


2016 Community Health Needs Assessment

Sutter Health Memorial Medical Center
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Approved by Sutter Health Valley Area Board of Directors
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To provide feedback about this Community Health Needs Assessment, email SHCB@sutterhealth.org

CHNA REPORT FOR SUTTER HEALTH MEMORIAL MEDICAL CENTER

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Sutter Health Memorial Medical Center (SHMMC) has conducted CHNAs in previous years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

B. Summary of Prioritized Needs

This report provides an overview of the significant health needs in the SHMMC service area. Through a prioritization process with SHMMC leadership that was informed by secondary data, Stanislaus County stakeholders, and community members participating in focus groups, nine identified health needs were prioritized into low, medium and high priority:

- High priority: Obesity/HEAL/Diabetes, Mental Health, Access to Care
- Medium priority: Cancers, CVD/Stroke, Substance Abuse/Tobacco
- Low priority: Asthma, Violence/Injury Prevention, Economic Security

C. Summary of Needs Assessment Methodology and Process

SHMMC partnered with Kaiser Foundation Hospital (KFH) Modesto to conduct this CHNA. All secondary data cited in the CHNA report comes from the Community Commons (www.communitycommons.org) data platform. The data platform contains over 150 publically available indicators for Stanislaus County mapped to one or more potential health needs. Indicators from the data platform were reviewed and potential health needs that benchmarked poorly compared to state averages were identified. Stakeholder interviews with those having special knowledge of health needs, health disparities, and vulnerable populations provided information that increased the understanding of the health needs in the SHMMC service area. Community residents who participated in focus groups provided additional insights into the priority health needs in the SHMMC service area. Once secondary and primary data were collected and analyzed, a prioritization process involving SHMCC leadership ranked the health needs. The prioritization process was informed by the secondary and primary data. Each need received a numerical score, which was the average score from secondary data, primary data and disparities. The next step in this process will be to develop an Implementation Strategy for addressing selected health needs, which will build on SHMMC's assets and resources, as well as evidence based strategies.

II. INTRODUCTION/BACKGROUND

A. About Sutter Health

SHMMC is affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, Sutter Health is creating a more integrated, seamless and affordable approach to caring for patients.

SHMMC's mission is to provide high-quality, compassionate care to each patient, while exercising prudent fiscal responsibility. SHMCC is a not-for-profit organization that exists to maintain and improve the health status of the citizens of greater Stanislaus County. Selected services are extended to other communities whenever this will meet a critical need and when it will enhance the productivity of local

resources. We pursue this mission by providing and promoting effective health care services and by fostering an integrated system of care for payers. Access is provided to a full continuum of care, built upon a core of sophisticated hospital-based services.

Over the past five years, Sutter Health has committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2014 commitment of $767 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- To provide care to Medi-Cal patients in 2014, Sutter Health invested $535 million more than the state paid. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.
- In 2014, Sutter Health's commitment to delivering charity care to patients was $91 million. Our charity care investment represented an average of nearly $1.8 million per week.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. We also support children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local health care priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and addresses real community needs.

B. About Sutter Health Memorial Medical Center Community Benefit

SHMMC has a long tradition of working to improve the health of the communities we serve through our community benefit activities and programs. These efforts are based on needs identified through a Community Health Needs Assessment, conducted once every three years. We conduct Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change and deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for SHMMC are available publicly at http://www.memorialmedicalcenter.org/about/community-benefit.html.

D. Sutter Health Memorial Medical Center's Approach to Community Health Needs Assessment

SHMMC has previously conducted CHNAs. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency. From data collection and analysis to the identification of prioritized needs and the development of an Implementation Strategy, the intent was to develop and implement a transparent, rigorous, and when possible, collaborative approach to understanding the needs and assets in our communities to yield meaningful results.

SHMMC's approach to CHNAs included reviewing secondary data from the publically available, web-based Community Commons data platform. The data platform provides access to a core set of approximately 150 indicators for Stanislaus County to understand health through a framework that

includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition, SHMMC collaborated with KFH Modesto, to collect primary data through key informant interviews and focus groups. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included identification of existing community assets and resources to address the health needs.

A set of criteria was developed to determine what constituted a health need in Stanislaus County. Once all of the community health needs were identified, they were prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, SHMMC will develop an Implementation Strategy for the priority health needs the hospital will address. These strategies will build on SHMMC's assets and resources, as well as best practice strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, http://www.memorialmedicalcenter.org/about/community-benefit.html.

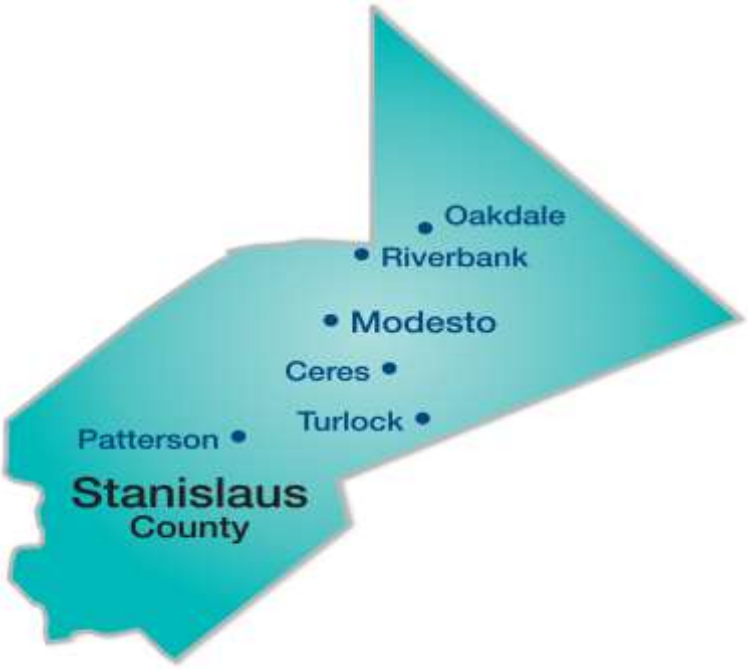
III. COMMUNITY SERVED

A. Sutter Health Memorial Medical Center's Definition of Community Served

SHMMC defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and Description of Community Served

i. Map



ii. Geographic description of the community served (towns, counties, and/or zip codes)

SHMMC is located at 1700 Coffee Rd, Modesto, CA 95355 and its service area includes the cities of Ceres, Hughson, Modesto, Newman, Oakdale, Patterson, Riverbank, Turlock, and Waterford. The service area includes all of Stanislaus County, making Stanislaus County data a good proxy for data for the SHMMC service area.

iii. Demographic profile of community served

The demographics of a community significantly impact its health profile. Different ethnic, age, and socioeconomic groups may have unique needs and take varied approaches to health. This section provides an overview of the demographics of Stanislaus County, with comparisons to California and the United States for reference. All estimates are sourced from the U.S. Census Bureau's American Community Survey, 2009-13.

Demographic Data	
Total Population	518,321
White	76.51%
Black	2.82%
Asian	5.28%
Native American/ Alaskan Native	0.82%
Pacific Islander/ Native Hawaiian	0.74%
Some Other Race	9.49%
Multiple Races	4.35%
Hispanic/Latino	42.5%

Socio-economic Data	
Living in Poverty (<200% FPL)	44.19%
Children in Poverty	28.34%
Unemployed	10.4
Uninsured	17.84%
No High School Diploma	23.59%

Total Population

The total population for Stanislaus County is 518,321. Stanislaus County's population density is much higher than California.

Table A: Total Population

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Stanislaus County, CA	518,321	1,494.37	346.85
California	37,659,180	155,738.02	241.81
United States	311,536,591	3,530,997.6	88.23

Total Population by Age Groups, Percent

Stanislaus County has a slightly younger population than California. A greater percentage of children age 0-17 live in Stanislaus County compared to the state. A slightly lower percentage of adults age 45-65 live in Stanislaus County compared to California overall.

Table B: Total Population by Age Groups, Percent

Report Area	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65
Stanislaus County, CA	7.64%	20.58%	10.48%	13.73%	12.83%	13.26%	10.43%	11.04%
California	6.71%	17.83%	10.52%	14.39%	13.73%	13.9%	11.1%	11.81%
United States	6.44%	17.28%	9.97%	13.39%	13.12%	14.29%	12.08%	13.43%

Total Population by Race Alone, Percent

Over 76% of the population in Stanislaus County is White compared to 62% for California. Stanislaus County has fewer Blacks and far fewer Asian residents compared to the state (2.82% vs 5.99% and 5.28% vs. 13.29% respectively).

Table C: Total Population by Race Alone, Percent

Report Area	White	Black	Asian	Native American / Alaska Native	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
Stanislaus County, CA	76.51%	2.82%	5.28%	0.82%	0.74%	9.49%	4.35%
California	62.31%	5.99%	13.29%	0.76%	0.39%	12.93%	4.32%
United States	74.02%	12.57%	4.89%	0.82%	0.17%	4.73%	2.8%

Total Population by Ethnicity Alone, Percent

A greater percent of the population in Stanislaus County is Hispanic or Latino (42.5%) compared to California (37.89%).

Table D: Total Population by Ethnicity Alone

Report Area	Total Population	Hispanic or Latino Population	Percent Population Hispanic or Latino	Non-Hispanic Population	Percent Population Non-Hispanic
Stanislaus County, CA	518,321	220,267	42.5%	298,054	57.5%
California	37,659,180	14,270,345	37.89%	23,388,836	62.11%
United States	311,536,608	51,786,592	16.62%	259,750,000	83.38%

Key Drivers of Health

Three indicators were determined to be the most powerful predictors of population health and facilitate identifying communities with the most significant health needs: poverty rate, percent of population uninsured, and proportion of adults without a high school diploma. Low-income, uninsured, and undereducated people have been found to be most at risk for poor health status. These key drivers are important to identifying areas likely to have the greatest health disparities.

Poverty - Population Below 100% FPL

This indicator reports the percentage of the population living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access (including health services, healthy food, and other necessities) that contribute to poor health status.

A greater percent of the population in Stanislaus County live in poverty (20.34%) compared to California (15.94%).

Table E: Population Below 100% FPL

Report Area	Total Population	Population in Poverty	Percent Population in Poverty
Stanislaus County, CA	512,206	104,173	20.34%
California	36,913,404	5,885,417	15.94%
United States	303,692,064	46,663,432	15.37%

Insurance - Uninsured Population

This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

A greater percent of the population in Stanislaus County are uninsured (17.84%) compared to California (17.78%). A 2011 report by the Public Policy Institute of California estimated that 7.6% of the Stanislaus County population was undocumented. Undocumented residents wouldn't be captured in the uninsured population therefore potentially masking an even greater need.

Table F: Uninsured Population

Report Area	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Stanislaus County, CA	514,872	91,838	17.84%
California	37,130,876	6,601,519	17.78%
United States	306,448,480	45,569,668	14.87%

Education - Less than High School Diploma (or Equivalent)

This indicator reports the percentage of the population age 25 and older without a high school diploma (or equivalency) or higher. This indicator is relevant because educational attainment is a key driver of population health.

A greater percent of the population in Stanislaus County age 25 and older do not have a high school diploma (23.59%) compared to California (18.76%).

Table G: Less than High School Diploma (or Equivalent)

Report Area	Total Population Age 25	Population Age 25 with No High School Diploma	Percent Population Age 25 with No High School Diploma
Stanislaus County, CA	317,714	74,947	23.59%
California	24,455,010	4,587,281	18.76%
United States	206,587,856	28,887,720	13.98%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

SHMMC collaborated with KFH Modesto to complete the assessment.

B. Other partner organizations that collaborated on the assessment

No other partner organizations collaborated on the assessment.

C. Identity and qualifications of consultants used to conduct the assessment

Ad Lucem Consulting

SHMMC contracted with Ad Lucem Consulting, a public health consulting firm, to conduct the CHNA. Ad Lucem Consulting specializes in initiative design, strategic planning, grants management

and program evaluation, tailoring methods and strategies to each project and adapting to client needs and priorities, positioning clients for success. Ad Lucem Consulting works in close collaboration with clients, synthesizing complex information into easy-to-understand, usable formats, bringing a hands-on, down to earth approach to each project. Ad Lucem Consulting supports clients through a variety of services that can be applied to a range of issues.

Ad Lucem Consulting has developed CHNA reports and Implementation Plans for hospitals including synthesis of secondary and primary data, needs prioritization, and identification of assets and implementation strategies.

To learn more about Ad Lucem Consulting please visit www.adlucemconsulting.com.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary data

i. Sources and dates of secondary data used in the assessment

SHMMC used the Community Commons data platform to review over 150 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. For details on specific sources and dates of the data used, please see Appendix A.

ii. Methodology for collection, interpretation and analysis of secondary data

All secondary data cited in this CHNA report comes from the Community Commons data platform. The SHMMC service area includes a large portion of Stanislaus County, making Stanislaus County data a good proxy for data for the Service Area.

The data platform identifies 14 major health needs. For each need, the data platform includes core and related indicators. Core indicators are a direct measure of the health need. Related indicators are upstream "drivers" that influence the potential health need. For example, in the Obesity/HEAL/Diabetes health need, overweight and obesity are core indicators and fruit and vegetable consumption and physical inactivity are related indicators.

Using a scoring rubric developed by Kaiser Permanente, core and related indicators were assigned a score of 0-2 depending on how the indicator benchmarked to the state average. A potential health need score was then calculated as the average of all point values assigned to both core and related indicators within the health need. The 14 health needs were ranked according to health need score.

Race and ethnicity data were reviewed for all health needs and indicators (when available). The number of groups experiencing disparities for each indicator was noted in the secondary data review process.

B. Community input

i. Description of the community input process

Community input was provided by a broad range of community members through key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from local public health departments as well as leaders, representatives, or members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

ii. Methodology for collection and interpretation

To obtain community members perspectives on the most pressing health issues facing their communities, in-depth stakeholder interviews with community leaders and focus groups with community residents were conducted in August and September 2015. The goal of the interviews and focus groups was to supplement the findings from the secondary data in order to identify the priority health needs in Stanislaus County, the populations most impacted and the community assets and resources available to address the health needs.

Stakeholder Interview Methodology

Ad Lucem Consulting conducted stakeholder interviews with seven individuals representing a diversity of sectors including: public health, community based organizations, safety net, education and government. The stakeholders were identified by SHMMC and KFH Modesto staff.

All interviews were conducted by telephone in English and took approximately 30-45 minutes to complete. The interviews followed a standard set of interview questions and the interviewer took detailed notes during the call. At the beginning of the interview, confidentiality was assured and the respondents were invited to skip questions not applicable to the respondent's experience.

Interview topics: Interview questions were developed by Ad Lucem Consulting with input from SHMMC and KFH Modesto. For the complete list of interview questions, see Appendix C. Questions addressed the following topics:

1. Top three health issues in Stanislaus County
2. Factors that contribute to the top health issues
3. Impacts on specific populations (e.g. low income, racial/ethnic subpopulations)
4. Successful strategies and community assets to address top health issues
5. Opportunities and role for community and SHMMC to address top health issues

Data Analysis: Upon completion of each interview, responses were grouped by question and analyzed for common themes across all respondents. Data were then coded and a set of relevant themes selected. The codes were subsequently quantified and tallied for their presence in response to each question. The number of times each theme occurred was tabulated. The most prominent themes were identified and included in each relevant topic area in the Health Needs Profiles and used to inform both the identification and health need prioritization process.

Focus Group Methodology

Ad Lucem Consulting conducted eight community resident focus groups in five different geographic areas within the SHMMC service area, including Ceres, Patterson, Turlock, Hughson and Modesto. Four groups were conducted in Spanish, three were conducted in English and one was conducted in Spanish and English. Participants were male and female adults who represented underserved, low-income, and varied ethnic communities. Population groups represented included Promotores, community service agency clients, and older adults.

Participants were recruited from communities throughout the SHMMC service area. SHMMC and KFH Modesto staff recruited participants and organized logistics for the focus groups, including providing incentives and refreshments. Each focus group session averaged 90 minutes and was facilitated by Ad Lucem Consulting. All focus groups were recorded and the moderator or co-moderator took notes. Community resident participants were provided with a meal or snack and received a gift card in appreciation of their participation.

Focus group question guide: A focus group guide was used to ensure consistency across groups. The focus group questions were developed by Ad Lucem Consulting with input from SHMMC and

KFH Modesto. Questions were open-ended and additional probing questions were used as needed to elicit more in-depth responses and richer details. The questions were translated into Spanish by a native Spanish-speaker experienced in translation; the guide was modified slightly to maintain question flow and intent in Spanish. At the beginning of each focus group session, participants were welcomed and assured anonymity of their responses and identity. An overview of the discussion was provided as well as a review of discussion ground rules, such as "there are no right or wrong answers." For the complete list of focus group questions, see Appendix D. Questions addressed the following topics:

1. Vision for a healthy community
2. Top three health issues in Stanislaus County
3. Factors that contribute to the top health issues
4. Successful strategies and community assets to address top health issues and resources needed
5. Opportunities to engage community members in creating a healthy community

Data Analysis: Audio recordings of the focus groups were transcribed verbatim by a professional transcription company. Responses were analyzed by key questions and themes were identified and coded across focus groups in a systematic manner. In reporting the results, care was taken to ensure that the views of the participants were voiced. The most prominent themes were identified and included in each relevant topic area in the Health Needs Profiles and used to inform both the identification and health need prioritization process.

C. Written comments

SHMMC requested written comments from the public on its 2013 Community Health Needs Assessment and most recently adopted Implementation Strategy through http://www.memorialmedicalcenter.org/about/community-benefit.html. At the time of the development of this CHNA report, SHMMC had not received written comments. However, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community we serve for the 2016 CHNA through key informant interviews and focus groups. SHMMC will continue to use its website as a tool to solicit for public comments, and ensure that these comments are considered community input in the development of future CHNAs.

D. Data limitations and information gaps

The Community Commons data platform includes secondary indicators for Stanislaus County that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying community health needs

i. Definition of "health need"

For the purposes of the CHNA, SHMMC defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the

comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

The following criteria were used to identify the community health needs for the SHMMC service area:

- The health need fits the SHMMC definition of a "health need" as described above.
- The health need was confirmed by multiple data sources (i.e., the health need was identified in both secondary and primary data).
- Indicator(s) related to the health need performed poorly against a defined benchmark (e.g. state average). Those that either exceeded state averages or were much lower than state averages were determined to be a health concern for SHMMC.
- The community prioritized the health need. A health need was prioritized based on the frequency with which stakeholders and focus groups mentioned the need. A need was only included in the final list of health needs if at least three stakeholders and focus groups identified it as a need.

The following methods were used to identify the community health needs for SHMMC:

- A health needs identification table was developed which included all core and related indicators that benchmarked poorly to the state. Race and ethnicity data were reviewed (when available) to identify all indicators for which disparities existed. The number of groups experiencing disparities for a given indicator was noted and addressed during prioritization. Primary data were reviewed and health needs that were not mentioned in primary data collection were not included as a health need.
- AIDS/HIV/STD, maternal child health, climate and health, and oral health indicators performed poorly against state averages in secondary data, however they were not mentioned in primary data collection and therefore were not included as health needs for the SHMMC service area in this CHNA.

Nine health needs met the above criteria:

- Obesity/HEAL/Diabetes
- CVD/Stroke
- Mental Health
- Access to Care
- Economic Security
- Violence/Injury Prevention
- Asthma
- Cancers
- Substance Abuse/Tobacco

B. Process and criteria used for prioritization of the health needs

The following steps were taken to determine the preliminary ranking for prioritizing health needs:

- Step 1: A prioritization matrix (Table H) was developed with rows for each health need and columns listing health need scores for secondary data, primary data, and ethnic/racial disparities (based on secondary data).
- Step 2: A scoring rubric was applied to each data type (see tables I, J and K below) to calculate a numerical score for the data type.

- Step 3: Scores were averaged across data types for each health need to calculate an overall health need score.
- Step 5: Health needs were rank ordered by score.

Table H: Prioritization Matrix

Health Need	Secondary Data Score	Primary Data Score	Disparities Score	Average
1. HEAL, Obesity, Diabetes	1.04	1.73	2	1.59
2. CVD/Stroke	1.25	0.66	2	1.30
3. Mental Health	0.67	1.13	2	1.27
4. Access to Care	1.17	1.2	1	1.12
5. Economic Security	1	0.33	2	1.11
6. Violence/Injury Prevention	1.07	0.2	2	1.09
7. Asthma	1.33	0.73	1	1.02
8. Cancers	0.83	0.4	1	0.74
9. Substance abuse/Tobacco	0.67	0.46	0	0.38

Secondary Data scoring

Secondary data scores were taken from the Community Commons data platform. The health need score is the average of all point values assigned to both core and related indicators within the potential health need.

Table I: Secondary Data scoring

Health Need	Health Needs Score
HEAL, Obesity, Diabetes	1.04
CVD/Stroke	1.25
Mental Health	0.67
Access to Care	1.17
Economic Security	1
Violence/Injury Prevention	1.07
Asthma	1.33
Cancers	0.83
Substance Abuse/Tobacco	0.67

Primary Data scoring

In order to determine the relative importance of health needs according to the community input, a high, medium or low designation was applied to each of the health needs. A health need received a “high” designation if the stakeholder or focus group (as a whole) identified it as one of the top three health needs for Stanislaus County. A health need received a medium designation if it was mentioned but not identified as one of the top three health needs. A health need received a low designation if it was not mentioned by a stakeholder or a focus group. There were a total of 15 primary data sessions (seven stakeholder interviews and eight focus groups).

To calculate a primary data score for each health need, a point value was assigned to each of the designations as follows:

- High 2 Points
- Medium 1 Point
- Low 0 Points

Low scores were excluded from Table J because they received 0 points and did not impact the overall score.

To get an average score for a health need, the point values for the high and medium designations were calculated and summed and then averaged over the total number of stakeholders/focus groups.

Table J: Primary Data scoring

Health Need	High		Medium		Total Score	Average score (total score/15)
	# of sessions assigning a "High" designation	Points	# of sessions assigning a "Medium" designation	Points		
HEAL, Obesity, Diabetes	12	24	2	2	26	1.73
Mental Health	8	16	1	1	17	1.13
Access to Care	7	14	4	4	18	1.20
Violence/Injury Prevention	2	2	1	1	3	0.20
Substance Abuse/Tobacco	3	6	1	1	7	0.46
Economic Security	2	4	1	1	5	0.33
Asthma	2	4	7	7	11	0.73
Cancer	2	4	2	2	6	0.40
CVD/Stroke	3	6	4	4	10	0.66

Disparities scoring

The secondary data revealed that certain ethnic/racial groups had worse health outcomes when compared to the county overall. With the exception of Substance Abuse/Tobacco, all health needs had a least one core or related indicator where ethnic/racial disparity data were available. Because there were no disparities data available for Substance Abuse/Tobacco, that health need received a disparities score of zero, which may not accurately reflect true disparities. Disparities scores were assigned based on the number of ethnic/racial groups that had disparities for core and related indicators for each health need. These data are limited by availability of disparities data but it is important to consider ethnic/racial disparities during health need scoring as disparities paint a more detailed picture of the need in a community and how specific groups of people may be disproportionately impacted by certain health needs

Point values were assigned as follows:

- 0 = No disparities and/or no disparity data among any groups in core or related indicators
- 1 = One-two groups had disparities in at least one core or related indicator
- 2 = 3 or more groups had disparities in at least one core or related indicator

Table K: Disparities scoring

Health Need	Disparities Score
HEAL, Obesity, Diabetes	2
CVD/Stroke	2
Mental Health	2
Access to Care	1
Economic Security	2
Violence/Injury Prevention	2
Asthma	1
Cancers	1
Substance Abuse/Tobacco	0

Prioritization Process

A multi-voting method was used to prioritize the nine identified health needs as high, medium or low priorities. In addition to the prioritization matrix, participants (SHMMC leadership) were asked to consider the following criteria when prioritizing health needs:

- Severity of the issue
- Opportunity to intervene at the prevention level
- Existing resources dedicated to the issue
- Effective and feasible interventions exist

Participants in this process included the Chief Executive Officer, Chief Medical Officer, Chief Nurse Executive, Director of Philanthropy, Director of Marketing, Assistant Manager of Community Benefit, Outreach Coordinator and a licensed clinical social worker.

Participants took part in two rounds of voting to prioritize the nine health needs. For the first round, all nine health needs were listed and participants voted for their top three priority health needs. The three needs that received the most votes were identified as high priority health needs. The same voting process was used for round two: participants voted for their top three priority health needs among the remaining six health needs. The three health needs that received the most votes were identified as medium priority health needs. The remaining three needs were identified as low priority health needs.

C. Prioritized description of all the community health needs identified through the CHNA

As a result of this prioritization process, the health needs were grouped into high, medium, and low priority. (Detailed profiles of each health need are found in Appendix E.)

High priority

- **Obesity/HEAL/Diabetes**: A lifestyle that includes healthy eating and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly and life-threatening health outcomes such as obesity, diabetes, cardiovascular disease, and strokes. Obesity rates, diabetes prevalence and related hospitalizations were higher in Stanislaus County as compared to the state. Obesity was the most frequently cited health concern among stakeholders and focus groups. Lack of access to healthy food and safe places for physical activity were frequently mentioned as barriers in primary data and confirmed by secondary data.

- **Mental Health**: Mental health and well-being is essential to living a meaningful and productive life. Mental health and well-being provides people with the necessary skills to cope with and move on from daily stressors and life's difficulties allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. Access to mental health providers is limited in Stanislaus County. Compared to the state average of 157 mental health providers per 100,000 population, in Stanislaus County there are 61.9 providers per 100,000 population. Primary data described that low-income individuals are particularly impacted by high levels of stress due to lack of employment, education and housing opportunities. Non-Hispanic White, Asian and Native Hawaiian/Pacific Islander populations in Stanislaus County are disproportionately affected by suicide.
- **Access to Care:** Access to high quality, culturally competent, affordable healthcare and health services is essential to the prevention and treatment of morbidity and increase the quality of life, especially for the most vulnerable. In Stanislaus County, residents have less access to dentists, primary care providers and mental health providers as compared to the state. Secondary data revealed that health care access is a particular concern for low-income populations and those without health insurance. Lack of transportation, long wait times, difficulty scheduling appointments, language issues, and poor quality of care were frequently discussed by stakeholders and in the focus groups.

Medium priority

- **Cancers**: Screening and early treatment of cancers saves and prolongs lives. Additionally, preventive measures and reducing behavioral risk factors (e.g., obesity, physical inactivity, smoking, and UV light exposure) can be effective at reducing the incidence of cancer. Overall cancer mortality and colon/rectum and lung cancer incidence rates are greater in Stanislaus County as compared to the state. Whites are disproportionately impacted by lung cancer. Obesity, physical inactivity and poor air quality were identified by stakeholders and in the focus groups as contributors to cancer.
- **CVD/Stroke:** In the United States, cardiovascular disease is the leading cause of death and strokes are the third leading cause of death. These diseases can be prevented and managed through early adoption of healthy behaviors including physical activity, not smoking, and healthy eating. The rate of heart disease and stroke mortality in Stanislaus County is higher than the state average. Ethnic/racial groups are disproportionately affected by heart disease and stroke; non-Hispanic blacks have over twice the prevalence of heart disease as compared to the county. Lack of access to safe parks, low cost exercise opportunities, and high rates of obesity and overweight were frequently cited as contributing factors by stakeholders and in the focus groups.
- **Substance Abuse/Tobacco:** Reducing tobacco use and treating/reducing substance abuse improves quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Tobacco usage is higher in Stanislaus County than the state. The prevalence of drugs in local parks, particularly among the homeless population, was frequently mentioned in primary data, as was the intersection of substance abuse, poverty and mental illness.

Low priority

- **Asthma:** Prevention and management of asthma by reducing exposure to triggers such as tobacco smoke and poor air quality improves quality of life and productivity as well as reduces the cost of care. Asthma prevalence and the hospitalization rate are greater in Stanislaus County than in the state. Many stakeholders agreed that asthma was a major health concern.
- **Violence/Injury Prevention:** Safe communities contribute to overall health and well-being.

Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Ethnic/racial groups are disproportionately affected by violence/injury; the homicide rate for blacks is over three times the rate for the county. Unsafe parks, homelessness, drugs and stray dogs were frequently mentioned in primary data as barriers to safety.

- **Economic Security:** Economic security contributes to good health. It facilitates access to healthcare services, healthy eating, and other factors that play a role in overall wellbeing. Stanislaus County benchmarks poorly compared to the state on all economic security indicators and there are a significant number of ethnic/racial disparities within the county. Black, Native American/Alaska Native and Hispanic/Latino populations are among those most impacted by poverty. Homelessness, lack of employment, food insecurity and poor educational attainment are connected with economic security and were mentioned as important issues by stakeholders and in the focus groups.

D. Community resources potentially available to respond to the identified health needs

i. Community resources

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
2-1-1	X	X	X	X	X	X	X	X	X
American Diabetes Association	X							X	
American Cancer Society									X
American Red Cross		X							
Behavioral Health and Recovery Services, Stanislaus County			X			X	X		
Boys and Girls Club	X		X			X	X		
CareMore exercise facilities	X							X	
Catholic Charities		X			X				
Center for Human Services	X		X					X	X
Church food banks	X				X			X	X
Community Hospice, Inc.			X						

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Community Housing & Shelter Services	X	X	X		X				
Community Services Agency	X	X	X	X	X	X	X	X	
Disability Resource Agency for Independent Living		X	X						
El Concilio	X	X			X				
Family Resource Centers	X	X	X		X	X	X	X	X
The First Tee Central Valley	X		X						
Food Banks	X				X			X	X
Haven's Women's Center of Stanislaus		X	X			X			
Healthy Aging Association	X	X		X				X	
Healthy Start Program	X	X	X	X	X	X	X		
Inter-Faith Ministries		X	X			X			
Mancini Senior Center	X		X					X	X
Parent Institute for Quality Education		X							
Parents United Inc.		X							
Salvation Army Modesto Corps		X	X			X			
Salvation Army Red Shield Center		X	X			X			
Salvation Army Turlock		X	X			X			

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
corps									
Second Harvest Food Bank	X				X				
Senior Citizens Center Modesto	X		X					X	X
Sierra Vista Child & Family Services	X	X	X			X			
STANCO Affordable Housing Corporation		X			X				
Stanislaus Literacy Center		X							
St. Vincent de Paul Society			X		X	X			
West Modesto King Kennedy Neighborhood collaborative	X	X	X		X				
United Samaritans Foundation	X	X							
United Way of Stanislaus County	X	X	X	X	X	X		X	X

ii. Health Care Facilities

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Doctor's Medical Center	X	X	X	X		X	X	X	X
Emanuel Medical Center, Inc.	X	X	X	X		X		X	X
Golden Valley Health Center – Corner of Hope	X	X	X	X		X		X	X
Golden Valley	X	X	X	X	X	X		X	X

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Health Center – Florida Suites									
Golden Valley Health Center – Hanshaw School	X	X	X	X	X	X		X	X
Golden Valley Health Center – Robertson Road School	X	X	X	X	X	X		X	X
Golden Valley Health Center – Tenaya	X	X	X	X	X	X		X	X
Golden Valley Health Center – Patterson	X	X	X	X	X	X		X	X
Golden Valley Health Center – Riverbank	X	X	X	X	X	X		X	X
Golden Valley Health Center – Turlock	X	X	X	X	X	X		X	X
Golden Valley Health Center – West Turlock	X	X	X	X	X	X		X	X
Golden Valley Health Center – Westley	X	X	X	X	X	X		X	X
Golden Valley Health Center - Ceres	X	X	X	X	X	X		X	X
Golden Valley Health Center - Newman	X	X	X	X	X	X		X	X
Golden Valley Health Center – West Modesto	X	X	X	X	X	X		X	X
Health Services Agency – Administrative Offices				X		X		X	
Health Services Agency - McHenry Medical Office		X							
Health Services Agency - Paradise		X							

	Obesity/ HEAL/ Diabetes	Access to Care	Mental Health	Asthma	Economic Security	Substance Abuse/ Tobacco	Violence/ Injury prevention	CVD/ Stroke	Cancers
Medical Office Urgent Care – Valley Family Medicine Residency of Modesto									
Health Services Agency - Pediatric		X							
Kaiser Permanente Modesto Medical Center	X	X	X	x		X		X	X
Memorial Medical Center	X	X	X	X		X	X	X	X
Oak Valley District Hospital	X	X	X	X		X		X	X
Stanislaus Surgical Hospital		X							

VII. SUTTER HEALTH MEMORIAL MEDICAL CENTER 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

Sutter Health Memorial Medical Center's 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on SHMMC's Implementation Strategy, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit http://www.memorialmedicalcenter.org/about/community-benefit.html. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by SHMMC in the 2013 Implementation Strategy report.

1. Access to Care – Lack of Healthcare Insurance
2. Access to Care – Healthcare Provider Shortage
3. Modifiable Risk Factors for Disease
4. Quality of Clinical Care – Chronic Disease Prevention and Control
5. Burden of Disease – Access to Mental Health and Behavioral Health Programs

SHMMC is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served,

collaborations and partnerships, and MMC in-kind resources. In addition, MMC tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, SHMMC had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, SHMMC will continue to monitor impact for strategies implemented in 2016.

B. 2013 Implementation Strategy Evaluation Of Impact Overview

In the 2013 IS process, SHMMC planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal MMC programs including charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **SHMMC Programs:** From 2014-2015, SHMMC supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:
    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. SHMMC provided services for Medicaid beneficiaries.
    - Financial Assistance Program: The Financial Assistance program at SHMMC provides financial assistance for emergency and medically necessary services, inpatient and outpatient care, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
    - Means Tested Program: The Means Tested program at Memorial provides healthcare services to low-income individuals and families who have no access to public or private health coverage programs.
    - Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.
    - Research: SHMMC contributes to research through support of a Tumor Registry to inform epidemiological research.
- **Grantmaking:** For 60 years, SHMMC has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015 SHMMC awarded 13 grants amounting to a total of $865,700 in service of 2013 health needs and 2 grants amounting to $490,000 in the Workforce area.

- **In-Kind Resources:** SHMMC's commitment to community health means reaching out far beyond our patients to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of MMC's approach to improving the health of all of our communities. In 2014-2015, SHMMC donated a variety of in-kind resources in service of 2013 Implementation Strategies and health needs, including community and non-profit use of the SHMMC Conference Center; trainings of nurses, radiology technicians and other medical providers on the SHMMC campus, and utilizing SHMMC personnel to provide expert health perspectives on community health issues. Other in kind donations included computers, medications for medical missions, bicycle helmets, and supplies for cancer patients.

- **Collaborations and Partnerships:** SHMMC has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, SHMMC engaged in partnerships and collaborations in service of 2013 Implementation Strategies with organizations including Modesto Junior College, Cal State University Stanislaus, Doctor's Medical Center, Stanislaus County Health Services Agency, the Public Health Department, Stanislaus County Parks & Recreation, Stanislaus County Office of Education, Modesto City Schools, City of Modesto, WellSpace, the Heart Coalition, and Boys and Girls Club.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

Sutter Health Memorial Medical Center Priority Health Need -- Access to Care: Lack of Healthcare Insurance

Long Term Goal: Improve access to insurance programs and basic primary care for our community.		
Intermediate Goal: Assist patients and community residents with accessing insurance options.		
Access to Care: Lack of Health Care Insurance – SHS Administered Program Highlights		
SHMMC Program Name	**SHMMC Program Description**	**Results to Date**
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. SHMMC provided services for Medicaid beneficiaries.	• SHMMC provided $40,492,102 for Medi-Cal in 2014. • There were 4,104 discharged Medi-Cal patients in 2014. • There were 4, 011 discharged Medi-Cal patients in 2015.
Financial Assistance Program	The Financial Assistance Program at SHMMC provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• SHMMC provided $36,016,306 for this program in 2014 and $13,859,865 for the program in 2015. • In 2014, there were 2,297 Financial Assistance patients served. • In 2015, there were 1,635 Financial Assistance Patients served.
Means Tested Program	Means Tested Programs provide health care services to low-income individuals and families who have no access to public or private health coverage programs.	• SHMMC provided $75,376 for this program in 2014. • One patient was served using the Means Tested Program; most participants were converted to the Covered California program.

Access to Care: Lack Health Care Insurance -- Grantmaking Highlights			
Summary of Impact: During 2014-2015, SHMMC paid for services totaling $1,357,949 to address the need of providing healthcare insurance to those without insurance in the SHMMC service area.[1]			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Diversified Health Care	$ 778,447 – 2014 $ 579,502 – 2015	SHMMC hired Diversified Health Care to assist patients with accessing Medi-Cal and other insurances under the Affordable Care Act.	1,805 people were assisted with insurance coverage options and obtained coverage during 2014 – 2015.
Access to Care: Lack of Health Care Insurance -- Collaboration/Partnership Highlights			

[1] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Stanislaus County Health Services Agency (HSA)	SHMMC's partners with HSA to provide assistance to community members in accessing health plan coverage.	The HSA assisted 7,453 patients with accessing Medi-Cal or other insurance options through the Affordable Care Act.
Access to Care: Lack of Health Insurance -- In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Stanislaus County Health Services Agency	SHMMC provided the Sutter Health Conference Center for training over 50 Stanislaus County Health Services Agency insurance assisters on helping community members acquire affordable insurance through Medi-Cal.	

Sutter Health Memorial Medical Center Priority Health Need -- Access to Care: Health Care Provider Shortage

Long Term Goal: Improve the quality and availability of trained medical professionals to better serve our growing community.			
Intermediate Goal: Assist in education and provide the training ground to increase the number of physicians, nurses and ancillary personnel in the MMC service area.			
Access to Care: Healthcare Provider Shortage -- Grantmaking Highlights			
Summary of Impact: During 2014-2015, there were 3 active SHMMC grants, totaling $725,000, addressing Access to Care in the SHMMC service area.[2]			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Valley Consortium for Medical Education (VCME)	$216,000 – 2014 $414,000 – 2015	The VCME provides residency programs for family care providers in partnership with hospitals, including SHMMC, and other health care organizations. The program increases the number of physicians in the community.	58 family practice physicians were trained over the past 5 years. 29 physicians stayed in Stanislaus County to practice. Residents see an average of 23,000 outpatients each year and over 30 inpatients each day. All clients are underinsured and underserved.
Mobile Clinic WellSpace Federally Qualified Health Center (FQHC)	$95,000 – 2015	WellSpace, a Federally Qualified Health Center will manage a mobile clinic to provide basic clinical services to rural residents in SHMMC's service area.	This program was established and funded in 2015. Outcomes have not yet been achieved.
Access to Care: Healthcare Provider Shortage -- Collaboration/Partnership Highlights			

[2] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Partner Organizations: • Modesto Junior College • Yosemite College District • Merced Radiologic Technology School • CSU Stanislaus University • Stanislaus Education Foundation • VCME Board	SHMMC provides trainers, lecturers, space, supplies, labs and computer training to its partners to simulate real clinical situations for students.	Trained 18 Radiologic Techs; 7 Physical Therapists; and 44 Pharmacy Techs
Doctors Medical Center and Stanislaus County Health Services Agency (Public Health Department)	Local hospitals, the Health Services Agency and the Public Health Department collaborate to provide physician residency programs in the SHMMC service area.	Stanislaus County providers have increased by 10% over the past 5 years due to this collaboration. The partnership has increased the number of no insurance or underinsured patients receiving primary care.

Access to Care: Healthcare Provider Shortage -- In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Local physicians, nurses, residents and ancillary providers	The SHMMC Conference Center was utilized for 5 Professional Symposia (including Diabetes, Cancer and Cardiac symposia during 2014 and 2015) for the medical community designed specifically to improve the knowledge level and treatment skills of local providers. Other classes open to health care professionals included Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and CPR.

Sutter Health Memorial Medical Center Priority Health Need: Modifiable Risk Factors for Disease

Long Term Goal: Identify and decrease risk factors for disease in vulnerable populations.

Intermediate Goal: Offer programs in depressed and underserved areas to increase opportunities for healthy practices among adults.

Modifiable Risk Factors for Disease: Grantmaking Highlights

Summary of Impact: During 2014-2015, there was 1 active SHMMC grant, totaling $11,450 addressing Modifiable Risk Factors for Disease in the SHMMC service area.[3]

Grantee	Grant Amount	Project Description	Results to Date
Congregations Building Community Center at Marshall Park	$11,450 – 2015	The Congregations Building Community Center at Marshall Park is located in a predominately Latino community. While the Center provides after school programs for children, local residents have not had adequate access to the Center or the adjacent park. With this grant, the Center will provide language classes, health and nutrition programs, and exercise and parenting classes to community residents. Through the programs and classes, the Center will contribute to decreasing risk factors for disease in this high need area.	The Center provided GED and English as a Second Language classes to 37 people; Zumba 2x/week with 25 participants per session; and cooking classes. Parents advocated successfully for a stop sign to be installed on the route their children walk to school.

Modifiable Risk Factors for Disease: Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Partner Organizations: City of Modesto, Stanislaus County Parks & Recreation, Stanislaus Community Foundation, Catholic Charities	To revitalize the Community Center to serve youth and adults and build community cohesion in support of reducing risk factors for poor health outcomes.	The Community Center has become a community hub where adults and youth can access health and other programming. Insurance enrollment assistance was provided through the partnership with Catholic Charities.

Modifiable Risk Factors for Disease: In Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
School-aged youth	Bike helmets were provided at school events and health fairs to underserved youth during 2014 and 2015. Trauma nurses fit the helmets properly and provided safety training.

[3] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

Sutter Health Memorial Medical Center Priority Health Need: Quality of Clinical Care -- Chronic Disease Prevention and Control

Long Term Goal: Prevent obesity and chronic disease by increased awareness of good nutrition, tobacco avoidance, and physical activity in children and youth.			
Intermediate Goal: Provide programs to introduce healthy eating and exercise opportunities.			
Quality of Clinical Care: Chronic Disease Prevention and Control - Grantmaking Highlights			
Summary of Impact: During 2014-2015, there were 7 active SHMMC grants, totaling $72,250 addressing Chronic Disease Prevention and Control, including pediatrics patients, in the SHMMC service area.[4]			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Stanislaus County Office of Education After School Program	$15,000 – 2014 $15,000 – 2015	After School is an ideal setting for providing education and training to students on healthy eating and physical activity. Youth receive education on healthy eating and physical activity to reduce obesity.	Pre- and post-program surveys indicated that 75% of students were more likely to choose healthy eating and physical activity practices post program.
Modesto City School Gardens	$6,000 – 2014	Modesto City Schools in collaboration with Stanislaus County Office of Education and SHMMC collaborated on providing school gardens for 5th graders in 7 sites around the county. Gardens provided vegetables and fruits to students and families.	The program impacted each school site's 5th grade class, reaching 350 students and their parents. Parents were invited at harvest to sample menus and take vegetables home.
Boys and Girls Club of Stanislaus County	$5,000 – 2014 $1,250 – 2015	Boys and Girls Club provides after school activities and counseling for underserved and at-risk youth.	A survey conducted during the 2013-2014 school year indicated that 78% of those with attendance issues improved their attendance due to Boys and Girls Club influences. Improved attendance increases opportunities to learn healthy practices and achieve academic success.
PHAST (Promoting Health and Slamming Tobacco)	$15,000 – 2014 $15,000 – 2015	PHAST promotes anti-smoking behavior by mobilizing teens to decrease tobacco use through peer-focused activities in middle and high schools throughout the county.	4,890 high school and middle school students were exposed to PHAST. Surveys showed that 7th – 9th graders reduced tobacco use up to 23%.

[4] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

Quality of Clinical Care: Chronic Disease Prevention and Control – Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Partner Organizations: Stanislaus County Office of Education, Modesto City Schools, Boys and Girls Club, Stanislaus County Parks & Recreation, Heart Coalition of Stanislaus County, American Heart Association, American Cancer Society, Sutter Gould Medical Group	To impact youth positively with messages and trainings to embrace healthy lifestyles, and prevent heart disease, cancer and other chronic diseases.	In partnership with the Stanislaus County Office of Education and the Tobacco Prevention Program, SHMMC teamed up with Modesto Junior College and California State University Stanislaus to bring a leading tobacco and addiction researcher/speaker, Dr. Victor DeNoble, to the students. His presentation was directed at high school and college students to reduce the incidence of tobacco use. Collaborating with the Heart Coalition of Stanislaus County, SHMMC and Sutter Gould Medical Group presented the documentary “Fed Up” to the community to stress the importance of sugar reduction in children’s diets and carried the film’s key messages to school board, government and healthcare leadership.

Quality of Clinical Care: Chronic Disease Prevention and Control -- In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
American Heart Association, American Cancer Society, Support Groups, Soroptimist International Service Club	The SHMMC Conference Center was utilized for over 1,800 events (including community classes, support groups and school activities for students and youth) equating hundreds of thousands of dollars in in-kind donations to increase awareness of healthy practices. For example, the Conference Center was utilized for the full day “Live Your Dream” workshop for 7th and 8th grade underserved girls to build self-esteem and encourage healthy living practices, and teach Internet safety and how to recognize and avoid human trafficking.
Children’s Crisis Center	Provided computers for families and children in stressful life circumstances to utilize at the Center.

Memorial Medical Center Priority Health Need: Burden of Disease – Access to Mental Health and Behavioral Health Programs

Long Term Goal: Increase the number of Latinos accessing mental/behavioral health programs in the community.

Intermediate Goal: Support local programs within Latino communities.

Burden of Disease: Access to Mental Health and Behavioral Health Programs -- Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 2 active SHMMC grants, totaling $57,000, addressing Access to Mental Health and Behavioral Health Programs in the SHMMC service area.[5]

Grantee	Grant Amount	Project Description	Results to Date
Center for Human Services	$50,000 – 2014 $7,000 – 2015	Center for Human Services promotoras reach out to Latino community members to increase access to health information, insurance coverage, medical homes, and mental and behavioral health programs.	Nine lead promotoras and 59 neighborhood promotoras reached 135 Latino residents in Turlock and 375 Latino residents in Newman, providing support for accessing health services. Examples include accompanying participants to medical and mental health appointments and providing interpretation during visits. To date, 95 clients were referred to insurance programs, and 5 clients were referred to Medical Homes.

Burden of Disease: Access to Mental Heath and Behavioral Health Programs -- Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Stewardship Council	The goal of the Stewardship Council, a collaborative of diverse community and governmental organizations, is to reduce homelessness in Stanislaus County.	The Stewardship Council has increased awareness of the needs of the homeless population and risk factors for homelessness. The Council is developing strategies to address and prevent homelessness. SHMMC offers expertise on the healthcare component of homelessness and mental illness.

Burden of Disease: Access to Mental Heath and Behavioral Health Programs -- In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Behavioral Health and Recovery Services and Garden Gate Respite Center	SHMMC provided the Conference Center to bring 25 partners of the Garden Gate Respite Center together. The Respite Center provides temporary safe housing for mentally ill residents who are likely to end up in the hospital or at inpatient mental health facilities. The “Partner Picnic” that SHMMC hosted included law enforcement, emergency personnel and mental health providers.

[5] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

Sutter Health Memorial Medical Center - Priority Health Need: Workforce Development

SHMMC - Workforce Development Highlights			
Long Term Goal: Address health care workforce shortages and cultural and linguistic disparities in the health care workforce.			
Intermediate Goal: Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care.			
Summary of Impact: During 2014-2015, SHMMC awarded 2 Workforce Development grants, totaling $490,000 that served the SHMMC service area.[6].			
Grantee	**Grant Amount**	**Project Description**	**Results to Date**
Hospital Council of Northern and Central California (HCNCC)	$245,000 – 2014 $245,000 – 2015	Provided training opportunities at hospitals for Modesto Junior College, Yosemite Community College District nursing students.	In 2014 and 2015, 340 nursing students were trained and mentored by hospital personnel/preceptors.

Workforce Development - Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Partner Organizations: Modesto Junior College, Yosemite College District, Stanislaus State University, Regional Occupational Program, Davis High Health Academy	The goal of the partnerships is to increase the health workforce pipeline.	The partners have developed a health care experience curriculum for high school, junior college and university students to expose them to health careers.

Workforce Development - In-Kind Resources Highlights	
Recipient	**Description of Contribution**
Modesto Junior College, Stanislaus State University	The SHMMC hospital campus and nursing department provided training and mentoring to nursing students.

[6] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

Sutter Health Memorial Medical Center - Priority Health Need: Research

SHMMC Research Highlights
Long Term Goal: Increase awareness of the changing health needs of diverse communities of cancer patients via the Tumor Registry Department.
Intermediate Goal: Increase access to, and the availability of, relevant public health and clinical care data and research regarding tumors and cancers.
Summary of Impact: During 2014-2015, SHMMC offered Tumor Registry services to the local public health department and SHMMC's service area. Registry results are shared community wide and further as requested.

VIII. APPENDICES

- **A. Secondary Data Sources and Dates**
- **B. Community Input Tracking Form**
- **C. Stakeholder Interview Questions**
- **D. Focus Group Interview Questions**
- **E. Health Need Profiles**

A. APPENDIX A: Secondary Data Sources and Dates

1. California Department of Education. 2012-2013.
2. California Department of Education. 2013.
3. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.
4. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2011.
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6. California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
7. California Department of Public Health, CDPH – Tracking. 2005-2012.
8. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.
9. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
10. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
11. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
12. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
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14. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
15. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
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17. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
18. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
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21. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
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23. Centers for Medicare and Medicaid Services. 2012.
24. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
25. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
26. Environmental Protection Agency, EPA Smart Location Database. 2011.
27. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
28. Feeding America. 2012.
29. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
30. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
31. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
32. New America Foundation, Federal Education Budget Project. 2011.
33. Nielsen, Nielsen Site Reports. 2014.
34. Public Policy Institute of California, Unauthorized Immigrants in California: Estimates for Counties. 2011.

35. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
36. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
37. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
38. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
39. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
40. US Census Bureau, American Community Survey. 2009-2013.
41. US Census Bureau, American Housing Survey. 2011, 2013.
42. US Census Bureau, County Business Patterns. 2011.
43. US Census Bureau, County Business Patterns. 2012.
44. US Census Bureau, County Business Patterns. 2013.
45. US Census Bureau, Decennial Census. 2000-2010.
46. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
47. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
48. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
49. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
50. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
51. US Department of Education, EDFacts. 2011-2012.
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54. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
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56. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
57. US Department of Housing and Urban Development. 2013.
58. US Department of Labor, Bureau of Labor Statistics. June 2015.
59. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
60. US Drought Monitor. 2012-2014

B. APPENDIX B: Community Input Tracking Form

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and organization or focus group name**	**Number of participants**	**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
1	*Key Informant Interview*	Public Health Officer, Stanislaus County Health Services Agency	*1*	*Health Department representative*	*Leader*	*8/25/15*
2	*Key Informant Interview*	Chief Executive Officer, United Way of Stanislaus County	*1*	*Community Based Organization representative*	*Leader*	*8/24/15*
3	*Key Informant Interview*	Director of Patient Education, Golden Valley Health Centers	*1*	Minority, Medically underserved, low income	Leader	9/3/15
4	*Key Informant Interview*	Executive Director, Center for Human Services	*1*	Minority, Medically underserved, low income	Leader	8/26/15
5	*Key Informant Interview*	Director of Student Support Services, Stanislaus County Office of Education	*1*	Education representative	Leader	8/24/15
6	*Key Informant Interview*	Community Development and Empowerment Manager, Stanislaus County	*1*	County representative	Leader	9/17/15
7	*Key Informant Interview*	Chief Executive Officer, Stanislaus County	*1*	County representative	Leader	9/17/15
8	*Key Informant Interview*	Clinical Director, Sierra Vista Child & Family Services	*1*	Medically underserved, low income	Leader	8/26/15
9	*Focus Group*	Ceres Promotores focus group in Spanish (all female)	16	Minority, medically underserved, low income	Members	8/25/15

10	Focus Group	Modesto/King Kennedy Center community advocates focus group in English	7	Minority, medically underserved, low income	Representatives and Members	8/28/15
11	Focus Group	Senior Health focus group in English	9	Minority, medically underserved, low income	Representatives and Members	8/28/15
12	Focus Group	Patterson Promotores focus group in Spanish	11	Minority, medically underserved, low income	Members	9/1/15
13	Focus Group	Turlock Promotores focus group in Spanish (all female)	10	Minority, medically underserved, low income	Members	9/9/15
14	Focus Group	Hughson Family Resource Center focus group in Spanish	9	Minority, medically underserved, low income	Members	9/10/15
15	Focus Group	Salvation Army focus group in English and Spanish	6	Minority, medically underserved, low income	Representatives and Members	9/11/15
16	Focus Group	Young at Heart Exercise older adult focus group in English	7	Medically underserved, low income	Representatives and Members	9/18/15

C. APPENDIX C: Stakeholder Interview Questions

1. What are Stanislaus County's 3 most critical health issues? Why are these the top priorities?

2. Starting with (health issue #1), what are the factors that contribute to making this a priority?

3. How do the health issues you've identified specifically impact low income, underserved/uninsured populations? Which populations do the issues impact most?

4. How do the health issues you've identified impact ethnic/racial subpopulations? Which populations do the issues impact most?

5. Based on your knowledge and expertise, what are the successful strategies that could be implemented to address the top 3 health issues you have identified? What are some of the challenges to addressing the health issues?

6. What assets and services are available in Stanislaus County to address the top health issues?

7. Beyond the 3 top health issues you've identified, are there any other health issues that you think are also important to address?

8. What are your suggestions for ways to engage community members, particularly low income, underserved/uninsured populations and ethnic/racial subpopulations, in addressing the health issues?

9. What role can Kaiser Permanente Central Valley and Sutter Health Memorial Medical Center play in addressing the health issues?

10. Is there anything else you would like to share about the top health issues in Stanislaus County and how to address the issues?

D. APPENDIX D: Focus Group Interview Questions

1. Please describe for me your idea of what a healthy community looks like.

2. Now think about how your community is right now. What is healthy about your community?
    i. What makes it easy to be healthy in your community?

3. What makes it difficult to be healthy in your community?

4. In 2013, we asked community members to describe the top health issues in the community. Asthma, obesity/overweight/diabetes and access to care came up as top health issues facing your community. How important do you think these issues are today?
    i. What other health issues are important?
    ii. Of all the health issues we've discussed what would you say are three most urgent ones?

5. What are the top three things that could be done to make your community healthier?
    i. For each of these, what are some successful ways to address them that you've seen either in your community or other communities you know about?
    ii. If you haven't seen or heard about things that have been successful, do you have any ideas for ways to make your community healthier?

6. What are some organizations, services or resources in your community that help people to be healthy?
    i. How do these organizations, services or resources help people to be healthy?
    ii. What does the County/your community need in terms of health (services, programs, etc.) that does not currently exist in the community?

7. What do you recommend as the best ways to get people in your community involved in making your community healthier? Please be specific.
    i. What are the challenges to engaging people in your community
    ii. How can these challenges be overcome?

8. We're just about ready to wrap up. Is there anything else you feel is important for us to know about health in your community?

E. APPENDIX E: Health Need Profiles

HEALTH NEEDS	HEALTH NEED CRITERIA
Obesity/Healthy Eating Active Living/Diabetes	1. Meets the definition of a health need (either a poor health outcome and its associated driver or a health driver that is associated with a poor health outcome that hasn't yet itself arisen as a need). 2. The health need is confirmed by multiple data sources. 3. Indicator(s) related to the health need perform(s) poorly against a state benchmark.
Access to Care	
Economic Security	
Mental Health	
Asthma	
Cardiovascular Disease/Stroke	
Cancers	
Substance Abuse/Tobacco	
Violence/Injury Prevention	

NOTES:
Disparities were drawn from core indicators that had race and ethnicity data available on Communitycommons.org. Other disparities may exist but are not included due to data gaps.
Contributing factors were drawn from related indicators on Communitycommons.org. Other evidence-based contributing factors may exist but are not included due to data gaps.
Racial/ethnic disparities are highlighted in red. Unlike the indicators, which benchmark to the state, the racial/ethnic disparities benchmark to the county.
Additional indicators for each health need can be found on Communitycommons.org. The indicators listed below are only those that benchmark poorly to the state.

* 1-2% difference from benchmark for Stanislaus County
** > 2% difference from benchmark for Stanislaus County

Obesity/Healthy Eating Active Living (HEAL)/Diabetes

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]		CONTRIBUTING FACTORS
A healthy lifestyle that includes eating healthy and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly health outcomes such as obesity, diabetes, cardiovascular disease, and strokes. Rates of obesity are high in Stanislaus County when compared to state benchmarks. Adults have an obesity rate that is 10% greater than the state average. Diabetes prevalence and related hospitalizations in Stanislaus County are also greater than the State average. Stanislaus County benchmarks poorly on many of the related indicators contributing to high obesity rates, including fruit and vegetable consumption among youth, physical inactivity among youth and adults, breastfeeding, and access to parks. Many racial/ethnic groups including, non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic other and Hispanic/Latino have lower rates of exclusive breastfeeding when compared to the county. Additionally, stakeholders and focus group participants frequently identified Obesity/Healthy Eating Active Living (HEAL)/Diabetes as the top health issue in Stanislaus County.	Overweight (Youth)* Multiple race** Obesity (Youth)** Obesity (Adult)** Diabetes Prevalence* Diabetes Hospitalizations**	[20.37% // 19.30%] [38.35% // 20.37%] [21.99% // 18.99%] [32.20% // 22.30%] [9.10% // 8.05%] [10.40 // 14.35]	Fruit and Vegetable Consumption (Youth)** Physical Inactivity (Adult)* Physical Inactivity (Youth)** Non-Hispanic Multiple Races, Hispanic/Latino Park Access** Recreation and Fitness Facility Access* Breastfeeding (Any)** Non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic Other Breastfeeding (Exclusive) Non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic Other, Hispanic/Latino Food Insecurity* Drinking water safety** Walk/bike to work* Commute alone in car** Walk/bike to school**
PRIMARY DATA:	Obesity/HEAL/Diabetes was the most frequently cited health concern, with 80% of stakeholders and focus groups identifying it as a top health need. Lack of accessible, affordable healthy food and safe places for physical activity were frequently cited as barriers. Many focus group participants indicated that the parks in the community are unsafe and not well maintained. Additionally, lack of sidewalks, poor lighting and stray dogs made walking outside feel unsafe. Respondents also cited a high prevalence of fast food restaurants.		

ETHNIC/RACIAL DISPARITIES:	Overweight disproportionately affects youth of multiple races. Many racial/ethnic groups including, non-Hispanic Black, Non-Hispanic Asian, Non-Hispanic other and Hispanic/Latino have lower rates of exclusive breastfeeding when compared to the county. Additionally, Hispanic/Latino youth and non-Hispanic multiple race youth are more physically inactive than youth in the rest of the county.

Access to Care

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]		CONTRIBUTING FACTORS
Access to high quality, culturally competent, affordable healthcare and health services that provide a coordinated system of community care is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. Compared to State benchmarks, residents in Stanislaus County have less access to dentists, primary care providers and mental health providers. Stanislaus County residents are also less likely to have a consistent source of primary care when compared to the State. The lack of mental health providers is particularly acute with a rate of 61.9 per 100,000 population compared to the state average of 157 per 100,000 population. Stakeholders and focus groups consistently cited lack of access to services as a major need. Low income populations and those without insurance are disproportionately impacted. Accessibility of existing services is a major concern among residents.	Access to Dentists**	[58 // 77.5]	Health Professional Shortage Area - Primary Care** Preventable Hospital Events** Insurance - Population Receiving Medicaid** Cancer Screening - Pap Test** Uninsured population Some Other Race, Hispanic/Latino
	Access to Primary Care**	[67.9 // 77.2]	
	Lack of Consistent Source of Primary Care**	[18.40% // 14.30%]	
	Non-Hispanic Other*	[19.57% // 18.40%]	
	Hispanic/Latino**	[21.46% // 18.40%]	
	Access to Mental Health Providers**	[61.9 // 157]	

PRIMARY DATA:	Lack of access to health care services was frequently cited as a top health issue in stakeholder interviews and focus groups. Health access was perceived as a particular concern for low-income populations and those without health insurance. Lack of transportation was the most commonly cited factor. In addition to transportation barriers, long wait times, difficulty scheduling appointments and language barriers were also frequently mentioned. Many focus group respondents felt the quality of care was poor, especially for the uninsured and low-income.
ETHNIC/RACIAL DISPARITIES:	The percent of Hispanic/Latino adults who lack a consistent source of primary care is greater than other ethnic/racial groups in Stanislaus County. Hispanic/Latino populations are also more likely to be uninsured than other ethnic/racial groups in the county.

Economic Security

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Economic security contributes to good health. It facilitates access to healthcare services, eating healthier, and other necessities that play a role in overall wellbeing. Poverty impacts Stanislaus County residents as a whole, and certain ethnic/racial groups, in particular. As a whole, Stanislaus County has a greater percentage of adults living below 100% Federal Poverty Level (FPL) and 200% FPL. Stanislaus County also has more children living below 100% FPL and a greater unemployment rate as compared to the State. Many ethnic/racial groups are disproportionately impacted by poverty. Black, Native American/Alaska Native and Hispanic/Latino populations are among those most impacted by poverty. Economic Security was mentioned as both a health need and a driver of other health needs by stakeholders. Other drivers of health, including education and insurance are closely related to economic security and benchmark poorly compared to the state.	Economic Security - Unemployment Rate** [11.1 //7.9] Poverty - Population Below 100% FPL** [20.34%//15.94%] Black** [33.18%//20.34%] Native American/Alaskan Native** [26.03%//20.34%] Native Hawaiian/Pacific Islander** [28.98%//20.34%] Some other race ** [29.74%//20.34%] Hispanic/Latino** [27.98%//20.34%] Poverty - Population Below 200% FPL** [43.81% //35.91%] Poverty - Children Below 100% FPL** [28.40%//22.15%] Black** [46.18%//28.40%] Native American/Alaskan Native** [42.91%//28.40%] Native Hawaiian/Pacific Islander** [49.79%//28.40%] Some other race** [36.90%//28.40%] Hispanic/Latino** [35.84%//28.40%]	Education - Reading Below Proficiency** Children Eligible for Free/Reduced Price Lunch** Food Security - Population Receiving SNAP** Insurance - Population Receiving Medicaid** Education - Less than High School Diploma (or Equivalent)** Some other race, Hispanic/Latino Education - School Enrollment Age 3-4** Food Security - Food Insecurity Rate** Education - High School Graduation Rate Non-Hispanic Black, Hispanic/Latino Insurance - Uninsured Population Some other race, Hispanic/Latino
PRIMARY DATA:	Economic security was mentioned both as a health need and as a driver of other health needs in the stakeholder interviews. Homelessness, lack of employment opportunities, food insecurity and poor educational attainment are all factors connected with economic security. Respondents said that poverty primarily impacts Hispanic/Latino and African American populations. While no focus group participants identified economic security as a health need, it was frequently mentioned as a driver of other health needs, in particular around healthy food access and access to health services.	
ETHNIC/RACIAL DISPARITIES:	Not only does Stanislaus County benchmark poorly on all economic security indicators, there are a significant number of ethnic/racial disparities within the county. Five ethnic/racial groups are disproportionately represented in the population living below 100% FPL and children living below 100% FPL. Black, Native American/Alaska Native and Hispanic/Latino populations are those most impacted by poverty.	

Mental Health

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Mental health and well-being is essential to living a meaningful and productive life. Mental health and well-being provides people with the necessary skills to cope with and move on from daily stressors and life's difficulties allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. In Stanislaus County, access to mental health providers is limited. Compared to the state average of 157 mental health providers per 100,000 population in Stanislaus County there are 61.9 providers per 100,000 population. Lack of mental health services was a common theme in stakeholder interviews and focus groups. Suicide rates are higher for non-Hispanic whites, Asians and Native Hawaiian/Pacific Islanders than the rest of the County. In particular, Native Hawaiian/Pacific Islanders are disproportionately impacted by suicide when compared to all other ethnic/racial groups in the county.	Access to Mental Health Providers** [61.9 // 157] Mental Health- Needing Mental Health Care** [26.50% // 15.90%] Non-Hispanic Black* [27.80% // 26.50%] Non-Hispanic Other** [43.10% // 26.50%] Suicide [10.7 // 9.8] Non-Hispanic white** [14.0 // 10.7] Asian** [14.3 // 10.7] Native Hawaiian/Pacific Islander** [24.3 // 10.7]	

PRIMARY DATA:	Lack of access to mental health services was mentioned in stakeholder interviews and focus groups as a major barrier to well-being. Respondents also cited a lack of knowledge of existing mental health services and stigma in seeking care. Substance abuse and homelessness were frequently mentioned as co-occurring conditions. Respondents said that low income individuals experience more stress because of lack of employment, education and housing opportunities.
ETHNIC/RACIAL DISPARITIES:	Non-Hispanic White, Asian and Native Hawaiian/Pacific Islander populations have a greater rate of suicide than the county as a whole. Native Hawaiian/Pacific Islanders are more than twice as likely to die by suicide than the general population in Stanislaus County. A greater percentage of Non-Hispanic Other population needs mental health care as compared to the other ethnic/racial groups in Stanislaus County.

Asthma

RATIONALE	HEALTH OUTCOMES INDICATORS [REPORT AREA // BENCHMARK]		CONTRIBUTING FACTORS
Prevention and management of asthma by reducing exposures to triggers and other risk factors that increase the severity of asthma, such as tobacco smoke and poor air quality, improves quality of life and productivity as well as reduces the cost of care. Asthma is more prevalent in Stanislaus County than the state. 16.9% of adults reported having asthma in Stanislaus County as compared to 14.2% for the state. Poor air quality, tobacco usage and obesity and overweight are all related indicators that impact asthma prevalence and hospitalizations. Many stakeholders agreed that asthma was a major health concern in the county.	Asthma - Prevalence** Asthma - Hospitalizations*	[16.90% // 14.20%] [10.85 // 8.90]	Tobacco Usage** Air Quality - Particulate Matter 2.5** Obesity (Adult)** Obesity (Youth)** Overweight (Youth)* Multiple races
PRIMARY DATA:	When asked if asthma was a major health concern, many stakeholders agreed. Poor air quality, agricultural pollution, and allergies were commonly mentioned as factors contributing to asthma. Respondents mentioned that low income neighborhoods are more impacted by agricultural pollution and the impacts of dust.		
ETHNIC/RACIAL DISPARITIES:	Ethnic/racial disparity data were unavailable in the Community Commons data platform for the core asthma indicators. Focus group participants indicated that low-income neighborhoods were particularly impacted by asthma triggers including agricultural pollution and dust.		

Cardiovascular Disease/Stroke

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]	CONTRIBUTING FACTORS
In the United States, cardiovascular disease is the leading cause of death and strokes are the third leading cause of death. These diseases can be prevented and managed through early adoption of preventative measures and a lifestyle that includes physical activity, not smoking, and healthy eating. There is a higher rate of heart disease and stroke mortality in Stanislaus County as compared to the state. Non-Hispanic whites and Non-Hispanic Blacks are disproportionately affected by heart disease. Non-Hispanic Blacks have over twice the prevalence of heart disease as compared to the county. Stanislaus County benchmarks poorly on many of the related indicators contributing to Cardiovascular Disease (CVD)/Stroke, including access to parks, and diabetes prevalence and related hospitalizations, obesity among adults and youth, and physical inactivity among youth and adults.	Heart Disease Prevalence [5.30% // 6.30%] Non-Hispanic White** [7.60% // 5.30%] Non-Hispanic Black** [10.60% // 5.30%] Mortality - Ischemic Heart Disease** [221.18 // 163.18] Non-Hispanic White** [245.32 // 221.18] Black** [240.71 // 221.18] Native Hawaiian/Pacific Islander** [273.12 // 221.18] Mortality - Stroke** [43.98 // 37.38] Black** [52.78 // 43.98] Native Hawaiian/Pacific Islander** [54.71 // 43.98]	Physical Inactivity (Adult)* Physical Inactivity (Youth)** Non-Hispanic Multiple Races, Hispanic/Latino Park Access** Recreation and Fitness Facility Access* Tobacco Usage** Obesity (Adult)** Overweight (Youth)* Multiple races Obesity (Youth)** Diabetes Prevalence* Diabetes Hospitalizations**

PRIMARY DATA:	Although cardiovascular disease was not a major concern, it was mentioned as a top health need in one stakeholder interview and in 2 focus groups. The contributing factors to CVD were frequently mentioned in both stakeholder interviews and focus groups. In particular, lack of access to safe parks and low cost exercise opportunities and high rates of obesity and overweight were frequently cited as top needs.
ETHNIC/RACIAL DISPARITIES:	Several ethnic/racial groups are disproportionately affected by heart disease and stroke. Non-Hispanic Blacks are twice as likely to have heart disease as compared to the county as a whole. Heart Disease mortality is greater for Non-Hispanic White, Black and Native Hawaiian/Pacific Islander populations as compared to the county. Blacks and Native Hawaiian/Pacific Islanders also experience higher rates of mortality from stroke as compared to the county.

Cancers

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Screening and early treatment of cancers saves and prolongs lives. Additionally, preventative measures and reducing behavioral risk factors (e.g., obesity, physical inactivity, smoking, and UV light exposure) can be effective at reducing the incidence of cancer. Overall, cancer mortality is greater in Stanislaus County as compared to the state. In particular, Non-Hispanic Whites are disproportionately affected by cancer mortality. Colon/rectum and lung cancer incidence rates are also greater in Stanislaus County than in the state. Whites are nearly three times more likely to have lung cancer as compared to the county as a whole. Many factors contributing to cancers such as obesity, physical inactivity and poor air quality were identified by stakeholders and focus groups as key areas of concern. The secondary data supports the primary data as those contributing factors mentioned above also benchmark poorly to the state.	Mortality - Cancer** [167.85 // 157.10] Non-Hispanic White** [189.77 // 167.85] Cancer Incidence - Colon and Rectum** [47.40 // 41.50] Black** [59 // 47.40] Cancer Incidence - Prostate [123.40 // 136.40] Black** [173 // 123.40] Cancer Incidence - Lung** [62.20 // 49.50] White** [173 // 62.20]	Tobacco Usage** Obesity (Adult)** Cancer Screening - Pap Test** Physical Inactivity (Adult)* Air Quality - Particulate Matter 2.5**

PRIMARY DATA:	Cancer did not come up as a health need in stakeholder interviews and although it came up in 4 focus groups, there was minimal discussion around it.
ETHNIC/RACIAL DISPARITIES:	Non-Hispanic Whites are more likely to die from cancer than the other ethnic/racial groups in the County. Whites are almost three times as likely to have lung cancer than the county population as a whole. Blacks have greater incidence of colon/rectum cancer and prostate cancer than the rest of the county.

Substance Abuse/Tobacco

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY // BENCHMARK]	CONTRIBUTING FACTORS
Reducing tobacco use and treating/reducing substance abuse improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Tobacco usage is higher in Stanislaus County than the state. Substance use emerged as a theme in the focus groups. The prevalence of drugs in local parks was commonly mentioned. Additionally, many respondents identified other health needs including economic security, mental health and violence as frequently co-occurring with substance abuse.	Tobacco Usage** [16.80% // 12.80%] Note: Tobacco usage is the only indicator from the Community Commons data platform that benchmarks poorly to the State.	
PRIMARY DATA:	The prevalence of drugs in the parks, particularly among the homeless population was frequently mentioned in focus groups. Many respondents talked about the intersection of substance abuse, poverty and mental illness and how closely related these issues are in the population. Respondents described how mental illness is exacerbated by substance use and how poverty contributes to substance use. Respondents also indicated a need for more treatment centers.	
ETHNIC/RACIAL DISPARITIES:	Ethnic/racial disparity data were unavailable in the Community Commons data platform for tobacco/substance abuse indicators. Primary data would suggest there are socioeconomic disparities related to tobacco/substance abuse. Substance abuse was frequently described as an issue among the homeless population.	

Violence/Injury Prevention

RATIONALE	HEALTH OUTCOMES INDICATORS [STANISLAUS COUNTY// BENCHMARK]	CONTRIBUTING FACTORS
Safe communities contribute to overall health and well-being. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. In Stanislaus County, violence/injury prevention affects both certain ethnic/racial communities and the county overall. In particular, Blacks are disproportionately affected by homicide. The homicide rate for Blacks is over three times the rate for the county as a whole. Many focus group respondents felt their community was unsafe.	Mortality - Homicide* [7.02 // 5.15] Black** [24.28 // 7.02] Native Hawaiian/Pacific Islander* [8.31 // 7.02] Hispanic/Latino* [8.68 // 7.02] Mortality - Suicide [10.70 // 9.8] Non-Hispanic White** [13.99 // 10.70] Asian** [14.33 // 10.70] Native Hawaiian/ Pacific Islander ** [24.30 // 10.70] Mortality - Motor Vehicle Accidents* [6.46 // 5.18] Non-Hispanic White* [8.39 // 6.46] Violence - Youth Intentional Injury** [921 // 738.7] Violence - Assault (Injury)** [388.40 // 290.3] Violence - Domestic Violence** [13.3 // 9.5] Violence - Assault (Crime)** [339.6 // 249.4]	Violence - All Violent Crimes** Violence - Rape (Crime)** Violence - School Suspensions**

PRIMARY DATA:	Two stakeholders identified child abuse and domestic violence as major issues. Other stakeholders identified a lack of education on parenting and the bad economy as contributing to abuse. Focus group participants frequently mentioned unsafe parks, homeless people, drugs and stray dogs as factors in the environment that made them feel unsafe. Additionally, poor lighting and the need for built environment improvements were mentioned. A few respondents mentioned the need for more police officers.
ETHNIC/RACIAL DISPARITIES:	Many ethnic/racial groups are disproportionately affected by violence. The homicide rate for Blacks is over three times the rate for the county as a whole. Non-Hispanic White, Asian and Native Hawaiian/Pacific Islander populations have a greater rate of suicide than the county as a whole.