
A large, grey, curved sign for Sutter Health Memorial Hospital Los Banos. The sign features the Sutter Health logo on the left, followed by the text "Sutter Health" in teal, "Memorial Hospital" in white, and "Los Banos" in white. The sign is set on a concrete base surrounded by a circular border of stone blocks.

 **Sutter Health**
Memorial Hospital
Los Banos

MEMORIAL HOSPITAL LOS BANOS

2022 Community Health Needs Assessment

Mission

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

Vision

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

Community Health Needs Assessment

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

2022 Community Health Needs Assessment

Conducted on behalf of

Memorial Hospital Los Banos
520 West I Street
Los Banos, CA 93635

Conducted by



March 2022

Acknowledgments

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

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

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Report Summary

Purpose

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

Community Definition

The definition of the community served by the hospital was defined by four ZIP Code boundaries: 93620, 93635, 93665, and 95322. This service area was identified as the area where the majority of patients served by the hospital resided. The total population of the service area was 61,211.

The city and community of Los Banos is located in Merced County near the Interstate 5 corridor. Los Banos sits at the intersection of State Routes 152 and 165. According to the 2020 U.S. census, the city of Los Banos had a population of just over 44,000 residents, second only to the city of Merced as the county's largest city. The community serves as a bedroom community for those commuting to and from the Bay Area.

Merced County, named after the Merced River, sits in the heart of California's central valley and much of its economy is driven by agriculture. The county covers approximately 2,000 square miles. From an employment perspective, the county's largest industries include government, agriculture, and healthcare. According to *County Health Rankings*¹ Merced County ranks as the 38th most healthy county among the 58 in California. Hispanic/Latino's account for over 60% of the total population, followed by non-Hispanic Whites at just over 26%.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.² This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 11 community health experts, social-service providers, and medical personnel. Furthermore, 18 community residents or community service provider organizations participated in 4 focus groups across the service area.

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

² Ibid.

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

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including MHLB's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and the COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

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

List of Prioritized Significant Health Needs

The following significant health needs identified for Memorial Hospital Los Banos are listed below in prioritized order.

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

Resources Potentially Available to Meet the Significant Health Needs

In all, 143 resources were identified in the service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2019 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

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

Introduction and Purpose

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the significant health needs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: “Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)” (p. 78963).³

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Memorial Hospital Los Banos (MHLB), located at 520 West I Street, Los Banos, CA 93635. MHLB’s primary service area includes the city of Los Banos and surrounding community and was defined by four ZIP Codes: 93620, 93635, 93665, and 95322. The total population of the service area was 61,211.

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

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

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the MHLB service area. In all, 12 significant health needs were identified. Primary data were then used to prioritize these significant health needs.

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

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

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

| Prioritized Health Needs | Percentage of Key Informants and Focus Groups Identifying Health Need | Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority |
|---|---|--|
| Access to Basic Needs Such as Housing, Jobs, and Food | 100% | 27% |
| Access to Mental/Behavioral Health and Substance-Use Services | 100% | 20% |
| Access to Specialty and Extended Care | 100% | 10% |
| Access to Quality Primary Care Health Services | 82% | 14% |
| Injury and Disease Prevention and Management | 82% | 13% |
| Access to Functional Needs | 91% | 1% |
| Increased Community Connections | 82% | 2% |
| Active Living and Healthy Eating | 64% | 7% |
| Safe and Violence-Free Environment | 55% | 5% |
| System Navigation | 64% | ~ |
| Access to Dental Care and Preventive Services | 36% | ~ |
| Healthy Physical Environment | 9% | ~ |

~ Health need not mentioned

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and were more frequently identified among the top priority needs.⁴ The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

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

Memorial Hospital Los Banos 2022 Prioritized Health Needs

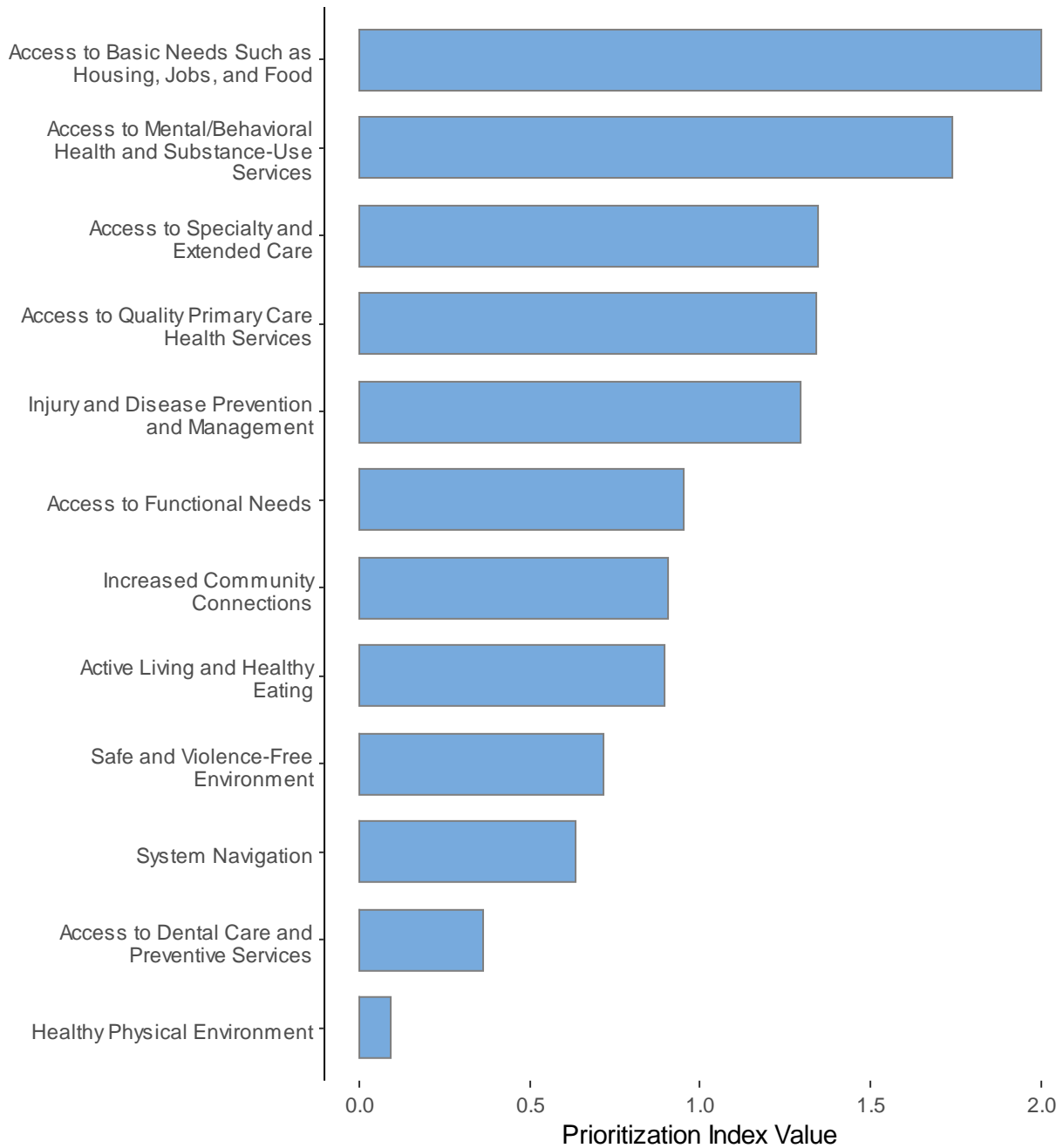


Figure 1: Prioritized significant health needs for MHLB service area.

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

The significant health needs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health ordered by their relationship to the conceptual model used to guide data collection for this report.

Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of this report).

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

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow’s Hierarchy of Needs⁵ suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.⁶

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • There are limited options for youth to find employment in the community. • Homelessness is on the rise in the community. • The community lacks affordable housing. • The community needs more housing options for low-income residents. • Food insecurity is on the rise in the community. • The community needs more employment opportunities that pay a living wage. • Too many residents must travel out of the community to find employment. • There are not enough shelters for community members experiencing homelessness. • The area needs more nonprofit organizations providing services. • The community needs more job training services for residents that are unskilled. • The lack of housing options makes it difficult to attract workers from outside the area. • Families experiencing homelessness have nowhere to go in the area. | <ul style="list-style-type: none"> • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • COVID-19 Mortality • COVID-19 Case Fatality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • COVID-19 Cumulative Incidence • Asthma ED Rates • Asthma ED Rates for Children • Drug Induced Death • Adult Obesity • Limited Access to Healthy Foods • Food Environment Index • Medically Underserved Area • COVID-19 Cumulative Full Vaccination Rate • Some College • High School Completion |

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

⁶ Robert Wood Johnson Foundation, and University of Wisconsin, 2022. Research Articles. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale>.

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| | <ul style="list-style-type: none"> • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Unemployment • Children in Single-Parent Households • Social Associations • Children Eligible for Free Lunch • Children in Poverty • Median Household Income • Uninsured Population under 64 • Homeownership |

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

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

| Primary Data Analysis | Secondary Data Analysis |
|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • There are not enough providers serving the community. • Providers need more cultural competence to serve all populations in the community. • Mental health services are too expensive for many that need them. • There are excessive wait-times to see a mental health provider. • There are limited providers that can serve the LGBTQ community. • Mental health services for youth are needed in the schools. • There is excessive tobacco and substance use among youth in the community. • Many youths suffer from Adverse Childhood Experiences (ACES) and need treatment. • Many organizations need trained to deliver "trauma informed" care to the community. • There is limited substance use treatment options in | <ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Drug Induced Death • Adult Smoking • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Firearm Fatalities Rate • Juvenile Arrest Rate • Disconnected Youth |

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| <p>The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants:</p> <p>the community.</p> <ul style="list-style-type: none"> • Opioid use is a growing problem in the community. • There are too few mental health providers that take Medi-Cal. • The county needs a sobering facility. • Because of the lack of available services, many patients that need mental health services go to the emergency room. | <p>The following indicators performed worse in the service area when compared to state averages:</p> <ul style="list-style-type: none"> • Social Associations |

3. Access to Specialty and Extended Care

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

| Primary Data Analysis | Secondary Data Analysis |
|--|--|
| <p>The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants:</p> <ul style="list-style-type: none"> • Residents must travel out of the area to access specialists. • There are not enough specialists willing to see low-income populations. • The community lacks many specialty providers. • The community needs more culturally competent specialists. • Mothers are not getting adequate pre-natal and postpartum care. • The community needs more options for eye-care. • The lack of specialists places more pressure on primary care providers. • The community lacks long-term care options for the elderly. | <p>The following indicators performed worse in the service area when compared to state averages:</p> <ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Liver Disease Mortality • Kidney Disease Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Lung Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children |

| Primary Data Analysis | Secondary Data Analysis |
|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| | <ul style="list-style-type: none"> • Drug Induced Death • Psychiatry Providers • Specialty Care Providers • Preventable Hospitalization |

4. Access to Quality Primary Care Health Services

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

| Primary Data Analysis | Secondary Data Analysis |
|--|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • There are excessive wait times to see a doctor. • Many providers do not have adequate interpretive services. • Providers need more training in providing culturally competent care to patients. • Because of physician turnover in the community, it is challenging to develop lasting relationships with one's provider. • Providers often do not understand the specific healthcare needs of the LGBTQ community. • Many undocumented residents do not have access to healthcare services. • The uninsured in the community have difficulty accessing healthcare services. • The community has a shortage of primary care providers. • There are not enough providers that accept Medi-Cal in the community. • The outlying areas of the community have limited providers making access more difficult. • The capacity of the hospital is limited. | <ul style="list-style-type: none"> • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Liver Disease Mortality • Kidney Disease Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Influenza and Pneumonia Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Lung Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Primary Care Shortage Area • Medically Underserved Area • Primary Care Providers • Preventable Hospitalization |

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| | <ul style="list-style-type: none"> • COVID-19 Cumulative Full Vaccination Rate • Uninsured Population under 64 |

5. Injury and Disease Prevention and Management

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

| Primary Data Analysis | Secondary Data Analysis |
|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • The community lacks after-school programs for youth. • There is too much focus on treatment in the area, and not enough focus on prevention. • The community needs more health education opportunities. • A focus on maternal-child health is lacking in the community. • The community needs nutrition education options. | <ul style="list-style-type: none"> • Child Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Liver Disease Mortality • Kidney Disease Mortality • Unintentional Injuries Mortality • COVID-19 Mortality • COVID-19 Case Fatality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • COVID-19 Cumulative Incidence • Asthma ED Rates • Asthma ED Rates for Children • Drug Induced Death • Adult Obesity • Physical Inactivity • Chlamydia Incidence • Teen Birth Rate • Adult Smoking • COVID-19 Cumulative Full Vaccination |

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| | Rate <ul style="list-style-type: none"> • Firearm Fatalities Rate • Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level |

6. Access to Functional Needs

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

| Primary Data Analysis | Secondary Data Analysis |
|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • Buses are inadequate, too many residents must walk to get around the area. • There are limited transportation options for residents that do not have a car. • It is challenging to access healthcare using only the bus system, especially for mothers of small children. • Lower income populations do not have access to the internet, making telehealth visits impossible. • There are no transportation options for those living in the rural areas of the county. • There are limited transportation options for the disabled. | <ul style="list-style-type: none"> • Disability • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Adult Obesity • COVID-19 Cumulative Full Vaccination Rate |

7. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests “individuals who feel a sense of security, belonging, and trust in their community have better health. People who don’t feel connected are less inclined to act in healthy ways

or work with others to promote well-being for all.”⁷ Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Further, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| <p>The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants:</p> | <p>The following indicators performed worse in the service area when compared to state averages:</p> |
| <ul style="list-style-type: none"> • Youth need more opportunities to connect to support services. • Non-English speakers need more support from the community. • Some members of the community are fearful to engage in civic activities due to immigration status. • It is difficult to engage in community activities when working multiple jobs. • A “community-minded approach” is needed in the community. • Increasing partnerships with providers outside of the community could bring more services into the area. • Medical and mental health services need to be more integrated. • UC Merced can be an "ivory tower" in a poor community. | <ul style="list-style-type: none"> • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Diabetes Mortality • Unintentional Injuries Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Drug Induced Death • Physical Inactivity • Access to Exercise Opportunities • Teen Birth Rate • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Specialty Care Providers • Primary Care Providers • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate • Homicide Rate • Firearm Fatalities Rate • Violent Crime Rate • Juvenile Arrest Rate • Some College • High School Completion |

⁷ Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved 31 Jan 2022 from <https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html>

| Primary Data Analysis | Secondary Data Analysis |
|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| | <ul style="list-style-type: none"> • Disconnected Youth • Unemployment • Children in Single-Parent Households • Social Associations |

8. Active Living and Healthy Eating

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

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • The community lacks opportunities for youth to stay active. • The community needs more farmer's markets. • There is limited access to healthy foods in parts of the community. • Schools need to provider healthier food to students, lowering the salt content. • Nutritious and healthy foods are less affordable. • There are no grocery stores in Gustine or Santa Nella, limiting access to healthy foods in those communities. • The community needs more options for physical activity, such as fitness centers or gyms. • There are food deserts in the community. | <ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Diabetes Mortality • Kidney Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Adult Obesity • Physical Inactivity • Limited Access to Healthy Foods • Food Environment Index • Access to Exercise Opportunities |

9. Safe and Violence-Free Environment

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

| Primary Data Analysis | Secondary Data Analysis |
|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • Parks are no longer safe places to go in the community. • Some areas are not safe due to gang violence in the community. • Some parents work outside of the area leaving children unsupervised for long periods. • Gang activity is growing in the community. • There are areas in the community where LGTBQ do not feel safe. • There is increased violence in the community brought on by gangs. • Some neighborhoods need better lighting and more sidewalks. • There are not enough safe spaces for kids to gather and play outdoors. • There is human trafficking in the community; need more awareness and prevention. | <ul style="list-style-type: none"> • Life Expectancy • Premature Death • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Physical Inactivity • Access to Exercise Opportunities • Homicide Rate • Firearm Fatalities Rate • Violent Crime Rate • Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth • Social Associations |

10. System Navigation

System navigation refers to an individual’s ability to traverse fragmented social-services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.⁹ Further, accessing social-services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

| Primary Data Analysis | Secondary Data Analysis |
|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • It is difficult to access and navigate the healthcare | (there are no quantitative indicators) |

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

⁹ Natale-Pereira, A. et. al. .2011. The Role of Patient Navigators in Eliminating Health Disparities. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

| Primary Data Analysis | Secondary Data Analysis |
|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <p>system.</p> <ul style="list-style-type: none"> • The lack of integration in the system makes it difficult to navigate. • Many families to not know what services are available to them. | associated with this health need). |

11. Access to Dental Care and Preventive Services

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

| Primary Data Analysis | Secondary Data Analysis |
|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • Some parts of the community have no dentists. • It is difficult to get an appointment with a dentist. • There are limited dental services available for low-income community members. • Oral health needs to focus more on prevention in the area. • There are no specialty dental services in the community. | <ul style="list-style-type: none"> • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Dental Care Shortage Area • Dentists |

12. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one’s living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one’s lifestyle, heredity, or access to medical services.¹⁰

| Primary Data Analysis | Secondary Data Analysis |
|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| <ul style="list-style-type: none"> • The community has limited re-cycling programs. | <ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death |

¹⁰ Blum, H. L. 1983. Planning for Health. New York: Human Sciences Press

| Primary Data Analysis | Secondary Data Analysis |
|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants and focus group participants: | The following indicators performed worse in the service area when compared to state averages: |
| | <ul style="list-style-type: none"> • Chronic Lower Respiratory Disease Mortality • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Lung Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Adult Smoking • Pollution Burden Percent • Air Pollution - Particulate Matter • Drinking Water Violations |

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation’s County Health Rankings model.¹¹ This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. MHLB requested written comments from the public on its 2019 CHNA and most recently adopted Implementation Strategy through SHCB@sutterhealth.org.

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

¹¹ Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/>.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 8 interviews with 11 community health experts and 4 focus groups conducted with a total of 18 community residents or community service providers.

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

Data Analysis

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

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

Description of Community Served

The definition of the community served by the hospital was defined by four ZIP Code boundaries: 93620, 93635, 93665, and 95322. This service area was identified as the area where the majority of patients served by the hospital resided. The total population of the service area was 61,211.

The city and community of Los Banos is located in Merced County near the Interstate 5 corridor. Los Banos sits at the intersection of State Routes 152 and 165. According to the 2020 U.S. census, the city of Los Banos had a population of just over 44,000 residents, second only to the city of Merced as the county's largest city. The community serves as a bedroom community for those commuting to and from the San Francisco Bay Area.

Merced County, named after the Merced River, sits in the heart of California's central valley and much of its economy is driven by agriculture. The county covers approximately 2,000 square miles. From an employment perspective, the county's largest industries include government, agriculture, and

healthcare. According to *County Health Rankings*,¹² Merced County ranks as the 38th most healthy county among the 58 in California. Hispanic/Latino's account for over 60% of the total population, followed by non-Hispanic Whites at just over 26%. The service area is shown in Figure 2.

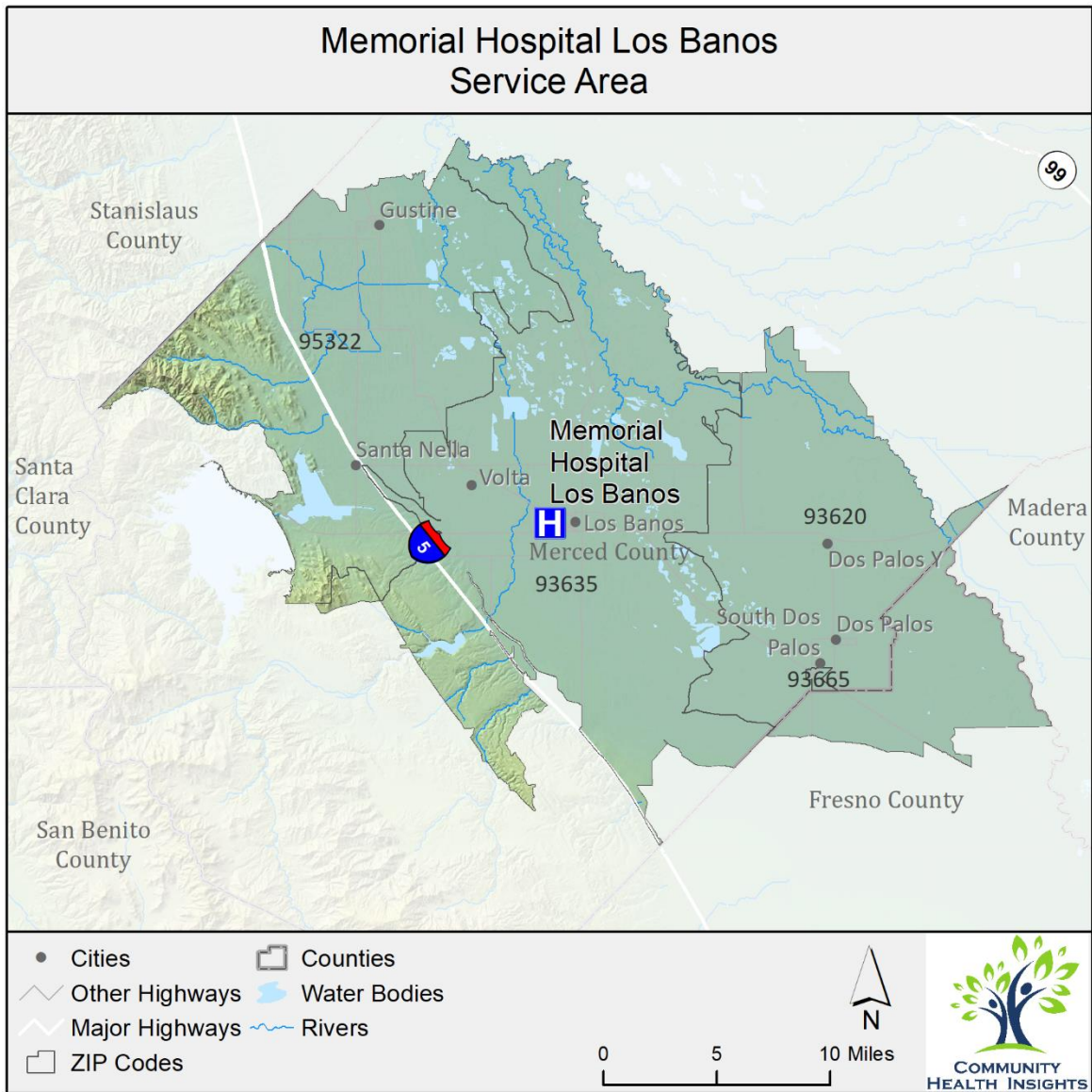


Figure 2: Community served by MHLB.

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

¹² See www.countyhealthrankings.org

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

| ZIP Code | Total Population | % Non-White or Hispanic/Latinx | Median Age (yrs.) | Median Income | % Poverty | % Unemployment | % Uninsured | % Without High School Graduation | % With High Housing Costs | % With Disability |
|---------------|------------------|--------------------------------|-------------------|---------------|-----------|----------------|-------------|----------------------------------|---------------------------|-------------------|
| 93620 | 8,906 | 77.2 | 31.5 | \$45,014 | 17.8 | 13.2 | 12.5 | 36.5 | 32.7 | 9.1 |
| 93635 | 41,180 | 78.8 | 30.7 | \$62,526 | 17.5 | 12.8 | 9.1 | 30.6 | 37.1 | 11.2 |
| 93665 | 752 | 100.0 | 28.5 | \$40,263 | ~ | 31.6 | 5.9 | 47.4 | ~ | 16.5 |
| 95322 | 10,373 | 66.3 | 35.1 | \$54,820 | 22.1 | 11.7 | 10.4 | 28.5 | 32.8 | 15.7 |
| Merced County | 271,382 | 72.4 | 31.1 | \$53,672 | 21.2 | 11.9 | 8.3 | 30.9 | 35.4 | 13.0 |
| California | 39,283,497 | 62.8 | 36.5 | \$75,235 | 13.4 | 6.1 | 7.5 | 16.7 | 40.6 | 10.6 |

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

~ Values for these indicators were determined to be unreliable and are omitted intentionally.

Health Equity

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

“Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”¹³

Inequities experienced early and throughout one’s life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation.”¹⁴

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

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

¹³ Robert Wood Johnsons Foundation. 2017. What is Health Equity? And What Difference Does a Definition Make? Health Equity Issue Brief #1. Retrieved 31 Jan 2022 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf .

¹⁴ Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.

Health Outcomes - the Results of Inequity

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

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

| Health Outcomes | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|---|--|--------------------------------|-------|----------|----------|---------|---------|
| Life Expectancy | Average number of years a person can expect to live. | ~ | 83.3 | 71.6 | 83.2 | 76.9 | 79.2 |
| Child Mortality | Number of deaths among children under age 18 per 100,000 population. | ~ | ~ | 99.9 | 41.4 | 37.5 | 40.9 |
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 403.5 | 274.8 | 667.1 | 256.8 | 418.3 | 342.3 |
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | ~ | 5,110 | 14,778.6 | 5,354.6 | 7,915.2 | 6,593 |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | 11.8% | 6.2% | 12.9% | 6% | 5.5% | 6.2% |
| ~ Data Not Available | | | | | | | |
| Data sources included in the technical section of the report. | | | | | | | |

When examining health outcomes, inequities are apparent among the different race and ethnic groups. For example, life expectancy was significantly lower among Blacks when compared to other groups, while child mortality, premature age-adjusted mortality, premature death and low birthweight were notably higher.

Health Factors - Inequities in the Service Area

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

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

| Health Factors | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|---|---|--------------------------------|----------|----------|----------|----------|----------|
| Some College ^a | Percentage of adults ages 25 and over with some post-secondary education. | 41.4% | 52.7% | 55.1% | 31.4% | 58.9% | 43.9% |
| High School Completion ^a | Percentage of adults ages 25 and over with at least a high school diploma or equivalent. | 69.9% | 69.6% | 86.4% | 54.7% | 88.1% | 69.1% |
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | ~ | 2.9 | ~ | 2.6 | 3.1 | 2.7 |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | ~ | 2.7 | ~ | 2.4 | 2.8 | 2.5 |
| Children in Poverty | Percentage of people under age 18 in poverty. | 44.4% | 23.2% | 29.6% | 33.9% | 17.2% | 22.5% |
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | \$41,875 | \$63,559 | \$40,809 | \$48,145 | \$64,537 | \$59,733 |
| Uninsured Population ^b | Percentage of the civilian non-institutionalized population without health insurance. | 6.3% | 6.3% | 5.8% | 10.3% | 5% | 8.3% |
| ~ Data Not Available | | | | | | | |
| Unless otherwise noted, data sources included in the technical section of the report. | | | | | | | |
| ^a From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I. | | | | | | | |
| ^b From 2019 American Community Survey 5-year estimates table S2701. | | | | | | | |

Inequities can be seen among the health factors that lead to health outcomes when compared across groups. For example, while less than 20% of White children lived in poverty in the county, almost 45% of American Indian/Alaskan Native children lived in poverty. Further, while almost 90% of Whites completed high school, just over half of all Hispanics did.

Population Groups Experiencing Disparities

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

the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

Frequency of Mentions in Interviews

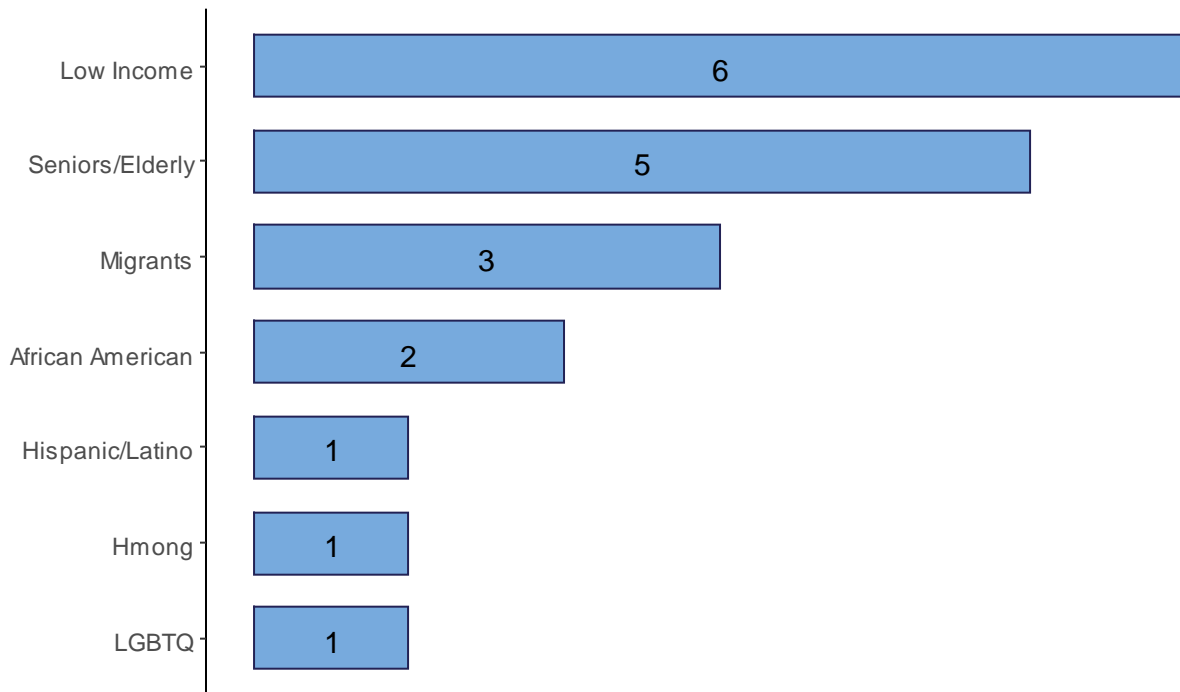


Figure 3: Populations experiencing disparities the MHLB service area.

California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)¹⁵ values for the MHLB service area. The HPI is an index based on 25 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

¹⁵ Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from <https://healthyplacesindex.org/about/>.

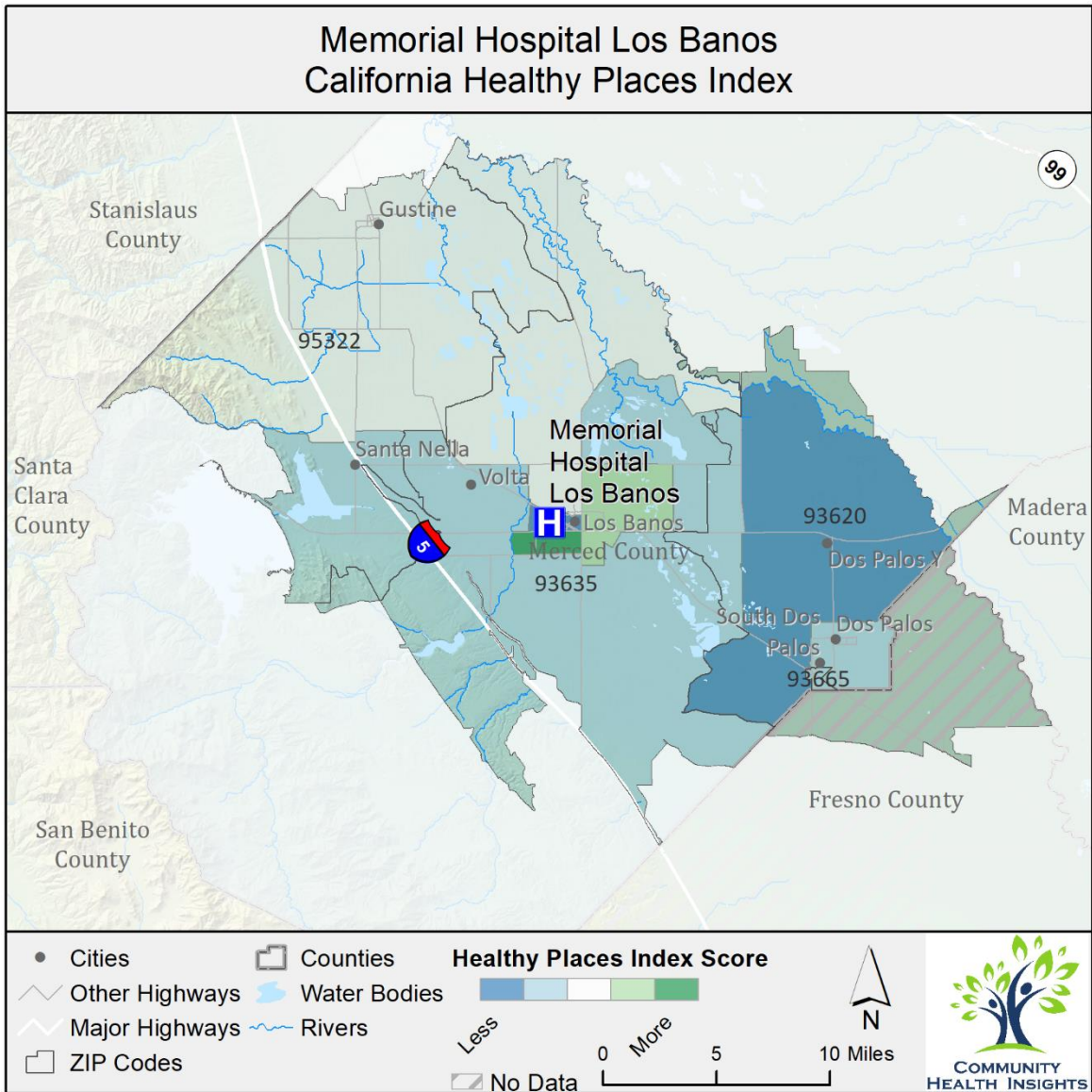


Figure 4: Healthy Places Index for MHLB.

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators regard the HSA are noted in Table 5.

Table 5: COVID-19-related rates for the MHLB service area.

| Indicators | Description | Merced | | California | |
|---|--|----------|----------|------------------|----------------------|
| COVID-19 Mortality | Number of deaths due to COVID-19 per 100,000 population. | 287.0 | 215.6 | Merced: 287 | California: 215.6 |
| COVID-19 Case Fatality | Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases. | 1.3% | 1.0% | Merced: 1.3% | California: 1% |
| COVID-19 Cumulative Incidence | Number of laboratory-confirmed COVID-19 cases per 100,000 population. | 22,658.5 | 21,335.2 | Merced: 22,658.5 | California: 21,335.2 |
| COVID-19 Cumulative Full Vaccination Rate | Number of completed COVID-19 vaccinations per 100,000 population. | 51,461.8 | 69,774.3 | Merced: 51,461.8 | California: 69,774.3 |

COVID-19 data collected on February 28 2022

Key informants and focus group participants were asked how the COVID-19 pandemic had impacted the health needs they described during interviews. A summary of their responses is shown in Table 6.

Table 6: The impacts of COVID-19 on health need as identified in primary data sources.

| Key Informant and Focus Group Responses |
|---|
| <ul style="list-style-type: none"> • School closures resulted in youth getting behind in school and experiencing isolation and the lack of socialization. • The pandemic brought economic hardships to the area, especially for the more vulnerable in the community; unemployment and poverty rates increased. • There is a distrust of government institutions and this resulted in many not getting vaccinations. • The community saw an increase in mental/behavior health and substance-use needs, including an increase in depression, substance-use, domestic violence, and child abuse. • Those living in multi-generational housing were not able to isolate during the pandemic. • The pandemic exacerbated an existing shortage in healthcare workers. • Many in the community avoided preventative care. • The pandemic increased food insecurity across the community. • Economic issues brought on by the pandemic were especially devastating for the poor. • Many ceased engaging in physical activities and gained weight over the course of the pandemic. |

Resources Potentially Available to Meet the Significant Health Needs

In all, 143 resources were identified in the MHLB service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 58 social-service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Memorial Hospital Los

Banos CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 7.

Table 7: Resources potentially available to meet significant health needs in priority order.

| Significant Health Needs (in Priority Order) | Number of Resources |
|---|----------------------------|
| Access to Basic Needs Such as Housing, Jobs, and Food | 16 |
| Access to Mental/Behavioral Health and Substance-Use Services | 23 |
| Access to Specialty and Extended Care | 5 |
| Access to Quality Primary Care Health Services | 18 |
| Injury and Disease Prevention and Management | 18 |
| Access to Functional Needs | 4 |
| Increased Community Connections | 21 |
| Active Living and Healthy Eating | 3 |
| Safe and Violence-Free Environment | 7 |
| System Navigation | 18 |
| Access to Dental Care and Preventive Services | 9 |
| Healthy Physical Environment | 1 |
| Total Resources | 143 |

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

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital’s CHNA report include “an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility’s prior CHNA(s) (p. 78969).”¹⁶ MHLB invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

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

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

¹⁶ Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Memorial Hospital Los Banos (MHLB) hospital service area (HSA).

Results of Data Analysis

Compiled Secondary Data

The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. The associated figures show rates for the county compared to the California state rates.

Length of Life

Table 8: County length of life indicators compared to state benchmarks.

| Indicators | Description | Merced | California | |
|---|--|---------|------------|--------------------------------------|
| Early Life | | | | |
| Infant Mortality | Number of all infant deaths (within 1 year), per 1,000 live births. | 3.9 | 4.2 | Merced: 3.9 California: 4.2 |
| Child Mortality | Number of deaths among children under age 18 per 100,000 population. | 40.9 | 36.0 | Merced: 40.9 California: 36 |
| Life Expectancy | Average number of years a person can expect to live. | 79.2 | 81.7 | Merced: 79.2 California: 81.7 |
| Overall | | | | |
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 342.3 | 268.4 | Merced: 342.3 California: 268.4 |
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | 6,593.0 | 5,253.1 | Merced: 6,593 California: 5,253.1 |
| Stroke Mortality | Number of deaths due to stroke per 100,000 population. | 36.5 | 41.2 | Merced: 36.5 California: 41.2 |
| Chronic Lower Respiratory Disease Mortality | Number of deaths due to chronic lower respiratory disease per 100,000 population. | 38.0 | 34.8 | Merced: 38 California: 34.8 |

| Indicators | Description | Merced | | California | |
|---|--|--------|-------|---------------|-------------------|
| Diabetes Mortality | Number of deaths due to diabetes per 100,000 population. | 26.7 | 24.1 | Merced: 26.7 | California: 24.1 |
| Heart Disease Mortality | Number of deaths due to heart disease per 100,000 population. | 145.2 | 159.5 | Merced: 145.2 | California: 159.5 |
| Hypertension Mortality | Number of deaths due to hypertension per 100,000 population. | 11.6 | 13.8 | Merced: 11.6 | California: 13.8 |
| Cancer, Liver, and Kidney Disease | | | | | |
| Cancer Mortality | Number of deaths due to cancer per 100,000 population. | 138.3 | 152.9 | Merced: 138.3 | California: 152.9 |
| Liver Disease Mortality | Number of deaths due to liver disease per 100,000 population. | 15.7 | 13.9 | Merced: 15.7 | California: 13.9 |
| Kidney Disease Mortality | Number of deaths due to kidney disease per 100,000 population. | 10.6 | 9.7 | Merced: 10.6 | California: 9.7 |
| Intentional and Unintentional Injuries | | | | | |
| Suicide Mortality | Number of deaths due to suicide per 100,000 population. | 10.2 | 11.2 | Merced: 10.2 | California: 11.2 |
| Unintentional Injuries Mortality | Number of deaths due to unintentional injuries per 100,000 population. | 50.1 | 35.7 | Merced: 50.1 | California: 35.7 |
| COVID-19 | | | | | |
| COVID-19 Mortality | Number of deaths due to COVID-19 per 100,000 population. | 287.0 | 215.6 | Merced: 287 | California: 215.6 |
| COVID-19 Case Fatality | Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases. | 1.3% | 1.0% | Merced: 1.3% | California: 1% |
| Other | | | | | |
| Alzheimer's Disease Mortality | Number of deaths due to Alzheimer's disease per 100,000 population. | 23.8 | 41.2 | Merced: 23.8 | California: 41.2 |

| Indicators | Description | Merced | | California | |
|-----------------------------------|---|--------|------|------------|----------------|
| Influenza and Pneumonia Mortality | Number of deaths due to influenza and pneumonia per 100,000 population. | 16.0 | 16.0 | Merced: 16 | California: 16 |

Quality of Life

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

| Indicators | Description | Merced | | California | |
|----------------------------|--|--------|-------|---------------|-------------------|
| Chronic Disease | | | | | |
| Diabetes Prevalence | Percentage of adults ages 20 and above with diagnosed diabetes. | 13.1% | 8.8% | Merced: 13.1% | California: 8.8% |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | 6.2% | 6.9% | Merced: 6.2% | California: 6.9% |
| HIV Prevalence | Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population. | 136.0 | 395.9 | Merced: 136 | California: 395.9 |
| Disability | Percentage of the total civilian noninstitutionalized population with a disability | 13.0% | 10.6% | Merced: 13% | California: 10.6% |
| Mental Health | | | | | |
| Poor Mental Health Days | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). | 5.0 | 3.7 | Merced: 5 | California: 3.7 |
| Frequent Mental Distress | Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). | 15.5% | 11.3% | Merced: 15.5% | California: 11.3% |
| Poor Physical Health Days | Average number of physically unhealthy days reported in past 30 days (age-adjusted). | 5.4 | 3.9 | Merced: 5.4 | California: 3.9 |
| Frequent Physical Distress | Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted). | 16.7% | 11.6% | Merced: 16.7% | California: 11.6% |
| Poor or Fair Health | Percentage of adults reporting fair or poor health (age-adjusted). | 28.4% | 17.6% | Merced: 28.4% | California: 17.6% |
| Cancer | | | | | |

| Indicators | Description | Merced | | California | |
|-------------------------------|---|----------|----------|------------------|----------------------|
| Colorectal Cancer Prevalence | Colon and rectum cancers per 100,000 population (age-adjusted). | 38.1 | 34.8 | Merced: 38.1 | California: 34.8 |
| Breast Cancer Prevalence | Female in situ breast cancers per 100,000 female population (age-adjusted). | 20.3 | 27.9 | Merced: 20.3 | California: 27.9 |
| Lung Cancer Prevalence | Lung and bronchus cancers per 100,000 population (age-adjusted). | 46.7 | 40.9 | Merced: 46.7 | California: 40.9 |
| Prostate Cancer Prevalence | Prostate cancers per 100,000 male population (age-adjusted). | 69.6 | 91.2 | Merced: 69.6 | California: 91.2 |
| COVID-19 | | | | | |
| COVID-19 Cumulative Incidence | Number of laboratory-confirmed COVID-19 cases per 100,000 population. | 22,658.5 | 21,335.2 | Merced: 22,658.5 | California: 21,335.2 |
| Other | | | | | |
| Asthma ED Rates | Emergency department visits due to asthma per 10,000 (age-adjusted). | 599.0 | 422.0 | Merced: 599 | California: 422 |
| Asthma ED Rates for Children | Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted). | 762.0 | 601.0 | Merced: 762 | California: 601 |

Health Behavior

Table 10: County health behavior indicators compared to state benchmarks.

| Indicators | Description | Merced | | California | |
|--------------------|--|--------|-------|---------------|-------------------|
| Excessive Drinking | Percentage of adults reporting binge or heavy drinking (age-adjusted). | 17.0% | 18.1% | Merced: 17% | California: 18.1% |
| Drug Induced Death | Drug induced deaths per 100,000 (age-adjusted). | 16.3 | 14.3 | Merced: 16.3 | California: 14.3 |
| Adult Obesity | Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m ² . | 33.4% | 24.3% | Merced: 33.4% | California: 24.3% |

| Indicators | Description | Merced | | California | |
|----------------------------------|--|--------|-------|---------------|-------------------|
| Physical Inactivity | Percentage of adults ages 20 and over reporting no leisure-time physical activity. | 27.4% | 17.7% | Merced: 27.4% | California: 17.7% |
| Limited Access to Healthy Foods | Percentage of population who are low-income and do not live close to a grocery store. | 7.3% | 3.3% | Merced: 7.3% | California: 3.3% |
| Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). | 7.2 | 8.8 | Merced: 7.2 | California: 8.8 |
| Access to Exercise Opportunities | Percentage of population with adequate access to locations for physical activity. | 69.6% | 93.1% | Merced: 69.6% | California: 93.1% |
| Chlamydia Incidence | Number of newly diagnosed chlamydia cases per 100,000 population. | 601.8 | 585.3 | Merced: 601.8 | California: 585.3 |
| Teen Birth Rate | Number of births per 1,000 female population ages 15-19. | 27.5 | 17.4 | Merced: 27.5 | California: 17.4 |
| Adult Smoking | Percentage of adults who are current smokers (age-adjusted). | 16.4% | 11.5% | Merced: 16.4% | California: 11.5% |

Clinical Care

Table 11: County clinical care indicators compared to state benchmarks.

| Indicators | Description | Merced | California |
|----------------------------------|---|--------|----------------------------|
| Primary Care Shortage Area | Presence of a primary care health professional shortage area within the county. | Yes | Merced: Yes California: |
| Dental Care Shortage Area | Presence of a dental care health professional shortage area within the county. | Yes | Merced: Yes California: |
| Mental Health Care Shortage Area | Presence of a mental health professional shortage area within the county. | Yes | Merced: Yes California: |
| Medically Underserved Area | Presence of a medically underserved area within the county. | Yes | Merced: Yes California: |

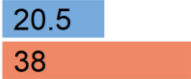

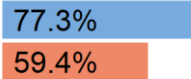
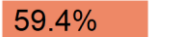
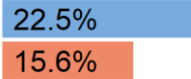
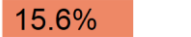
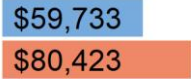
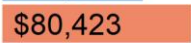
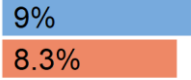
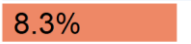


| Indicators | Description | Merced | | California | |
|---|---|----------|----------|------------------|----------------------|
| Mammography Screening | Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. | 37.0% | 36.0% | Merced: 37% | California: 36% |
| Dentists | Dentists per 100,000 population. | 46.1 | 87.0 | Merced: 46.1 | California: 87 |
| Mental Health Providers | Mental health providers per 100,000 population. | 188.7 | 373.4 | Merced: 188.7 | California: 373.4 |
| Psychiatry Providers | Psychiatry providers per 100,000 population. | 1.5 | 13.5 | Merced: 1.5 | California: 13.5 |
| Specialty Care Providers | Specialty care providers (non-primary care physicians) per 100,000 population. | 50.2 | 190.0 | Merced: 50.2 | California: 190 |
| Primary Care Providers | Primary care physicians per 100,000 population + other primary care providers per 100,000 population. | 107.1 | 147.3 | Merced: 107.1 | California: 147.3 |
| Preventable Hospitalization | Preventable hospitalizations per 100,000 (age-sex-poverty adjusted) | 1,152.5 | 948.3 | Merced: 1,152.5 | California: 948.3 |
| COVID-19 | | | | | |
| COVID-19 Cumulative Full Vaccination Rate | Number of completed COVID-19 vaccinations per 100,000 population. | 51,461.8 | 69,774.3 | Merced: 51,461.8 | California: 69,774.3 |

Socio-Economic and Demographic Factors

Table 12: County socio-economic and demographic factors indicators compared to state benchmarks.

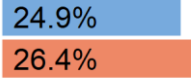
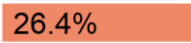
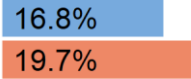
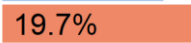
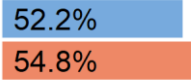
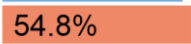
| Indicators | Description | Merced | | California | |
|-------------------------|--|--------|-----|-------------|-----------------|
| Community Safety | | | | | |
| Homicide Rate | Number of deaths due to homicide per 100,000 population. | 8.0 | 4.8 | Merced: 8 | California: 4.8 |
| Firearm Fatalities Rate | Number of deaths due to firearms per 100,000 population. | 8.9 | 7.8 | Merced: 8.9 | California: 7.8 |

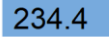
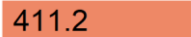
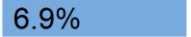
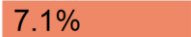
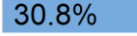

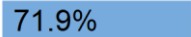
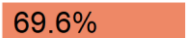
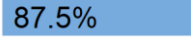




| Indicators | Description | Merced | California | |
|--------------------------------------|---|--------|------------|------------------------------------|
| Violent Crime Rate | Number of reported violent crime offenses per 100,000 population. | 555.3 | 420.9 | Merced: 555.3 California: 420.9 |
| Juvenile Arrest Rate | Felony juvenile arrests per 1,000 juveniles | 3.0 | 2.1 | Merced: 3 California: 2.1 |
| Motor Vehicle Crash Death | Number of motor vehicle crash deaths per 100,000 population. | 18.6 | 9.5 | Merced: 18.6 California: 9.5 |
| Education | | | | |
| Some College | Percentage of adults ages 25-44 with some post-secondary education. | 48.6% | 65.7% | Merced: 48.6% California: 65.7% |
| High School Completion | Percentage of adults ages 25 and over with a high school diploma or equivalent. | 69.1% | 83.3% | Merced: 69.1% California: 83.3% |
| Disconnected Youth | Percentage of teens and young adults ages 16-19 who are neither working nor in school. | 8.3% | 6.4% | Merced: 8.3% California: 6.4% |
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | 2.7 | 2.9 | Merced: 2.7 California: 2.9 |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | 2.5 | 2.7 | Merced: 2.5 California: 2.7 |
| Employment | | | | |
| Unemployment | Percentage of population ages 16 and older unemployed but seeking work. | 8.1% | 4.0% | Merced: 8.1% California: 4% |
| Family and Social Support | | | | |
| Children in Single-Parent Households | Percentage of children that live in a household headed by single parent. | 25.8% | 22.5% | Merced: 25.8% California: 22.5% |
| Social Associations | Number of membership associations per 10,000 population. | 4.2 | 5.9 | Merced: 4.2 California: 5.9 |

| Indicators | Description | Merced | California | |
|---|---|------------|------------|--|
| Residential Segregation (Non-White/White) | Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents. | 20.5 | 38.0 | Merced:  California:  |
| Income | | | | |
| Children Eligible for Free Lunch | Percentage of children enrolled in public schools that are eligible for free or reduced price lunch. | 77.3% | 59.4% | Merced:  California:  |
| Children in Poverty | Percentage of people under age 18 in poverty. | 22.5% | 15.6% | Merced:  California:  |
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | \$59,733.0 | \$80,423.0 | Merced:  California:  |
| Uninsured Population under 64 | Percentage of population under age 65 without health insurance. | 9.0% | 8.3% | Merced:  California:  |
| Income Inequality | Ratio of household income at the 80th percentile to income at the 20th percentile. | 4.5 | 5.2 | Merced:  California:  |

Physical Environment

Table 13: County physical environment indicators compared to state benchmarks.

| Indicators | Description | Merced | California | |
|----------------------------|---|--------|------------|--|
| Housing | | | | |
| Severe Housing Problems | Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 24.9% | 26.4% | Merced:  California:  |
| Severe Housing Cost Burden | Percentage of households that spend 50% or more of their household income on housing. | 16.8% | 19.7% | Merced:  California:  |
| Homeownership | Percentage of occupied housing units that are owned. | 52.2% | 54.8% | Merced:  California:  |

| Indicators | Description | Merced California | | |
|--------------------------------------|---|-------------------|-------|--|
| Homelessness Rate | Number of homeless individuals per 100,000 population. | 234.4 | 411.2 | Merced:  California:  |
| Transit | | | | |
| Households with no Vehicle Available | Percentage of occupied housing units that have no vehicles available. | 6.9% | 7.1% | Merced:  California:  |
| Long Commute - Driving Alone | Among workers who commute in their car alone, the percentage that commute more than 30 minutes. | 30.8% | 42.2% | Merced:  California:  |
| Access to Public Transit | Percentage of population living near a fixed public transportation stop | 71.9% | 69.6% | Merced:  California:  |
| Air and Water Quality | | | | |
| Pollution Burden Percent | Percentage of population living in a census tract with a CalEnviroScreen 3.0 pollution burden score percentile of 50 or greater | 87.5% | 51.6% | Merced:  California:  |
| Air Pollution - Particulate Matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). | 12.0 | 8.1 | Merced:  California:  |
| Drinking Water Violations | Presence of health-related drinking water violations in the county. | Yes | | Merced:  California: |

CHNA Methods and Processes

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

Conceptual Model

The conceptual model used in this needs assessment is shown in Figure 5. This model organizes populations' individual health-related characteristics in terms of how they relate to up- or downstream health and health-disparities factors. In this model, health outcomes (quality and length of life) are

understood to result from the influence of health factors describing interrelated individual, environmental, and community characteristics, which in turn are influenced by underlying policies and programs.

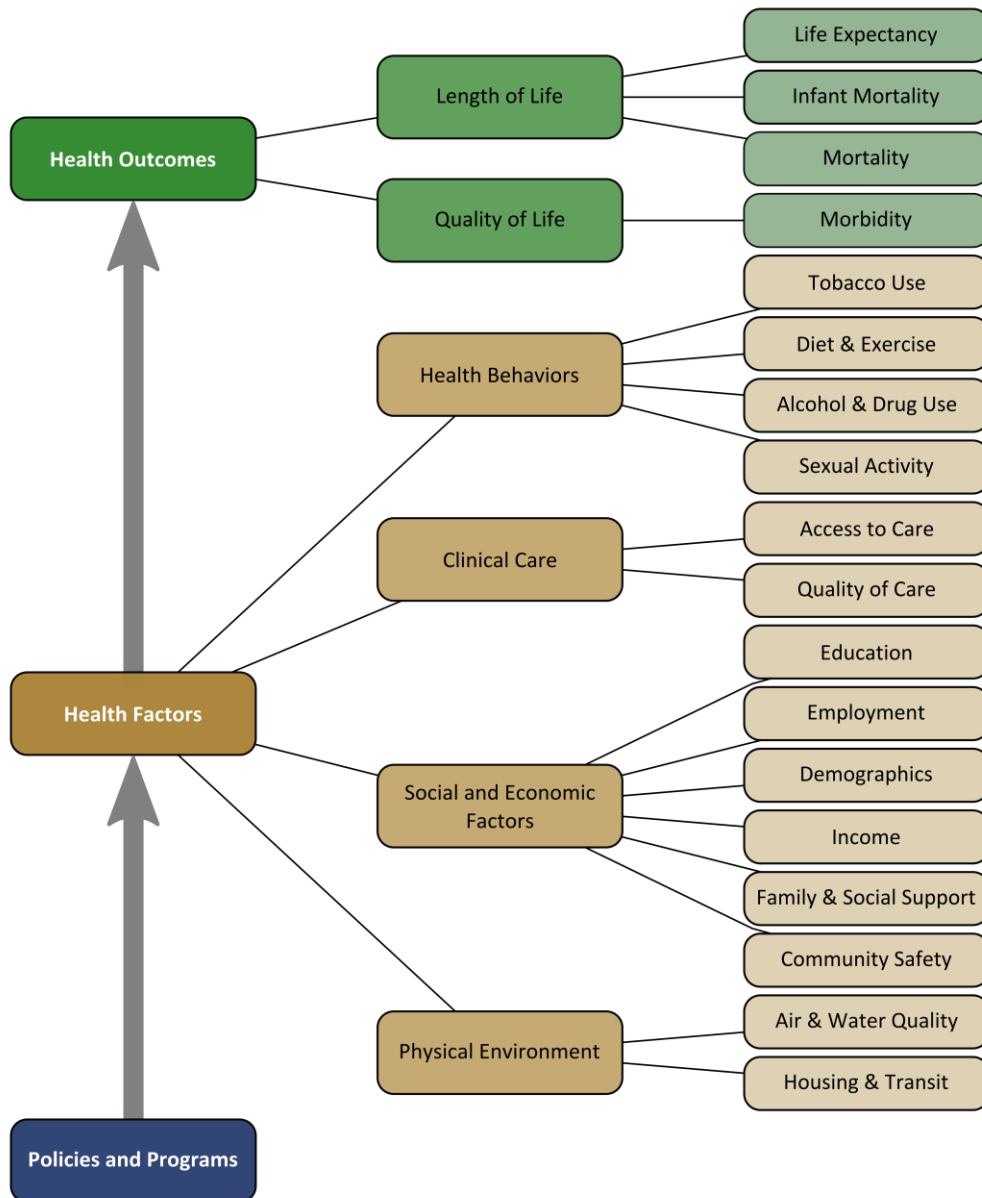


Figure 5: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

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

altered by adding a “Demographics” category to the “Social and Economic Factors” in recognition of the influence of demographic characteristics on health outcomes.

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

Process Model

Figure 6 outlines the data collection and analysis stages of this process. The project began by confirming the HSA for MHLB for which the CHNA would be conducted. Primary data collection included key informant interviews and focus-groups with community health experts and residents. Initial key informant interviews were used to identify areas or population subgroups within the county experiencing health disparities.

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

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

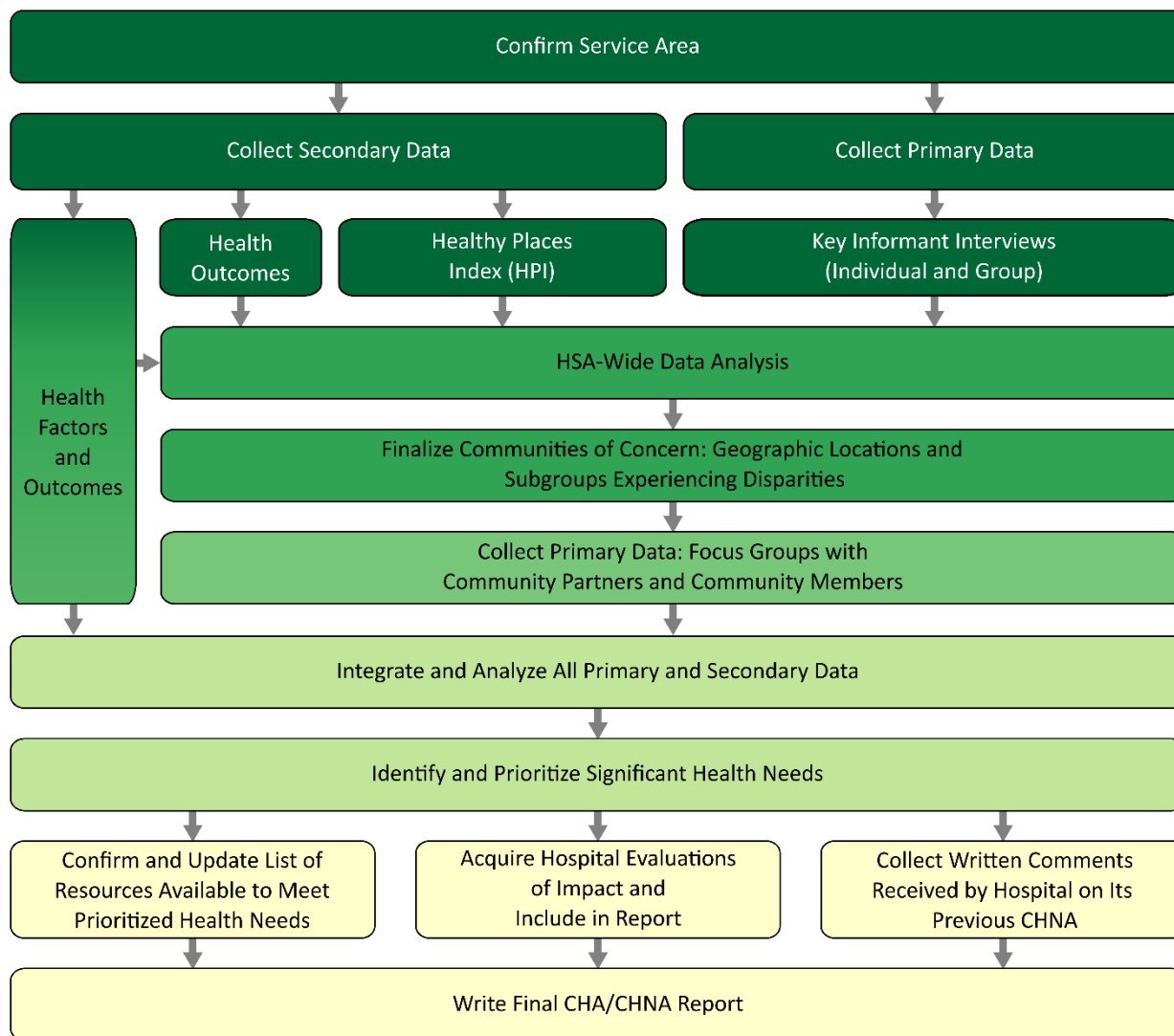


Figure 6: CHNA process model for MHLB.

Primary Data Collection and Processing

Primary Data Collection

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

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

Key Informant Results

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

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

Table 14 contains a listing of community health experts, or key informants, that contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

Table 14: Key Informant List

| Organization | Date | Number of Participants | Area of Expertise | Populations Served |
|---|------------|------------------------|---|--|
| Memorial Hospital Los Banos | 01/12/2022 | 2 | Acute care hospital | Areas of Merced County |
| Los Banos Unified School District | 01/12/2022 | 1 | Youth education and adult learners | Los Banos |
| Gustine Unified School District | 01/18/2022 | 1 | Youth education and adult learners | Gustine |
| Merced County Department of Public Health | 01/18/2022 | 2 | Public Health | Merced County |
| Merced County Behavioral Health and Recovery Services | 01/19/2022 | 1 | Mental health, substance use, behavioral health | Medi-Cal and indigent in Merced County |
| Golden Valley Health Centers | 01/21/2022 | 2 | Medical and dental services | Low income; homeless |
| First 5 Merced County | 01/24/2022 | 1 | Child development | Merced County |
| Community Foundation of Merced County | 01/25/2022 | 1 | Community investment | Merced County |

Key Informant Interview Guide

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

2022 CHNA Group/Key Informant Interview Protocol

1. BACKGROUND

- a) Please tell me about your current role and the organization you work for?
 - i. Probe for:

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

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

Focus Group Results

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

Table 15 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table 15: Focus Group List

| Hosting Organization | Date | Number of Participants | Populations Represented |
|--|------------|------------------------|--|
| Alliance for Community Transformation | 02/11/2022 | 1 | LGBTQ in Merced County |
| Boys and Girls Club of Merced | 02/15/2022 | 3 | Underserved; youth |
| United Way of Merced County - Cultiva La Salud | 02/22/2022 | 10 | Spanish speaking from Dos Palos, Los Banos and Gustine |
| Merced Lao Family Community | 02/25/2022 | 4 | Hmong |

Focus Group Interview Guide

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

2022 CHNA Focus Group Interview Protocol

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

Primary Data Processing

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

Secondary Data Collection and Processing

We use "secondary data" to refer to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to support the identification of health needs within the MHLB HSA. This section details the data sources and processing steps used to obtain the secondary data used for this analysis.

Significant Health Need Identification Dataset

The main set of data used in the CHNA includes the health factor and health outcome indicators used to identify significant health needs. The selection of these indicators was guided by the previously identified conceptual model. Table 16 lists these indicators, their sources, the years they were measured, and the health-related characteristics from the conceptual model they are primarily used to represent.

Table 16: Health factor and health outcome indicators used in health need identification.

| Conceptual Model Alignment | | Indicator | Data Source | Time Period |
|----------------------------|----------------|------------------|------------------------|-------------|
| Health Outcomes | Length of Life | Infant Mortality | County Health Rankings | 2013 - 2019 |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period | | |
|----------------------------|-----------------|---|---|-------------------------|------------------------|-------------|
| | Life Expectancy | Child Mortality | County Health Rankings | 2016 - 2019 | | |
| | | Life Expectancy | County Health Rankings | 2017 - 2019 | | |
| | | Premature Age-Adjusted Mortality | County Health Rankings | 2017 - 2019 | | |
| | | Premature Death | County Health Rankings | 2017 - 2019 | | |
| | | Stroke Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Chronic Lower Respiratory Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Diabetes Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Heart Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Hypertension Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Cancer Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Liver Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Kidney Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Suicide Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Unintentional Injuries Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | COVID-19 Mortality | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-02-28 | | |
| | | COVID-19 Case Fatality | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-02-28 | | |
| | | Alzheimer's Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Influenza and Pneumonia Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | | Quality of Life | Morbidity | Diabetes Prevalence | County Health Rankings | 2017 |
| | | | | Low Birthweight | County Health Rankings | 2013 - 2019 |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period | |
|----------------------------|---|------------------------|-------------------------------|--|-------------------------|
| | | | HIV Prevalence | County Health Rankings | 2018 |
| | | | Disability | 2019 American Community Survey 5 year estimate variable S1810_C03_001E | 2015 - 2019 |
| | | | Poor Mental Health Days | County Health Rankings | 2018 |
| | | | Frequent Mental Distress | County Health Rankings | 2018 |
| | | | Poor Physical Health Days | County Health Rankings | 2018 |
| | | | Frequent Physical Distress | County Health Rankings | 2018 |
| | | | Poor or Fair Health | County Health Rankings | 2018 |
| | | | Colorectal Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | Breast Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | Lung Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | Prostate Cancer Prevalence | California Cancer Registry | 2013 - 2017 |
| | | | COVID-19 Cumulative Incidence | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-02-28 |
| | | | Asthma ED Rates | Tracking California | 2018 |
| | | | Asthma ED Rates for Children | Tracking California | 2018 |
| | | | Health Factors | Health Behavior | Alcohol and Drug Use |
| Drug Induced Death | CDPH 2021 County Health Status Profiles | 2017 - 2019 | | | |
| Diet and Exercise | Adult Obesity | County Health Rankings | | | 2017 |
| | Physical Inactivity | County Health Rankings | | | 2017 |
| | Limited Access to Healthy Foods | County Health Rankings | | | 2015 |
| | Food Environment Index | County Health Rankings | | | 2015 & 2018 |
| | Access to Exercise Opportunities | County Health Rankings | | | 2010 & 2019 |
| Sexual Activity | Chlamydia Incidence | County Health Rankings | | | 2018 |
| | Teen Birth Rate | County Health Rankings | | | 2013 - 2019 |
| Tobacco Use | Adult Smoking | County Health Rankings | | | 2018 |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period |
|----------------------------|--|---|---|-------------------------|
| Clinical Care | Access to Care | Primary Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | Dental Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | Mental Health Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | Medically Underserved Area | U.S. Heath Resources and Services Administration | 2021 |
| | | Mammography Screening | County Health Rankings | 2018 |
| | | Dentists | County Health Rankings | 2019 |
| | | Mental Health Providers | County Health Rankings | 2020 |
| | | Psychiatry Providers | County Health Rankings | 2020 |
| | | Specialty Care Providers | County Health Rankings | 2020 |
| | | Primary Care Providers | County Health Rankings | 2018; 2020 |
| | Quality Care | Preventable Hospitalization | California Office of Statewide Health Planning and Development Prevention Quality Indicators for California | 2019 |
| | | COVID-19 Cumulative Full Vaccination Rate | CDPH COVID-19 Vaccine Progress Dashboard Data | Collected on 2022-02-28 |
| | Socio-Economic and Demographic Factors | Community Safety | Homicide Rate | County Health Rankings |
| Firearm Fatalities Rate | | | County Health Rankings | 2015 - 2019 |
| Violent Crime Rate | | | County Health Rankings | 2014 & 2016 |
| Juvenile Arrest Rate | | | Criminal Justice Data: Arrests, OpenJustice, California Department of Justice | 2015 - 2019 |
| Motor Vehicle Crash Death | | | County Health Rankings | 2013 - 2019 |
| Education | | Some College | County Health Rankings | 2015 - 2019 |
| | | High School Completion | County Health Rankings | 2015 - 2019 |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period | | |
|----------------------------|--------------------------------------|---------------------------|---|---|------------------------|-------------|
| | | | Disconnected Youth | County Health Rankings | 2015 - 2019 | |
| | | | Third Grade Reading Level | County Health Rankings | 2018 | |
| | | | Third Grade Math Level | County Health Rankings | 2018 | |
| | | Employment | Unemployment | County Health Rankings | 2019 | |
| | | Family and Social Support | Children in Single-Parent Households | County Health Rankings | 2015 - 2019 | |
| | | | Social Associations | County Health Rankings | 2018 | |
| | | | Residential Segregation (Non-White/White) | County Health Rankings | 2015 - 2019 | |
| | | Income | Children Eligible for Free Lunch | County Health Rankings | 2018 - 2019 | |
| | | | Children in Poverty | County Health Rankings | 2019 | |
| | | | Median Household Income | County Health Rankings | 2019 | |
| | | | Uninsured Population under 64 | County Health Rankings | 2018 | |
| | | | Income Inequality | County Health Rankings | 2015 - 2019 | |
| | | Physical Environment | Housing and Transit | Severe Housing Problems | County Health Rankings | 2013 - 2017 |
| | | | | Severe Housing Cost Burden | County Health Rankings | 2015 - 2019 |
| | | | | Homeownership | County Health Rankings | 2015 - 2019 |
| | Homelessness Rate | | | US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report | 2020 | |
| | Households with no Vehicle Available | | | 2019 American Community Survey 5-year estimate variable DP04_0058PE | 2015 - 2019 | |
| | Long Commute - Driving Alone | | | County Health Rankings | 2015 - 2019 | |
| | Access to Public Transit | | | OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau | 2021; 2020 | |

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|----------------------------|--|-----------------------|------------------------------------|---|-------------|
| | | Air and Water Quality | Pollution Burden Percent | California Office of Environmental Health Hazard Assessment | 2018 |
| | | | Air Pollution - Particulate Matter | County Health Rankings | 2016 |
| | | | Drinking Water Violations | County Health Rankings | 2019 |

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

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings¹⁷ dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 17.

Table 17: Sources and time periods for indicators obtained from County Health Rankings.

| CHR Indicator | Time Period | Data Source |
|----------------------------------|-------------|---|
| Infant Mortality | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Child Mortality | 2016 - 2019 | National Center for Health Statistics - Mortality Files |
| Life Expectancy | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Premature Age-Adjusted Mortality | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Premature Death | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Diabetes Prevalence | 2017 | United States Diabetes Surveillance System |
| Low Birthweight | 2013 - 2019 | National Center for Health Statistics - Natality files |
| HIV Prevalence | 2018 | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention |
| Poor Mental Health Days | 2018 | Behavioral Risk Factor Surveillance System |

¹⁷ University of Wisconsin Population Health Institute. 2021. County Health Rankings State Report 2021. Retrieved 6 May 2021 from <https://www.countyhealthrankings.org/app/oregon/2021/downloads> and <https://www.countyhealthrankings.org/app/california/2021/downloads>.

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

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

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

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa¹⁸ online data query system for the years 2015-2019. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

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

¹⁸ State of California, Department of Public Health. 2021. California Vital Data (Cal-ViDa), Death Query. Retrieved 1 Jun 2021 from <https://cal-vida.cdph.ca.gov/>.

state and the total by-cause mortality reported across all counties in the state for each cause and year were also calculated.

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

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

COVID-19 Data

Data on the cumulative number of cases and deaths¹⁹ and completed vaccinations²⁰ for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles²¹ and report age-adjusted deaths per 100,000.

U.S. Health Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration²² (HRSA). These included Dental, Mental Health, and Primary Care Health

¹⁹ State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved February 28 2022 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

²⁰ State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved February 28 2022 from <https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv>.

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

²² US Health Resources & Services Administration. 2021. Area Health Resources Files and Shortage Areas. Retrieved on 3 Feb 2021 from <https://data.hrsa.gov/data/download>.

Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

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

Psychiatry and Specialty Care Providers

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

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

California Cancer Registry

Data obtained from the California Cancer Registry²³ includes age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2013 to 2017, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

²³ California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from <https://www.cancer-rates.info/ca/>.

Tracking California

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California.²⁴ These data reported age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

US Census Bureau

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

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroScreen 3.0²⁵ dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroScreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators.²⁶ These data are reported as risk-adjusted rates per 100,000.

California Department of Justice

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.²⁷ This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015 - 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated

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

²⁵ California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from <https://oehha.ca.gov/calenviroscreen/maps-data>.

²⁶ Office of Statewide Health Planning and Development. 2021. Prevention Quality Indicators (PQI) for California. Data files for Statewide and County. Retrieved 12 Mar 2021 from <https://oshpd.ca.gov/data-and-reports/healthcare-quality/ahrq-quality-indicators/>.

²⁷ California Department of Justice, OpenJustice. 2021. Criminal Justice Data: Arrests. Retrieved 17 Jun 2021 from <https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2020-07/OnlineArrestData1980-2019.csv>.

to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I respectively.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report²⁸ were used to calculate homelessness rates for the counties and state. This data reported point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

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

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

Proximity to Transit Stops

The proximity to transit stops variable reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Likely due to delays in data releases stemming from the COVID-19 pandemic, the most recent Census block population data available at the time of the analysis was from the 2010 Decennial Census,²⁹ so this was the data used to represent the distribution of population for this indicator.

Transit stop data were identified first by using tools in the TidyTransit³⁰ library for the R statistical programming language.³¹ This was used to identify transit providers with stops located within 100 miles of the state boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData,³² Transitland,³³

²⁸ US Department of Housing and Urban Development. 2021. 2020 Annual Homeless Assessment Report: 2007 - 2020 Point-in-Time Estimates by CoC. Retrieved 14 Jul 2021 from <https://www.huduser.gov/portal/sites/default/files/xls/2007-2020-PIT-Estimates-by-CoC.xlsx>.

²⁹ US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from <https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/>.

³⁰ Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. Retrieved 10 Sep 2021 from <https://CRAN.R-project.org/package=tidytransit>.

³¹ R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>.

³² OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from <https://openmobilitydata.org/l/67-california-usa>.

Transitwiki.org,³⁴ and Santa Ynez Valley Transit.³⁵ Each of these websites list public transit data that have been made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf³⁶ library in R was then used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

The collected and processed primary and secondary data were integrated in two main analytical stages. First, secondary data were combined with results from key informant interviews and focus groups (primary data) to identify significant health needs within the service area. Then, primary data were used to prioritize those identified significant health needs. The specific details for these analytical steps are given in the following sections.

Significant Health Need Identification

The general methods through which significant health needs (SHNs) were identified are shown in Figure 7 and described here in greater detail. The first step in this process was to identify a set of potential health needs (PHNs) from which significant health needs could be selected. This was done by reviewing the health needs identified during prior CHNAs among various hospitals throughout Central and Northern California and then supplementing this list based on a preliminary analysis of the primary qualitative data collected for the current CHNA. This resulted the list of PHNs shown in Table 18.

³³ Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from <https://www.transit.land/operators>.

³⁴ Transitwiki.org. 2021. List of publicly-accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.

³⁵ Santa Ynez Valley Transit. GTFS Files. Retrieved 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.

³⁶ Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, <https://doi.org/10.32614/RJ-2018-009>.

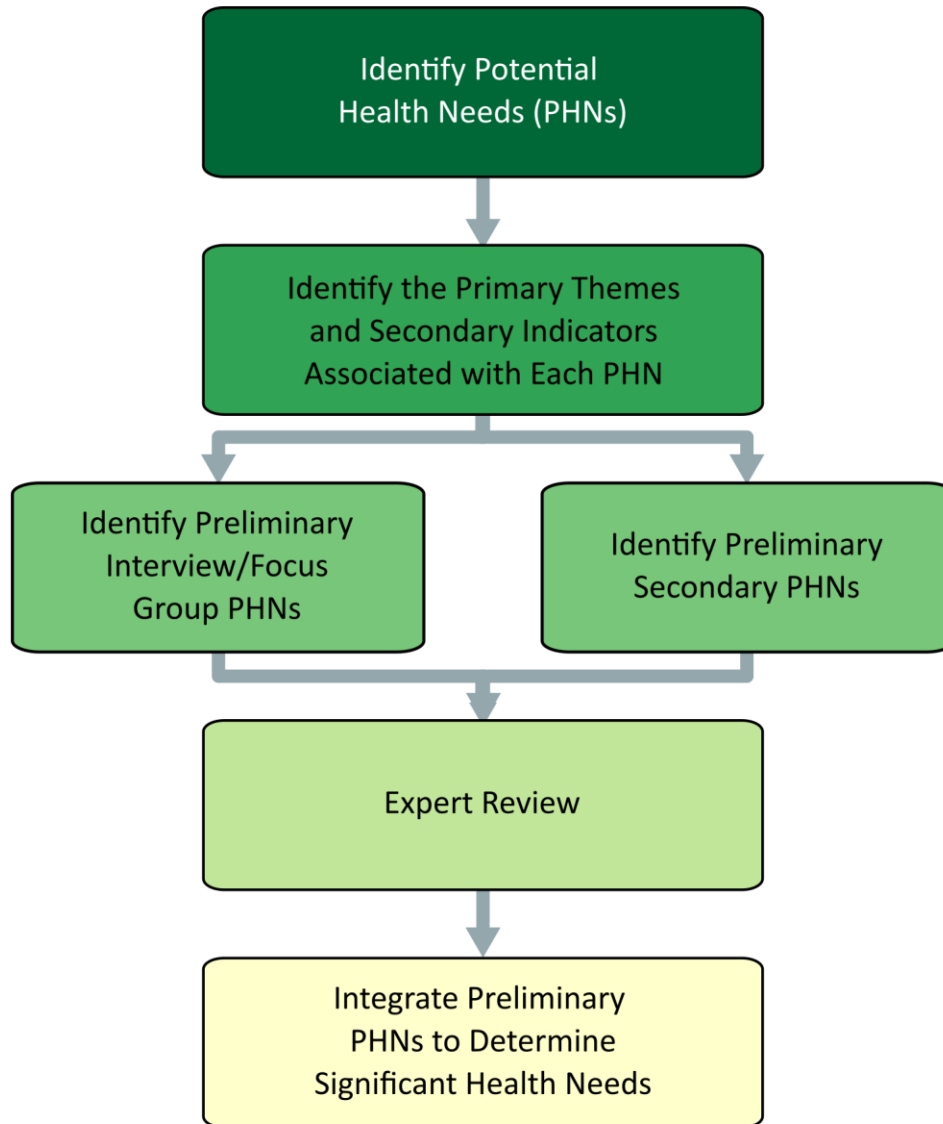


Figure 7: Significant health need identification process.

Table 18: 2022 Potential Health Needs.

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

Potential Health Needs (PHNs)

PHN11 Increased Community Connections

PHN12 System Navigation

The next step in the process was to identify primary themes and secondary indicators associated with each of these health needs as shown in Tables 19 through 30. Primary theme associations were used to guide coding of the primary data sources to specific PHNs.

Access to Mental/Behavioral Health and Substance-Use Services

Table 19: Primary themes and secondary indicators associated with PHN1.

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

Access to Quality Primary Care Health Services

Table 20: Primary themes and secondary indicators associated with PHN2

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

| Primary Themes | Secondary Indicators |
|----------------|----------------------|
| | Homelessness Rate |

Active Living and Healthy Eating

Table 21: Primary themes and secondary indicators associated with PHN3

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

| Primary Themes | Secondary Indicators |
|----------------|--------------------------|
| | Access to Public Transit |

Safe and Violence-Free Environment

Table 22: Primary themes and secondary indicators associated with PHN4

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

Access to Dental Care and Preventive Services

Table 23: Primary themes and secondary indicators associated with PHN5

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

| Primary Themes | Secondary Indicators |
|----------------|----------------------|
| | Homelessness Rate |

Healthy Physical Environment

Table 24: Primary themes and secondary indicators associated with PHN6

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

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

Table 25: Primary themes and secondary indicators associated with PHN7

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

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

Access to Functional Needs

Table 26: Primary themes and secondary indicators associated with PHN8

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

Access to Specialty and Extended Care

Table 27: Primary themes and secondary indicators associated with PHN9

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

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

Injury and Disease Prevention and Management

Table 28: Primary themes and secondary indicators associated with PHN10

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

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

Increased Community Connections

Table 29: Primary themes and secondary indicators associated with PHN11

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

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

System Navigation

Table 30: Primary themes and secondary indicators associated with PHN12

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

| Primary Themes | Secondary Indicators |
|---|----------------------|
| healthcare system | |
| Dealing with medical and insurance paperwork can be overwhelming. | |
| Medical terminology is confusing. | |
| Some people just don't know where to start in order to access care or benefits. | |

Next, values for the secondary health-factor and health-outcome indicators identified were compared to state benchmarks to determine if a secondary indicator performed poorly within the county. Some indicators were considered problematic if they exceeded the benchmark, others were considered problematic if they were below the benchmark, and the presence of certain other indicators within the county, such as health professional shortage areas, indicated issues. Table 31 lists each secondary indicator and describes the comparison made to the benchmark to determine if it was problematic.

Table 31: Benchmark comparisons to show indicator performance.

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

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

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

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

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

For this report, a PHN was selected as a preliminary quantitative significant health need if 60% of the associated quantitative indicators were identified as performing poorly, and as a preliminary qualitative significant health need if it was identified by 60% or more of the primary sources as performing poorly. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in either or both of these categories.

Health Need Prioritization

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

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the

community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need.

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

Detailed List of Resources to Address Health Needs

Table 32: Resources available to meet health needs.

| Organization Information | | | Significant Health Needs | | | | | | | | | | | |
|---|------------------|--|---|--|---------------------------------------|--|--|----------------------------|---------------------------------|----------------------------------|------------------------------------|-------------------|---|------------------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Mental/Behavioral Health and Substance-Use | Access to Specialty and Extended Care | Access to Quality Primary Care Health Services | Injury and Disease Prevention and Management | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Safe and Violence-Free Environment | System Navigation | Access to Dental Care and Preventive Services | Healthy Physical Environment |
| 211 Merced | Whole County | www.211ca.org | | X | X | X | | X | | | | | X | |
| Adult Protective Services | Whole County | www.co.merced.ca.us/1480/Adult-Protective-Services | | X | | | | | | | | | | |
| Aegis Treatment Centers Merced | 95340 | pinnacle-treatment.com/location/california/merced/aegis-treatment-centers-merced | | X | | | | | | | | X | | |
| Alliance for Community Transformations | 95338 | https://alliance4community.org/ | X | | | | | | X | | X | | | |
| American Cancer Society | Whole County | www.cancer.org/about-us/local/california.html | | | | | X | | | | | | | |
| Apex Medical Group | 95635 | www.apexmedicalgroup.org | | | | X | X | | | | | | | |
| Boys and Girls Club of Merced County | 95340 | www.bgcmerced.org | | | | | | | X | | X | | | |
| California Children Services Merced | Whole County | www.co.merced.ca.us/552/California-Children-Services | | | | X | | | | | | | | |
| Caring Kids | 95341 | www.mcoe.org/deptprog/earlyed/CK/pages/caring-kids.aspx | | X | | | | | X | | | | | |
| Castle Family Health Center | 95301 | www.cfhc.care | | X | | X | X | | | | | | X | |
| Central California Alliance for Health | Whole County | thealliance.health | | X | | X | | X | | | | X | X | |
| Community Foundation of Merced County | Whole County | www.mercedfoundation.org | | | | | | | X | | | | | |
| Cultiva L Salud-United Way of Merced County | Whole County | www.unitedwaymerced.org | X | | | X | | | X | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | |
|---|------------------|--|---|--|---------------------------------------|--|--|----------------------------|---------------------------------|----------------------------------|------------------------------------|-------------------|---|------------------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Mental/Behavioral Health and Substance-Use | Access to Specialty and Extended Care | Access to Quality Primary Care Health Services | Injury and Disease Prevention and Management | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Safe and Violence-Free Environment | System Navigation | Access to Dental Care and Preventive Services | Healthy Physical Environment |
| Dignity Health- Merced US Davis Cancer Center | 95430 | www.dignityhealth.org/central-california/locations/mercymedical-merced/services/mercy-uc-davis-cancer-center | | | | | X | | X | | | | | |
| Dignity Health- Mercy Medical Center (Merced) | 95340 | www.dignityhealth.org/central-california/locations/mercymedical-merced | | | | | X | | | | | | | |
| First 5 Merced County | Whole County | www.co.merced.ca.us/598/First-5 | | X | | X | | | X | X | | | X | |
| Geo Reentry Services | Whole County | www.georeentry.com/merced-county-expands-reentry-services-new-programs | | X | | | | | | | | X | | |
| Golden Valley Health Centers | Whole County | www.gvhc.org | | X | | X | X | | | | | X | X | |
| Gustine Unified School District | 95322 | www.gustineusd.org | X | X | | | | | | | X | X | | |
| Healthy House | 95340 | healthyhousemerced.org | | | | X | | | X | | | X | | |
| Human Services Agency | Whole County | www.co.merced.ca.us/74/Human-Services-Agency | X | X | | X | | | X | | | X | | |
| Junior Giants | Whole County | www.co.merced.ca.us/1871/Junior-Giants | | | | | | | X | | X | | | |
| Lifetime of Wellness-National Diabetes Prevention Program | Whole County | www.co.merced.ca.us/2660/Lifetime-of-Wellness | | | | | X | | | X | | | | |
| Livingston Community Health | Whole County | www.visitlch.org/contact-us | | X | | X | | | | | | X | X | |
| Los Banos Chamber of Commerce | 93635 | www.losbanos.com | | | | | | | X | | X | | | |
| Los Banos Unified School District | 93635 | www.losbanosusd.org | X | X | | | | | | | X | X | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | |
|---|------------------|---|---|--|---------------------------------------|--|--|----------------------------|---------------------------------|----------------------------------|------------------------------------|-------------------|---|------------------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Mental/Behavioral Health and Substance-Use | Access to Specialty and Extended Care | Access to Quality Primary Care Health Services | Injury and Disease Prevention and Management | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Safe and Violence-Free Environment | System Navigation | Access to Dental Care and Preventive Services | Healthy Physical Environment |
| Love, Inc. | 95344 | loveinmerced.com | x | | | | x | | | | | | | |
| Marie Green Center | 95341 | www.co.merced.ca.us/483/Marie-Green-Center | | x | | | | | | | | | | |
| Maternal, Child and Adolescent Health Services | Whole County | www.co.merced.ca.us/614/Maternal-Child-Health | | x | | x | | | | | | x | | |
| Medi-Cal, Denti-Cal Merced County | Whole County | www.co.merced.ca.us/458/Medi-Cal | | | | x | | | | | | | x | |
| Memorial Hospital Los Banos | 93635 | www.sutterhealth.org/find-location/facility/memorial-hospital-los-banos | | | | | x | | x | | | x | | |
| Merced Cancer Society Foundation | 95348 | mercedcancersociety.org | | | | | x | | x | | | | | |
| Merced County Behavioral Health and Recovery Services | Whole County | www.co.merced.ca.us/78/Behavioral-Health-Recovery-Services | | x | | | | | x | | | | | |
| Merced County Department of Public Health | Whole County | www.co.merced.ca.us/2832/Public-Health | x | x | x | x | x | | | | | | x | |
| Merced County Food Bank | Whole County | mmcfb.org | x | | | | | | | | | | | |
| Merced County HIV Programs | Whole County | www.co.merced.ca.us/574/HIV | | | | | | | | | | | | |
| Merced County Homeless Assistance | 95340 | www.co.merced.ca.us/848/Homeless-Assistance | x | | | | | | | | | | | |
| Merced County Rescue Mission | 95340 | www.mercedcountyyrescuemission.org | x | | | | | | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | |
|--|------------------|---|---|--|---------------------------------------|--|--|----------------------------|---------------------------------|----------------------------------|------------------------------------|-------------------|---|------------------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Mental/Behavioral Health and Substance-Use | Access to Specialty and Extended Care | Access to Quality Primary Care Health Services | Injury and Disease Prevention and Management | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Safe and Violence-Free Environment | System Navigation | Access to Dental Care and Preventive Services | Healthy Physical Environment |
| Merced Faculty Associates Medical Group | Whole County | www.mfamg.com | | | | x | x | | | | | x | | |
| Merced Head Start | 95341 | www.mcoe.org/deptprog/earlyed/HeadStart/Pages/default.aspx | | | x | | x | | x | | | x | | |
| Merced Lao Family Community | 95348 | www.laofamilymerced.org | | x | | | | | x | | | | | |
| Merced Strong Families Program | Whole County | www.co.merced.ca.us/2418/Strong-Families | | | | | x | | x | | | | | |
| Merced Transit Buses | Whole County | www.mercedthebus.com/181/Merced-Routes | | | | | | x | | | | | | |
| Merced WIC | Whole County | www.wicmerced-mariposa.com | x | | | | | | | | | x | | |
| Mercy Merced Family Residency Program | Whole County | https://www.familydocs.org/fmrp-mercy-merced/ | | | | x | | | | | | | | |
| National Alliance on Mental Illness NAMI Merced County | Whole County | namimerced.org | | x | | | | | x | | | | | |
| Older Adulthood System of Care Program | Whole County | www.co.merced.ca.us/3118/Older-Adult-System-of-Care-Program | | | x | | | x | x | | | | | |
| Oral Health Program | Whole County | www.co.merced.ca.us/3198/Oral-Health-Program | | | | | | | | | | x | x | |
| Planned Parenthood | 95348 | www.plannedparenthood.org/health-center/california/merced/95348/merced-health-center-2526-90130 | | | x | x | x | | | | | | | |
| Salvation Army | 95341 | merced.salvationarmy.org | x | x | | | x | | | x | x | | | x |
| Sierra Vista Child and Family Services | 95340 | www.sierravistacares.org | | x | | | | | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | |
|--|------------------|--|---|--|---------------------------------------|--|--|----------------------------|---------------------------------|----------------------------------|------------------------------------|-------------------|---|------------------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Mental/Behavioral Health and Substance-Use | Access to Specialty and Extended Care | Access to Quality Primary Care Health Services | Injury and Disease Prevention and Management | Access to Functional Needs | Increased Community Connections | Active Living and Healthy Eating | Safe and Violence-Free Environment | System Navigation | Access to Dental Care and Preventive Services | Healthy Physical Environment |
| SNAP-Ed | Whole County | www.co.merced.ca.us/2659/SNAP-Ed | | | | | X | | X | | | | | |
| Suicide Prevention Hotline | Whole County | www.co.merced.ca.us/482/Crisis-Intervention | | | | | | | | | | | | |
| The David J. Riordan's Hobie House | 95301, 95340 | www.csmainc.org | X | X | | | | | | | | X | | |
| Turning Point | 95341 | www.tpcp.org/program-cat/merced-county | X | X | | | | | | | | | | |
| Turning Point Community Programs-New Direction | 95341 | www.tpcp.org/programs/new-direction | X | | | | | | | | | X | | |
| United Way of Merced County | 95340 | www.unitedwaymerced.org | X | | | X | | | X | | | | | |
| Valley Children's Satellite Clinic | 95348 | www.valleychildrens.org/locations/olive-wood-specialty-care-center-merced | | | | | X | | | | | X | | |

Limits and Information Gaps

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

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

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

Appendix A – Impact of Actions Taken by the Hospital

MENTAL HEALTH

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| Name of program/activity/initiative | Area Wide Mental Health Strategy |
| Description | The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and tele psych options to the underserved. |
| Goals | By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve. |
| Outcomes | <p>In 2020, the mental health strategy helped with the following initiatives:</p> <ul style="list-style-type: none"> • Advance legislation that expands the California Mental Health Parity Act and ensures that medical necessity coverage determinations are consistent with generally accepted standards of care. This legislation -- Senate Bill 855 – passed in June 2020. • Additionally, based on parity advocacy, the Governor publicly touted parity enforcement as a priority on a number of occasions and the enacted budget for California includes over \$2.7 million in additional resources for the Department of Managed Health Care (DMHC) to enforce parity this year with \$4.7 million annually thereafter. <p>In 2021, the mental health strategy helped with the following initiatives:</p> <ul style="list-style-type: none"> • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of \$2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing \$803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature budget achievements: \$4.5 billion over five years to meet the behavioral health needs of children. |
| Name of program/activity/initiative | Merced County Behavioral Health Links Program |
| Description | Collaboration with Merced County Behavioral Health to hire a Alcohol and Drug Counselor and Mental Health Clinician to provide services to the community of Los Banos. |
| Goals | Goal is to be able to complete screening for substance use disorders (SUD) and co-occurring disorders in the community and linking those individuals assessed as needing additional services to treatment and |

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| | other resources. The practice of actively screening, initiating psychosocial and pharmacological interventions, and linking patients with SUD to ongoing medication maintenance and behavioral health therapies, has been identified as a critical component to successful recovery. |
| Outcomes | <ul style="list-style-type: none"> • 2021 – Program initiated and scope defined, staff in the process of being hired. • Once staff are hired in 2022, 75% of community and hospital-based referrals will receive a mental health/substance use disorder screening and be connected to the appropriate level of care. • 90% of individuals in need of housing will receive a warm hand-off to housing resources including the respite house. |

NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT

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|--|---|
| Name of program/activity/initiative | Boys & Girls Club of Merced County |
| Description | Providing a positive, safe, healthy, fun and educational after school program for the children in Los Banos Monday through Friday to help bring out the best in each young person and enable them to reach their full potential as productive, caring, and responsible citizens. |
| Goals | <ul style="list-style-type: none"> • To provide quality after-school enrichment activities that focus on academic success, healthy lifestyles, great character and leadership development. • To provide students a structured and safe environment that stresses responsible behavior, respect for others, and positive caring attitudes. • To provide caring staff mentors who provide guidance, support and encouragement to help children to build confidence and self-esteem so that they can realize their true potential. • To provide communication and resources to parents regarding their children's general wellbeing. • To fill in the gaps during the pandemic to help children with their virtual learning so that they do not fall behind or have learning loss. |
| Outcomes | <ul style="list-style-type: none"> • 2020: 37 children and youth served; and 30 families. • Success story: we have two students who were homeless and not able to attend their virtual school classes, they were failing school, feeling lost and struggling emotionally. It was a very low and difficult time for them. However, we were able to work with the school and other resources to help find housing for the family. A few board members also helped to provided some clothing and basic needs for the family and the children we are able to come to the Los Banos Boys & Girls Club site to attend their virtual classes, get homework help, connect with friends and caring mentors. They are no longer feeling despair or lost and are doing very well in school, they are engaged in learning, having fun and able to be a kid again. • 2021: 17 children and youth served; 476 services provided. |

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| Name of program/activity/initiative | Shady Creek Outdoor Education Foundation – Fit Quest |
| Description | <p>The three tenets of Fit Quest are nutrition, physical activity, and mental wellness and the students' overall health. The Fit Quest program serves students in the 5th and 6th grades (ages 9-13 years old in their respective communities) either in the classroom or, if the school permits, by interactive virtual assemblies (at least 2 site visits, if approved by the school) to accommodate current health concerns.</p> <p>The Fit Quest curriculum, now adapted to a live streaming interactive assembly, continues to immerse the students in three arenas, nutrition, mental wellness and physical activity. Using these topics we discuss and engage students in how to create a healthy, active lifestyle.</p> <p>Students in now six of the Merced schools will participate in age appropriate grade standard based nutrition, physical activity, and mental wellness experiential learning program. This will include zoom classroom/assembly instruction, (3 visits with the Fit Quest teaching team) visits are conducted by the former naturalists.</p> |
| Goals | <ul style="list-style-type: none"> • This program raises awareness in students regarding the need to 1.) be thoughtful in food choices, 2.) be responsible for what they can control, 3.) choose to be active, 4.) provide mental wellness tools and mindfulness techniques. • To provide tools, education, resources, and understanding of these tenets to students with a message that their choices today affect their health tomorrow, into their future. School visits and interactive virtual assemblies reinforce the program's message. |
| Outcomes | <ul style="list-style-type: none"> • 2020 – Served 500 youth, and 36 adults. • 2021 –Served 12 adults; challenges with delivering programming during the pandemic. |

ACCESS TO HEALTH SERVICES

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| Name of program/activity/initiative | Golden Valley Health Centers Street Medicine |
| Description | Golden Valley Health Centers Street Medicine Team provides acute medical services and access to care to people who are homeless. A Licensed Vocational Nurse (LVN) and a Community Health Worker (CHW) are connecting with the homeless population by bringing medical services to them with the use of a van equipped with medical supplies to perform basic medical services such as wound care, blood pressure checks, and health assessments. The general scope of the medical team is to provide outreach, triage, mobile medicine, transportation, and referrals to GVHC and community partners. Outreach entails making connections with the homeless population by listening and learning their needs as told by the community. The CHW provides water, snacks, socks, and education on how to access health care and other community resources. |
| Goals | Our yearly goal is to provide direct medical services and/or access to a medical provider for at least 1,200 people within Stanislaus and Merced Counties. |
| Outcomes | <ul style="list-style-type: none"> • 2019 – 960 adults served; 543 services provided; 1,589 service referrals. • 2020 – 1,000 adults served; 717 services provided; 4,661 service |

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- referrals.
 - 2021 –223 adults served; 92 services provided; 223 service referrals.
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Name of program/activity/initiative

United Way of Merced County – Cultiva La Salud

Description

Cultiva La Salud recognizes residents play a critical role in cultivating and sustaining healthy communities and they must always be included in changing systems that impact their overall health. However, low income residents don't often do not have access to civic engagement opportunities because some systems deliberately prevent them from uplifting their voices and concerns. Cultiva la Salud will continue to work with residents in creating policies and systems changes that improve the overall health of their communities. These may include no smoking in public places healthy water in schools, parent engagement in the Local Control Funding Formula to improve school health, joint use, healthy parks and other initiatives that support healthy equity opportunities. We will work with the first cohort of Mujeres Poderosas on a monthly basis and will train an additional 25 new residents to continue to build resident power.

Goals

Train 25 to 30 new residents in Cultiva La Salud's Powerful People Leadership Training and continue to work with the current (28 Residents Leaders from Cohort #1) to create positive social changes in the community of Los Banos and its surrounding area.

Outcomes

- 2020 – Directly served 84 individuals and reached 6,628 people through events and outreach. Provided 125 services and 421 service referrals.
 - 2021 – Directly served 334 individuals and reached 5,560 people through events and outreach. Provided 140 services and 3,295 service referrals.
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-