for each year/cause was then compared to the difference between the reported total county and state deaths for the corresponding year/cause. If the number of estimated county deaths exceeded this difference, county estimates were further adjusted. This was done by iteratively ranking county estimates for a given year/cause, then from highest to lowest, reducing the estimates by 1 until they reached a minimum of 1 death. This continued until the estimated deaths for counties with masked values equaled the difference between the state and total reported county values.

COVID-19 Data

Data on the cumulative number of cases and deaths[21] and completed vaccinations[22] for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles[23] and report age-adjusted deaths per 100,000.

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[21] State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved March 23 2022 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

[22] State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved March 23 2022 from https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv.

[23] State of California, Department of Public Health, Vital Records Data and Statistics. 2021. County Health Status Profiles 2021: CHSP 2021 Tables 1-29. Spreadsheet. Retrieved 21 Jul 2021 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP_2021_Tables_1-29_04.16.2021.xlsx.

U.S. Heath Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration[24] (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

The health professional shortage area and medically underserved area data were not provided at the county level. Rather, they show all areas in the state that were designated as shortage areas. These areas could include a portion of a county or an entire county, or they could span multiple counties. To develop measures at the county level to match the other health-factor and health-outcome indicators used in health need identification, these shortage areas were compared to the boundaries of each county in the state. Counties that were partially or entirely covered by a shortage area were noted.

Psychiatry and Specialty Care Providers

The HRSA's Area Health Resource Files provide information on physicians and allied healthcare providers for U.S. counties. This information was used to determine the rate of specialty care providers and the rate of psychiatrists for each county and for the state. For the purposes of this analysis, a specialty care provider was defined as a physician who was not defined by the HRSA as a primary care provider. This was found by subtracting the total number of primary care physicians (both MDs and DOs, primary care, patient care, and non-federal, excluding hospital residents and those 75 years of age or older) from the total number of physicians (both MDs and DOs, patient care, non-federal) in 2018. This number was then divided by the 2018 total population given in the 2018 American Community Survey 5-year Estimates table B03002, and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

The total of specialty care physicians in each county was summed to find the total specialty care physicians in the state, and state rates were calculated following the same approach as used for county rates. This same process was also used to calculate the number of psychiatrists per 100,000 for each county and the state using the number of total patient care, non-federal psychiatrists from the Area Health Resource Files. It should be noted that psychiatrists are included in the list of specialty care physicians, so that indicator represents a subset of specialty care providers rather than a separate group.

California Cancer Registry

Data obtained from the California Cancer Registry[25] includes age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2013 to 2017, and report cases per 100,000. For low-

[24] US Health Resources & Services Administration. 2021. Area Health Resources Files and Shortage Areas. Retrieved on 3 Feb 2021 from https://data.hrsa.gov/data/download.
[25] California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from https://www.cancer-rates.info/ca/.

population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

Tracking California

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California.[26] These data reported age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

US Census Bureau

Data from the US Census Bureau was used for two additional indicators: the percentage of households with no vehicles available (table DPO4, variable 0058PE), and the percentage of the civilian non-institutionalized population with some disability (table S1810, variable C03_001E). Values for both of these variables were obtained from the 2019 American Community Survey 5-year Estimates dataset.

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroscreen 3.0[27] dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroscreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators.[28] These data are reported as risk-adjusted rates per 100,000.

California Department of Justice

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.[29] This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015

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[26] Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.
[27] California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from https://oehha.ca.gov/calenviroscreen/maps-data.
[28] Office of Statewide Health Planning and Development. 2021. Prevention Quality Indicators (PQI) for California. Data files for Statewide and County. Retrieved 12 Mar 2021 from https://oshpd.ca.gov/data-and-reports/healthcare-quality/ahrq-quality-indicators/.
[29] California Department of Justice, OpenJustice. 2021. Criminal Justice Data: Arrests. Retrieved 17 Jun 2021 from https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2020-07/OnlineArrestData1980-2019.csv.

- 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I respectively.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report[30] were used to calculate homelessness rates for the counties and state. This data reported point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

To calculate county rates, CoC were first related to county boundaries. Rates for CoC that covered single counties were calculated by dividing the CoC PIT estimate by the county population. If a given county was covered by multiple CoC, their PIT were totaled and then divided by the total county population to calculate the rate. When a single CoC covered multiple counties, the CoC PIT was divided by the total of all included county populations, and the resulting rate was applied to each individual county.

Population data came from the total population value reported in Table B03002 from the 2019 American Community Survey 5-year Estimates dataset. Derived rates were multiplied by 100,000 to report rates per 100,000.

Proximity to Transit Stops

The proximity to transit stops variable reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Likely due to delays in data releases stemming from the COVID-19 pandemic, the most recent Census block population data available at the time of the analysis was from the 2010 Decennial Census,[31] so this was the data used to represent the distribution of population for this indicator.

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[30] US Department of Housing and Urban Development. 2021. 2020 Annual Homeless Assessment Report: 2007 - 2020 Point-in-Time Estimates by CoC. Retrieved 14 Jul 2021 from https://www.huduser.gov/portal/sites/default/files/xls/2007-2020-PIT-Estimates-by-CoC.xlsx.

[31] US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/.

Transit stop data were identified first by using tools in the TidyTransit[32] library for the R statistical programming language.[33] This was used to identify transit providers with stops located within 100 miles of the state boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData,[34] Transitland,[35] Transitwiki.org,[36] and Santa Ynez Valley Transit.[37] Each of these websites list public transit data that have been made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf[38] library in R was then used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

The collected and processed primary and secondary data were integrated in three main analytical stages. First, secondary health outcome and health factor data were combined with area-wide key informant interviews help identify Communities of Concern. These Communities of Concern could potentially include geographic regions as well as specific sub-populations bearing disproportionate health burdens. This information was used to focus the remaining interview and focus-group collection efforts on those areas and subpopulations. Next, the resulting data, along with the results from the service provider survey, were combined with secondary health need identification data to identify significant health needs within the service area. Finally, primary data were used to prioritize those identified significant health needs. The specific details for these analytical steps are given in the following three sections.

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Community of Concern Identification

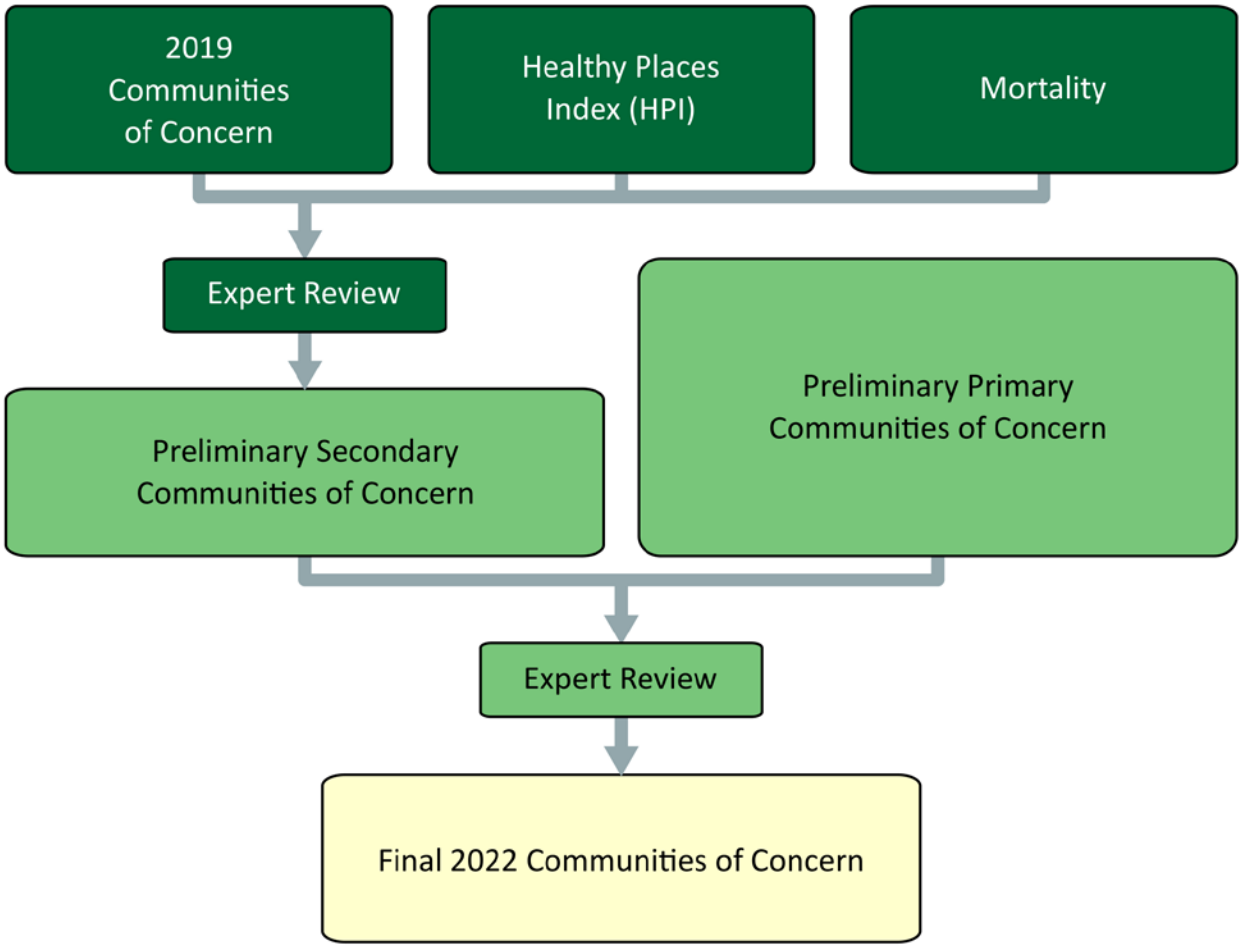

Figure 9: Community of Concern identification process.

As illustrated in Figure 9, 2022 Communities of Concern were identified through a process that drew upon both primary and secondary data. Three main secondary data sources were used in this analysis: Communities of Concern identified in the 2019 CHNA; the census tract-level California Healthy Places Index (HPI); and the CDPH ZCTA-level mortality data.

An evaluation procedure was developed for each of these datasets and applied to each ZCTA within the HSA. The following secondary data selection criteria were used to identify preliminary Communities of Concern.

2019 Community of Concern

A ZCTA was included if it was included in the 2019 CHNA Community of Concern list for the HSA. This was done to allow greater continuity between CHNA rounds and reflects the work of the hospital systems oriented to serve these disadvantaged communities.

Healthy Places Index (HPI)

A ZCTA was included if it intersected a census tract whose HPI value fell within the lowest 20% of those in the HSA. These census tracts represent areas with consistently high concentrations of demographic subgroups identified in the research literature as being more likely to experience health-related disadvantages.

CDPH Mortality Data

The review of ZCTAs based on mortality data utilized the ZCTA-level CDPH health outcome indicators described previously. These indicators were heart disease, cancer, stroke, CLD, Alzheimer's disease, unintentional injuries, diabetes, influenza and pneumonia, chronic liver disease, hypertension, suicide, and kidney disease mortality rates per 100,000 people. The number of times each ZCTA's rates for these indicators fell within the top 20% in the HSA was counted. Those ZCTAs whose counted values exceeded the 80th percentile for all of the ZCTAs in the HSA met the Community of Concern mortality selection criteria.

Integration of Secondary Criteria

Any ZCTA that met any of the three selection criteria (2019 Community of Concern, HPI, and Mortality) was reviewed for inclusion as a 2022 Community of Concern, with greater weight given to those ZCTAs meeting two or more of the selection criteria. An additional round of expert review was applied to determine if any other ZCTAs not thus far indicated should be included based on some other unanticipated secondary data consideration. This list then became the final Preliminary Secondary Communities of Concern.

Preliminary Primary Communities of Concern

Preliminary primary Communities of Concern were identified by reviewing the geographic locations or population subgroups that were consistently identified by the area-wide primary data sources.

Integration of Preliminary Primary and Secondary Communities of Concern

Any ZCTA that was identified in either the Preliminary Primary or Secondary Community of Concern list was considered for inclusion as a 2022 Community of Concern. An additional round of expert review was then applied to determine if, based on any primary or secondary data consideration, any final adjustments should be made to this list. The resulting set of ZCTAs was then used as the final 2022 Communities of Concern.

Significant Health Need Identification

The general methods through which significant health needs (SHNs) were identified are shown in Figure 10 and described here in greater detail. The first step in this process was to identify a set of potential health needs (PHNs) from which significant health needs could be selected. This was done by reviewing the health needs identified during prior CHNAs among various hospitals throughout Central and Northern California and then supplementing this list based on a preliminary analysis of the primary qualitative data collected for the current CHNA. This resulted the list of PHNs shown in Table 21.

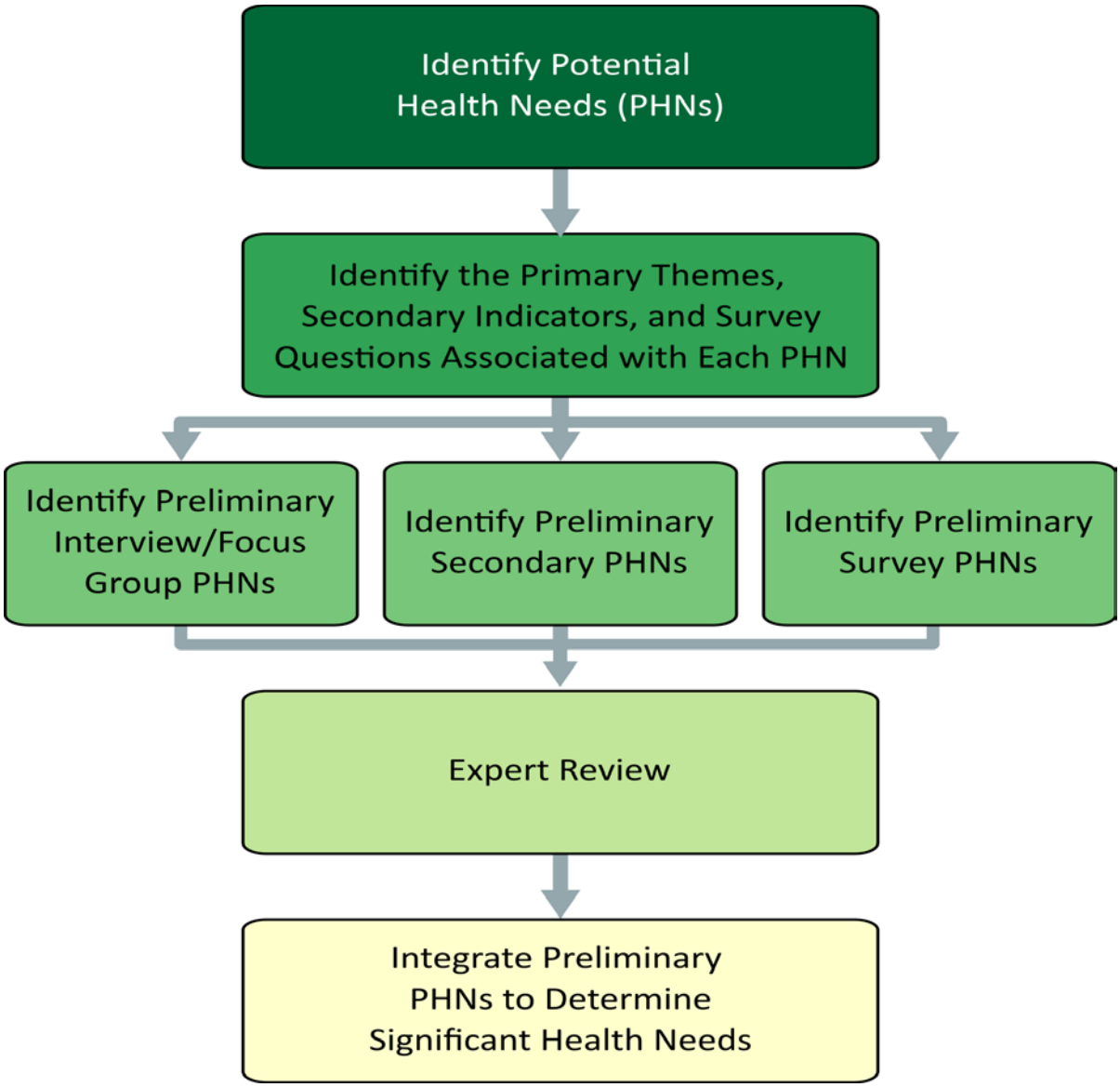

Figure 10: Significant health need identification process.

Table 21: 2022 Potential Health Needs.

Potential Health Needs (PHNs)	
PHN1	Access to Mental/Behavioral Health and Substance Use Services
PHN2	Access to Quality Primary Care Health Services
PHN3	Active Living and Healthy Eating
PHN4	Safe and Violence-Free Environment
PHN5	Access to Dental Care and Preventive Services
PHN6	Healthy Physical Environment
PHN7	Access to Basic Needs Such as Housing, Jobs, and Food
PHN8	Access to Functional Needs
PHN9	Access to Specialty and Extended Care
PHN10	Injury and Disease Prevention and Management

Potential Health Needs (PHNs)
PHN11 Increased Community Connections
PHN12 System Navigation

The next step in the process was to identify primary themes and secondary indicators associated with each of these health needs as shown in Tables 22 through 33. Primary theme associations were used to guide coding of the primary data sources to specific PHNs.

Access to Mental/Behavioral Health and Substance Use Services

Table 22: Primary themes and secondary indicators associated with PHN1.

Primary Themes	Secondary Indicators
There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).	Life Expectancy
The cost for mental/behavioral health treatment is too high.	Premature Age-Adjusted Mortality
Treatment options in the area for those with Medi-Cal are limited.	Premature Death
Awareness of mental health issues among community members is low.	Liver Disease Mortality
Additional services specifically for youth are needed (e.g., child psychologists, counselors and therapists in the schools).	Suicide Mortality
The stigma around seeking mental health treatment keeps people out of care.	Poor Mental Health Days
Additional services for those who are homeless and dealing with mental/behavioral health issues are needed.	Frequent Mental Distress
The area lacks the infrastructure to support acute mental health crises.	Poor Physical Health Days
Mental/behavioral health services are available in the area, but people do not know about them.	Frequent Physical Distress
It's difficult for people to navigate for mental/behavioral healthcare.	Poor or Fair Health
Substance use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).	Excessive Drinking
There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers).	Drug Induced Death
Substance use treatment options for those with Medi-Cal are limited.	Adult Smoking
There aren't enough services here for those who are homeless and dealing with substance use issues.	Primary Care Shortage Area
The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community.	Mental Health Care Shortage Area
Substance use is an issue among youth in particular.	Medically Underserved Area
There are substance use treatment services available here, but people do not know about them.	Mental Health Providers
	Psychiatry Providers
	Firearm Fatalities Rate
	Juvenile Arrest Rate
	Disconnected Youth
	Social Associations
	Residential Segregation (Non-White/White)
	Income Inequality
	Severe Housing Cost Burden
	Homelessness Rate

Access to Quality Primary Care Health Services

Table 23: Primary themes and secondary indicators associated with PHN2.

Primary Themes	Secondary Indicators
Insurance is unaffordable.	Infant Mortality
Wait-times for appointments are excessively long.	Child Mortality
Out-of-pocket costs are too high.	Life Expectancy
There aren't enough primary care service providers in the area.	Premature Age-Adjusted Mortality
Patients have difficulty obtaining appointments outside of regular business hours.	Premature Death
	Stroke Mortality
Too few providers in the area accept Medi-Cal.	Chronic Lower Respiratory Disease Mortality
It is difficult to recruit and retain primary care providers in the region.	Diabetes Mortality
Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).	Heart Disease Mortality
	Hypertension Mortality
The quality of care is low (e.g., appointments are rushed, providers lack cultural competence).	Cancer Mortality
	Liver Disease Mortality
Patients seeking primary care overwhelm local emergency departments.	Kidney Disease Mortality
	COVID-19 Mortality
Primary care services are available, but are difficult for many people to navigate.	COVID-19 Case Fatality
	Alzheimer's Disease Mortality
	Influenza and Pneumonia Mortality
	Diabetes Prevalence
	Low Birthweight
	Poor Mental Health Days
	Frequent Mental Distress
	Poor Physical Health Days
	Frequent Physical Distress
	Poor or Fair Health
	Colorectal Cancer Prevalence
	Breast Cancer Prevalence
	Lung Cancer Prevalence
	Prostate Cancer Prevalence
	Asthma ED Rates
	Asthma ED Rates for Children
	Primary Care Shortage Area
	Medically Underserved Area
	Mammography Screening
	Primary Care Providers
	Preventable Hospitalization
	COVID-19 Cumulative Full Vaccination Rate
	Residential Segregation (Non-White/White)
	Uninsured Population under 64
	Income Inequality

Primary Themes	Secondary Indicators
	Homelessness Rate

Active Living and Healthy Eating

Table 24: Primary themes and secondary indicators associated with PHN3.

Primary Themes	Secondary Indicators
There are food deserts in the area where fresh, unprocessed foods are not available. Fresh, unprocessed foods are unaffordable. Food insecurity is an issue here. Students need healthier food options in schools. The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, or parks are inaccessible). The community needs nutrition education programs. Homelessness in parks or other public spaces deters their use. Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming. There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues) The food available in local homeless shelters and food banks is not nutritious. Grocery store options in the area are limited.	Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Kidney Disease Mortality Diabetes Prevalence Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Prostate Cancer Prevalence Asthma ED Rates Asthma ED Rates for Children Adult Obesity Physical Inactivity Limited Access to Healthy Foods Food Environment Index Access to Exercise Opportunities Residential Segregation (Non-White/White) Income Inequality Severe Housing Cost Burden Homelessness Rate Long Commute - Driving Alone

Primary Themes	Secondary Indicators
	Access to Public Transit

Safe and Violence-Free Environment

Table 25: Primary themes and secondary indicators associated with PHN4.

Primary Themes	Secondary Indicators
People feel unsafe because of crime.	Life Expectancy
There are not enough resources to address domestic violence and sexual assault.	Premature Death
Isolated or poorly-lit streets make pedestrian travel unsafe.	Hypertension Mortality
Public parks seem unsafe because of illegal activity taking place.	Poor Mental Health Days
Youth need more safe places to go after school.	Frequent Mental Distress
Specific groups in this community are targeted because of characteristics like race/ethnicity or age.	Frequent Physical Distress
There isn't adequate police protection police protection.	Poor or Fair Health
Gang activity is an issue in the area.	Physical Inactivity
Human trafficking is an issue in the area.	Access to Exercise Opportunities
The current political environment makes some concerned for their safety.	Homicide Rate
	Firearm Fatalities Rate
	Violent Crime Rate
	Juvenile Arrest Rate
	Motor Vehicle Crash Death
	Disconnected Youth
	Social Associations
	Income Inequality
	Severe Housing Problems
	Severe Housing Cost Burden
	Homelessness Rate

Access to Dental Care and Preventive Services

Table 26: Primary themes and secondary indicators associated with PHN5.

Primary Themes	Secondary Indicators
There aren't enough providers in the area who accept Denti-Cal.	Frequent Mental Distress
The lack of access to dental care here leads to overuse of emergency departments.	Poor Physical Health Days
	Frequent Physical Distress
Quality dental services for kids are lacking.	Poor or Fair Health
It's hard to get an appointment for dental care.	Dental Care Shortage Area
People in the area have to travel to receive dental care.	Dentists
Dental care here is unaffordable, even if you have insurance.	Residential Segregation (Non-White/White)
	Income Inequality

Primary Themes	Secondary Indicators
	Homelessness Rate

Healthy Physical Environment

Table 27: Primary themes and secondary indicators associated with PHN6.

Primary Themes	Secondary Indicators
The air quality contributes to high rates of asthma.	Infant Mortality
Poor water quality is a concern in the area.	Life Expectancy
Agricultural activity harms the air quality.	Premature Age-Adjusted Mortality
Low-income housing is substandard.	Premature Death
Residents' use of tobacco and e-cigarettes harms the air quality.	Chronic Lower Respiratory Disease Mortality
Industrial activity in the area harms the air quality.	Hypertension Mortality
Heavy traffic in the area harms the air quality.	Cancer Mortality
Wildfires in the region harm the air quality.	Frequent Mental Distress
	Frequent Physical Distress
	Poor or Fair Health
	Colorectal Cancer Prevalence
	Breast Cancer Prevalence
	Lung Cancer Prevalence
	Prostate Cancer Prevalence
	Asthma ED Rates
	Asthma ED Rates for Children
	Adult Smoking
	Income Inequality
	Severe Housing Cost Burden
	Homelessness Rate
	Long Commute - Driving Alone
	Pollution Burden Percent
	Air Pollution - Particulate Matter
	Drinking Water Violations

Access to Basic Needs Such as Housing, Jobs, and Food

Table 28: Primary themes and secondary indicators associated with PHN7.

Primary Themes	Secondary Indicators
Lack of affordable housing is a significant issue in the area.	Infant Mortality
The area needs additional low-income housing options.	Child Mortality
Poverty in the county is high.	Life Expectancy
Many people in the area do not make a living wage.	Premature Age-Adjusted Mortality
Employment opportunities in the area are limited.	Premature Death
Services for homeless residents in the area are insufficient.	Hypertension Mortality

Primary Themes	Secondary Indicators
Services are inaccessible for Spanish-speaking and immigrant residents. Many residents struggle with food insecurity. It is difficult to find affordable childcare. Educational attainment in the area is low.	COVID-19 Mortality COVID-19 Case Fatality Diabetes Prevalence Low Birthweight Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health COVID-19 Cumulative Incidence Asthma ED Rates Asthma ED Rates for Children Drug Induced Death Adult Obesity Limited Access to Healthy Foods Food Environment Index Medically Underserved Area COVID-19 Cumulative Full Vaccination Rate Some College High School Completion Disconnected Youth Third Grade Reading Level Third Grade Math Level Unemployment Children in Single-Parent Households Social Associations Residential Segregation (Non-White/White) Children Eligible for Free Lunch Children in Poverty Median Household Income Uninsured Population under 64 Income Inequality Severe Housing Problems Severe Housing Cost Burden Homeownership Homelessness Rate Households with no Vehicle Available Long Commute - Driving Alone

Access to Functional Needs

Table 29: Primary themes and secondary indicators associated with PHN8.

Primary Themes	Secondary Indicators
Many residents do not have reliable personal transportation.	Disability
Medical transport in the area is limited.	Frequent Mental Distress
Roads and sidewalks in the area are not well-maintained.	Frequent Physical Distress
The distance between service providers is inconvenient for those using public transportation.	Poor or Fair Health
	Adult Obesity
Using public transportation to reach providers can take a very long time.	COVID-19 Cumulative Full Vaccination Rate
The cost of public transportation is too high.	
Public transportation service routes are limited.	Income Inequality
Public transportation schedules are limited.	Homelessness Rate
The geography of the area makes it difficult for those without reliable transportation to get around.	Households with no Vehicle Available
Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children).	Long Commute - Driving Alone
There aren't enough taxi and ride-share options (e.g.,Uber, Lyft).	Access to Public Transit

Access to Specialty and Extended Care

Table 30: Primary themes and secondary indicators associated with PHN9.

Primary Themes	Secondary Indicators
Wait-times for specialist appointments are excessively long.	Infant Mortality
It is difficult to recruit and retain specialists in the area.	Life Expectancy
Not all specialty care is covered by insurance.	Premature Age-Adjusted Mortality
Out-of-pocket costs for specialty and extended care are too high.	
People have to travel to reach specialists.	Premature Death
Too few specialty and extended care providers accept Medi-Cal.	Stroke Mortality
The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care)	Chronic Lower Respiratory Disease Mortality
There isn't enough OB/GYN care available.	Diabetes Mortality
Additional hospice and palliative care options are needed.	Heart Disease Mortality
The area lacks a kind of specialist or extended care option not listed here.	Hypertension Mortality
	Cancer Mortality
	Liver Disease Mortality
	Kidney Disease Mortality
	COVID-19 Mortality
	COVID-19 Case Fatality
	Alzheimer's Disease Mortality
	Diabetes Prevalence
	Poor Mental Health Days
	Frequent Mental Distress
	Poor Physical Health Days
	Frequent Physical Distress

Primary Themes	Secondary Indicators
	Poor or Fair Health
	Lung Cancer Prevalence
	Asthma ED Rates
	Asthma ED Rates for Children
	Drug Induced Death
	Psychiatry Providers
	Specialty Care Providers
	Preventable Hospitalization
	Residential Segregation (Non-White/White)
	Income Inequality
	Homelessness Rate

Injury and Disease Prevention and Management

Table 31: Primary themes and secondary indicators associated with PHN10.

Primary Themes	Secondary Indicators
There isn't really a focus on prevention around here.	Infant Mortality
Preventive health services for women are needed (e.g., breast and cervical cancer screening).	Child Mortality
	Stroke Mortality
There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease).	Chronic Lower Respiratory Disease Mortality
Vaccination rates are lower than they need to be.	Diabetes Mortality
Health education in the schools needs to be improved.	Heart Disease Mortality
Additional HIV and STI prevention efforts are needed.	Hypertension Mortality
The community needs nutrition education opportunities.	Liver Disease Mortality
Schools should offer better sexual health education.	Kidney Disease Mortality
Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants).	Suicide Mortality
	Unintentional Injuries Mortality
Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision).	COVID-19 Mortality
	COVID-19 Case Fatality
	Alzheimer's Disease Mortality
	Diabetes Prevalence
	Low Birthweight
	HIV Prevalence
	Poor Mental Health Days
	Frequent Mental Distress
	Frequent Physical Distress
	Poor or Fair Health
	COVID-19 Cumulative Incidence
	Asthma ED Rates

Primary Themes	Secondary Indicators
	Asthma ED Rates for Children
	Excessive Drinking
	Drug Induced Death
	Adult Obesity
	Physical Inactivity
	Chlamydia Incidence
	Teen Birth Rate
	Adult Smoking
	COVID-19 Cumulative Full Vaccination Rate
	Firearm Fatalities Rate
	Juvenile Arrest Rate
	Motor Vehicle Crash Death
	Disconnected Youth
	Third Grade Reading Level
	Third Grade Math Level
	Income Inequality
	Homelessness Rate

Increased Community Connections

Table 32: Primary themes and secondary indicators associated with PHN11.

Primary Themes	Secondary Indicators
Health and social-service providers operate in silos; we need cross-sector connection.	Infant Mortality
Building community connections doesn't seem like a focus in the area.	Child Mortality
Relations between law enforcement and the community need to be improved.	Life Expectancy
The community needs to invest more in the local public schools.	Premature Age-Adjusted Mortality
There isn't enough funding for social services in the county.	Premature Death
People in the community face discrimination from local service providers.	Stroke Mortality
City and county leaders need to work together.	Diabetes Mortality
	Heart Disease Mortality
	Hypertension Mortality
	Suicide Mortality
	Unintentional Injuries Mortality
	Diabetes Prevalence
	Low Birthweight
	Poor Mental Health Days
	Frequent Mental Distress
	Poor Physical Health Days
	Frequent Physical Distress
	Poor or Fair Health
	Excessive Drinking

Primary Themes	Secondary Indicators
	Drug Induced Death
	Physical Inactivity
	Access to Exercise Opportunities
	Teen Birth Rate
	Primary Care Shortage Area
	Mental Health Care Shortage Area
	Medically Underserved Area
	Mental Health Providers
	Psychiatry Providers
	Specialty Care Providers
	Primary Care Providers
	Preventable Hospitalization
	COVID-19 Cumulative Full Vaccination Rate
	Homicide Rate
	Firearm Fatalities Rate
	Violent Crime Rate
	Juvenile Arrest Rate
	Some College
	High School Completion
	Disconnected Youth
	Unemployment
	Children in Single-Parent Households
	Social Associations
	Residential Segregation (Non-White/White)
	Income Inequality
	Homelessness Rate
	Households with no Vehicle Available
	Long Commute - Driving Alone
	Access to Public Transit

System Navigation

Table 33: Primary themes and secondary indicators associated with PHN12.

Primary Themes	Secondary Indicators
People may not be aware of the services they are eligible for.	
It is difficult for people to navigate multiple, different health care systems.	
The area needs more navigators to help to get people connected to services.	
People have trouble understanding their insurance benefits.	

Primary Themes	Secondary Indicators
Automated phone systems can be difficult for those who are unfamiliar with the healthcare system	
Dealing with medical and insurance paperwork can be overwhelming.	
Medical terminology is confusing.	
Some people just don't know where to start in order to access care or benefits.	

Next, values for the secondary health-factor and health-outcome indicators identified were compared to state benchmarks to determine if a secondary indicator performed poorly within the county. Some indicators were considered problematic if they exceeded the benchmark, others were considered problematic if they were below the benchmark, and the presence of certain other indicators within the county, such as health professional shortage areas, indicated issues. Table 34 lists each secondary indicator and describes the comparison made to the benchmark to determine if it was problematic.

Table 34: Benchmark comparisons to show indicator performance.

Indicator	Benchmark Comparison Indicating Poor Performance
Infant Mortality	Higher
Child Mortality	Higher
Life Expectancy	Lower
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Stroke Mortality	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Diabetes Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Cancer Mortality	Higher
Liver Disease Mortality	Higher
Kidney Disease Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
COVID-19 Mortality	Higher
COVID-19 Case Fatality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Diabetes Prevalence	Higher
Low Birthweight	Higher
HIV Prevalence	Higher
Disability	Higher
Poor Mental Health Days	Higher
Frequent Mental Distress	Higher
Poor Physical Health Days	Higher
Frequent Physical Distress	Higher
Poor or Fair Health	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
Colorectal Cancer Prevalence	Higher
Breast Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
COVID-19 Cumulative Incidence	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher
Excessive Drinking	Higher
Drug Induced Death	Higher
Adult Obesity	Higher
Physical Inactivity	Higher
Limited Access to Healthy Foods	Higher
Food Environment Index	Lower
Access to Exercise Opportunities	Lower
Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Primary Care Shortage Area	Present
Dental Care Shortage Area	Present
Mental Health Care Shortage Area	Present
Medically Underserved Area	Present
Mammography Screening	Lower
Dentists	Lower
Mental Health Providers	Lower
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Primary Care Providers	Lower
Preventable Hospitalization	Higher
COVID-19 Cumulative Full Vaccination Rate	Lower
Homicide Rate	Higher
Firearm Fatalities Rate	Higher
Violent Crime Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Some College	Lower
High School Completion	Lower
Disconnected Youth	Higher
Third Grade Reading Level	Lower
Third Grade Math Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Social Associations	Lower
Residential Segregation (Non-White/White)	Higher
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Median Household Income	Lower
Uninsured Population under 64	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
Income Inequality	Higher
Severe Housing Problems	Higher
Severe Housing Cost Burden	Higher
Homeownership	Lower
Homelessness Rate	Higher
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Access to Public Transit	Lower
Pollution Burden Percent	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present

Once these poorly performing quantitative indicators were identified, they were used to determine preliminary secondary significant health needs. This was done by calculating the percentage of all secondary indicators associated with a given PHN that were identified as performing poorly within the HSA. While all PHNs represented actual health needs within the HSA to a greater or lesser extent, a PHN was considered a preliminary secondary health need if the percentage of poorly performing indicators exceeded one of a number of established thresholds: any poorly performing associated secondary indicators; or at least 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80% of the associated indicators were found to perform poorly. A similar set of standards was used to identify the preliminary interview and focus-group health needs: any of the respondents mentioned a theme associated with a PHN, or if at least 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80% of the respondents mentioned an associated theme. Finally, similar thresholds (any mention, 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80%) were also applied to the percent of CSP survey respondents selecting a particular health need as one of the top health needs in the HSA.

These sets of criteria (any mention, 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80%) were used because we could not anticipate which specific standard would be most meaningful within the context of the HSA. Having multiple objective decision criteria allows the process to be more easily described but still allows for enough flexibility to respond to evolving conditions in the HSA. To this end, a final round of expert reviews was used to compare the set selection criteria to find the level at which the criteria converged towards a final set of SHNs.

For this report, a PHN was selected as a preliminary quantitative significant health need if 70% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by 70% or more of the primary sources as performing poorly; and as a preliminary community survey provider survey significant health need if it was identified by at least 70% of survey respondents. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in any two (2) of these three (3) of these categories.

Health Need Prioritization

The final step in the analysis was to prioritize the identified SHNs. To reflect the voice of the community, significant health need prioritization was based solely on primary data. Key informants and focus-group participants were asked to identify the three most significant health needs in their communities. These responses were associated with one or more of the potential health needs. This, along with the

responses across the rest of the interviews and focus groups, was used to derive two measures for each significant health need.

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need. Finally, the number of times each health need was selected as one of the top health needs by survey respondents was also included.

These three measures were then rescaled so that the SHN with the maximum value for each measure equaled one, the minimum equaled zero, and all other SHNs had values appropriately proportional to the maximum and minimum values. The rescaled values were then summed to create a combined SHN prioritization index. SHNs were ranked in descending order based on this index value so that the SHN with the highest value was identified as the highest-priority health need, the SHN with the second highest value was identified as the second-highest-priority health need, and so on.

Detailed List of Resources to Address Health Needs

Table 35: Resources available to meet health needs.

Organization Information			Significant Health Needs										Other Health Needs		
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance	Access to Quality Primary Care Health Services	Increased Community Connections	Access to Functional Needs	Injury and Disease Prevention and Management	Active Living and Healthy Eating	System Navigation	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Healthy Physical Environment	Access to Specialty and Extended Care
211	County-Wide	stanislauscounty211.org	x	x	x		x	x	x	x	x	x	x	x
Adult Protective Services	County-Wide	www.csa-stanislaus.com/adult-services/#_aps								x	x			x
Aging and Veterans Services	County-Wide	www.stancounty.com/aging	x	x	x		x	x	x		x			x
Alzheimer/Dementia Support Center	95350	stanislaus.networkofcare.org/mh/services/agency.aspx?pid=AlzheimersDementiaSupportCenterAlzheimersDementiaSupportGroup_182_2_0		x		x		x						
Alzheimer's Association	County-Wide	www.alz.org/norcal?set=1				x		x						
American Cancer Society	95350	www.cancer.org/about-us/local/california.html				x		x	x					x
American Red Cross	95354	www.redcross.org/local/california/northern-california-coastal/about-us/locations/heart-of-the-valley.html	x		x	x								
Bethany's House-Modesto	95350	bethany.org/locations/us/california/modesto	x	x		x				x				x
Boys and Girls Club Stanislaus	95354	www.bgcstanislaus.org	x	x		x			x		x			
Breast Cancer and Cervical Cancer Treatment Program (BCCTP)	County-Wide	www.dhcs.ca.gov/services/medical/Pages/BCCTP.aspx								x				x
Every Woman Counts	County-Wide	www.dhcs.ca.gov/services/cancer						x						x

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Cal Fresh	County-Wide	www.csa-stanislaus.com/cal-fresh	x							x				
California Children Services (CCS830)	County-Wide	www.schsa.org/PublicHealth/programs/pages/californiaChildrenServices.shtm		x						x				x
CARE Program	County-Wide	www.stancounty.com/cares	x	x						x	x			
CASA del Rio FRC – Healthy Start Family Resource Centers	95367	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
Catholic Charities Assisted Transportation, Homemaker Program	County-Wide	www.ccstockton.org/senior-services				x	x							
Catholic Charities Diocese of Stockton	95354	www.ccstockton.org	x	x		x			x		x			
Catholic Charities Homemaker Program	County-Wide	www.ccstockton.org/senior-services	x											
Center for Human Services	95350	www.centerforhumanservices.org	x	x						x				
Central Valley Counseling Center	95361	ellentruschel.com		x						x				
Central Valley Opportunity Center	County-Wide	www.cvoc.org	x			x								
Central Valley Pride Center	95354	centralvalleypridecenter.org		x		x					x			
Ceres Community Center	95307	www.ci.ceres.ca.us/237/Ceres-Community-Center	x			x			x					
Ceres Healthy Start FRC	95307	www.ceres.k12.ca.us/student_support/student_services/ceres_healthy_start_program/contacts	x	x	x			x	x	x				

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Ceres Partnership	95307	www.centerforhumanservices.org/what-we-do/family-resource-centers/ceres-partnership	x	x	x	x			x					
Children's Crisis Center	County-Wide	www.childrenscrisiscenter.com/contact		x						x				
Church Food Banks	95307, 95350, 95316, 95354, 95355, 95356, 95351, 95358, 95361, 95363, 95367, 95380, 95386	www.needhelppayingbills.com/html/modesto_food_pantries.html	x			x								
City of Patterson-Hammon Senior Center	95363	www.ci.patterson.ca.us/440/Hammon-Senior-Center	x			x		x	x					
Cleansing Hope Shower Shuttle	95354	www.showershuttle.org	x											
Committed Movement/Life of an Athlete	95350	www.crowdproject.org/programs-committed.shtm				x			x					
Commodity Supplemental Food Program	County-Wide	www.fns.usda.gov/csfp/commodity-supplemental-food-program	x											
Community Emergency Response Team	County-Wide	www.stancounty.com/bhrs/emergency-services.shtm		x										

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Community Hospice, Inc.	95356	hospiceheart.org		x	x					x				x
Community Housing & Shelter Services	95354	www.communityhousingandshelterservices.org	x							x				
Community Impact Central Valley	County-Wide	www.cicvca.org	x					x		x				
Community Services Agency	95358	www.csa-stanislaus.com	x		x	x			x	x				
Community Sharing Christian Center in Oakdale	95361	www.oakdalecommunitysharing.org	x			x								
Disability Resource Agency for Independent Living	95350	drail.org	x	x			x			x				
Doctor's Medical Center	95350	www.dmc-modesto.com		x	x			x		x				x
Downey Healthy Start FRC	95355	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
East Stanislaus Resource Conservation District	95358	eaststanrcd.org							x				x	
El Concilio	95202	www.elconcilio.org	x	x						x	x			
El Rio Memory Care	95356	koelschseniorcommunities.com/senior-living/ca/modesto/memory-care/el-rio/						x		x				x
Emanuel Medical Center, Inc.	95382	www.emanuelmedicalcenter.org			x			x		x				x
Empowerment Center - Turning Point	County-Wide	www.tpcp.org	x	x		x								
Family Caregiver Support Program	County-Wide	www.stancounty.com/aging/family-caregiver.shtm		x		x				x				x

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Family Planning, Access, Care and Treatment Program - Family PACT	County-Wide	familypact.org		x						x				
First 5 Stanislaus County	County-Wide	www.first5stan.org/about_us.shtm	x	x	x	x		x	x		x			
Friends Are Good Medicine - Support Groups	County-Wide	www.friendsaregoodmedicine.com		x		x								
Go Go Grandparent	County-Wide	www.gogograndparent.com					x							
Golden Valley Health Center – Ceres	95307	www.gvhc.org/locations/ceres		x	x			x		x		x		
Golden Valley Health Center – Corner of Hope	95354	www.gvhc.org/locations/modesto/modesto-corner-of-hope		x	x			x	x	x				
Golden Valley Health Center – Florida North	95350	www.gvhc.org/locations/modesto/modesto-florida-north		x	x			x		x				
Golden Valley Health Center – Florida Suite	95350	www.gvhc.org/locations/modesto/modesto-florida-suites			x			x	x	x				
Golden Valley Health Center – Hanshaw School	95358	www.gvhc.org/locations/modesto/modesto-hanshaw-school		x	x			x	x	x		x		
Golden Valley Health Center – Newman	95360	www.gvhc.org/locations/newman			x			x	x	x		x		
Golden Valley Health Center – Patterson	95363	www.gvhc.org/locations/patterson		x	x			x	x	x		x		
Golden Valley Health Center – Riverbank	95367	www.gvhc.org/locations/riverbank			x			x	x	x				

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Golden Valley Health Center – Robertson Road School	95351	www.gvhc.org/locations/modesto/modesto-robertson-road			x			x	x	x		x		
Golden Valley Health Center – Tenaya	95354	www.gvhc.org/locations/modesto/modesto-tenaya			x			x		x				
Golden Valley Health Center – Turlock	95382	www.gvhc.org/locations/turlock			x			x	x	x				
Golden Valley Health Center – West Modesto	95354	www.gvhc.org/locations/modesto/modesto-west		x	x			x	x	x				x
Golden Valley Health Center – West Turlock	95380	www.gvhc.org/locations/turlock			x			x	x	x		x		
Golden Valley Health Center – Westley	95387	www.gvhc.org/locations/westley			x			x	x	x				
Stanislaus County Healthy Start	95387	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x			x	x	x				
Haven Women's Center of Stanislaus	95354, 95380	www.havenstan.org/haven	x	x		x				x	x			
HAWK - Safety Home Visits	95354	(209) 342-6150	x								x			
Health Services Agency – Administrative Offices	95353	www.schsa.org	x		x			x	x	x				x
Health Services Agency - Family and Pediatric	95350	schsa.org/clinics			x			x	x	x				
Health Services Agency – McHenry Medical Office	95350	schsa.org/clinics			x			x		x				x
Health Services Agency - Paradise	95351	schsa.org/clinics			x			x		x				x

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Healthy Aging Association	95355	www.healthyagingassociation.org	x					x	x					
HOST (Help Others Sleep Tonight) House	95363	(209) 894-2652	x											
Housing Assessment Team	County-Wide	www.tpcp.org/programs/hat	x											
Howard Prep	95351	www.howardprep.org	x			x								
Hughson Community Center	95326	hughson.org/our-community/city-parks-community-centers	x			x			x					
Hughson Family Resource Center	95326	hughson.org/our-community/resources/hughson-family-resource-center	x	x	x	x		x	x					x
Hughson Healthy Start FRC	95326	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
Jessica's House	95380	www.jessicashouse.org		x		x					x			
John B. Allard Healthy Start FRC	95354	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
Kaiser Permanente Modesto Medical Center	95355	www.healthy.kaiserpermanente.org/northern-california/facilities/modesto-medical-center-and-medical-offices		x	x			x	x	x				x
Keyes Healthy Start FRC	95328	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
Learning Quest - Stanislaus Literacy Centers	95354	www.lqslc.com	x					x						

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Livingston Community Health- Bentley Health Center	95386	www.visitlch.org		x	x			x		x		x		x
Maddux Youth Center	95351	www.modestogov.com/2768/Maddux-Youth-Center	x			x			x					
Medi-Cal Access Program (MCAP)	County-Wide	www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Medi-CalAccessProgram.aspx			x					x				
Medically Indigent Adult Program	County-Wide	www.schsa.org/services/ihcp			x					x				
MEDIVAN	95351	www.stancounty.com/vets/medivan.shtm					x							
Memorial Medical Center	95355	www.sutterhealth.org/find-location/facility/memorial-medical-center		x	x	x		x	x	x				x
Modesto Area Express	95351	www.stanrta.org					x							
Modesto Care Center	95354	www.caremore.com		x	x			x	x	x			x	x
Modesto City Schools	County-Wide	www.mcs4kids.com/district	x						x	x	x			
Modesto Dial-A-Ride	95351	www.stanrta.org/149/Dial-A-Ride					x							
Modesto Family Promise	95358	www.modestofamilypromise.org	x			x								
Modesto Gospel Mission	95354	modestogospelmission.org/?v=7516fd43adaa	x	x						x				
Modesto Senior Center	95354	www.modestogov.com/1717/Senior-Center-Activities	x			x		x	x					
Modesto Veterans Clinic	95351	www.va.gov/directory/guide/facility.asp?ID=5198		x						x				
MOVE	95355	www.movestanislaus.org					x							

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New Hope Recovery House	95350	www.newhope-recovery.org		x										
Newman Family Resource Center	95360	www.centerforhumanservices.org/what-we-do/family-resource-centers/newman	x	x	x	x		x	x					
North Modesto/Salida Family Resource Center	95350	www.sierravistacares.org/family-resource-centers	x	x	x	x		x	x					x
Oak Valley Community Health Center- Oakdale Clinic	95361	oakvalleycares.org/clinics			x			x		x		x		x
Oak Valley District Hospital	95361	oakvalleyhospital.com			x			x		x				x
Oak Valley Hospital District- Riverbank Clinic	95367	oakvalleycares.org/clinics			x			x		x				
Oak Valley Hospital District- Waterford Clinic	95386	oakvalleycares.org/clinics			x			x		x				
Oakdale Family Resource and Counseling Center	95361	www.centerforhumanservices.org/what-we-do/family-resource-centers/oakdale	x	x	x	x		x	x					
Oakdale Senior Center	95361	www.oakdalegov.com/senior-services		x		x								
Ombudsman of Stanislaus County	County-Wide	www.ccstockton.org/senior-services	x											
Orville Wright Healthy Start FRC	95354	wright.mcs4kids.com/parents/healthy-start-family-resource-center	x	x	x	x		x	x					
PACE Healthy Start FRC	95358	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
Parent Institute for Quality Education	95354	www.piqe.org/piqe-modesto	x			x								
Parent Resource Center	95351	parent-resource-center.square.site	x	x		x			x		x			

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Parents United Inc.	95354	www.stanbhrsprevention.com/csap.shtm	x	x		x	x				x			
Patterson Family Resource Center	95363	www.centerforhumanservices.org/what-we-do/family-resource-centers/patterson	x	x	x	x		x	x					
Petersen Alternative Center for Education (PACE) Healthy Start FRC	95358	www.stancoe.org/pace	x	x	x	x		x	x					
Planned Parenthood Modesto Health Center	95350	www.plannedparenthood.org/healthcenter/california/modesto						x		x				x
Project HOPE/Friendly Visitor	County-Wide	www.stancounty.com/aging/projecthope.shtm		x		x			x					
Project Sentinel (Fair Housing)	95354	www.housing.org	x											
Promotores	County-Wide	www.stanbhrsprevention.com/promotores.shtm	x	x	x		x	x	x	x	x	x	x	x
Riverbank Christian Food Sharing	95367	www.stancounty.com/living-visiting/food-assistance.shtm	x			x								
Robertson Road Healthy Start FRC	95351	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x	x		x	x					
Sacred Heart Church	95363	sacredheartpatterson.org	x			x								
Salvation Army Modesto Corps	95354	modestocitadel.salvationarmy.org/modesto_citadel_corps	x	x		x				x				
Salvation Army Red Shield Center	95358	modestoredshield.salvationarmy.org	x	x		x				x				
Salvation Army Turlock	95380	turlock.salvationarmy.org	x	x		x				x				
Second Harvest Food Bank	95337	localfoodbank.org	x			x			x					

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SER - Jobs for Progress	County-Wide	sercalifornia.org	x											
Sierra Vista Child & Family Services	95354	www.sierravistacares.org	x	x		x								
Sierra Vista Child & Family Services- First Step	95350	www.sierravistacares.org/first-step-perinatal-substance		x		x								
Society for Disabilities	95354	societyfordisabilities.org	x			x		x						
St. Vincent de Paul Society	95354	www.ststanislausbandera.com/st-vincent-de-paul-society.html	x			x								
STANCO Affordable Housing Corporation	95354	stancoahc.com	x											
Stanislaus County Dept of Education: Comeback Kids Program	County-Wide	www.stancoe.org/cbk	x			x								
Stanislaus County-Behavioral Health and Recovery Services	95350	www.stancounty.com/bhrs		x	x					x				
Stanislaus County Office of Education- Franklin Healthy Start FRC	95351	www.stancoe.org/division/educational-options/prevention-programs/healthy-start	x	x	x			x	x	x				
Stanislaus County Public Health	County-Wide	www.schsa.org/PublicHealth		x	x	x		x						
Stanislaus Recovery Center	County-Wide	www.stanislausrecoverycenter.com		x		x								
Stanislaus Surgical Hospital	95355	stanislaussurgical.com			x					x				x
Stanislaus Workforce Development	County-Wide	www.stanworkforce.com	x											

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StanLink2Care	County-Wide	www.stanlink2care.org	x				x							
Stanislaus County-Veterans Services	County-Wide	www.stancounty.com/vets	x	x	x					x				
Stockton PACE	County-Wide	communityconnectionssjc.org/programs/details/stockton-pace-stockton-pace	x	x						x				
Supportive Services for Veterans (Housing/Homelessness)	County-Wide	www.va.gov/homeless/ssvf/index.html	x							x				
Sutter Health- Memorial Medical Center	95355	www.sutterhealth.org/mmc			x			x	x	x				x
Sutter Health- Patterson Care Center	95363	www.sutterhealth.org/find-location/facility/patterson-care-center			x			x	x	x			x	x
Sutter Medical Foundation South Valley	95354	www.sutterhealth.org			x			x	x	x				x
Telecare	95354	www.telecarecorp.com/stanislaus-county-psychiatric-health-facility		x										
The Bridge Family Resource Center	95351	www.sierravistacares.org/family-resource-centers	x	x	x	x		x	x					x
The Food Initiative of Greater Stanislaus (Interfaith Ministries)	95354	foodinitiative.org	x											
Turlock Care Center	95382	www.sutterhealth.org/find-location/facility/turlock-care-center		x	x			x	x	x			x	x
Turlock Senior Citizens Center	95380	www.turlockseniors.org	x			x			x					
United Patterson Initiative	95363	sites.google.com/patterson.k12.ca.us/unitedpatterson/home	x			x			x					

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United Samaritans Foundation	95380	unitedsamaritans.org	x			x								
United Way of Stanislaus County	95354	uwaystan.org	x			x					x			
V.A. Medical Clinic	95355	www.va.gov/palo-alto-health-care		x	x			x		x				x
Valley Caregiver Resource Center	County-Wide	valleycrc.org				x		x						x
Valley Children's Healthcare	93636	www.valleychildrens.org/locations/pelandale		x		x		x	x			x		
Valley Family Medicine Residency of Modesto	95350	www.valleymodestofm.com			x									x
Valley Medical Transport	County-Wide	www.valleymedicaltransport.com					x							
Valley Mountain Regional Center	County-Wide	www.vmrc.net	x	x						x				x
Visually Impaired Persons Support	County-Wide	www.vipsmodesto.org		x		x		x						x
Waterford Dial-A-Ride	95386	www.modestoareaexpress.com/289/Other-Dial-A-Ride-Services					x							
Waterford Family Resource Center	95386	www.sierravistacares.org/family-resource-centers	x	x	x	x			x					
We Care Program Turlock	95380	wecareturlock.org	x											
West Modesto Community Collaborative- King Kennedy Memorial Center	95351	www.westmodestocollaborative.com	x	x		x			x					
Westside Food Pantry	95363	(209) 892-5709	x											

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Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance	Access to Quality Primary Care Health Services	Increased Community Connections	Access to Functional Needs	Injury and Disease Prevention and Management	Active Living and Healthy Eating	System Navigation	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Healthy Physical Environment	Access to Specialty and Extended Care
Without Permission	95354	www.withoutpermission.org									x			
Youth Navigation Center of Stanislaus County-Hutton House	95354	www.yncstanislaus.org/services		x		x				x				
Zephyr Clarke Wellness Center	95351	www.westmodestocollaborative.com/programs/zephyrclarkewellnesscenter	x	x				x		x				

Limits and Information Gaps

Study limitations for this CHNA included obtaining secondary quantitative data specific to population subgroups, and assuring community representation through primary data collection. Most quantitative data used in this assessment were not available by race/ethnicity. The timeliness of the data also presented a challenge, as some of the data were collected in different years; however, this is clearly noted in the report to allow for proper comparison.

For primary data, gaining access to participants that best represent the populations needed for this assessment was a challenge for the key informant interviews, focus groups and the CSP survey. The COVID-19 pandemic made this more difficult as community members were more difficult to recruit for focus groups. Though an effort was made to verify all resources (assets) through a web search, ultimately some resources that exist in the service area may not be listed.

Finally, though this CHNA was conducted with an equity focus, data that point to differences among population subgroups that are more “upstream” focused are not as available as those data that detail the resulting health disparities. Having a clearer picture of early-in-life opportunity differences experienced among various populations that result in later-in-life disparities can help direct community health improvement efforts for maximum impact.

Appendix A: Impact of Actions Taken

ACCESS TO BASIC NEEDS, SUCH AS HOUSING, JOBS, AND FOOD

Name of program/activity/initiative	Salvation Army Berberian Shelter
Description	The Salvation Army operates two shelters on the 320-330 9th Street campus. This money will help support costs incurred specifically at the Berberian Shelter site. The Berberian Shelter operates a 211 emergency shelter program that includes a Veterans Program and Sheriff Alternative Program.
Goals	To increase the quality and capacity of services that are being provided within the shelter.
Outcomes	• Hiring of two medical department employees to support the implementation of medical support services to the shelter campus. Provided much needed furniture and renovations to our shelter building, dining room and bathrooms. • In 2020 – total of 702 individuals served; 47,586 bed nights provided at the shelter; 33 exited to transitional housing and 24 secured permanent housing.
Name of program/activity/initiative	Modesto Gospel Mission
Description	The Modesto Gospel Mission Respite Program has 10 beds available for emergency housing. 6 Male beds and 4 Female beds. Respite has a medical component and a mental health component. Respite is up to 10 Days. After the 10-day respite period, the respite guest can transfer to the Mission's homeless emergency shelter program, which allows a person to stay for approximately 9 months if all conditions are met, or the Mission's residential 18-month New Life Program. Case managers also try to work with the respite guest to locate transitional or alternate housing. This 10-day respite period can be extended for a short period of time depending on the respite guest's medical condition and availability of respite beds.
Goals	• To provide a healthy and supportive environment for all respite guests, whether that be medical respite or mental health respite. • To provide support and encouragement to work diligently on the goals they have whether that is finding and securing permanent housing, finding a long-term substance abuse program, or helping someone get connected with mental health services. • To provide a safe place to continue the healing process for those coming out of a medical hospital.
Outcomes	• 2019 – 4,946 total adults and youth served shelter-wide; 3,374 total service provided; 266 service referrals and 4,598 pounds of food distributed. • 2020 – 40 individuals served in respite; 10,229 total services provided shelter-wide; 7,501 pounds of food distributed shelter-wide. • 2020 – 14 individuals served in respite with 290 total services provided to them; 10,794 pounds of food distributed shelter-wide.
Name of program/activity/initiative	Second Harvest Food Bank Mobile Fresh Program

Description	The Mobile Fresh Program is a direct-distribution of supplemental foods to extend food resources for those that are struggling with food insecurity. The Program is designed to bring the food out to meet the people where they live, addressing some of the barriers of the low-income population.
Goals	To increase consumption of produce and healthy food choices.
Outcomes	• 2019 – 324 total individuals served; 120,006 pounds of food distributed. • 2020 – 726 total individuals served; 52,587 pounds of food distributed. • 2021 – 1,800 total individuals served; 194,042 pounds of food distributed.

ACCESS TO MENTAL, BEHAVIORAL, AND SUBSTANCE-ABUSE SERVICES

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and tele psych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Outcomes	In 2020, the mental health strategy helped with the following initiatives: • Advance legislation that expands the California Mental Health Parity Act and ensures that medical necessity coverage determinations are consistent with generally accepted standards of care. This legislation -- Senate Bill 855 – passed in June 2020. • Additionally, based on parity advocacy, the Governor publicly touted parity enforcement as a priority on a number of occasions and the enacted budget for California includes over $2.7 million in additional resources for the Department of Managed Health Care (DMHC) to enforce parity this year with $4.7 million annually thereafter. In 2021, the mental health strategy helped with the following initiatives: • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of $2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing $803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature

	budget achievements: $4.5 billion over five years to meet the behavioral health needs of children.

ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES

Name of program/activity/initiative	Golden Valley Health Centers Street Medicine
Description	Golden Valley Health Centers Street Medicine Team provides acute medical services and access to care to people who are homeless. A Licensed Vocational Nurse (LVN) and a Community Health Worker (CHW) are connecting with the homeless population by bringing medical services to them with the use of a van equipped with medical supplies to perform basic medical services such as wound care, blood pressure checks, and health assessments. The general scope of the medical team is to provide outreach, triage, mobile medicine, transportation, and referrals to GVHC and community partners. Outreach entails making connections with the homeless population by listening and learning their needs as told by the community. The CHW provides water, snacks, socks, and education on how to access health care and other community resources.
Goals	Our yearly goal is to provide direct medical services and/or access to a medical provider for at least 1,200 people within Stanislaus and Merced Counties.
Outcomes	• 2019 – 960 adults served; 543 services provided; 1,589 service referrals. • 2020 – 1,000 adults served; 717 services provided; 4,661 service referrals. • 2021 –223 adults served; 92 services provided; 223 service referrals.
Name of program/activity/initiative	Golden Valley Health Centers Emergency Department Navigation
Description	The Memorial Medical Center (MMC) ED Patient Service Navigator Program is a partnership between Sutter Health and Golden Valley Health Centers (GVHC) wherein GVHC provides two Patient Service Navigators (PSNs) who are based in Memorial Medical Center Emergency Department (ED). The PSN's role is to connect with ED patients so they can be provided with support services such as scheduling clinic appointment with their preferred Primary Care Provider (PCP).Other services offered by ED PSNs are scheduling patients for dental appointment, temporary housing referral and other community resources such as soup kitchens around the vicinity.
Goals	The PSNs will receive a "warm hand-off" of the discharged patients from the ER Staff prior to assessing patients' needs. The PSNs will review the patients' file and discuss with the patients the options of a follow up clinic appointment and other assistance that the patients may need such as temporary housing and other community resources and linkages. PSNs will schedule an appointment at a clinic of the patient's preference and provide information regarding available and/or needed resources.
Outcomes	• 2019 – 12,616 total individuals served; 738 services provided. • 2020 – 4,398 total individuals served; 368 services provided.

	• 2021 – 3,281 total individuals served; 517 services provided.

SAFE AND VIOLENCE-FREE ENVIRONMENT

Name of program/activity/initiative	Haven Women's Center of Stanislaus: HARRT (Healthy And Responsible Relationships Troop)
Description	Haven's Healthy And Responsible Relationships Troop (HARRT) is a school-based youth leadership and adolescent relationship abuse (ARA) prevention program. HARRT builds students' knowledge, leadership skills and capacity to address and prevent ARA while promoting healthy teen relationships. HARRT peer educators conduct annual ARA prevention campaigns to affect positive school systems change and improve campus climates. Additionally, HARRT participants advocate for school districts to adopt comprehensive ARA prevention policies to reduce health risks and negative educational outcomes associated with abusive relationships, of which one in three high schoolers are likely to experience.
Goals	The overarching goal of the HARRT program is to reduce and prevent Adolescent Relationship Abuse (ARA), promote healthy teen relationships, and increase youth awareness of resources and supportive services for youth experiencing dating violence in Stanislaus County.
Outcomes	• 2020 –75 youth engaged in the program. • 2021 – 40 youth engaged in the program; 193 were reached through events/outreach. • Example – With so many youth yearning for genuine connection and a space to share their struggles and triumphs with each other, there were many moments that truly illustrated the impact of the program. One example took place at Patterson High, when a student who had heard of the HARRT club through active participation on campus, social media, and PSA videos asked the HARRT club to coordinate with her on creating a rally event that brought awareness to sexual violence. The HARRT members were enthusiastic in creating an event that would educate and serve the entire school, and it all stemmed from one person who saw and connected with our message.

INJURY AND DISEASE PREVENTION AND MANAGEMENT

Name of program/activity/initiative	Stanislaus County Office of Education: Tobacco Use Prevention Education (TUPE)
Description	The Stanislaus County Office of Education (SCOE), Tobacco Use Prevention Education (TUPE) program has a long history of providing quality programming in the 26 school districts in Stanislaus County. The program fully funds a staff of 4 and program advisors at 74 school sites. TUPE staff work diligently to ensure all grant requirements are executed with quality in a timely manner. TUPE/PHAST has received funding from Sutter Health Memorial Hospital for the past 10 years to provide tobacco prevention education to K-12 youth in Stanislaus County.
Goals	The anticipated program outcomes are to reach students, staff, parents and community members in their communities with vaping prevention education to combat the high rates of youth use in Stanislaus County. As well as decrease community use of vaping products and realign the social norms of tobacco use and vaping by changing attitude towards health and personal responsibility through an increase in knowledge.

Outcomes	• 2019 – 46,216 individuals reached through events/outreach. • 2020 – 1,062 individuals reached through events/outreach. • 2021 – 906 individuals reached through events/outreach. • Example – The presentations were a huge success during the 2021 school year and school sites enjoyed the virtual offerings in this time of uncertainty. A short evaluation was completed by 261 attendees of the presentations. From the responses of the evaluation survey, 90% of attendees from all the presentations were students, 8% were staff members and 2% were parents or community members. Of respondents, 49% were of Hispanic/Latino descent and 17% were a part of the LGTBQ+ community. Respondents were asked what they learned from the presentations, 89% said they strongly agree or agree that after the presentation they know more about how the brain becomes addicted to drugs like nicotine. Also, after the presentation, 61% of respondents strongly agree or agree that they understand why most people who currently smoke or use tobacco started before the age of 21. Finally after the presentation, 87% of respondents strongly agree or agree they understand more about how the tobacco industry has used the science of addiction to hook its consumers.

ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Boys and Girls Club of Stanislaus: West Modesto Clubhouse
Description	The Boys & Girls Clubs of Stanislaus County is an after-school and summer youth enrichment organization that provides quality educational, leadership, and character-building programs in positive settings for youth ages 6-18.
Goals	Our mission is to enable all youth people, especially those who need us most, to reach their full potential. This program's goal is to provide services to 120 unduplicated youth in underserved communities of west Modesto.
Outcomes	• 2021 – 182 children and youth served; 85 families served; 182 total services provided. Funding allowed the Club to open a new west Modesto building to serve more youth.
Name of program/activity/initiative	Stanislaus County Office of Education Soccer for Success Program
Description	The Stanislaus County Office of Education partners with local schools and the community to support quality education. The U.S. Soccer Foundation's mission is to enhance, assist, and grow the sport of soccer in the United States, with a special emphasis on under-served communities. Since its founding in 1994, the Foundation has established programs proven to help children embrace an active and healthy lifestyle while nurturing their personal growth beyond sports. We view soccer as a powerful vehicle for social change.
Goals	To educate the community on the importance of healthy choices and behaviors, through youth soccer.
Outcomes	• 2019 – 383 total individuals served. • 2020 – unable to implement programming due to pandemic.