



SUTTER TRACY COMMUNITY HOSPITAL

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 Sutter Tracy Community Hospital's 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

Sutter Tracy Community Hospital
1420 North Tracy Blvd.
Tracy, CA 95376

Conducted by



March 2022

Acknowledgments

We are deeply grateful to all those who contributed to the community health needs assessment conducted on behalf of Sutter Tracy Community Hospital. Many 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. 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. We also extended gratitude to the many partners of the CHNA San Joaquin County CHNA Steering Committee for engaging in qualitative data sharing.

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Sutter Tracy Community Hospital. 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 Sutter Tracy Community Hospital (STCH) service area. 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 for the STCH service area. 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 included the primary service area of the Sutter Tracy Community Hospital (STCH). The service area consists of seven ZIP codes across three counties, in San Joaquin County. The ZIP code areas are: 95330, 95376, 95377, 95391, 95385 and 95387.

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, 41 community residents or community service provider organizations participated in 4 focus groups across the service area.² Finally, 15 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, including STCH's service area. 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

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

² Two focus groups were provided by the San Joaquin County CHNA Steering Committee as a part of a data sharing agreement.

incorporated into the quantitative data analysis and COVID-19 impact was captured 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 beyond those 12 PHNs identified in previous CHNAs.

List of Prioritized Significant Health Needs

The following significant health needs identified for Sutter Tracy Community Hospital 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. Safe and Violence-Free Environment
5. Increased Community Connections
6. Active Living and Healthy Eating
7. Access to Dental Care and Preventive Services
8. Access to Functional Needs
9. Access to Specialty and Extended Care
10. Injury and Disease Prevention and Management
11. Healthy Physical Environment

Resources Potentially Available to Meet the Significant Health Needs

In all, 248 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 STCH's 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).³

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Sutter Tracy Community Hospital (STCH), located at 1420 North Tracy Blvd., Tracy, CA 95376. STCH’s primary service area includes seven ZIP codes across three counties, though predominantly in San Joaquin County. The ZIP code areas are: 95330, 95376, 95377, 95391, 95385 and 95387. The total population of the service area was 145,970.

STCH is an affiliate of Sutter Health, a nonprofit healthcare system. The CHNA was conducted over a period of six months, beginning in October 2021, and concluding March 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 STCH. 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 at the county level were analyzed to identify and prioritize the significant health needs in the STCH service area. For the purposes of this assessment, only San Joaquin County data was used in the determination of health needs. In all, 11 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.

³ Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

Table 1: Health need prioritization inputs for STCH 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%	37%	79%
Access to Mental/Behavioral Health and Substance-Use Services	75%	20%	71%
Access to Quality Primary Care Health Services	75%	16%	21%
Safe and Violence-Free Environment	58%	7%	36%
Increased Community Connections	67%	10%	~
Active Living and Healthy Eating	58%	2%	14%
Access to Dental Care and Preventive Services	58%	4%	7%
Access to Functional Needs	58%	~	7%
Access to Specialty and Extended Care	50%	2%	7%
Injury and Disease Prevention and Management	42%	2%	~
Healthy Physical Environment	17%	1%	14%

~ 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.⁴ 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.

⁴ Further details regarding the creation of the prioritization index can be found in the technical report.

Sutter Tracy Community Hospital 2022 Prioritized Health Needs

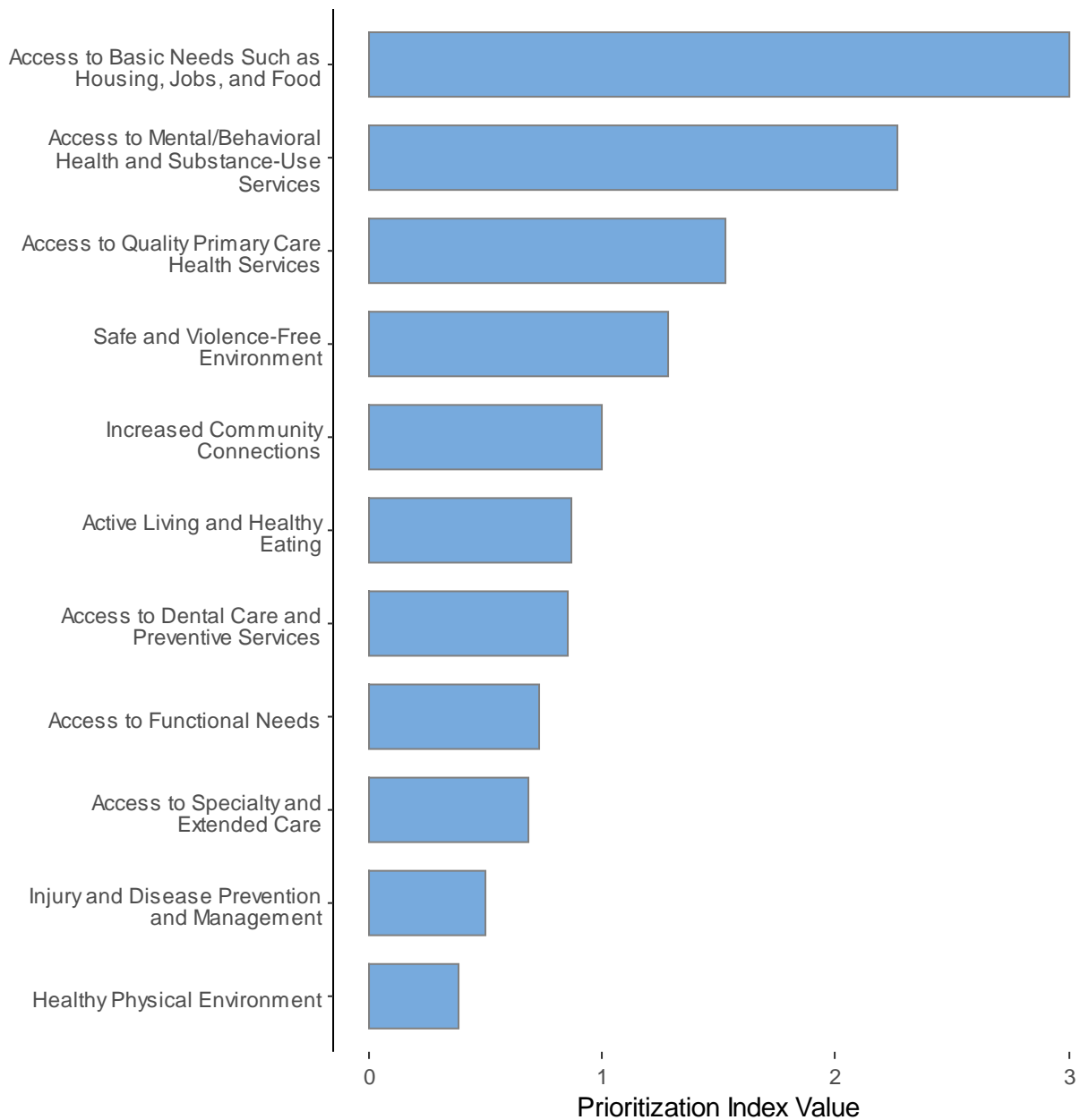


Figure 1: Prioritized significant health needs for STCH service area.

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. Participants were asked about the specific effects of COVID-19. Those results are provided elsewhere in this report.

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 Needs⁵ 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.⁶

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	
<ul style="list-style-type: none"> • Increased access to stable employment. • Area jobs are low paying, need access to higher paying jobs. • Housing prices are high resulting from some residents commuting from the Bay Area, with higher paying jobs. • increase in homelessness over the last few years. • Communication and cultural barriers exist for limited English-speaking community members. • Streamline the Medi-Cal process and acceptance. • Food insecurity with lack of access and affordability of healthy foods. • More shelters needed, especially specific to women and children. • Increase insurance access and 	<ul style="list-style-type: none"> • Lack of affordable housing is a significant issue in the area. • The area needs additional low-income housing options. • Many people in the area do not make a living wage. • Poverty in the county is high. • Services for homeless residents in the area are insufficient. • It is difficult to find affordable childcare. • Many residents struggle with food insecurity. • Educational attainment in the area is low. • Employment 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • 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

⁵ McLeod, S. 2020. Maslow’s Hierarchy of Needs. Retrieved 31 Jan 2022 from <http://www.simplypsychology.org/maslow.html>.

⁶ 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>.

<p>coverage, copay cost too high.</p> <ul style="list-style-type: none"> • Inadequate access to all connectivity and technology associated with school. • Long term affects from ACES (adverse childhood experiences). • Rural areas of Tracy - food insecurity and lack of access to health and social services. • Increased access to higher education in the area, need a 4 year university. • Medical resources for Medi-Cal patients are limited, especially for follow up care. • Increased access to affordable housing. • Safe parking for those sleeping in their car. • Change in the stigma around people living on the street. • Increased understanding of the eviction process and consumer rights around housing. • Transportation to services is inadequate, especially for rural residents. • In Banta, there is no access to grocery stores, markets or fruit stands to obtain healthy food. • Childcare and elder care options/support needed in the area. • Big commuter community, children have very few "after-school" programs and support. • Homeless camp areas are close to some area schools. Kids are exposed to homeless bathing. • Utility costs are high for many families. • City of Lathrop lacks many social services - WIC, VA, DMV, hospital, financial institutions. 	<p>opportunities in the area are limited.</p> <ul style="list-style-type: none"> • Services are inaccessible for Spanish-speaking and immigrant residents. 	<ul style="list-style-type: none"> • 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 • Children Eligible for Free Lunch • Children in Poverty • Median Household Income
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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	
<ul style="list-style-type: none"> • More mental health care providers needed. • Lack of treatment options for substance use, especially for youth. • Decriminalization of drug users means they are kept on the streets. • There are many therapists in the area, but most do not care for the low income/ take Medi-Cal. • Need for in-patient services to help with substance use (opioid, methamphetamine, and alcohol). • Need for increased shelter space for mentally ill homeless. • Regulation of substance use (i.e., marijuana, opioids, vape, meth, etc.) among parents and youth. • Vape and cannabis pens are regularly available in schools. • Limited access to school psychologists, mentors, counselors, and providers in school and county-wide. • Teachers need mental health services and additional support in classrooms. • Lack of support from the foster care system. 	<ul style="list-style-type: none"> • Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. • Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). • The stigma around seeking mental health treatment keeps people out of care. • There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). • There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers). • There aren't enough services here for those who are homeless and dealing with substance-abuse issues. • Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools). • It's difficult for people to navigate for mental/behavioral healthcare. • Awareness of mental health issues among community members is low. • The cost for mental/behavioral 	<ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Poor Mental Health Days • 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 • Firearm Fatalities Rate • 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	
	<p>health treatment is too high.</p> <ul style="list-style-type: none"> • Treatment options in the area for those with Medi-Cal are limited. • Substance-abuse is an issue among youth in particular. • Substance-use treatment options for those with Medi-Cal are limited. • The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community. • There are substance-abuse treatment services available here, but people do not know about them. • Mental/behavioral health services are available in the area, but people do not know about them. • The area lacks the infrastructure to support acute mental health crises. 	

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	
<ul style="list-style-type: none"> • Population growth in the area has created a need for an expansion of hospital services. • Cost of care for area dentists 	<ul style="list-style-type: none"> • Patients have difficulty obtaining appointments outside of regular business hours. 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted

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	
<p>and doctors is too high.</p> <ul style="list-style-type: none"> • Co pay/ cost of medicines are too high for low income and uninsured. • Local clinic is now out of town center, hard for people to access care. • Co-pays are too high. • Primary/medical system has negative bias toward homeless. • Wait times for appointments are long, sometimes months. • In Lathrop, only urgent care, no access to emergency care. 	<ul style="list-style-type: none"> • Primary care services are available but are difficult for many people to navigate. • Quality health insurance is unaffordable. • Out-of-pocket costs are too high. • Patients seeking primary care overwhelm local emergency departments. • Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). • The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). • 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. • There aren't enough primary care service providers in the area. 	<p>Mortality</p> <ul style="list-style-type: none"> • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Alzheimer's Disease Mortality • Influenza and Pneumonia Mortality <p>Diabetes Prevalence</p> <ul style="list-style-type: none"> • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • 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 • Mammography Screening • Primary Care Providers • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate

4. 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.⁷

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	
<ul style="list-style-type: none"> • Streets need better lighting for increased safety. • Safer and cleaner places to exercise; families would feel better walking or playing with their children outside. • Not safe going to stores/gas stations alone due to hearing about sex trafficking/theft. • Increased incidents of violence in the community. • Parents do not feel comfortable with students having to walk through the park with the presence of homelessness. • Gang prevention is important. • Presence of domestic violence is notable in area. • Parents are concerned about their kids not being safe at school because of smoking, vaping, bullying etc. 	<ul style="list-style-type: none"> • Human trafficking is an issue in the area. • People feel unsafe because of crime. • Public parks seem unsafe because of illegal activity taking place. • Youth need more safe places to go after school. • Gang activity is an issue in the area. • There are not enough resources to address domestic violence and sexual assault. • There isn't adequate police protection police protection. • Isolated or poorly-lit streets make pedestrian travel unsafe. • Specific groups in this community are targeted because of characteristics like race/ethnicity or age. 	<ul style="list-style-type: none"> • Life Expectancy • Premature Death • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Physical Inactivity • Access to Exercise Opportunities • Homicide Rate • Firearm Fatalities Rate • Violent Crime Rate • Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth • Social Associations

⁷ Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

5. 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.”⁸ 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 coordinate fashion, where individual organizations collaborate with others to build a network of care.

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	
<ul style="list-style-type: none"> • More events that encourage families to be more active and healthier. • Need more things for children, youth, and families to do. • Ability to for community members to connect with available and existing services. • More networking between area providers is needed including more collaboration between public with private sectors. • Not enough after school programs for kids once they hit eighth grade to help keep kids occupied. • More afternoon programs that increase a sense of community agency. • Need a centralized place in the community to gain access to the resources. • Recreation programs for seniors to 	<ul style="list-style-type: none"> • Survey respondents did not mention with health need. 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Diabetes Mortality • Heart Disease 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 • Drug Induced Death • Physical Inactivity • Access to Exercise Opportunities • Teen Birth Rate

⁸ 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	
bring them together.		<ul style="list-style-type: none"> • 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 • Access to Public Transit
<ul style="list-style-type: none"> • Increased communication between schools and parents. • More community volunteers to help at community service organizations. • Lathrop- Bring in more sit-down chain restaurants. 		

6. 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 with fast food and other establishments 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

Key Informant and Focus Group Responses	Community Service Provider Survey Responses	to state averages:
<ul style="list-style-type: none"> Local grocery stores lack healthy foods. Lack of exercise or places that are clean and safe to be active. Fast food is the easy choice in the area. Need increased access to healthy foods. Safe routes to school are needed. Safe and clean parks and sidewalks are needed. In Tracy, there is an abundance of fast food and liquor stores. Tracy is a food desert. 	<ul style="list-style-type: none"> Food insecurity is an issue here. 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. The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, or parks are inaccessible). There are food deserts in the area where fresh, unprocessed foods are not available. There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues). 	<ul style="list-style-type: none"> Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Diabetes Mortality Heart Disease 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 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

7. Access to Dental Care and Preventive Services

Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk of other chronic disease, as well as play a large role in chronic absenteeism from school in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

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	
<ul style="list-style-type: none"> More dental clinics to serve 	<ul style="list-style-type: none"> Dental care here is 	<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> the un and underinsured. Oral health services for kids in the area. Oral health services for the homeless. Long wait times to see dentists that take public insurance. 	<ul style="list-style-type: none"> unaffordable, even if you have insurance. It's hard to get an appointment for dental care. Quality dental services for kids are lacking. There aren't enough providers in the area who accept Denti-Cal. 	<ul style="list-style-type: none"> Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Dentists

8. Access to Functional Needs

Functional needs refers 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	
<ul style="list-style-type: none"> Bus system has only two lines and does not service the rural areas. More transportation options to get kids to school. In Tracy, need bike paths for community residents. Medical transport for those in wheelchairs. Lathrop - no bus system in the city. Ace Commuter to the "bay" is offered at limited times. 	<ul style="list-style-type: none"> Many residents do not have reliable personal transportation. Medical transport in the area is limited. Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children). Public transportation schedules are limited. Public transportation service routes are limited. The distance between service providers is inconvenient for those 	<ul style="list-style-type: none"> Disability Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Adult Obesity COVID-19 Cumulative Full Vaccination Rate Access to Public Transit

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	
<ul style="list-style-type: none"> • Need for support to transport community members living in rural areas to county services. 	<ul style="list-style-type: none"> • using public transportation. • The geography of the area makes it difficult for those without reliable transportation to get around. • There aren't enough taxi and ride-share options (e.g., Uber, Lyft). • Using public transportation to reach providers can take a long time. 	

9. Access to Specialty and Extended Care

Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

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	
<ul style="list-style-type: none"> • Senior support services are needed, not enough long term, affordable care options. • Need more access to specialty care for chronic disease management. • Day care options for seniors. • Home health care for house bound seniors. 	<ul style="list-style-type: none"> • It is difficult to recruit and retain specialists in the area. • Out-of-pocket costs for specialty and extended care are too high. • People have to travel to reach specialists. • The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). • Too few specialty and extended care providers accept Medi-Cal. 	<ul style="list-style-type: none"> • Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality

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	
	<ul style="list-style-type: none"> • Wait-times for specialist appointments are excessively long. 	<ul style="list-style-type: none"> • 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 • 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

10. 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 focus 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.

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	
<ul style="list-style-type: none"> • Self-management patient education on chronic conditions. • More events that encourage families to be more active and healthier. • County has a high prevalence of 	<ul style="list-style-type: none"> • Survey respondents did not mention with health need. 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality

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	
<p>obesity, malnutrition, and type 2 diabetes.</p> <ul style="list-style-type: none"> • Education about how to shop healthy at the supermarket, or convenience store. • Health literacy levels are low, people are unclear about next steps with outpatient instructions. • Vaccination status is extremely low in area. • Vaccine outreach in rural areas around Tracy needed. • Education for parents to bring them up to speed about technology. • Educating parents about resources available for their kids. 		<ul style="list-style-type: none"> • Heart Disease Mortality • Liver Disease Mortality • Kidney Disease Mortality • Unintentional Injuries Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Alzheimer's Disease Mortality • Diabetes Prevalence • Low Birthweight • 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 • 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

11. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one’s living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one’s lifestyle, heredity, or access to medical services.⁹

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	
<ul style="list-style-type: none"> • Air quality in the area is bad. • Local fires contribute to more bad air days for the area. • Drought emergency in the area. • Growing fruits and vegetables getting more difficult due to nutrient loss in the soil. 	<ul style="list-style-type: none"> • The air quality contributes to high rates of asthma. • Agricultural activity harms the air quality. • Low-income housing is substandard. • Wildfires in the region harm the air quality. 	<ul style="list-style-type: none"> • Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Chronic Lower Respiratory Disease Mortality • Cancer Mortality • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Lung Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Adult Smoking • Pollution Burden Percent • Air Pollution - Particulate Matter • Drinking Water Violations

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.¹⁰ This model of population health includes

⁹ Blum, H. L. 1983. Planning for Health. New York: Human Sciences Press

¹⁰ Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/>.

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. STCH requested written comments from the public on its 2019 CHNA and most recently adopted Implementation Strategy.

At the time of the development of this CHNA report, STCH 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. STCH 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.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 8 interviews with 12 community health experts, 4 focus groups (of which 2 were provided through the data sharing agreement) conducted with a total of 41 community residents or community-facing service providers, and 15 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 hospital 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, 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 STCH service area. This included identifying 12 PHNs in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's 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 the primary service area of STCH. STCH's primary service area includes seven ZIP codes across three counties, though predominantly in San Joaquin County. The ZIP code areas are: 95330, 95376, 95377, 95391, 95385 and 95387. A portion of the service area to the West laps over into Alameda County and the southern portion of the service area crosses over into Stanislaus County.

STCH is located in Tracy, California in San Joaquin County. San Joaquin County is located in the Central Valley of California, about 58 miles south of the state capitol of Sacramento. The county was founded in 1850 includes approximately 1,426 square miles and is named after the San Joaquin River that flows through the area. The county includes the major communities of Stockton, Lodi, and Tracy.

The City of Tracy (known as Tracy) was incorporated in 1910 and is the second largest city in San Joaquin County. Tracy has served as a major hub of transport for goods up and down the state of California since its founding. Tracy has three school districts, with the largest being Tracy Unified School District. Over the last 20-30 years Tracy saw extensive growth in population due to the economic and population growth of the nearby San Francisco Bay Area, resulting in with coming to the Tracy area desiring to live in more affordable housing, while working in the Western Bay Area. This has impacted the community of Tracy in several ways, including inadvertently increasing the service area of STCH. The total population of the service area was 145,970 in 2020. The service area is shown in Figure 2.

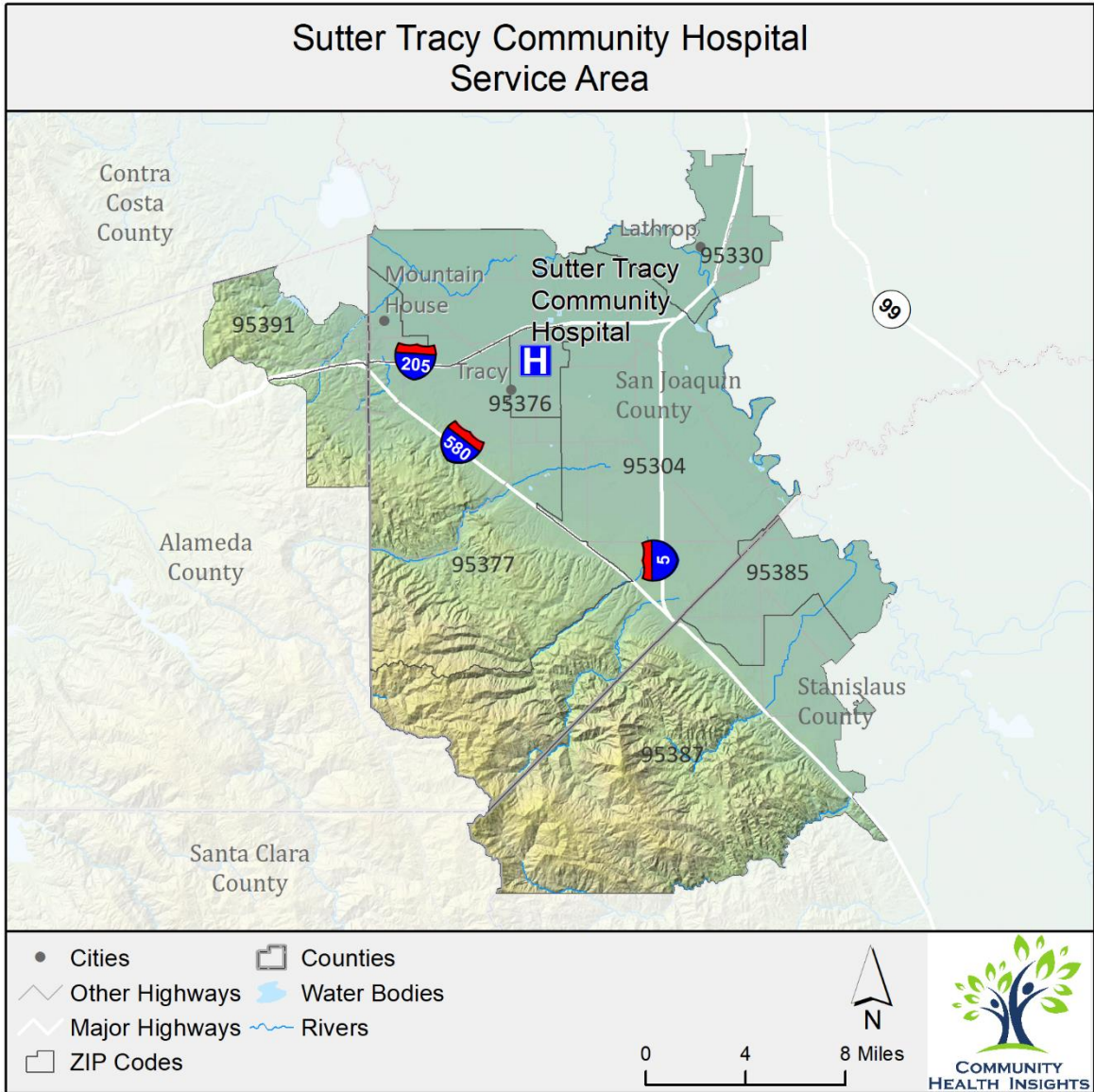


Figure 2: Community served by STCH.

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 in orange.

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

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95304	14,282	61.4	37.2	\$98,088	8.6	6.4	5.3	24.1	33	11
95330	22,760	79.6	32.1	\$85,092	10.8	6.7	6.5	19.2	34	11.5
95376	55,655	67	33.2	\$82,390	10.3	5.4	6.9	17.8	36.6	10.1
95377	32,091	66.9	35.7	\$111,076	4.2	5.1	5.2	9.8	33.6	7.3
95391*	20,131	73.5	31.2	\$138,500	4.2	4.7	1.9	6.6	28.9	4.3
95385**	415	56.9	35.1	\$68,542	3.9	7.4	7.7	24.9	10.8	12
95387**	636	91.2	28.9	\$39,919	7.4	40.7	0	51.2	27.9	19.7
San Joaquin	742,603	68.2	34.3	\$64,432	14.5	7.8	6.4	20.7	38.4	12.5
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.

*Alameda County

**Stanislaus County

Health Equity

The Robert Wood Johnson Foundation’s definition of health equity and social justice is used here to help establish a mutual 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.”¹¹

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

¹¹ 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 .

health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation.”¹²

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 San Joaquin, Alameda and Stanislaus Counties.

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 San Joaquin County for life expectancy, mortality, and low birth weight. The rates for Alameda, Contra Costa and Stanislaus County are not reported here as they do not comprise the majority of the service area.

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

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
San Joaquin							
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	~	3.5	6.9	3.2	2.8	3.6
Life Expectancy	Average number of years a person can expect to live.	82.3	88.6	75.7	84.5	82.2	83.1
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	~	28	52.4	33.4	23.6	31.3
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-	395.8	130.3	501.5	211.1	229.2	227.8

¹² 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.

	adjusted).						
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	8,387.4	2,663.3	9,979.8	4,186	4,088.1	4,341.2
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	8.5%	7.9%	11%	6.2%	5.6%	7.2%

~ Data Not Available

Data sources included in the technical section of the report.

Health outcome data by race and ethnicity for San Joaquin County revealed that data for the Black community showed a clear disproportionate burden. The Black community has the highest infant mortality rate, the lowest life expectancy, the highest child mortality rate, highest rate of premature age-adjusted mortality in adults, highest premature death rate, and the largest percentage of low birthweight babies than any other race and ethnic group. The rates for American Indian/Alaskan Natives were also high for premature age-adjusted mortality, premature death, and low birthweight.

Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the HSA, 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 STCH service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
San Joaquin							
Some College ^a	Percentage of adults ages 25 and over with some post-secondary education.	56.3%	75.7%	67.3%	41.8%	83%	70.9%
High School Completion	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	82%	88.8%	90.8%	70.8%	96.5%	88.4%
Third Grade Reading	Average grade level	~	3.6	2.3	2.5	3.6	3.1

Level	performance for 3rd graders on English Language Arts standardized tests						
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	3.7	2.1	2.4	3.5	3
Children in Poverty	Percentage of people under age 18 in poverty.	18.1%	5.4%	29%	16.7%	4.8%	9.8%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$71,268	\$124,079	\$51,749	\$77,990	\$114,427	\$107,589
Uninsured Population ^b	Percentage of the civilian non-institutionalized population without health insurance.	8%	2.7%	5.1%	9%	2.4%	4.4%

~ Data Not Available

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

^aFrom 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.

^bFrom 2019 American Community Survey 5-year estimates table S2701.

Health factor data by race and ethnicity showed that the Hispanic population had the lowest percentage of college completion, high school completion, and highest percentage of population that is uninsured. Data for the Black community revealed the lowest levels of third grade reading and math levels, highest percent of population in poverty, lowest median household income, and second highest population that is uninsured.

Population Groups Experiencing Disparities

The figure below describes populations in the STCH 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.

Frequency of Mentions in Interviews

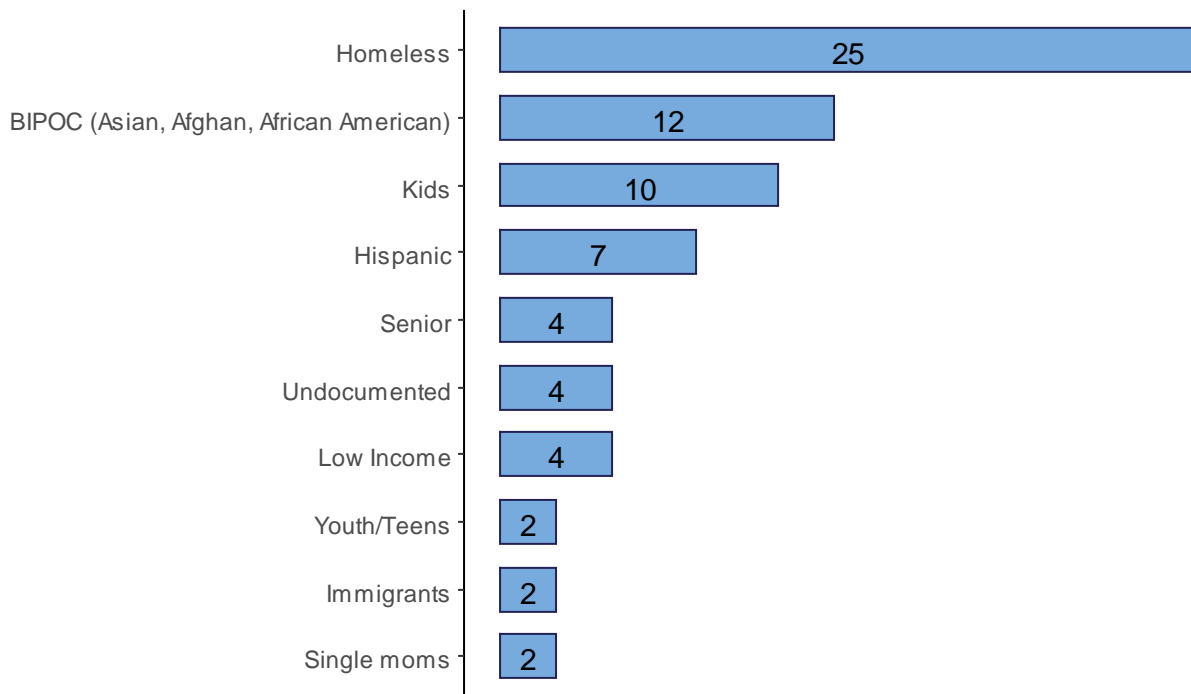


Figure 3: Populations experiencing disparities the STCH service area.

California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)¹³ values for the STCH 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.

¹³ Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from <https://healthyplacesindex.org/about/>.

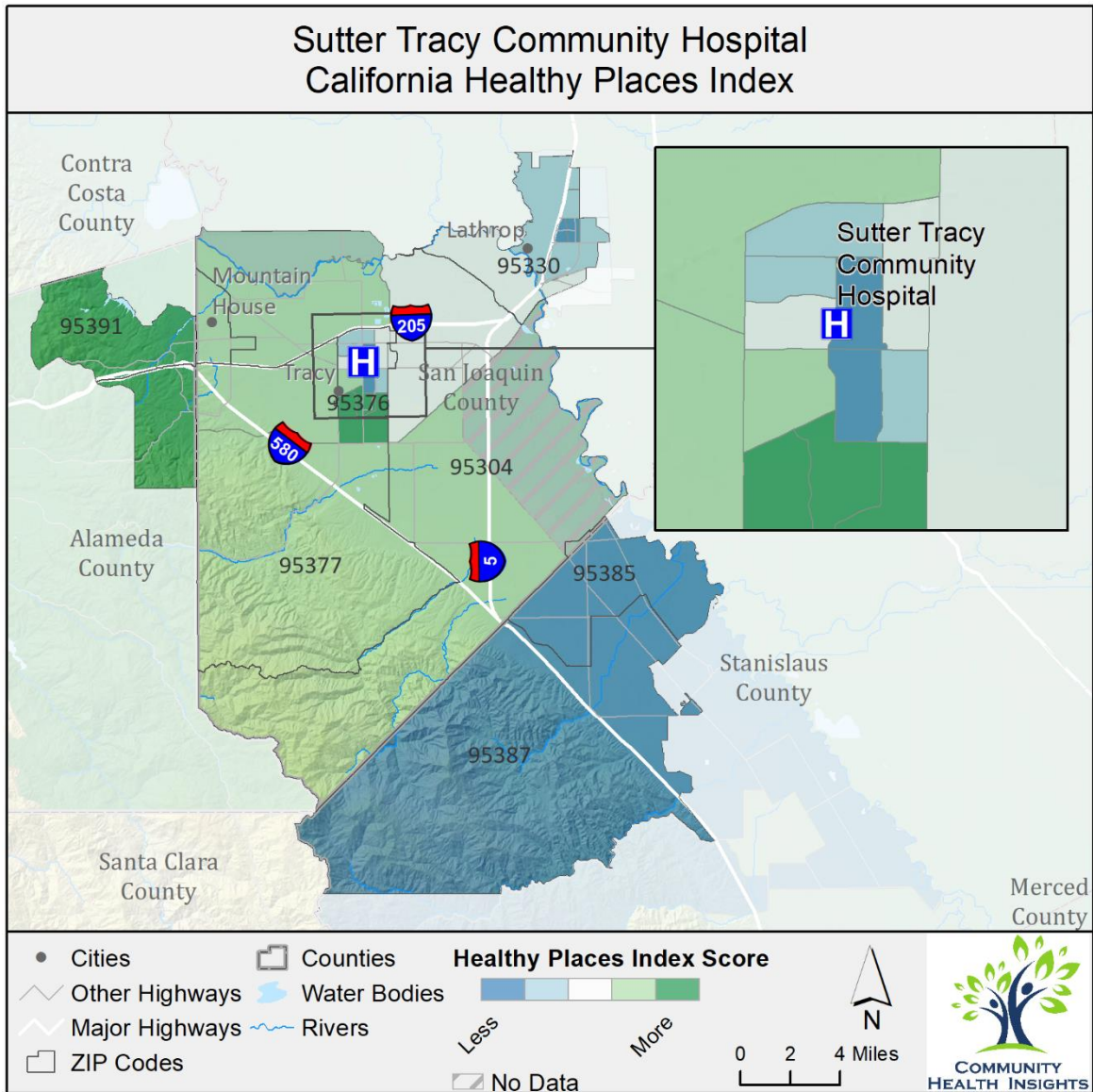


Figure 4: Healthy Places Index for STCH.

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. The darker areas are likely to be a higher concentration of residents in these locations experiencing health disparities. The darker areas of the hospital service area are located in the center of Tracy, and to the east of the city in the area of Lathrop. The southern/eastern portion of the service area also showed low HPI scores, however these areas of low population density.

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 region experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 3 ZIP Codes that met the criteria to be classified as Communities of Concern. These 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 STCH service area.

ZIP Code	Community\Area	Population
<i>Primary Community of Concern</i>		
95376	Tracy	55,655
<i>Secondary Communities of Concern</i>		
95304	Tracy	14,282
95330	Lathrop	22,760
<i>Total Population in Communities of Concern</i>		<i>92,697</i>
<i>Total Population in Hospital Service Area</i>		<i>145,970</i>
<i>Percentage of Service Area Population in Community of Concern</i>		<i>63.5%</i>
Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.		

Figure 5 displays the ZIP Codes highlighted in pink that are Communities of Concern for the STCH service area.

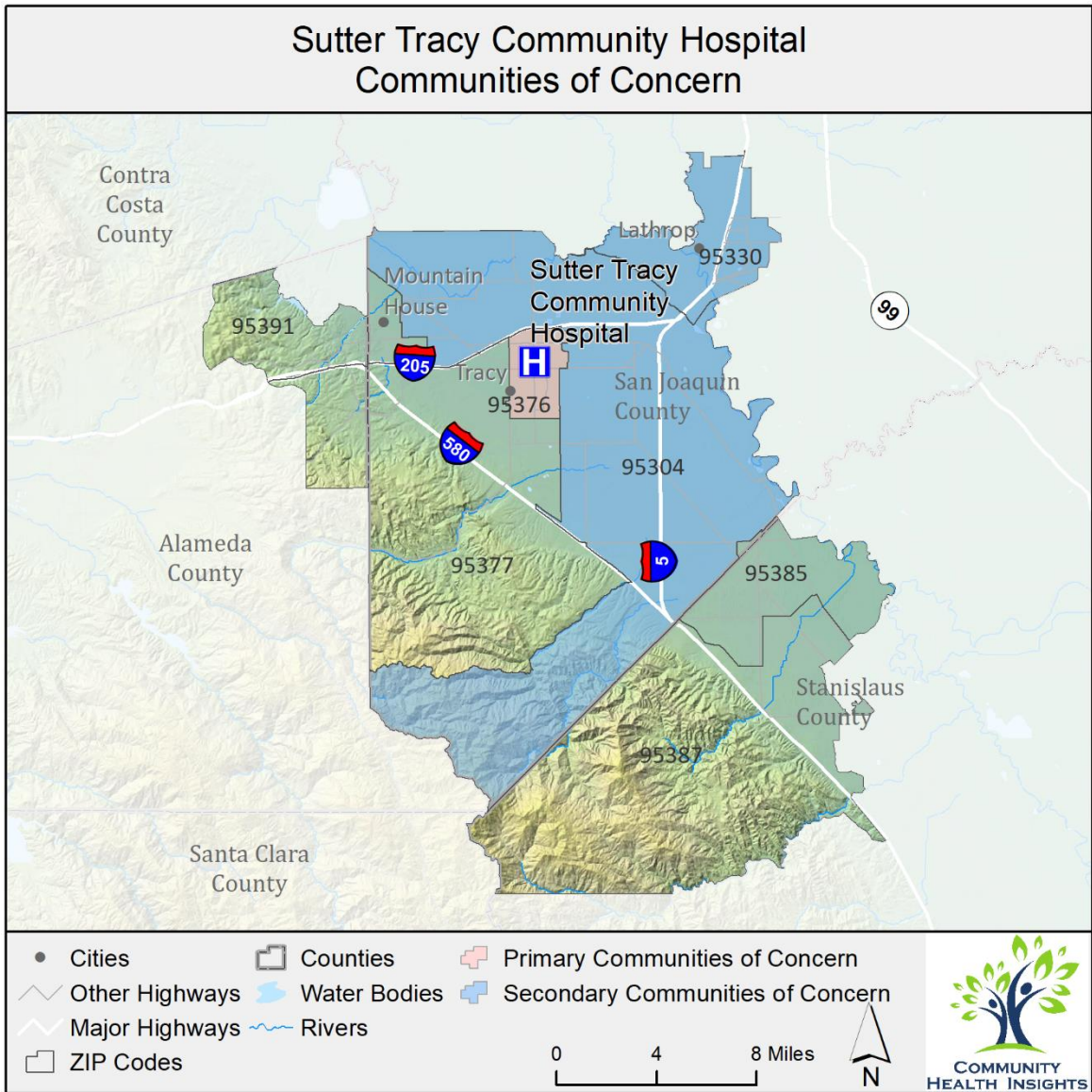


Figure 5: STCH Communities of Concern.

Primary and secondary communities of concern are presented in figure 5. Figure 6 below shows the population density of the service area, and specially the population density in the communities of concern.

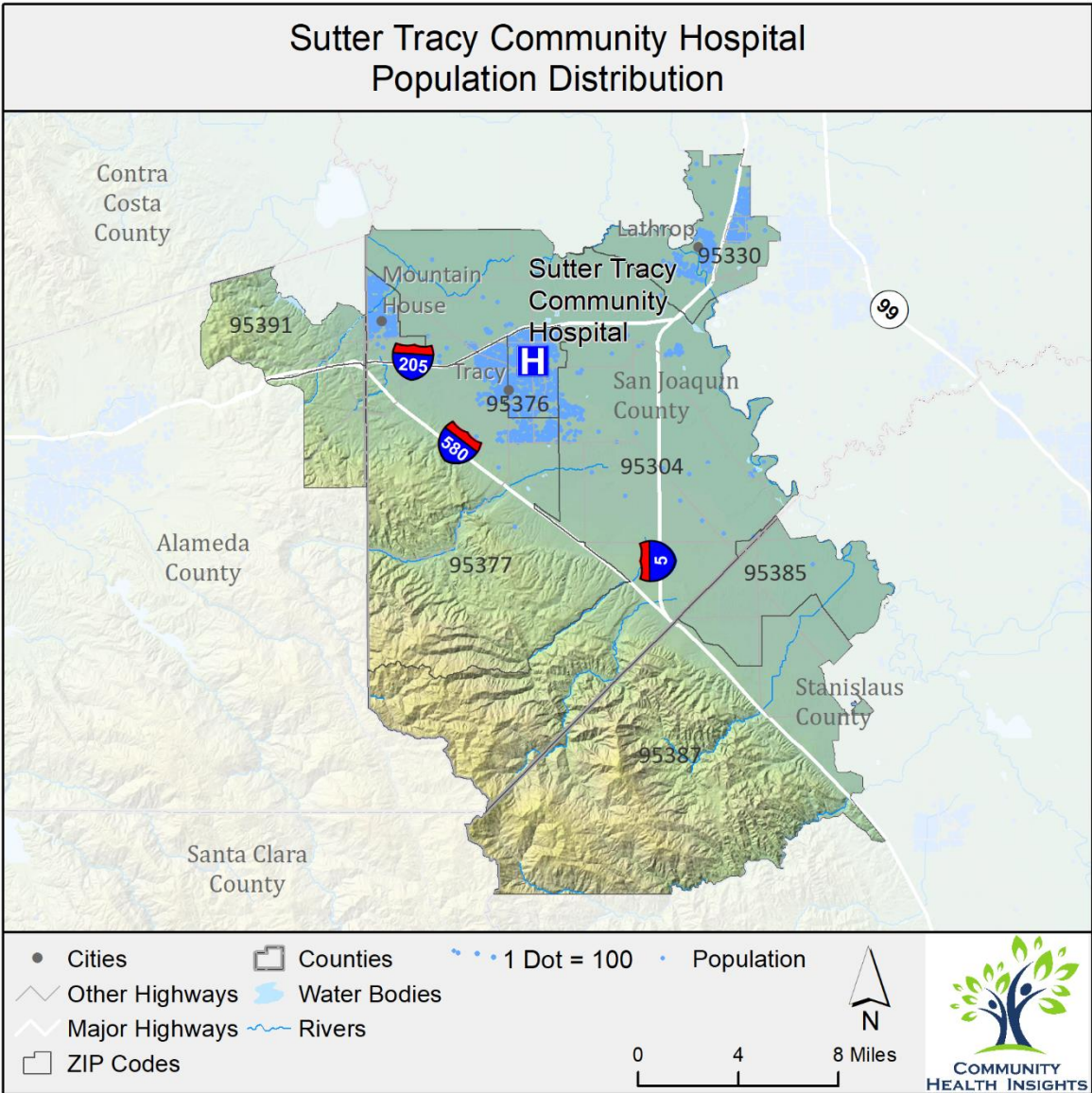


Figure 6. Map of population distribution around the STCH service area.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators regard the HSA are noted in Table 6.

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

Indicators	Description	San Joaquin	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	275.8	213.8	San Joaquin: San Joaquin: 275.8 Alameda: 103.6 Stanislaus: 276.7 California: 213.8
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.2%	1.0%	San Joaquin: San Joaquin: 1.2% Alameda: 0.7% Stanislaus: 1.3% California: 1%
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	22,140.8	21,285.5	San Joaquin: San Joaquin: 22,140.8 Alameda: 15,142.1 Stanislaus: 21,520.1 California: 21,285.5
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	61,353.6	69,688.3	San Joaquin: San Joaquin: 61,353.6 Alameda: 81,210.4 Stanislaus: 56,435.3 California: 69,688.3

Rates of COVID-19 mortality and case fatality, and cumulative incidence rates for San Joaquin County were higher than the state rates. COVID-19 rates of vaccination are lower in San Joaquin County than the state rate.

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
<ul style="list-style-type: none"> • Concerns over quality of healthcare when done virtually. • Theft and community violence has risen. • Increased number of suicides and substance use in the county. • Increased the need for stable and affordable housing. • Increased behavioral health needs, especially in youth. • Increased behavioral problems among children in schools. • Increased lack of distrust with medical providers due to misinformation. • Lower income families lacking in technology support struggled to assure children had access to education. • The pandemic has made the need for affordable housing in Tracy clear. • COVID-19 brought people into the healthcare system, where other co-conditions were found. • Increased economic insecurity for many families. • Pandemic effected the number of volunteers to help run services. • More support is needed for parents around parenting skills. • Fear about returning to schools related to getting COVID-19 • Increased amount of food delivered during COVID-19 • Decrease in physical activity due to COVID-19 stay at home • Students who live in rural areas, like Banta, had low access to internet for schooling. • Small business really suffered economically. • When the rent moratorium ended, many families struggle to pay for housing. 	<ul style="list-style-type: none"> • Isolation is harming the mental health of community members. • Resident’s delay or forgo healthcare to limit their exposure to the virus. • Residents encounter economic hardships from lost or reduced employment. • Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services). • Residents in the community are being evicted from their homes.

Resources Potentially Available to Meet the Significant Health Needs

In all, 248 resources were identified in the STCH service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 114 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 Sutter Tracy Community Hospital 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	42
Access to Mental/Behavioral Health and Substance-Use Services	22
Access to Quality Primary Care Health Services	15
Safe and Violence-Free Environment	41
Increased Community Connections	62
Active Living and Healthy Eating	27
Access to Dental Care and Preventive Services	9
Access to Functional Needs	6
Access to Specialty and Extended Care	7
Injury and Disease Prevention and Management	9
Healthy Physical Environment	8
Total Resources	248

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).”¹⁴ STCH invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

CHNAs play a key 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 cycle.

¹⁴ 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 Sutter Tracy Community Hospital (STCH) Hospital 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 for STCH. Indicator values for San Joaquin were used in the identification of health needs. Rates for San Joaquin County that are higher than the respective state benchmark rate are highlighted.

In order to present all data pertaining to the HSA, Alameda and Stanislaus County data is also provided and compared to the California state benchmark, though not highlighted.

Length of Life

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

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Early Life					
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	5.8	3.6	4.9	4.2
					San Joaquin: 5.8 Alameda: 3.6 Stanislaus: 4.9 California: 4.2
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	46.2	31.3	41.2	36.0
					San Joaquin: 46.2 Alameda: 31.3 Stanislaus: 41.2 California: 36
Life Expectancy	Average number of years a person can expect to live.	78.6	83.1	78.2	81.7
					San Joaquin: 78.6 Alameda: 83.1 Stanislaus: 78.2 California: 81.7
Overall					

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	366.1	227.8	369.8	268.4
					San Joaquin: 366.1 Alameda: 227.8 Stanislaus: 369.8 California: 268.4
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	7,275.2	4,341.2	7,117.3	5,253.1
					San Joaquin: 7,275.2 Alameda: 4,341.2 Stanislaus: 7,117.3 California: 5,253.1
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	50.2	43.4	41.1	41.2
					San Joaquin: 50.2 Alameda: 43.4 Stanislaus: 41.1 California: 41.2
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	42.5	25.9	48.9	34.8
					San Joaquin: 42.5 Alameda: 25.9 Stanislaus: 48.9 California: 34.8
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	26.2	20.8	27.9	24.1
					San Joaquin: 26.2 Alameda: 20.8 Stanislaus: 27.9 California: 24.1
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	163.1	123.3	191.8	159.5
					San Joaquin: 163.1 Alameda: 123.3 Stanislaus: 191.8 California: 159.5

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	11.3	14.6	15.1	13.8

Cancer, Liver, and Kidney Disease

Cancer Mortality	Number of deaths due to cancer per 100,000 population.	158.2	140.4	167.0	152.9
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Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	18.5	10.0	17.9	13.9
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Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	15.5	8.4	13.9	9.7
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Intentional and Unintentional Injuries

Suicide Mortality	Number of deaths due to suicide per 100,000 population.	10.6	9.6	11.2	11.2
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Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	46.9	27.7	45.0	35.7
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Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
COVID-19						
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	275.8	103.6	276.7	213.8	San Joaquin: 275.8 Alameda: 103.6 Stanislaus: 276.7 California: 213.8
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.2%	0.7%	1.3%	1.0%	San Joaquin: 1.2% Alameda: 0.7% Stanislaus: 1.3% California: 1%
Other						
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	43.0	37.0	53.6	41.2	San Joaquin: 43 Alameda: 37 Stanislaus: 53.6 California: 41.2
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	17.4	13.7	15.6	16.0	San Joaquin: 17.4 Alameda: 13.7 Stanislaus: 15.6 California: 16

Quality of Life

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

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Chronic Disease						
Diabetes Prevalence	Percentage of adults ages 20 and above with diagnosed diabetes.	10.3%	7.0%	10.2%	8.8%	San Joaquin: 10.3% Alameda: 7% Stanislaus: 10.2% California: 8.8%

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	7.4%	7.2%	6.3%	6.9%	San Joaquin: 7.4% Alameda: 7.2% Stanislaus: 6.3% California: 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.	217.0	427.3	179.6	395.9	San Joaquin: 217 Alameda: 427.3 Stanislaus: 179.6 California: 395.9
Disability	Percentage of the total civilian noninstitutionalized population with a disability	12.5%	9.2%	13.1%	10.6%	San Joaquin: 12.5% Alameda: 9.2% Stanislaus: 13.1% California: 10.6%
Mental Health						
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.4	4.0	4.8	3.7	San Joaquin: 4.4 Alameda: 4 Stanislaus: 4.8 California: 3.7
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	13.6%	10.8%	14.5%	11.3%	San Joaquin: 13.6% Alameda: 10.8% Stanislaus: 14.5% California: 11.3%
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	4.7	3.8	4.8	3.9	San Joaquin: 4.7 Alameda: 3.8 Stanislaus: 4.8 California: 3.9

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	14.1%	10.5%	14.7%	11.6%	San Joaquin: 14.1% Alameda: 10.5% Stanislaus: 14.7% California: 11.6%
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	22.3%	15.0%	22.1%	17.6%	San Joaquin: 22.3% Alameda: 15% Stanislaus: 22.1% California: 17.6%
Cancer						
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	37.7	33.9	38.7	34.8	San Joaquin: 37.7 Alameda: 33.9 Stanislaus: 38.7 California: 34.8
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	21.0	31.3	23.3	27.9	San Joaquin: 21 Alameda: 31.3 Stanislaus: 23.3 California: 27.9
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	48.4	39.8	48.1	40.9	San Joaquin: 48.4 Alameda: 39.8 Stanislaus: 48.1 California: 40.9
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	79.9	89.8	81.4	91.2	San Joaquin: 79.9 Alameda: 89.8 Stanislaus: 81.4 California: 91.2

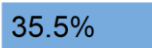


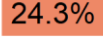
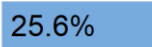

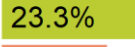
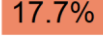
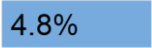


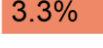
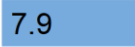

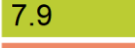

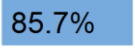
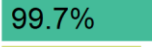

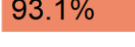
COVID-19

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	22,140.8	15,142.1	21,520.1	21,285.5
					San Joaquin: 22,140.8 Alameda: 15,142.1 Stanislaus: 21,520.1 California: 21,285.5
Other					
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	603.0	484.0	527.0	422.0
					San Joaquin: 603 Alameda: 484 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).	733.0	665.0	722.0	601.0
					San Joaquin: 733 Alameda: 665 Stanislaus: 722 California: 601

Health Behavior

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

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	18.3%	18.0%	19.3%	18.1%
					San Joaquin: 18.3% Alameda: 18% Stanislaus: 19.3% California: 18.1%
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	18.7	11.7	17.2	14.3
					San Joaquin: 18.7 Alameda: 11.7 Stanislaus: 17.2 California: 14.3

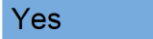
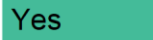
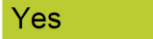
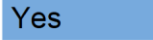


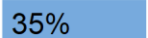
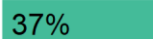
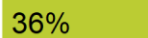
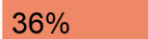


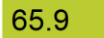








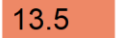
Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Adult Obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	35.5%	22.2%	31.5%	24.3%	San Joaquin:  Alameda:  Stanislaus:  California: 
Physical Inactivity	Percentage of adults ages 20 and over reporting no leisure-time physical activity.	25.6%	14.6%	23.3%	17.7%	San Joaquin:  Alameda:  Stanislaus:  California: 
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	4.8%	1.0%	4.9%	3.3%	San Joaquin:  Alameda:  Stanislaus:  California: 
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.9	8.9	7.9	8.8	San Joaquin:  Alameda:  Stanislaus:  California: 
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	85.7%	99.7%	91.0%	93.1%	San Joaquin:  Alameda:  Stanislaus:  California: 

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	582.4	583.3	531.5	585.3
					San Joaquin: 582.4 Alameda: 583.3 Stanislaus: 531.5 California: 585.3
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	21.8	9.9	24.4	17.4
					San Joaquin: 21.8 Alameda: 9.9 Stanislaus: 24.4 California: 17.4
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	14.9%	11.1%	15.8%	11.5%
					San Joaquin: 14.9% Alameda: 11.1% Stanislaus: 15.8% California: 11.5%

Clinical Care

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

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	Yes	Yes	Yes	San Joaquin: Yes Alameda: Yes Stanislaus: Yes California:
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	No	Yes	No	San Joaquin: No Alameda: Yes Stanislaus: No California:

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Mental Health Care Shortage Area	Presence of a mental health professional shortage area within the county.	Yes	Yes	Yes	San Joaquin:  Alameda:  Stanislaus:  California:	
Medically Underserved Area	Presence of a medically underserved area within the county.	Yes	Yes	Yes	San Joaquin:  Alameda:  Stanislaus:  California:	
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	35.0%	37.0%	36.0%	36.0%	San Joaquin:  Alameda:  Stanislaus:  California: 
Dentists	Dentists per 100,000 population.	57.6	96.1	65.9	87.0	San Joaquin:  Alameda:  Stanislaus:  California: 
Mental Health Providers	Mental health providers per 100,000 population.	247.6	647.7	218.3	373.4	San Joaquin:  Alameda:  Stanislaus:  California: 
Psychiatry Providers	Psychiatry providers per 100,000 population.	6.1	18.2	4.1	13.5	San Joaquin:  Alameda:  Stanislaus:  California: 

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	100.1	202.6	104.0	190.0	San Joaquin: 100.1 Alameda: 202.6 Stanislaus: 104 California: 190
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	96.9	167.4	128.3	147.3	San Joaquin: 96.9 Alameda: 167.4 Stanislaus: 128.3 California: 147.3
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted)	1,039.1	882.9	1,343.5	948.3	San Joaquin: 1,039.1 Alameda: 882.9 Stanislaus: 1,343.5 California: 948.3
COVID-19						
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	61,353.6	81,210.4	56,435.3	69,688.3	San Joaquin: 61,353.6 Alameda: 81,210.4 Stanislaus: 56,435.3 California: 69,688.3

Socio-Economic and Demographic Factors

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

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Community Safety						
Homicide Rate	Number of deaths due to homicide per 100,000 population.	9.1	6.0	4.6	4.8	San Joaquin: 9.1 Alameda: 6 Stanislaus: 4.6 California: 4.8

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	11.8	7.4	7.1	7.8	San Joaquin: 11.8 Alameda: 7.4 Stanislaus: 7.1 California: 7.8
Violent Crime Rate	Number of reported violent crime offenses per 100,000 population.	787.3	628.8	578.5	420.9	San Joaquin: 787.3 Alameda: 628.8 Stanislaus: 578.5 California: 420.9
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	2.9	2.4	3.0	2.1	San Joaquin: 2.9 Alameda: 2.4 Stanislaus: 3 California: 2.1
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	14.9	6.0	14.6	9.5	San Joaquin: 14.9 Alameda: 6 Stanislaus: 14.6 California: 9.5
Education						
Some College	Percentage of adults ages 25-44 with some post-secondary education.	51.2%	76.1%	53.6%	65.7%	San Joaquin: 51.2% Alameda: 76.1% Stanislaus: 53.6% California: 65.7%
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	79.3%	88.4%	78.9%	83.3%	San Joaquin: 79.3% Alameda: 88.4% Stanislaus: 78.9% California: 83.3%

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	8.2%	4.5%	7.5%	6.4%	San Joaquin: 8.2% Alameda: 4.5% Stanislaus: 7.5% California: 6.4%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	2.6	3.1	2.7	2.9	San Joaquin: 2.6 Alameda: 3.1 Stanislaus: 2.7 California: 2.9
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	2.5	3.0	2.5	2.7	San Joaquin: 2.5 Alameda: 3 Stanislaus: 2.5 California: 2.7
Employment						
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	5.9%	2.9%	6.0%	4.0%	San Joaquin: 5.9% Alameda: 2.9% Stanislaus: 6% California: 4%
Family and Social Support						
Children in Single-Parent Households	Percentage of children that live in a household headed by single parent.	22.9%	19.7%	22.6%	22.5%	San Joaquin: 22.9% Alameda: 19.7% Stanislaus: 22.6% California: 22.5%

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Social Associations	Number of membership associations per 10,000 population.	4.8	6.5	5.7	5.9
					San Joaquin: 4.8 Alameda: 6.5 Stanislaus: 5.7 California: 5.9
Residential Segregation (Non-White/White)	Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.	29.2	35.9	20.6	38.0
					San Joaquin: 29.2 Alameda: 35.9 Stanislaus: 20.6 California: 38
Income					
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	61.4%	43.2%	67.8%	59.4%
					San Joaquin: 61.4% Alameda: 43.2% Stanislaus: 67.8% California: 59.4%
Children in Poverty	Percentage of people under age 18 in poverty.	18.2%	9.8%	17.1%	15.6%
					San Joaquin: 18.2% Alameda: 9.8% Stanislaus: 17.1% California: 15.6%

Indicators	Description	San Joaquin	Alameda	Stanislaus	California
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$68,458.0	\$107,589.0	\$62,761.0	\$80,423.0
					San Joaquin: \$68,458 Alameda: \$107,589 Stanislaus: \$62,761 California: \$80,423
Uninsured Population under 64	Percentage of population under age 65 without health insurance.	7.8%	5.0%	7.1%	8.3%
					San Joaquin: 7.8% Alameda: 5% Stanislaus: 7.1% California: 8.3%
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.7	5.2	4.4	5.2
					San Joaquin: 4.7 Alameda: 5.2 Stanislaus: 4.4 California: 5.2

Physical Environment

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

Indicators	Description	San Joaquin	Alameda	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.	24.4%	23.5%	23.5%	26.4%
					San Joaquin: 24.4% Alameda: 23.5% Stanislaus: 23.5% California: 26.4%

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	18.1%	17.1%	17.2%	19.7%	San Joaquin: 18.1% Alameda: 17.1% Stanislaus: 17.2% California: 19.7%
Homeownership	Percentage of occupied housing units that are owned.	56.6%	53.5%	57.8%	54.8%	San Joaquin: 56.6% Alameda: 53.5% Stanislaus: 57.8% California: 54.8%
Homelessness Rate	Number of homeless individuals per 100,000 population.	360.5	491.1	387.9	411.2	San Joaquin: 360.5 Alameda: 491.1 Stanislaus: 387.9 California: 411.2
Transit						
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	6.1%	9.4%	5.9%	7.1%	San Joaquin: 6.1% Alameda: 9.4% Stanislaus: 5.9% California: 7.1%
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	40.0%	47.6%	35.3%	42.2%	San Joaquin: 40% Alameda: 47.6% Stanislaus: 35.3% California: 42.2%
Access to Public Transit	Percentage of population living near a fixed public transportation stop	63.6%	90.5%	68.3%	69.6%	San Joaquin: 63.6% Alameda: 90.5% Stanislaus: 68.3% California: 69.6%

Indicators	Description	San Joaquin	Alameda	Stanislaus	California	
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	78.6%	22.6%	97.2%	51.6%	San Joaquin: 78.6% Alameda: 22.6% Stanislaus: 97.2% California: 51.6%
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	14.1	8.7	12.6	8.1	San Joaquin: 14.1 Alameda: 8.7 Stanislaus: 12.6 California: 8.1
Drinking Water Violations	Presence of health-related drinking water violations in the county.	Yes	No	Yes		San Joaquin: Yes Alameda: No Stanislaus: Yes California:

Community Service Provider Survey Results

Table 15: Service provider survey results for San Joaquin, Alameda and Stanislaus Counties

Service Provider Survey Snapshot San Joaquin County (N=15)		% Reporting
Health Needs		
Most Frequently Reported		
	Access to Basic Needs	93.3
	Access to Mental/Behavioral Health and Substance-Abuse Services	80.0
	Active Living and Healthy Eating	80.0
	A Safe and Violence-Free Environment	73.3
Top 3/ Priority (Most Frequently Reported Characteristics)		
	Access to Mental/Behavioral Health and Substance-Abuse Services	73.3
	<i>There aren't enough services here for those who are homeless and dealing with substance-abuse issues.</i>	
	<i>Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).</i>	
	<i>Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.</i>	
	Access to Basic Needs	73.3
	<i>Lack of affordable housing is a significant issue in the area.</i>	

	<i>The area needs additional low-income housing options.</i>	
	<i>Many people in the area do not make a living wage.</i>	
	A Safe and Violence-Free Environment	40.0
	<i>Human trafficking is an issue in the area.</i>	
	<i>People feel unsafe because of crime.</i>	
	<i>Public parks seem unsafe because of illegal activity taking place.</i>	
	<i>Youth need more safe places to go after school.</i>	

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.

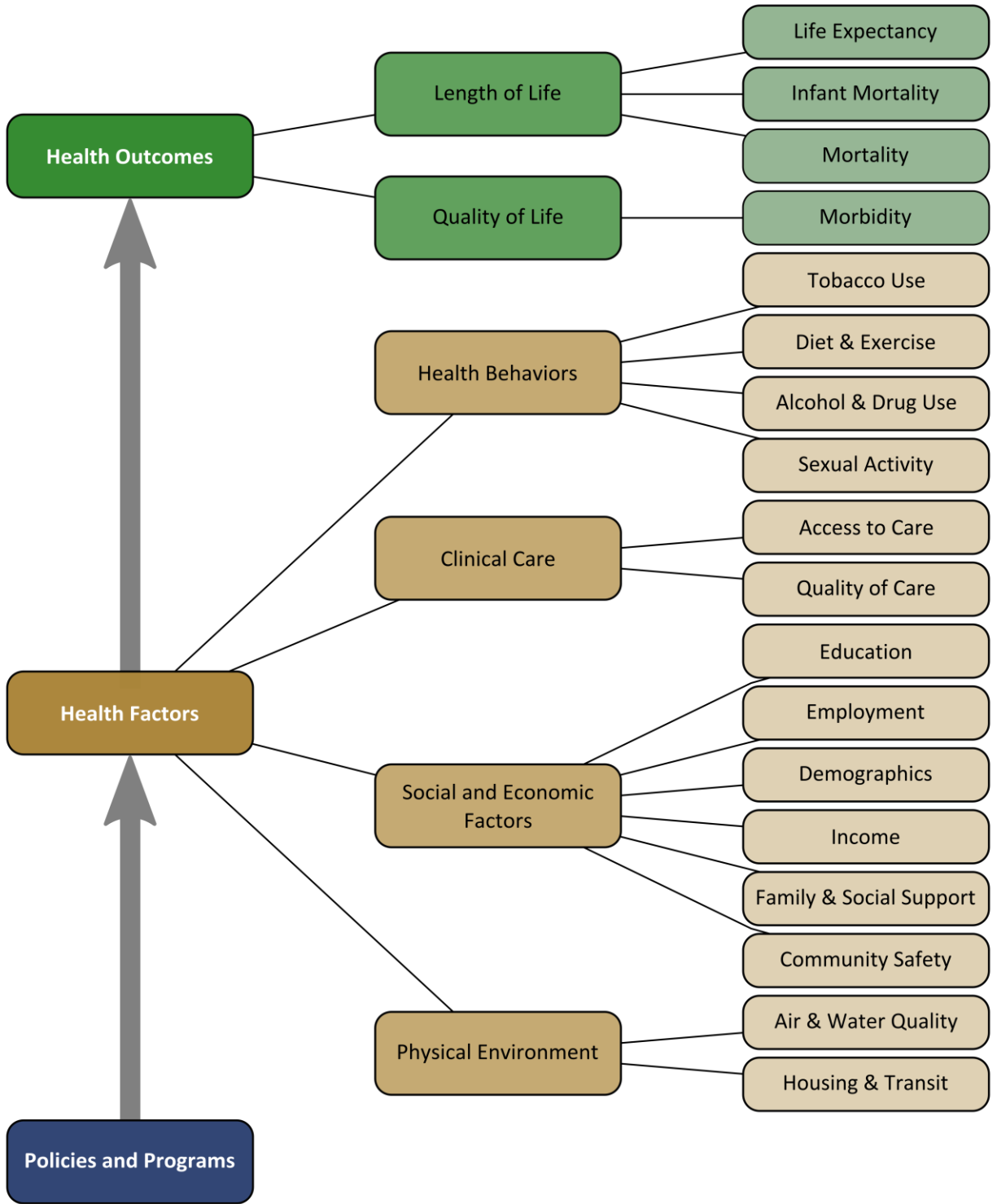


Figure 7: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015

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 Sutter Tracy Community Hospital for 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 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.

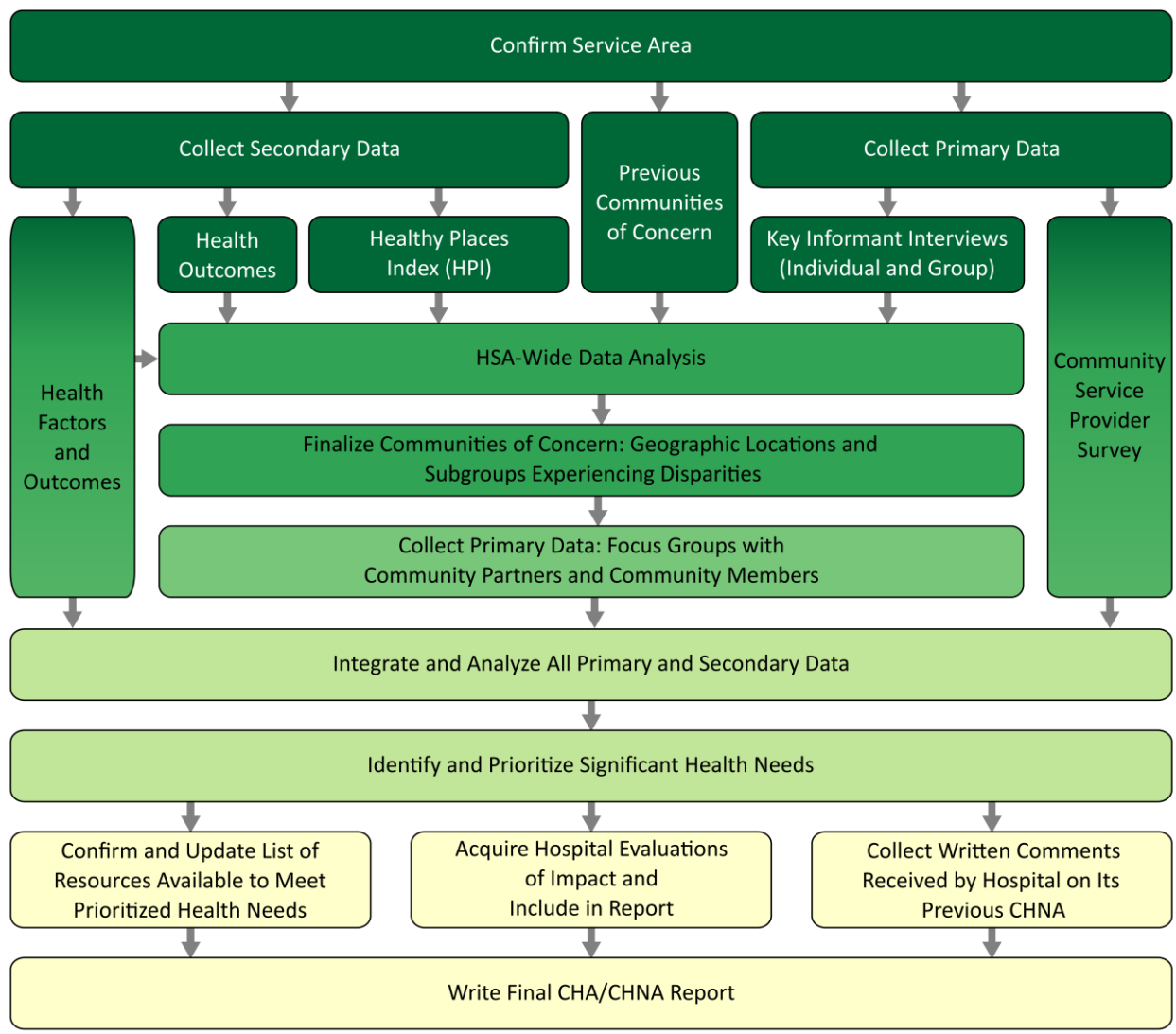


Figure 8: CHNA process model for STCH

Primary Data Collection and Processing

Primary Data Collection

Input from the community served by Sutter Tracy Community Hospital 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, which 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
Tracy Community Connections Center	10/19/2021	1	Modified Recuperative Care & Emergency Shelter	Homeless and at risk for homelessness
San Joaquin County Public Health	10/22/2021	1	Public Health	Residents of San Joaquin County
Sutter Tracy Community Hospital Staff	10/25/2021	2	Discharge planning, ED navigation, case management	Primarily residents of San Joaquin County
Tracy Family Resource Center (Community Partnership for Families of San Joaquin)	11/02/2021	2	Support services and referrals	Low income, Hispanic, Homeless, undocumented
Community Medical Centers	11/03/2021	1	FQHC Healthcare provider	Low to middle income, high risk, homeless
School Districts: Tracy, Banta, Jefferson	11/09/2021	3	Education	Youth, families, low income, undocumented
Tracy Interfaith Ministries	12/06/2021	1	Basic needs: food, clothing,	Low income, Hispanic, Afghan, seniors, Tracy, and surrounding areas including some from

				Banta and Lathrop
City of Lathrop	12/13/2021	1	City governance, policy	Residents of Lathrop

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. Added 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	Populations Represented
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		Participants	
San Joaquin County Child Abuse Prevention Council*	11/19/2021	10	City of Lathrop, low income, parents
San Joaquin County Child Abuse Prevention Council*	12/02/2021	10	City of Tracy, Spanish speaking, parents/guardians
Boys and Girls Club of Tracy	12/03/2021	9	Youth and families
Family Resource Center	12/08/2021	12	Low Income Hispanic from Central Tracy and Banta

*provided by the CHNA Steering Committee of San Joaquin County

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 with 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. We used a list of CSPs affiliated with the nonprofit

hospitals included in this report as our initial sampling frame and sent an email recruitment message to these CSPs detailing the survey aims and inviting them to participate. We also implemented a snowball sampling technique, encouraging participants 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. 15 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:

Angie Carr, Xena Ferrario, Carrie Grover, Meagan Hamby, Lynda Hawkins, Lindsay Lopez, Reina Maldonado, Randy Pinnelli, Stephanie Player, Al Rowlett, and Sofia Valenzuela

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, we included a set of questions 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. We ran descriptive statistics and frequencies 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 are expressed.

Secondary Data Collection and Processing

We use “secondary data” to refer 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 STCH 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),¹⁵ derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),¹⁶ health outcome indicators

¹⁵ 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.

¹⁶ State of California, Department of Public Health. 2021. California Comprehensive Master Death File (Static), 2015-2019.

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.

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 unique 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, 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 California¹⁷ were compared to ZCTA boundaries.¹⁸ 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.¹⁹ 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 small populations. The difference between raw rates and EBRs in ZCTAs with 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.

¹⁷ Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from <http://www.Zip-Codes.com>.

¹⁸ 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>.

¹⁹ 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	Child Mortality	County Health Rankings	2016 - 2019
			Life Expectancy	Life Expectancy	County Health Rankings	2017 - 2019
			Premature Age-Adjusted Mortality	Premature Age-Adjusted Mortality	County Health Rankings	2017 - 2019
			Premature Death	Premature Death	County Health Rankings	2017 - 2019
			Stroke Mortality	Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Chronic Lower Respiratory Disease Mortality	Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Diabetes Mortality	Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Heart Disease Mortality	Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Hypertension Mortality	Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
	Cancer Mortality	Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019		
	Liver Disease Mortality	Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019		
	Kidney Disease Mortality	Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019		
	Suicide Mortality	Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019		
	Unintentional Injuries Mortality	Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019		
	COVID-19 Mortality	COVID-19 Mortality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-02-25		
	COVID-19 Case Fatality	COVID-19 Case Fatality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-02-25		
	Alzheimer's Disease Mortality	Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019		
	Influenza and Pneumonia Mortality	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 2022-02-25	
		Asthma ED Rates	Tracking California	2018	
		Asthma ED Rates for Children	Tracking California	2018	
		Health Factors	Alcohol and Drug Use	Excessive Drinking	County Health Rankings
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 2022-02-25
	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
	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 Rankings²⁰ 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

²⁰ 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
Diabetes Prevalence	2017	United States Diabetes Surveillance System
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

CHR Indicator	Time Period	Data Source
Disconnected Youth	2015 - 2019	American Community Survey, 5-year estimates
Third Grade Reading Level	2018	Stanford Education Data Archive
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-ViDa²¹ 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

²¹ 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/>.

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.

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 deaths²² and completed vaccinations²³ 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.

²² State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved February 25 2022 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

²³ State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved February 25 2022 from <https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv>.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles²⁴ and report age-adjusted deaths per 100,000.

U.S. Health Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration²⁵ (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

²⁴ 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.

²⁵ 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>.

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 Registry²⁶ 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-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.²⁷ 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 3.0²⁸ 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.

²⁶ California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from <https://www.cancer-rates.info/ca/>.

²⁷ Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.

²⁸ California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from <https://oehha.ca.gov/calenviroscreen/maps-data>.

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.²⁹ 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.³⁰ 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 - 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 Report³¹ 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.

²⁹ 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/>.

³⁰ 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>.

³¹ 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>.

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. 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,³² so this was the data used to represent the distribution of population for this indicator.

Transit stop data were identified first by using tools in the TidyTransit³³ library for the R statistical programming language.³⁴ 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,³⁵ Transitland,³⁶ Transitwiki.org,³⁷ and Santa Ynez Valley Transit.³⁸ 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 sf³⁹ 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

³² US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from <https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/>.

³³ Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley, and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. Retrieved 10 Sep 2021 from <https://CRAN.R-project.org/package=tidytransit>.

³⁴ R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>.

³⁵ OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from <https://openmobilitydata.org/l/67-california-usa>.

³⁶ Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from <https://www.transit.land/operators>.

³⁷ Transitwiki.org. 2021. List of publicly-accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.

³⁸ Santa Ynez Valley Transit. GTFS Files. Retrieved 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.

³⁹ Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, <https://doi.org/10.32614/RJ-2018-009>.

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.

Community of Concern Identification

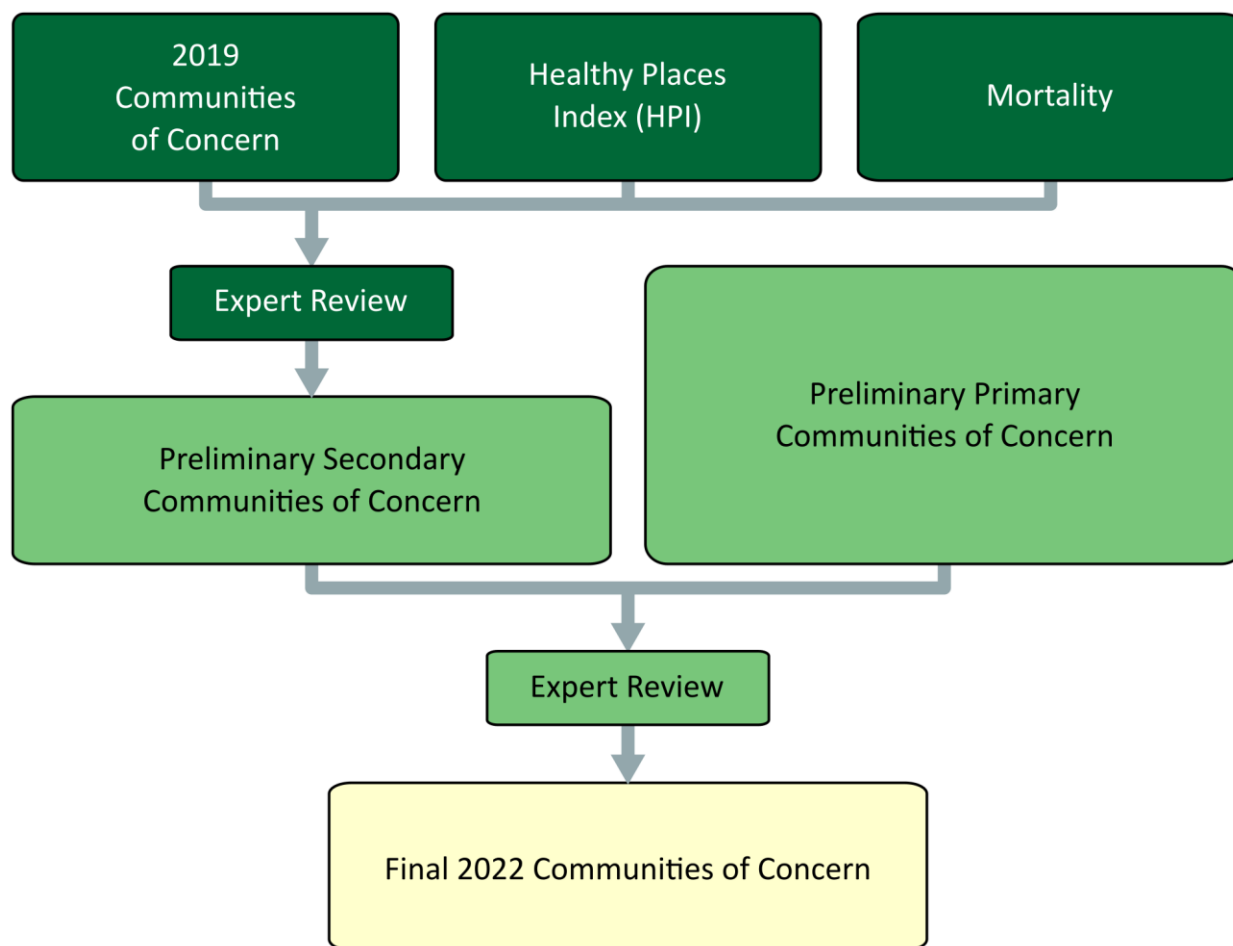


Figure 9: Community of Concern identification process

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.

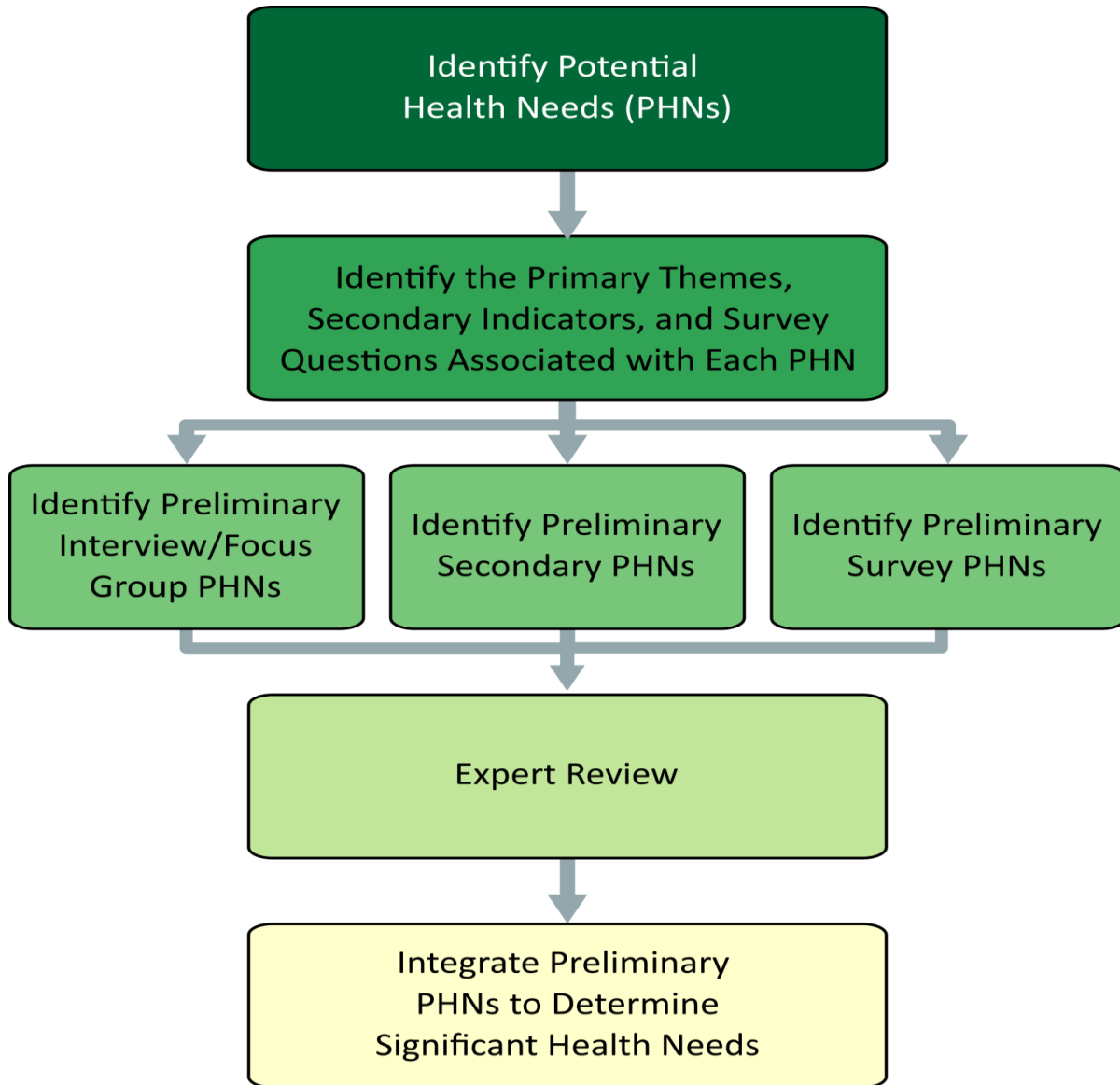


Figure 10: Significant health need identification process.

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
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
Too few providers in the area accept Medi-Cal.	Stroke Mortality
It is difficult to recruit and retain primary care providers in the region.	Chronic Lower Respiratory Disease Mortality
Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).	Diabetes Mortality
The quality of care is low (e.g., appointments are rushed, providers lack cultural competence).	Heart Disease Mortality
Patients seeking primary care overwhelm local emergency departments.	Hypertension Mortality
Primary care services are available but are difficult for many people to navigate.	Cancer Mortality
	Liver Disease Mortality
	Kidney Disease Mortality
	COVID-19 Mortality
	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.	Life Expectancy
Fresh, unprocessed foods are unaffordable.	Premature Age-Adjusted Mortality
Food insecurity is an issue here.	Premature Death
Students need healthier food options in schools.	Stroke Mortality
The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, or parks are inaccessible).	Diabetes Mortality
The community needs nutrition education programs.	Heart Disease Mortality
Homelessness in parks or other public spaces deters their use.	Hypertension Mortality
Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming).	Cancer Mortality
There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues)	Kidney Disease Mortality
The food available in local homeless shelters and food banks is not nutritious.	Diabetes Prevalence
Grocery store option in the area are limited.	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.	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
Quality dental services for kids are lacking.	Frequent Physical Distress
It's hard to get an appointment for dental care.	Poor or Fair Health
People in the area have to travel to receive dental care.	Dental Care Shortage Area
Dental care here is unaffordable, even if you have insurance.	Dentists
	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
<p>Services are inaccessible for Spanish-speaking and immigrant residents.</p> <p>Many residents struggle with food insecurity.</p> <p>It is difficult to find affordable childcare.</p> <p>Educational attainment in the area is low.</p>	<p>COVID-19 Mortality</p> <p>COVID-19 Case Fatality</p> <p>Diabetes Prevalence</p> <p>Low Birthweight</p> <p>Poor Mental Health Days</p> <p>Frequent Mental Distress</p> <p>Poor Physical Health Days</p> <p>Frequent Physical Distress</p> <p>Poor or Fair Health</p> <p>COVID-19 Cumulative Incidence</p> <p>Asthma ED Rates</p> <p>Asthma ED Rates for Children</p> <p>Drug Induced Death</p> <p>Adult Obesity</p> <p>Limited Access to Healthy Foods</p> <p>Food Environment Index</p> <p>Medically Underserved Area</p> <p>COVID-19 Cumulative Full Vaccination Rate</p> <p>Some College</p> <p>High School Completion</p> <p>Disconnected Youth</p> <p>Third Grade Reading Level</p> <p>Third Grade Math Level</p> <p>Unemployment</p> <p>Children in Single-Parent Households</p> <p>Social Associations</p> <p>Residential Segregation (Non-White/White)</p> <p>Children Eligible for Free Lunch</p> <p>Children in Poverty</p> <p>Median Household Income</p> <p>Uninsured Population under 64</p> <p>Income Inequality</p> <p>Severe Housing Problems</p> <p>Severe Housing Cost Burden</p> <p>Homeownership</p> <p>Homelessness Rate</p> <p>Households with no Vehicle Available</p> <p>Long Commute - Driving Alone</p>

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
Using public transportation to reach providers can take a long time.	Adult Obesity
The cost of public transportation is too high.	COVID-19 Cumulative Full Vaccination Rate
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.	Premature Death
People have to travel to reach specialists.	Stroke Mortality
Too few specialty and extended care providers accept Medi-Cal.	Chronic Lower Respiratory Disease Mortality
The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care)	Diabetes Mortality
There isn't enough OB/GYN care available.	Heart Disease Mortality
Additional hospice and palliative care options are needed.	Hypertension Mortality
The area lacks a kind of specialist or extended care option not listed here.	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
There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease).	Stroke Mortality
Vaccination rates are lower than they need to be.	Chronic Lower Respiratory Disease Mortality
Health education in the schools needs to be improved.	Diabetes Mortality
Additional HIV and STI prevention efforts are needed.	Heart Disease Mortality
The community needs nutrition education opportunities.	Hypertension Mortality
Schools should offer better sexual health education.	Liver 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).	Kidney Disease Mortality
Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision).	Suicide Mortality
	Unintentional Injuries Mortality
	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
<p>People may not be aware of the services they are eligible for.</p> <p>It is difficult for people to navigate multiple, different health care systems.</p> <p>The area needs more navigators to help to get people connected to services.</p> <p>People have trouble understanding their insurance benefits.</p> <p>Automated phone systems can be difficult for those who are unfamiliar with the</p>	

Primary Themes	Secondary Indicators
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
Colorectal Cancer Prevalence	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
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 identify 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 survey 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 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 50% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by 50% 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 50% of survey respondents. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in **REPORT AUTHOR TEXT** of these categories.

Health Need Prioritization

The ultimate 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 name 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 stand for how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health need 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 stand for 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	Mental/Behavioral Health and Substance-Use	Access to Quality Primary Care Health Services	Safe and Violence-Free Environment	Increased Community Connections	Active Living and Healthy Eating	Access to Dental Care and Preventive Services	Access to Functional Needs	Access to Specialty and Extended Care	Injury and Disease Prevention and Management	Healthy Physical Environment	System Navigation
180 Club	95240	www.180lodi.org				x	x						x	
Adventist Health Lodi Memorial	95240	www.adventisthealth.org/lodi-memorial			x	x					x	x		x
Aegis Medical Systems, Inc.	95376	pinnacletreatment.com/location/california/tracy/aegis-tracy		x										x
African American Chamber of Commerce of San Joaquin County	95202	www.aaccfsj.org	x				x							
Amelia Ann Adams Whole Life Center	95207	aaawlc.org	x				x							
Asian Pacific Self Development and Residential Association	95204	apsaraonline.org						x						
Banta Unified School District	95304	bantaesd.sharpschool.net					x	x						
Boys and Girls Club- Lodi	95240	www.bgclodi.com				x	x							
Boys and Girls Club-Stockton	95205	www.bgca.org				x	x							
Boys and Girls Club-Tracy	95376	bgctracy.org				x	x							
Boys and Girls Club-Manteca	95336	www.bgmanteca.org				x	x							
Cal State University Stanislaus	San Joaquin County	www.csustan.edu				x	x							

Organization Information			Significant Health Needs											Other Health Needs
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Mental/Behavioral Health and Substance-Use	Access to Quality Primary Care Health Services	Safe and Violence-Free Environment	Increased Community Connections	Active Living and Healthy Eating	Access to Dental Care and Preventive Services	Access to Functional Needs	Access to Specialty and Extended Care	Injury and Disease Prevention and Management	Healthy Physical Environment	System Navigation
California Human Development- San Joaquin County	95403	californiahumandevlopment.org					X	X						
Calvary Chapel Tracy	95377	calvarytracy.org				X	X							
Catholic Charities of the Diocese of Stockton	San Joaquin County	www.ccstockton.org								X	X		X	X
Child Abuse Prevention Council of San Joaquin County	95202	nochildabuse.org		X			X							X
City of Lathrop	95330	www.ci.lathrop.ca.us					X							
City of Manteca Senior Center	95337	www.ci.manteca.ca.us/parks/Seniors/Pages/default.aspx				X	X	X						
City of Stockton- Oak Park Senior Citizen's Center	95204	www.stocktongov.com/government/departments/communityservices/communitycenters.html					X	X						
City of Tracy	95376	www.cityoftracy.org/home					X							
City Parks and Recreation Departments	95240	www.sjparks.com				X	X							
Coalition of Tracy Citizens to Assist the Homeless	95376	tracyhomeless.com	X			X								
Community Medical Centers- Recovery Center	San Joaquin County	www.communitymedicalcenters.org/Services/Behavioral-Health	X	X						X				X
Community Medical Centers, Inc.	San Joaquin County	www.communitymedicalcenters.org		X	X				X					X
Community Partnership for Families of San Joaquin	San Joaquin County	cpfsj.networkforgood.com		X										X

Organization Information			Significant Health Needs										Other Health Needs	
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Mental/Behavioral Health and Substance-Use	Access to Quality Primary Care Health Services	Safe and Violence-Free Environment	Increased Community Connections	Active Living and Healthy Eating	Access to Dental Care and Preventive Services	Access to Functional Needs	Access to Specialty and Extended Care	Injury and Disease Prevention and Management	Healthy Physical Environment	System Navigation
Dameron Hospital	95203	www.dameronhospital.org			X			X				X		X
Dignity Health- St. Joseph's Behavioral Health Center	95204	www.dignityhealth.org/central-california/locations/stjosephsbehavioral		X										
Dignity Health- St. Joseph's Medical Center	95204	www.dignityhealth.org/central-california/locations/stjosephs-stockton/about-us		X	X			X			X	X		X
Disability Resource Agency for Independent Living (DRAIL)	95350, 95207	drail.org					X				X			
Eden Housing	San Joaquin County	edenhousing.org/county/san-joaquin	X											
El Concilio California	San Joaquin County	www.elconcilio.org		X			X			X	X			
Emergency Food Bank of Stockton/San Joaquin	95203	www.stocktonfoodbank.org	X				X							
Escalon Chamber of Commerce	95320	www.escalonchamberofcommerce.org	X				X							
Family Resource and Referral Center	San Joaquin County	frrcsj.org				X								X
First 5 San Joaquin County	San Joaquin County	www.sjckids.org			X		X							X
First Baptist Church of Tracy	95376	firstbaptistchurchtracy.yolasite.com				X	X							
Give Every Child a Chance- Manteca	95337	gecac.net					X	X						
Golden Valley Health Centers	San Joaquin County	www.gvhc.org		X	X				X					X

Organization Information			Significant Health Needs											Other Health Needs
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Mental/Behavioral Health and Substance-Use	Access to Quality Primary Care Health Services	Safe and Violence-Free Environment	Increased Community Connections	Active Living and Healthy Eating	Access to Dental Care and Preventive Services	Access to Functional Needs	Access to Specialty and Extended Care	Injury and Disease Prevention and Management	Healthy Physical Environment	System Navigation
Gospel Center Rescue Mission	95201	gcrms.org	x	x										
Grace and Mercy Foundation- Lodi	95240	gracemercyfoundation.com	x											
Grace Church	95376	www.gracelife.net				x	x							
Greater Stockton Chamber of Commerce	95203	stocktonchamber.org	x				x							
HOPE Ministries	95206	hopeministries-bip.org				x	x							
Housing Authority County of San Joaquin	San Joaquin County	hacsj.org	x											
Human Services Agency San Joaquin County- Home Energy Assistance Program (HEAP)	95202	www.sjchsa.org/Services/Aging-and-Community-Services/Home-Energy-Assistance-Program-HEAP	x											
Jefferson Unified School District- Tracy	95377	www.jeffersonschooldistrict.com				x		x						x
Kaiser Permanente Manteca	95337	healthy.kaiserpermanente.org/northern-california/facilities/Manteca-Medical-Offices-100355		x	x		x							x
Lammersville Unified School District	95391	www.lammersvilleschooldistrict.net				x		x						x
Lao Family Community Empowerment Center	95210	www.communityconnectionssjc.org/programs/details/lao_family_community_of_stockton	x	x	x		x							x
Lathrop District Chamber of Commerce	95330	www.lathropchamber.org	x				x							
Little Manila Rising	95206	www.littlemanila.org				x	x							

Organization Information			Significant Health Needs											Other Health Needs
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Lodi Chamber of Commerce	95240	www.lodichamber.com	x				x							
Lodi Unified School District	95240	www.lodiusd.net				x		x						x
LOEL Hansen Senior Center- Lodi	95240	www.loelcenter.net	x				x	x						
Love INC of Manteca	San Joaquin County	www.loveincmanteca.org	x				x							
Manteca Chamber of Commerce	95336	manteca.org	x				x							
Manteca Unified School District	95337	www.mantecausd.net				x		x						x
McHenry House Tracy Family Shelter	95376	www.mchenryhousetracy.org	x	x			x					x		x
Mercy Housing	San Joaquin County	www.mercyhousing.org	x											
Mission City Church	95304	www.tracymission.org				x	x							
Mountain's Hope Community Worship Center	95376	www.mhwc.org				x	x							
National Alliance on Mental Illness San Joaquin	San Joaquin County	namica.org/locations/nami-san-joaquin-county		x										x
Oasis City Center	95210	oasiscitycenter.org	x			x	x						x	
Our Lady of Guadalupe Lathrop	95330	olgchurchlathrop.com				x	x							
People of Christ Missionary Baptist Church	95304	www.pcobaptist.org				x	x							

Organization Information			Significant Health Needs											Other Health Needs
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Public Health Advocates-Stockton	95207	phadvocates.org						x						
REACH	95207	phadvocates.org/case-study/reach	x					x						
Ready to Work	95202	www.readytoworksjc.org	x			x								
Restore the Delta	95202	www.restorethedelta.org											x	
Salvation Army- Hope Harbor Shelter	95240	lodi.salvationarmy.org/lodi/hope-harbor-shelter	x											x
San Joaquin Bike Coalition	San Joaquin County	www.sjbike.org					x	x					x	
San Joaquin County and City Parks and Recreation	San Joaquin County	www.sjpark.com				x	x	x					x	
San Joaquin County Behavioral Health Services, WIC	San Joaquin County	www.sjcphs.org/Organization/programs.aspx		x							x	x		x
San Joaquin County-Child Health and Disability Prevention Program	San Joaquin County	www.sjcphs.org/familyhealth/chdpMain.aspx			x				x			x		x
San Joaquin County Hispanic Chamber of Commerce	95207	www.sjchispanicchamber.com	x				x							
San Joaquin County Human Services Agency	San Joaquin County	www.sjchsa.org	x		x			x	x					x
San Joaquin County Office of Education-Healthy Kids Resource Center	San Joaquin County	www.sjcoe.org/CompHealth/chkrc.aspx		x				x						

Organization Information			Significant Health Needs											Other Health Needs
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San Joaquin County Public Health Services/WIC	San Joaquin County	www.sjcphs.org	x					x				x	x	
San Joaquin County School District	San Joaquin County	www.sjcoe.org/SJCDistricts				x		x						x
San Joaquin County WorkNet	San Joaquin County	www.sjcworknet.org	x											
San Joaquin Delta College	95207	deltacollege.edu				x	x							
San Joaquin General Hospital	95231	www.sanjoaquingeneral.org			x							x		x
San Joaquin General Hospital- Look-alike clinics	95231, 95202	www.sjcclinics.org/en/about-us			x									x
San Joaquin Pride Center	95203	communityconnectionssjc.org/programs/details/sjpc		x			x							
San Joaquin River Club	95304	www.sjriverclub.com				x	x							
San Joaquin Treatment & Education for Everyone on Teeth and Health (SJ Teeth) Collaborative	San Joaquin County	www.sjteeth.org/en-us							x					
Second Harvest of the Greater Valley	95337	www.localfoodbank.org	x											
Southwinds Church	95304	www.southwinds.org				x	x							
Sow a Seed Community Foundation	95376	www.sowaseedcf.org		x		x	x							
St. Anne's Byron	94514	www.anne.church				x	x							

Organization Information			Significant Health Needs											Other Health Needs
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Mental/Behavioral Health and Substance-Use	Access to Quality Primary Care Health Services	Safe and Violence-Free Environment	Increased Community Connections	Active Living and Healthy Eating	Access to Dental Care and Preventive Services	Access to Functional Needs	Access to Specialty and Extended Care	Injury and Disease Prevention and Management	Healthy Physical Environment	System Navigation
St. Anthony's Manteca	95336	www.st-anthonys.org				X	X							
St. Bernard's Catholic Church	95376	st-bernards.org				X	X							
St. Mary's Dining Room	95203	www.stmarysdiningroom.org	X	X	X				X					
St. Raphael's Dental Clinic	95203	www.stmarysdiningroom.org/caring-for-health-issues							X					
STAND	95206	standaffordablehousing.org	X				X							
Stockton PACE	95204	welbehealth.com/sierra/services	X		X			X	X	X	X			
Stockton Unified School District	95202	www.stocktonusd.net				X		X						X
Sutter Health- Sutter Tracy Community Hospital	95376	www.sutterhealth.org/stch		X	X				X			X		X
The Hill Foundation Community Food Bank	95304	nicelocal.com/california/public_services/the_hill_foundation_community_food_bank	X											
The Wellness Center of San Joaquin County	95202, 95337	thewellnesscenterprs.org	X	X			X			X				
Tracy Adventist Church	95376	www.tracysdachurch.org				X	X	X						
Tracy Chamber of Commerce	95376	www.tracychamber.org	X				X							
Tracy Chamber of Commerce	95376	www.tracychamber.org	X				X							
Tracy Community Connections Center	95376	www.tracyccc.org	X	X										X

Organization Information			Significant Health Needs											Other Health Needs
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Mental/Behavioral Health and Substance-Use	Access to Quality Primary Care Health Services	Safe and Violence-Free Environment	Increased Community Connections	Active Living and Healthy Eating	Access to Dental Care and Preventive Services	Access to Functional Needs	Access to Specialty and Extended Care	Injury and Disease Prevention and Management	Healthy Physical Environment	System Navigation
Tracy Family Resource Center	95376	communityconnectionssjc.org/programs/details/community_partnership_for_families_of_san_joaquin_tracy_family_resource_center	x				x							x
Tracy First United Methodist Church	95376	www.facebook.com/fumctracy				x	x							
Tracy Interfaith Ministries	95376	tracyinterfaith.org	x											
Tracy Joint Unified School District	95376	www.tracy.k12.ca.us				x		x						x
Tracy Seniors Association	95377	tracyseniorsassn.com					x			x				
Uneed2	95304	www.uneed2.org	x											
Victory Christian Church Tracy	95377	www.vcctracy.org				x	x							
Visionary Home Builders of California	95202	visionaryhomebuilders.org	x					x					x	
Women's Center- Youth and Family Services	95202	www.womenscenteryfs.org	x											
YMCA of San Joaquin County	95207	ymcasjc.org				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 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: Evaluation of the Impact of Actions Taken Since the 2019 CHNA for Sutter Tracy Community Hospital

Responding to the 2019 Community Health Needs Assessment

MENTAL HEALTH

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	<p>In 2020, the mental health strategy helped with the following initiatives:</p> <ul style="list-style-type: none"> • 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. <p>In 2021, the mental health strategy helped with the following initiatives:</p> <ul style="list-style-type: none"> • 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.
Name of program/activity/initiative	Family Wellness Prevention and Early Intervention Program – Catholic Charities
Description	The PEI Family Wellness Program Provides short-term counseling to individuals who are low income or who are under-served by offering multi-lingual culturally appropriate counseling services in San Joaquin and Stanislaus Counties. The target populations for these services are adults and teens who are at risk of mental health services and LatinX populations experiencing mild to moderate depression, anxiety, grief, and other mental health disorders. Services are available to all individuals regardless of race, age, gender, religion, ethnicity, economic status, or sexual orientation. The program also provides community workshops and presentations in Spanish and English through partnership with businesses, churches, non-profit organizations, schools and other organizations. Topics focus on mental health awareness, prevention & early intervention, stigma reduction, access to resources, and suicide prevention.
Goals	The PEI Family Wellness Program will provide brief individual counseling sessions and mental health presentations and workshops in an effort to improve mental health outcomes in San Joaquin County (Stockton, Manteca, Tracy, and Ripon) and Stanislaus County (Modesto). A target of 100 unduplicated individuals will receive counseling sessions resulting in a minimum of 480-720 hours of counseling. Our overall goal is to provide accessible brief counseling sessions through multiple delivery locations, ensure all individuals served have a treatment plan, and receive 6-12 counseling sessions or case management services as appropriate.
Outcomes	<ul style="list-style-type: none"> • 2019: Served 27 individuals, 39 service referrals. • Jan-June 2021: Served 61 individuals; 334 counseling sessions; 23 referrals to other services.

ECONOMIC SECURITY

Name of program/activity/initiative	McHenry House
Description	<p>The McHenry House Family Crisis Intervention Program supports families experiencing homelessness through:</p> <ul style="list-style-type: none"> • Steady full-time employment; a client needs to actively seek and secure employment within 2 weeks of entering McHenry House (if they are not employed at the time of admittance). • Save 90% of their income to cover the 1st months' rent and deposit. • Children must be enrolled in school within 3 days of entering McHenry House, with mandatory attendance of the nightly

	<p>Homework Club to learn. Due to the COVID-19 pandemic we were forced to do distant learning and still help the children residents of the shelter.</p> <ul style="list-style-type: none"> • Mandatory attendance twice a month of a 2-hour counseling session that addresses: stress management, substance abuse issues, parenting and coping skills, contributing to becoming self-sufficient and to the success of their children in school. The counselor was available by phone to the adult clients due to the COVID-19 pandemic. We are hoping that in the near future to go back to the in person sessions. • Adult clients are drug tested as they move in and randomly as needed, if the test is positive the adults will be required to attend NA/AA three times a week and bring proof of attendance.
Goals	<p>Funds for the operation of the shelter and to continue providing free service to the homeless families we serve.</p> <ul style="list-style-type: none"> • To continue with the Homework Club that promotes education, improving grades and school attendance for children ages 3-17 years old. • To maintain and continue to offer the Counseling sessions on: parenting issues, stress management and substance abuse, as well as offering the Nutrition Workshop, that teaches the families how to eat healthy in order to prevent Heart Disease, Obesity & Diabetes.
Outcomes	<ul style="list-style-type: none"> • 2019: Served 194 families, 3,601 services provided. • 2020: Served 183 families, 38,730 services provided including 9,689 bed nights. • Jan-June 2021: Served 85 families, 11,889 services provided including 2,969 bed nights. • McHenry House Tracy Family Shelter offered an opportunity to families to have a safe place to live while they turned their situation around by securing employment, saving their money and finding a place of their own to live. McHenry House can provide shelter for 6 families daily for a period of 8-10 weeks. On average, this means that we can house approximately 45-50 families per year, depending on how long a family stays.
Name of program/activity/initiative	HOPE Family Ministries
Description	Program that will equip families in all areas of life; helping to minimize the trauma of being dislocated while strengthening and empowering them to become occupationally and residentially independent.
Goals	To serve at least 250 individuals including adult and children in finding permanent housing and provide job skills and preparation so that our families will learn to become residentially and occupationally independent of our help.
Outcomes	<ul style="list-style-type: none"> • 2019: Served 168 individuals including 48 families, 1,123 service referrals.

	<ul style="list-style-type: none"> • 2020: Served 202 individuals including 126 families, 98 services provided; 1,257 service referrals. • Jan-June 2021: Served 152 individuals including 37 families, 165,381 services provided; 877 service referrals.
Name of program/activity/initiative	Recuperative Care – Gospel Center Rescue Mission
Description	Gospel Center Rescue Mission (GCRM) Recuperative Care program offers a 24/7 shelter for people in need of recuperation from acute (short term) or exacerbation of a chronic illness. Services provided are non-medical care at a level that would be expected from a competent family member. Average Length of stay is 30 days.
Goals	During stay, guiding individuals towards lifestyle change for the better of their existing health conditions. Encouraging interaction with campus New Life Program Students for possibility of transition to life change upon Recuperative Care discharge if they meet qualifications. Helping client apply for and acquire Social Service documents such as: ID, SS Card, Birth Certificate, General Assistance, Social Security, Food Stamps, etc..... If applicable, assist with submitting documentation necessary to acquire stable housing, Board & Care, Assisted Living, etc...
Outcomes	This program was only supported in 2021. During the first half of 2021, it was our goal to reach a minimum of 125 individuals and help them with resources that would help them become residentially and occupationally independent; we reached 152 individuals surpassing our goal. We have helped to refer many more individuals to mental health care than any year before and are proud that we are able to assist our families with this support so successfully. Lastly we have found permanent housing for 42% of the individuals who we served.
Name of program/activity/initiative	Modified Recuperative Care and Emergency Shelter – Tracy Community Connections Center
Description	Tracy CCC's Modified Recuperative Care & Emergency Shelter Program provides case management and temporary, motel-based shelter to persons experiencing homelessness who are in need of a place to recover after being discharged from our local Sutter Hospital as well as temporary, motel-based emergency shelter for persons either experiencing homelessness or who are at risk of homelessness to better connect them with shelter, housing and supportive services. Sutter also provides support for our shower and laundry programs and for operations and outreach.
Goals	To provide: <ul style="list-style-type: none"> • Provide case management by 3 case managers, Monday-Friday, 8:00am-4:30pm • Recuperative Care Monday – Sunday 24 hours, seven days a week • Showers and hygiene supplies with our mobile shower unit twice per week, Mondays at and Thursdays at New Heart Church • Laundry services to the homeless at a local laundromat manned

	<p>by volunteers.</p> <ul style="list-style-type: none"> • Emergency shelter, food, clothing and hygiene supplies to homeless individuals being discharged from the hospital. • Housing solutions, emergency shelter, outreach supplies (via Operation Helping Hands), food, client assistance, transportation and automobile repair for homeless individuals in the community
Outcomes	<ul style="list-style-type: none"> • 2019: Served 167 individuals, 21 services provided, 1,337 service referrals. • 2020: Served 641 individuals, 4,428 services provided, 602 service referrals. • Jan-June 2021: Served 276 individuals, 1,581 services provided, 1,448 service referrals. • TCCC has showers and laundry services available to the homeless twice a week, as well as Community Medical Center, coming out to our Mobile Showers on Mondays to provide flu shots, and address other medical concerns for the homeless individuals. This has been exceedingly successful. The new temporary location for our shower program is central to other essential services that provide basic needs like public transportation, food, and it is in the vicinity of one of the larger homeless encampments in Tracy, making it easy for the homeless to get to TCCC.

OBESITY/HEALTHY EATING, ACTIVE LIVING/DIABETES

Name of program/activity/initiative	Boys & Girls Club’s Health, Well-Being, and Inclusion Program
Description	Triple Play is a program that addresses the health, wellness and fitness needs of the youth in the Boys & Girls Clubs community including youth with disabilities. Youth receive regular physical activity, access to fresh fruits/vegetables and daily healthy meals.
Goals	Program Goals (1): In 12 months 80% (112/140) of participants will engage in physical activity FIVE days a week with CDC goal of 60 minutes of activity per day. (2): In 12 months 80% (12/15) of regular attending Inclusion youth will engage in physical activity for 3 days per week. (3): In 12 months 80% (112/140) of participants will have access to clean water and 3 or more fruits and vegetables per day.
Outcomes	<ul style="list-style-type: none"> • 2019 – Served 280 children and youth. • 2020 – Served 280 children and youth and 500 families; 8,640 services to connect them to basic needs. • Jan-June 2021 – Served 140 children and youth; 1,000 services to connect them to basic needs; • "During Zoom, members became aware that other members were eating healthy snacks and due to positive dialogue of the benefits of eating healthy foods and encouraging members to be their best selves, all members on the chat Intentionally

	<p>began to eat healthy snacks". -Lisa Frymyer, Central Unit Director</p> <ul style="list-style-type: none"> Member's endurance during Triple Play improved. One member became very proud that he could complete the work-out after a couple of weeks. He said "wow I worked out the entire time without stopping".-Central Member
Name of program/activity/initiative	Tracy Family Resource Center
Description	<ul style="list-style-type: none"> The Tracy Family Resource Center (TFRC) helps families build protective factors including child development knowledge, parent/youth resilience, and access to concrete supports primarily through parent skill building, resource referral, and working with other organizations to improve service access. The TFRC focuses its work around five categories of service: outreach, healthcare, parenting classes and resources, counseling, and housing safety and security.
Goals	<ul style="list-style-type: none"> The mission of the Community Partnership for Families of San Joaquin (CPFSJ) is to provide tools, resources, and connections to help families improve their quality of life. CPFSJ's TFRC works with the public and private sector to help families achieve the following goals: <ol style="list-style-type: none"> Engage parents, youth, and appropriate service provider(s) in a multi-disciplinary step-by-step approach to untangling interrelated crises and risks, while also building protective factors that help prevent future crises. Involve families and youth in building nurturing and thriving neighborhoods and communities Connect low-income and under-served families with community resources that help prevent crisis.
Outcomes	<ul style="list-style-type: none"> 2019: 4,878 individuals served; 4,708 services provided; 3,815 service referrals, 579 obtained basic needs; 10,000 pounds of food distributed. 2020: 1,400 individuals served; 1,410 services provided; 2,678 service referrals, 76 obtained basic needs; 50,000 pounds of food distributed. Jan-June 2021: 1,032 individuals served; 275 services provided; 862 service referrals; 95,835 pounds of food distributed.

ACCESS TO CARE

Name of program/activity/initiative	Community Medical Centers Care Link Program
Description	Care Link will improve access to healthcare for homeless patients during the grant period by providing no-cost medical care, and follow-up appointments to medical, dental and other services at CMC clinic sites.
Goals	Provide medical care to homeless individuals through the Care Link program, including providing follow-up medical, dental, behavioral

	<p>health and case management services. Increase the number of uninsured patients linked to Medi-Cal eligibility and enrollment assistance.</p> <p>Provide case management to at least 50 individuals, making referrals and connections for enabling services.</p>
Outcomes	<ul style="list-style-type: none"> • 2019: served 1,911 adults, provided 1,122 services such as PCP appointments and nurse assessments; provided 1,588 service referrals. • 2020: 423 total outreaches. • 2021: 605 total outreaches; 2,637 total encounters including nearly 1,000 COVID tests. Total of 308 new patients reached who had never been seen at a CMC clinic.
Name of program/activity/initiative	Catholic Charities Homecoming Program
Description	Homecoming Program, is a transitional care program that bridges the gap between a hospital discharge and a strong recovery. The program assists at-risk patients to return home with increased stability through services that include follow-up care with primary physicians and case management.
Goals	Actively provide care management and services to patients discharged from the hospital as they return home to help stabilize and achieve optimal recovery.
Outcomes	<ul style="list-style-type: none"> • 2019: 106 individuals served including 70 services provided; 386 referrals to other services. • 2020: 68 individuals served including 46 services provided; 250 referrals to other services. • Jan-June 2021: 17 individuals served including 37 services provided; 91 referrals to other services. • Transitional Care Specialist received a referral from a social worker at Sutter Tracy Community Hospital. The patient lives with her sister but the family reported that they were overwhelmed with the new healthcare diagnosis. A phone call was placed to the patient's sister to inform her of the program services available to assist. Both the patient and his sister were agreeable to the services. According to the client "it was the help that we were looking for". Transitional Care Specialist conducted the initial phone screening interview and completed the program intake form to determine the needs associated with this case. A referral was placed to All Ways Caring for the patient to receive four weeks of homemaking services. This service assist clients at home with light housekeeping, laundry, transportation and meal prepping. All Ways Caring also provides assistance for the family, such as respite care. The client was also referred to the Linkages program and submitted to the San Joaquin County Human Services Agency for the patient to receive long-term case management and assistance

with resources needed. Referral to IHSS was completed and submitted for the patient to receive long-term caregiving services through the San Joaquin County Human Services Agency. An E-mail was submitted to MedData to follow up on patient's Medi-Cal transfer out of county status. A new Medi-Cal application was submitted and the patient was able to obtain local Medi-Cal benefits. By providing the client these services, we were able to improve his health and well-being. The client has avoided any new readmissions and is appreciative of services provided by the Homecoming Program.

- The Homecoming Project received a referral for an 88 year old female with a history of chest pains. Patient lives alone and lacked transportation and family support. Transitional Care Specialist (TCS) contacted client to inform her of program services and client was appreciative of services being provided. TCS was able to complete phone screening and obtain necessary information to assist client. Client was referred to All Ways Caring to receive up to four weeks of services which will assist at home with any light housekeeping and transportation needs. Client was also referred to Catholic Charities - Senior Assisted Transportation program to provide long term transportation assistance. Client did not have a reliable source of transportation to obtain her medications so TCS was able to coordinate services with Rx Express to have medications delivered to client's home. In order to access long term case management services, client was referred to Linkages with the San Joaquin County Human Services Agency. The client was closely monitored by our TCS for four weeks and determined that her social and health obstacles were vanishing due to the improvement of social/ health aspects. The client is now independent and able to maintain a healthy lifestyle.

VIOLENCE/INJURY PREVENTION

Name of program/activity/initiative

Tracy Seniors Association COVID Prevention

Description

Goals

To prevent keep low income seniors from contracting the COVID virus and reduce hospitalization by keeping them safe at home and supplied with the necessities to thrive.

Outcomes

- Jan-June 2021: 137 individuals served; 39 direct services provided.
- The impact was immediate - seniors were so grateful and it helped them to remain safe home during the Stay at Home order as they didn't need to go out to get food and supplies. We offered to schedule and transport seniors to get their COVID shot during this period - the seniors that took advantage

of our help to schedule and transport to get the vaccine were homebound without family to help; we believe that without the COVID relief program they may have been unvaccinated and possibly even hospitalized.

- TSA achieved our goal to provide food, paper products and sanitizing products to low income seniors during the COVID crisis where there were Stay at Home orders. The program grew from 125 to 137 seniors attributed to word of mouth. While contacting our list of seniors to arrange monthly supply delivery, we identified that some seniors that were unable to make their own COVID vaccination appointments or obtain transportation to the appointments. We were able to expand the program to also include reserving COVID vaccination appointments and providing transportation to those that needed it. We were able to help approximately 22 seniors out of our list of 137 get their COVID vaccinations.
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Name of program/activity/initiative

Women's Center - Youth & Family Services, Serenity House

Description

Serenity House is a 12-bed undisclosed emergency shelter for domestic violence victims and their children, and in special circumstances victims of sexual assault and/or sex trafficking. The shelter provides a safe haven and free, confidential services to victims in crisis, giving them safety, meeting their basic needs, and helping them create safety plans to keep them safe in a future emergency. Victims also have access to counseling to help them heal from their trauma, learn to express their emotions in healthy ways, build their self-confidence, and improve their ability to communicate. Serenity House is expected to shelter and serve at least 90 victims annually.

Goals

Individuals and families fleeing violence have access to a safe environment and comprehensive services to help them heal from their trauma and build resiliency. Shelter and comprehensive services are aimed at reducing - and ultimately ending - the cycle of domestic violence and building healthier families and a safer community.

Outcomes

- 2019: 191 individuals served; 1,712 services provided; 122 service referrals.
 - Jan-June 2021: 30 individuals served; 613 services provided; 9 service referrals.
 - During the first half of 2021, WCYFS provided 30 individuals (adults and children) shelter services. In addition, WCYFS provided comprehensive, wraparound services to each of these shelter residents and their families, including crisis intervention, peer counseling, educational support groups, clinical therapy, life skills training, mentoring and case management. As a result, participants have increased well-being, emotional stability, awareness of domestic violence risk factors and signs, and self-esteem.
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