



FAIRCHILD
MEDICAL CENTER

2022 COMMUNITY HEALTH NEEDS ASSESSMENT & 2019 REVIEW





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2022 COMMUNITY HEALTH NEEDS ASSESSMENT & 2019 REVIEW

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ABOUT FAIRCHILD MEDICAL CENTER

Fairchild Medical Center (FMC) is an independent non-profit hospital organization that serves communities across North Siskiyou County. The Board of Directors, Medical Staff and Management team are solely focused on preserving local access to healthcare services for our communities. FMC is a 25-bed Critical Access Hospital located in Yreka, California. Fairchild Medical Center is accredited by The Joint Commission, and a member of the American Hospital Association. In addition to the hospital, FMC operates two Rural Health Clinics; Fairchild Medical Clinic in Yreka and Scott Valley Rural Health Clinic in Etna, California.

Siskiyou County is located in far Northern California and the northern border of the county sits along the California/Oregon border. The County is one of the largest in California.

Fairchild Medical Center serves the rural populations of northern, western and eastern Siskiyou County. With a large geographic coverage area, patients who use the Fairchild facilities, range from Orleans, Seiad Valley and Happy Camp in the western part of the County, to the mountain valley communities of Fort Jones, Greenview, Etna and Callahan in Scott Valley; north to the Oregon Border with the towns of Hornbrook and Hilt; and east to Dorris and Tulelake; as well as communities from the areas of Somes Bar, Forks of Salmon, and Sawyers Bar.

As an acute hospital organization, Fairchild Medical Center is a leader in the local health care system and is an important partner with other community organizations. FMC offers a full scope of services to our communities including emergent, primary care, medical, surgical, imaging, laboratory and a variety of other outpatient services.

At Fairchild Medical Center, we value what it means to be a team, to put other people first and to be a leader in our local community. For more than 25 years, our organization has been providing quality health care to our rural area. As health care continues to change, we are committed to making access to quality care possible and we continue to evaluate how we can make the best possible impact upon the well-being of our community. As the single largest private employer in Siskiyou County, the hospital makes a significant economic contribution to our communities. Thank you for allowing us to care for you and your family.

At FMC, caring for you is at the heart of who we are.

OUR MISSION, VISION AND VALUES

Our Mission

Our mission is to provide health care services of exceptional quality to all who need us.

Our Vision

Fairchild Medical Center will serve the health care needs of our area by:

- Providing high quality, cost effective health care services related to inpatient, outpatient, wellness, prevention, and health education
- Seeking to involve the entire community in achieving a healthier population
- Being a leader and catalyst in the formation of a fully integrated health care system
- Ensuring the availability and accessibility of health care services to our communities

Our Values

The source of our strength is a team of caring people including the Board of Directors, Leaders, Hospital Employees, Medical Staff and Volunteers. We value teamwork, compassion, respect, innovation and quality.

TEAMWORK | COMPASSION | RESPECT | INNOVATION | QUALITY

Quality is paramount. Customers are the focus of everything we do. Customers include patients, patients' families, employees, physicians, volunteers, suppliers, and our community at large. Services will be provided with our customers in mind, through a business and humanitarian approach at a competitive price.

Continuous improvement is essential for our success. We will plan, measure, evaluate and improve the processes as necessary in order to continually make improvements in systems and services throughout our organization.



EXECUTIVE SUMMARY

At Fairchild Medical Center (FMC), as part of our commitment to continue providing access to quality health care in our rural area, it is important we engage our local community members around the issues of health and wellness. As a nonprofit organization, we are required every three years to complete a Community Health Needs Assessment (CHNA) as well as a Community Health Improvement Plan (CHIP).

The CHNA involves engaging community members as well as key stakeholders through a process to identify the felt and perceived health needs of the residents living in the areas we serve. After the completion of the CHNA survey process and the development of the final CHNA report, we have a four-and-a-half-month time frame in which to develop the resulting CHIP.

For our organization, this process has significant impact upon our planning and ultimately our community. In the following pages, you will find three distinct documents that collectively provide a road map of where we've been, where we're going and how we plan to get there.

The 2019 FMC Community Health Improvement Plan Review details the work FMC has accomplished between 2019 and 2021 to meet the needs our community identified during the 2019 CHNA.

The 2022 Community Health Needs Assessment provides in detail the results of independent survey work as well as data showing the health status of Siskiyou County as a whole.

The 2022 Community Health Improvement Plan details the planned efforts of FMC and provides a forecast of the health priorities we will focus on from 2022 – 2025.

2022 CHNA COLLABORATION

The 2022 Community Health Needs Assessment (CHNA) was commissioned in partnership with Fairchild Medical Center, Mercy Medical Center Mt. Shasta and the Siskiyou County Public Health Department. The CHNA was completed by an independent company, Community Health Insights in February of 2022 and can be found in this document beginning on page 33.

This document utilizes Siskiyou County as the geographic area for the CHNA and is inclusive of Fairchild Medical Center's (FMC's) primary service area which includes the northern, eastern, and western sections of the county. FMC's primary and secondary service area is Siskiyou County.

There are no identified material differences in the Community Health Insights CHNA and a CHNA that would have been produced independently by FMC. Therefore, the Community Health Insights 2022 Community Health Needs Assessment is adopted with the addition of the information specific to FMC included in this section.



2022 COMMUNITY HEALTH NEEDS ASSESSMENT SYNOPSIS & IRS REGULATIONS

The purpose of the 2022 Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs of the communities served by Fairchild Medical Center. The significant health needs identified in the 2022 CHNA will help guide Fairchild Medical Center's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health.

The following list of significant health needs were identified as an outcome of the CHNA process, and primary and secondary data evaluation during the assessment process. The assembled data, information, and analyses provide a comprehensive identification and description of significant community health needs.

The significant health needs in alphabetical order are:

- Access to Mental Health Care
- Access to Primary Care
- Access to Specialty Care

While there are potential resources available to address the identified needs of the community, the needs are too significant and diverse for any one organization. The community has many marginalized, underrepresented individuals. In order to reach out to the underrepresented individuals, open collaboration needs to begin with community organizations, local government, local business leaders and other institutions in order to make a substantial and upstream impact. Siskiyou County is home to a wealth of organizations, businesses, and non-profits that currently offer programs and services in several of the identified significant health needs areas. Fairchild Medical Center will continue to build community capacity by strengthening partnerships among local community-based organizations.

The 2022 CHNA meets the requirements of California Senate Bill 697 and section §501(r)(3) of the Internal Revenue Code that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

There are no known information gaps that limit the ability of the 2022 CHNA to assess the health needs of the communities served by Fairchild Medical Center.

FMC in partnership with Mercy Medical Center Mt. Shasta and Siskiyou County Public Health contracted with Community Health Insights to assist with development of the 2022 CHNA.

The 2022 CHNA was adopted by the Fairchild Medical Center Governing Board in June 2022 (tax year 2022) and follows the previous CHNA report adopted in November 2019 (tax year 2019).

This report is available to the public on the FMC website and requests for copies of the 2022 CHNA and any written comments on this report can be submitted to:

Fairchild Medical Center Contact:
Robin Bingham
rbingham@fairchildmed.org
Phone: (530) 841 - 6287
444 Bruce Street, Yreka, California 96097

Fairchild Medical Center did not receive any comments or feedback from the public on the 2019 CHNA.

The impact of actions taken since the 2019 CHNA are described on the following pages.



CARING FOR YOU IS **AT THE HEART** OF WHO WE ARE.



FAIRCHILD MEDICAL CENTER

2019 FMC COMMUNITY HEALTH IMPROVEMENT PLAN REVIEW

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2019 COMMUNITY HEALTH NEEDS IMPROVEMENT PLAN REVIEW



Fairchild Medical Center and Clinics are committed to providing health care services of exceptional quality to all who need us in the communities we serve. Our community benefit initiatives include financial assistance for those unable to afford medically necessary care and health improvement programs in collaboration with our community partners and investments.

In 2021, Fairchild Medical Center served 1,322 inpatients and provided more than 118,840 outpatient services.

Fairchild Medical Center provides care to persons covered by governmental programs at below cost. Recognizing its mission to the community, services are provided to both MediCare and MediCal patients. The Hospital realized MediCal/CMSRP payments below the cost the hospital incurs to provide the service of \$10,417,722. To the extent reimbursement is below cost, Fairchild Medical Center recognizes these amounts as a service to the community in meeting its mission.

Fairchild Medical Center currently has Medicare reimbursement reduced by 2% to an amount below cost. In 2021, reimbursement was reduced \$79,954.

The Hospital maintains a Charity Care Policy which defines how partial and/or full charity care will be based on the individual's ability to pay as defined by Federal Poverty Income Guidelines utilizing a sliding scale. Confidentiality of information and the individual's dignity are paramount.

Charity Care is also provided through many reduced price services and free programs offered throughout the year based on activities and services which Fairchild Medical Center believes will serve a bona fide community health need. These include:

- Free care for patients who are financially unable to pay for services in total or services in excess of private insurance reimbursement. During 2021, total charges written off for Charity Care were \$995,049 with a cost associated with charity at \$412,279 to a primary service area of a little over 24,000 people.
- Fairchild Medical Center has two Rural Health Clinics that provide care in designated Healthcare Professional Shortage Areas (HPSA) for all who need services. FMC Clinic provides Dental services for indigent patients.

- The Hospital maintains a toll-free dedicated telephone number for advice nurse services which supply information regarding access to urgent care services; clinical advice; personal health education; information on prescription and over-the-counter drugs; and mental health referrals, as appropriate. The annual cost to provide this service to our community is \$50,160.

The Hospital provides a patient transportation program through its Auxiliary organization. In 2021, the Auxiliary provided a little more than 1,000 rides to patients living in the Yreka, Montague, Grenada and Hornbrook areas. In 2019, the hospital and the hospital's Foundation assisted the Auxiliary with the purchase of a new van for the transportation program. The new van includes a rear automatic wheelchair lift, making it possible for the patient transportation program to also provide rides to patients who are wheelchair bound or who cannot take steps up into the van.



Priority One | Access to Healthcare

Preserving local access to care is the number one priority for the hospital and clinics. Access in the rural healthcare marketplace involves issues such as insurance coverage, contracting with payors to assure network adequacy, using technology to deliver efficient care, addressing social determinants of care, identifying adequate space for services and recruiting and retaining qualified workforce.

The goals and strategies outlined below primarily focus on the issues of space and workforce.

Goal 1: Increase Access for Primary Care Services including Immediate Care

In 2019, Fairchild Medical Clinic underwent a significant renovation that included expansion into the previous Physical Therapy/Rehabilitation space. The expansion redesigned 5,644 square feet that included patient care rooms, provider offices, staff work space and space designated especially for Fairchild Express Care.

Fairchild Express Care expanded from online only virtual visits to include walk-in and same day appointments for non-emergency immediate care needs in April 2021. Overseen by a Primary Care physician, Fairchild Express Care offers care seven days per week from 10am to 6pm and provides an alternative for patients not requiring care in the emergency department. Fairchild Express Care employs two nurse practitioners and one Physician Assistant and sees approximately 600 patients each month.

In addition to walk-in and same day visits, Fairchild Express Care Online continues to provide the option of virtual appointments as well.

Dr. Vina Swenson moved her private practice to the Fairchild Pediatric Clinic in 2021 and Dr. David Marriott will be joining Dr. Swenson and Dr. Bill Broeckel in the Pediatric Clinic on August 1, 2022. A renovation of the Pediatric Clinic will be completed in 2022 and includes updated child focused aesthetics creating a warm and welcoming environment for pediatric patients.

In the Fall of 2021, additional employee parking was created in a lot located to the west of the FMC Clinic on Wendy Drive. The new parking lot for employees helped to make additional parking spaces available for patients and visitors in the clinic parking lots.

Goal 2: Increase Access to Dental Services

The Fairchild Dental Clinic expanded access to care for adult MediCal patients in need of dental care. This includes expanded emergency care services during normal dental clinic hours. The expansion of the dental clinic was completed in late 2020 and was accepting new adult patients in January 2021. In addition to the operatory space created, a dental reception area was created to better allow patients to schedule additional appointments with the dental reception team.

Goal 3: Increase Access to Specialty Surgical Services

In 2020/2021, Fairchild Medical Center welcomed two general surgeons to the community. Brian Beckord, MD and Ricardo Noble, MD. General surgical services have expanded through the addition of Varicose Vein procedures and the addition of the Da Vinci Surgical Robot that was purchased and put into use in 2021.

Dr. Keith Ure joined the Orthopedics team in June 2020. Recruitment efforts for additional Orthopedic surgeons is ongoing. After a multi-year search, Dr. Scott Epperly has signed a contract. Dr. Epperly will be completing a fellowship in Orthopedic Surgery in June of 2022 and is expected to begin seeing patients at Fairchild Medical Center starting October 1, 2022.

In early 2022, the hospital began recruitment efforts for a urologist. The hospital is hoping to have Dr. Dimple Chanamolu begin seeing patients in August 2023.

In early 2022, the hospital continued a search for two OB-GYN's. Dr. Sharon Heichman signed a contract and will start seeing patients on September 1, 2022. Dr. Nino Pitiuri signed a contract and will start seeing patients on November 1, 2022.

Goal 4: Increase Access to Hospital Based Services

In 2021, the renovation and expansion of the FMC Nuclear Medicine suite was completed. The state-of-the-art, newly updated Siemens Symbia Evo dual-headed SPECT camera is able to provide improved imaging for patients. This includes the ability to image patients while in their hospital beds or gurneys, eliminating the need to transfer patients who are immobile or in severe pain. The new unit also reduces radioactive exposure for patients by almost half the previous amount and reduces the time needed for imaging studies.

In 2019, the imaging department began the process of selecting replacement x-ray equipment. The final remodel and equipment replacement is scheduled for late 2022.

The hospital's pharmacy underwent a significant renovation and expansion was completed and approved in 2022. This project consists of the Pharmacy Clean Room where sterile compounding will be performed.

As of 2020, Fairchild Medical Center is the only Certified Primary Care Stroke Center between Medford, Oregon and Redding, California. This program provides life-saving care to patients experiencing ischemic stroke.



Priority Two | Maternal/Child Health

As discussed in the 2019 Community Health Needs Assessment, the top concerns related to maternal and child health include infant mortality, adverse childhood events, teenage pregnancy, child abuse, food insecurity, and timely access to care.

The goals and strategies presented below focus on collaborative efforts to promote timely health screenings and care for women and children in our communities.

Goal 1: Improve Timeliness of Prenatal Care

Timely prenatal care is proven to improve health outcomes of pregnancy for mothers and their children. Increased access to health care during pregnancy and childbirth can prevent pregnancy-related deaths and disease. All patients with a diagnosis of pregnancy will be scheduled within no less than 14 weeks of gestation, or within 42 days of enrollment into Partnership.

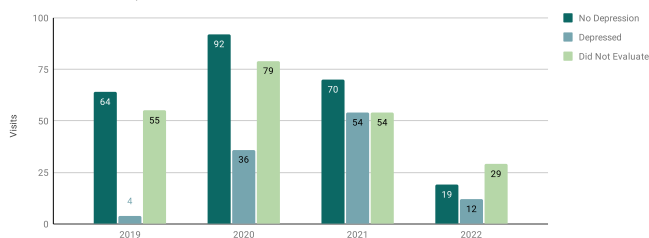
Additionally, the Women’s Health Clinic participated in the Partnership Perinatal Quality Improvement Program to improve timely access to prenatal care. Two hundred and eight women participated in the program in 2020, followed by 236 women in 2021.

Goal 2: Improve Postpartum Care

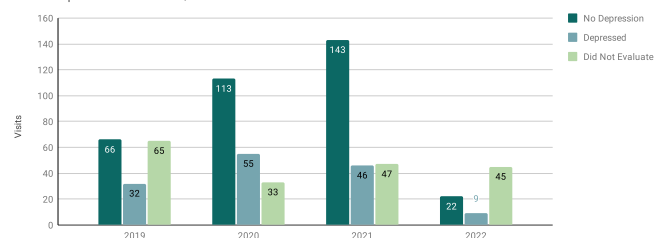
The postpartum visit is an important opportunity to educate new mothers on expectations about motherhood, to address concerns, and to reinforce the importance of routine preventive health care. The American College of Obstetricians and Gynecologists (ACOG) recommends that a timely postpartum visit be used to assess the health of the infant, the mother’s medical and psychological condition, breastfeeding, and contraceptive plan.

The Women’s Health Clinic adhered to ACOG recommendations with an additional focus on depression screenings during initial obstetric visits and postpartum visits. The results of these initial and postpartum depression screenings is illustrated below.

OB Initial Visit PHQ Results



OB Postpartum Visit PHQ Results



Goal 3: Improve Childhood Immunization Rates

Three Thousand Three Hundred and Fifty-Four (3,354) immunizations were given to 1,056 unique pediatric patients in 2020. In 2021, 4,003 immunizations were given to 1,333 unique pediatric patients.

Fairchild Medical Clinic's strategy to improve childhood immunization rates included providing education to families and increasing awareness on the importance of childhood immunizations. Additionally, efforts were made to increase patient outreach and to ensure that appointments are scheduled and ultimately kept.

Goal 4: Increase the Number of Well Child Visits within the First 15 Months

"Well child visits within the first 15 months" refers to patients who have had at least one comprehensive well-care visit with a Primary Care Provider within the first 15 months of life. Fairchild Medical Clinic strives to increase the number of these well child visits within the first 15 months of life to six (6) or more.

The percentage of children who met these enhanced criteria in 2021 was 29%. An additional 39% of children had at least one visit with their PCP. It should be noted that if a child misses any of their scheduled well-care visits, the visit is deducted from their total. This highlights the importance of effective patient outreach.

The Pediatrics Clinic anticipates improvement towards this goal as it continues to increase accessibility to pediatric care. David Marriott, MD will begin his practice in the FMC Clinic in August of 2022.

Goal 5: Increase Access to Women's Health Services

In late 2021, local family practice and obstetrician, Richard Swenson, MD moved his private practice to Fairchild Medical Clinic. Sarah Norris, WHNP also joined the team of providers in the Women's Health Clinic in 2021.

In September of 2022, Sharon Heichman, MD will begin her practice in the FMC Clinic. Her arrival will be followed closely by Nino Pitiuri, MD in November 2022.



Priority Three | Mental Health

Mental health remains a significant issue and a topic of concern for providers, patients, and the community. The top concerns related to mental health identified in the assessment include access to services, suicide, and mental health with a co-occurring diagnosis of substance abuse.

The goals and strategies presented below primarily focus on access to mental health care services and the coordinated provision of mental and physical health services.

Goal 1: Improve Integration of Behavioral Health and Primary Care

A five-year grant/project with Siskiyou Behavioral Health was completed in 2020. The project focused on patients with comorbidities and Moderate-to-Severe mental illness by integrating Primary Care and Behavioral Health services in treatment. The program concluded with eight (8) clients after beginning with twelve (12) clients.

Fairchild Medical Clinic continues to increase capacity and accessibility to behavioral health services for members of the community. Clinic-based behavioral health services include therapy, social work, medication management, substance use disorder (SUD), and virtual visits. The Behavioral Health department in Suite 200 completed 7,212 encounters in 2020, followed by 6,818 encounters in 2021. Justin Haddaler, PA-C joined the Clinic team in May 2022 and will serve patients in Yreka in addition to his weekly visits to the Scott Valley Rural Health Clinic.

Fairchild Medical Center will continue to support the integration of Behavioral Health and Primary Care by growing the Integrated Care Project with other stakeholders. Work will continue towards improving the health information exchange between medical providers and the County Behavioral Health Department.

Goal 2: Provide Substance Use Disorder (SUD) Services

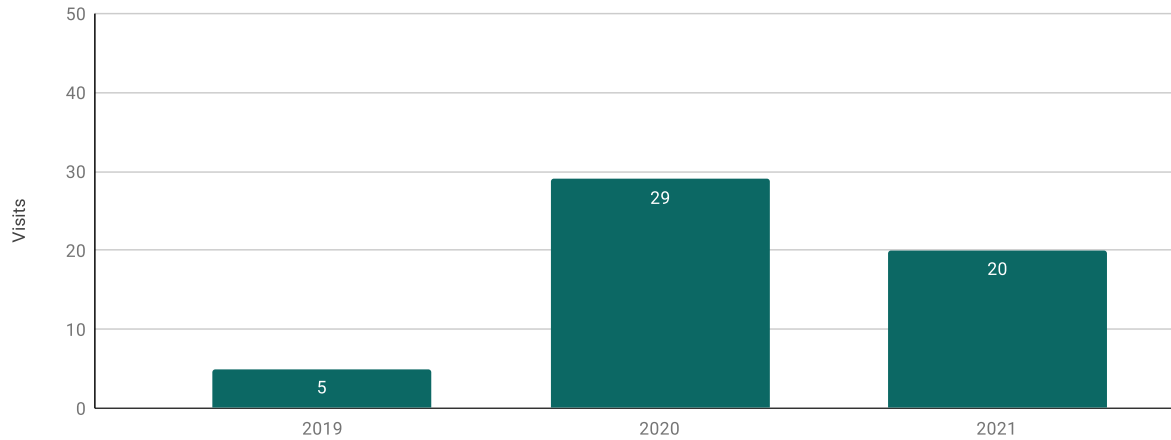
Fairchild Medical Center continues to collaborate with Siskiyou County to treat citizens who are prescribed the SUD medication, Suboxone. The clinic administers the medication while counseling is provided by Siskiyou Behavioral Health. It is common for patients to begin their treatment while incarcerated in the County Jail, and upon release being seen within the clinic.

Fairchild Medical Center will continue to coordinate SUD treatment with outpatient counseling services. Additionally, Fairchild Medical Center will increase the number of providers who can provide medicated assisted treatment (MAT) for patients with an opioid addiction.

Goal 3: Increase access to Telepsychiatry for Patients in Crisis

The Emergency department started to utilize Telepsychiatry in 2019. The following numbers show the increase in this service:

Emergency Department Telepsychiatry Visits for Patients in Crisis



For patients presenting to the Emergency department, the hospital will continue to develop and utilize a telepsychiatry service for patients in crisis to reduce length of stay and improve outcomes.



I got my
VACCINE



COVID-19 PANDEMIC | Crisis Care Impact

The COVID-19 pandemic had a severe impact on the organization in 2021. Administration expects further disruption in 2022 primarily as it relates to the workforce shortage.

From January to November 2021, the hospital treated a total of 196 in-house patients for COVID. Thirty, or 9.7%, of those patients, had been vaccinated with at least one dose of vaccine before contracting COVID and being admitted. One Hundred Sixty-Seven patients, or 90.2%, had NOT been vaccinated.

The hospital had 16 deaths from COVID during 2021. Of the 16 deaths, 5 had been vaccinated. The hospital and clinics saw a significant increase in demand for care due to COVID-positive patients through the end of August and into September. Because of this increase, the hospital was forced to move from conventional care to crisis care.

By definition, crisis care involves the following key points:

- Space – ICU level care is provided in non-ICU areas of the hospital. During the surge, the medical and hospital staff did an impressive job of expanding the hospital’s critical care capacity and a second ICU unit was established.
- Staffing – While staff continues to work within their licensed scope, staff may work in areas outside of their normal department. During the surge, the hospital moved to a team- based nursing model and engaged nurses from every department to care for inpatients. The nursing team sacrificed to accommodate the organization’s need for additional help after hours and on weekends.
- Supplies – Demand for supply resources such as ventilators and oxygen suddenly increased creating a situation where critical equipment and supplies became scarce.

The hospital worked with our community partners to request assistance from the State. In late September, the State deployed a team consisting of nurses, a doctor, and a pharmacist to administer monoclonal antibody therapies to patients who are at high risk for becoming ill and hospitalized due to a COVID infection.

The hospital worked with its oxygen supplier, engineers, and the State to design and install a temporary bulk oxygen system.

Vaccine Mandate

In late July, the California Department of Public Health (CDPH) ordered that healthcare workers receive the COVID-19 vaccine or qualify for a religious or medical exemption.

CDPH also mandated that unvaccinated staff be regularly tested.

As of January 19, 2022, 465 employees have been vaccinated. Two Hundred and Seven have



been vaccinated and boosted as of this date. The organization has approved 56 religious exemptions and 30 medical exemptions as of January 20, 2022.

One hundred twenty-two (122) employees tested positive in 2021 resulting in 1,607 missed workdays.

In December 22, 2021, CDPH changed the vaccine mandate to include the vaccine and the booster, effective February 1, 2022.

COVID-19 Testing

The hospital continued work in 2021 to monitor a sustainable and diversified strategy to keep COVID-19 testing available for patients, employees, medical staff, and the general public. Suppliers of COVID-19 tests had to receive emergency use authorization from the Food and Drug Administration for each test. In 2021, testing supplies became more available than in 2020. Manufacturers continued their supply allocation strategy, limiting the test collection kits and reagents in 2021. Several types of COVID-19 tests have been made available at Fairchild.

The hospital continued to actively offer COVID-19 testing in 2021. The following table summarizes the number of tests that were completed for the community and our staff:

COVID Numbers from Laboratory Charges Report 2021	
In-House	
COVID Antigen Tests	7,503
COVID PCR Tests	3,199
COVID Antibody Tests	267
Send-out PCR Tests	
COVID	3,204
Total	14,173

Clinical Management and Treatment

The evolution of clinical management of COVID-19 patients has not yet reached maturity level, rather continues to be a moving target. A plethora of clinical trials of therapeutics were presented. Some are promising, and some have been disappointing. The good news is that the vaccine continues to demonstrate that it is the most effective clinical tool in preventing COVID-19-related hospitalization and death.

The Delta variant of the COVID-19 virus dominated the spread of the virus for most of 2021. It was much more virulent and spreadable than the original strain. Yet, the three developed COVID-19 vaccines were effective against the Delta variant despite seeing an increase in breakthrough infections in some vaccinated individuals. Even in breakthrough infections among the vaccinated, the vaccination continued its powerful prevention against hospitalizations and death at a similar rate to the one before the emergence of the Delta variant. The emergence of the Omicron variant came with enough mutations to place it on the path to overtake the Delta variant quicker than any variant seen to date. Omicron presented additional challenges.

Therapeutics in Non-hospitalized COVID-19 Patients

During the year 2020, monoclonal antibody (mAb) treatments were developed and made available through Emergency Use Authorizations (EUAs) from the Food and Drug Administration (FDA) for the treatment of COVID-19 infection in high risk individuals. Monoclonal antibodies have been shown to reduce the risk of hospitalization and death in the outpatient setting in those with mild to moderate COVID-19 symptoms and certain risk factors for disease progression.

FMC administered 338 doses of mAb during 2021 to high-risk patients. Less than 10 patients were admitted to the hospital post mAb treatment. Due to this valuable clinical therapeutic tool, the hospital had a mAb team sent by the State of California who assisted Fairchild in administering mAb via drive-through workflow to protect as many infected at-risk populations as possible against COVID-related hospitalization and death. NIH put out a recommendation for post-exposure prophylaxis (PEP) to non-symptomatic COVID negative (or untested) high-risk patients.

Intravenous Remdesivir is approved by the Food and Drug Administration for the treatment of COVID-19 in hospitalized patients. A 3-day regimen of Remdesivir has been studied in non-hospitalized patients and resulted in a significant reduction in hospitalizations and deaths compared to placebo. Remdesivir is expected to retain activity against the Omicron variant.

Oral antiviral treatment for COVID-19 is now on the table following the FDA's emergency use authorization (EUA) for nirmatrelvir/ritonavir (Paxlovid). Paxlovid is authorized for use in adults and pediatric patients with mild-to-moderate COVID-19 who are at high risk of progressing to severe illness. It is administered as three pills (two of nirmatrelvir and one of ritonavir) twice daily for 5 days, for a total of 30 pills. It must be given within 5 days of symptom onset and is not authorized for use longer than 5 days.

Hospitalized COVID-19 Patients

Two main processes are thought to drive the pathogenesis of COVID-19. Early in the clinical course, the disease is primarily driven by the replication of SARS-CoV-2. Subsequently, the disease appears to be also driven by a dysregulated immune/inflammatory response to SARS-CoV-2 that leads to tissue damage. Based on this understanding, therapies that directly target SARS-CoV-2 are anticipated to have the greatest effect early in the course of the disease, whereas immunosuppressive/anti-inflammatory therapies are likely to be more beneficial after COVID-19 has progressed to stages characterized by hypoxia.

Consequently, other additional therapeutic options, in addition to Remdesivir that was developed in 2020, were implemented in 2021. These include dexamethasone, Tocilizumab, Sarilumab, Baricitinib, and tofacitinib. These therapeutics are not new and have been used in other medical conditions and redeployed to affect the overwhelming and damaging immune response to COVID infection. They are administered by following specific treatment protocols developed and recommended by NIH according to the patients' oxygen demand and the state of critical care interventions.



As COVID-19 continues to mutate and evolve, it is expected that the therapeutic options, vaccines, and post-exposure prophylaxis treatment will evolve. Hospital leadership will continue to work closely with the Medical Staff to assure that patients receive the most current and effective treatment.

Supplies

In 2021, high demand and low availability from normal suppliers for personal protective equipment (PPE) such as gowns, caps, masks, and exam gloves continued to be a high priority. In 2021, COVID created the highest and sustained usage of PPE, much more than was seen in 2020.

Supplier and distribution chains became stretched as lack of personnel became pervasive. The instability within the global transportation system heightened concern as both foreign and domestic ports experienced congestion.

Adding again to the pressure was a mandate from the State of California OSHA office to stockpile specific PPE items in an amount equal to three months of normal consumption or face potential daily fines and penalties. Materials Management on-hand inventory in 2021 increased from 2020 over 17% amounting to tens of thousands of additional inventory.

As seen by the graph below, fill rates for medical and non-medical supplies fell to historic lows in 2021. While the 2021 fill rate started above 98%, September 2021 rates fell to 88.1%. In 2022, Materials Management will continue their daily efforts to keep fill rates high.



The supply chain’s sluggish response to volume changes continues to be shown by the review of out-of-stock reasons for 2021. Both back-orders and volume increase were the two major causes of out-of-stock supplies.

Much of the same issues are expected to continue into 2022 as it relates to keeping supplies available for caregivers. Supply Chain experts don’t expect to see much improvement within the global transportation system until the second quarter and even then, improvement will be minimal. On-site storage of supplies escalated with increased required PPE stock.

Communication

Throughout 2021, Fairchild provided external public communications regarding COVID-19. The primary message focused on COVID-19 vaccines. Initial messaging focused on the vaccine being available to the frontline and essential workers and later transitioned to availability for the general public as allowed by CDC guidelines. Vaccine messaging focused on the availability of the vaccine as well as the efficacy, safety, and its ability to prevent hospitalization should breakthrough infection occur.

Messaging was shared on fairchildmed.org, Facebook, FMC TV, and on physical signage in FMC clinics as vaccines for expanded age groups, first 12-15 year-olds (May 2021) and then 5-11 year-olds (November 2021) became available. As COVID-19 cases surged (August/September 2021) in the local area, messaging around the availability of testing was increased. Messaging was primarily delivered via the Fairchild website, fairchildmed.org, and Facebook. Messages included information regarding testing at the hospital as well as other testing sites throughout the county.

Messaging around the availability of booster shots became an important component of Fairchild’s messaging in the second half of 2021. Booster shot availability, as per CDC guidelines, was shared.

Throughout the year, external communications also included Fairchild’s visitor restrictions within the hospital and clinics. This messaging was accomplished through physical signage at entry points as well as through fairchildmed.org and FMC TV (lobby screens).

Finally, beginning in late September 2021, the availability of monoclonal antibody therapy became a key component of Fairchild’s COVID-19 messaging. The primary platforms for delivering this messaging were Facebook and FMC TV and included graphics as well as short videos that provided information about the value of receiving a monoclonal antibody therapy for recently diagnosed or suspected COVID-19 patients.

Platforms for COVID-19 messaging included:

● Website - fairchildmed.org	● Social Media - Facebook
● Print - Siskiyou Daily News	● Radio - KSYC (until it’s closing)
● FMC TV (lobby screens)	● Message-on-Hold (Spectrio)





**At Fairchild Medical Center, our mission is to
provide health care services
of exceptional quality to all who need us.**



2022 COMMUNITY HEALTH NEEDS ASSESSMENT

2022 Community Health Needs Assessment

Conducted on behalf of

Dignity Health Mercy Medical Center Mt Shasta
914 Pine Street
Mt. Shasta, CA 96067

Fairchild Medical Center
444 Bruce Street
Yreka, CA 96097

Siskiyou County Public Health Department
810 South Main Street
Yreka, CA 96097

Conducted by



February 2022

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Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Siskiyou County. 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 Siskiyou County 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 CHNA at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com).

Community Definition

Siskiyou County was chosen as the geographical area for the CHNA because it is the primary service area of the two hospitals participating in the joint assessment and is the statutory service area of the public health department. Siskiyou County is located in the most northeastern portion of the state of California and is comprised of both mountain and rural communities. The Yreka is the county seat of Siskiyou County.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.¹ This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 16 community health experts, social service providers, and medical personnel. Furthermore, 9 community residents or community service provider organizations participated in 2 focus groups across the County. Finally, five community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including Siskiyou County. 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 COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

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

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 county. 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 Siskiyou County are listed below in prioritized order.

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

Resources Potentially Available to Meet the Significant Health Needs

In all, 139 resources were identified in the county 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 Siskiyou County and highlights the needs of community members living in parts of the county where the residents experience more health disparities. This report also serves as a resource for community organizations in their effort to improve health and well-being in the communities they serve.

Introduction and Purpose

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

This report documents the processes, methods, and findings of a CHNA conducted on behalf of a partnership between two not-for-profit hospitals and the county department of public health for all of Siskiyou County with a total population of 43,468.

The partners included:

- Mercy Medical Center Mt Shasta (an affiliate of Dignity Health) - 914 Pine Street., Mt Shasta, CA 96067
- Fairchild Medical Center - 444 Bruce Street, Yreka, CA 96097
- Siskiyou County Public Health Department - 411 Ski Village Dr UNIT C, Mt Shasta, CA 96067

The CHNA was conducted over a period of seven months, beginning in August 2021, and concluding in February 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 the partnership. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

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

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the Siskiyou County service area. In all, 9 significant health needs were identified. Primary data were then used to prioritize these significant health needs.

Prioritization was based on three measures that came from the key informant interview, focus group, survey provider survey and community survey 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.

Table 1: Health need prioritization inputs for Siskiyou County service area.

Prioritized Health Needs	Percentage of Key Informants, Focus Groups, and Service Provider Survey Respondents Identifying Health Need	Percentage of Times Key Informants, Focus Groups, and Service Provider Survey Respondents Identified Health Need as a Top Priority	Percentage of Top Priority Themes from Community Survey Associated with the Health Need
Access to Mental/Behavioral Health and Substance use Services	94%	32%	24%
Injury and Disease Prevention and Management	44%	9%	48%
Access to Basic Needs Such as Housing, Jobs, and Food	88%	22%	4%
Access to Quality Primary Care Health Services	62%	8%	4%
Access to Specialty and Extended Care	50%	6%	8%
Access to Dental Care and Preventive Services	44%	9%	4%
Active Living and Healthy Eating	12%	~	24%
Access to Functional Needs	44%	4%	~
Safe and Violence-Free Environment	19%	~	16%
~ Health need not mentioned			

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

Siskiyou County 2022 Prioritized Health Needs

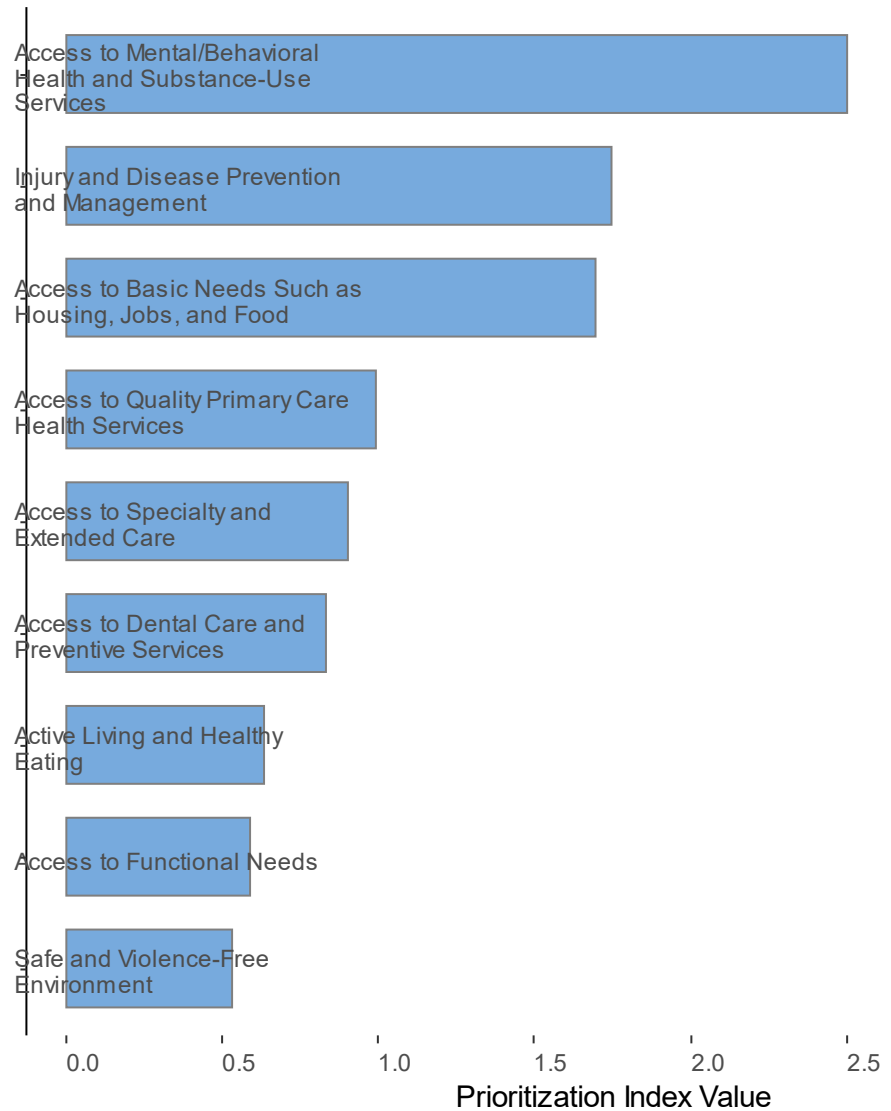


Figure 1: Prioritized significant health needs for Siskiyou County service area.

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.

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

The significant health needs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health ordered by their relationship to the conceptual model used to guide data collection for this report. Results from primary data analysis are also provided in the table. Community Survey questions were data performed poorly against corresponding benchmarks are also provided. (For a full description of the community surveys questions and their descriptive values see Table 16. Also, a full listing of all quantitative indicators can be found in the technical section of this report).

1. Access to Mental/Behavioral Health and Substance use Services

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). • Lack of providers, heavy reliance on part time and traveling mental health providers. • Lack of employment opportunities contributes to depression and anxiety • High substance usage of heroin, methamphetamines, and fentanyl. • High rates of drug addiction to methamphetamines and fentanyl in the area. • Limited substance use rehabilitation services for tribal communities. • Tribal mental health services are absent on the east side of the county. • Mistrust affecting community's desire to access county mental health services. • Long wait times to access mental health services. 	<ul style="list-style-type: none"> • Felt two or more years of depression • Self or other with suicidal thoughts 	<ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Suicide Mortality • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Adult Smoking • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area

<ul style="list-style-type: none"> • Services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools). • Important to ensure that mental health services are tailored to the rural communities. • Isolation for the elderly, especially in rural areas, contributes to poor mental health. • Mental health in children affected by the isolation related to the COVID-19 pandemic. • Lack of rehabilitation and detox centers in the area for substance use. • Emergency rooms are used as detox centers. • Need for pain management providers in the area. • Few mental health providers for children on Medi-Cal. • More behavioral health specialists needed in the schools. • The stigma around seeking mental health treatment keeps people out of care. • Rural areas have deep need for consistent mental health and behavioral services. • It's difficult for people to navigate for mental/behavioral healthcare. • There aren't enough services here for those who are homeless and dealing with substance-abuse issues. • A safe place to detox prior to transport to a rehab facility is needed. • Awareness of mental health issues among community members is low. • The area lacks the infrastructure to support acute mental health crises. • Substance use treatment options for those with Medi-Cal are limited. • The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community. • The cost for mental/behavioral health treatment is too high. 		<ul style="list-style-type: none"> • Psychiatry Providers • Firearm Fatalities Rate • Disconnected Youth • Homelessness Rate
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2. Injury and Disease Prevention and Management

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • Need more COVID education to address vaccine hesitancy. • Need more Promotoras and Community Health Workers for disease prevention. • Disease prevention is more cost effective than intervention. • Increase understanding of how social determinants of health affect health status. • Increase health education and healthy life skills in county schools. • Need for more prevention education around chronic disease prevention. • Increased need for parent education for teen parents. • Health education needs to be age and culturally appropriate. • Need educational and recreational opportunities for area youth and young adults after school. 	<ul style="list-style-type: none"> • Diagnosed with one or more chronic illness • What would help manage chronic illness: setting goals • What would help manage chronic illness: learning skills • What would help manage chronic illness: pain and fatigue management 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Liver Disease Mortality • Kidney Disease Mortality • Suicide Mortality • Unintentional Injuries Mortality • COVID-19 Case Fatality • Alzheimer's Disease Mortality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Adult Obesity • Physical Inactivity • Teen Birth Rate • Adult Smoking • COVID-19 Cumulative Full Vaccination Rate • Firearm Fatalities Rate

		<ul style="list-style-type: none"> • Motor Vehicle Crash Death • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Homelessness Rate
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3. 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 Needs⁴ suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.⁵

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • Lack of affordable housing. • Loss of logging industry negatively affected job opportunities. • Tenant Fire has resulted in increased job loss in the county. • Many residents struggle with food insecurity. • Food insecurity high with "fire refugees." • Low-income residents do not have the resources to move to an area with more housing options. • Happy Camp lost many homes in Slater Fire in 2020. These homes have not been rebuilt. 	<ul style="list-style-type: none"> • Prevented from mental/emotional health treatment, uncertainty around insurance acceptance • Prevented from mental/emotional health treatment, can't pay co-pays • Prevented from mental/emotional health treatment, stigma • Prevented from mental/emotional health treatment, no time 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Hypertension Mortality • COVID-19 Case Fatality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Drug Induced Death • Adult Obesity

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

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

<ul style="list-style-type: none"> • Childcare services in the region are very limited. • Major lack of services for 0-2 year old in Happy Camp. • Increased job opportunities in Happy Camp area. • Unincorporated areas need more septic camps and wells built. • Community members living without adequate water and sanitation. • Need for economic development that is environmentally-friendly. • Many families must choose between basic needs or paying for health care. • Need to increase food distribution at county Family Resource Centers (FRC). • Increased access to technology, especially in rural areas. • Poverty in the county is high. • Many people in the area do not make a living wage. • Services for homeless residents in the area are insufficient. • Services are inaccessible for Spanish-speaking and immigrant residents. • Educational attainment in the area is low. 		<ul style="list-style-type: none"> • Limited Access to Healthy Foods • Food Environment Index • Medically Underserved Area • COVID-19 Cumulative Full Vaccination Rate • Some College • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Unemployment • Children Eligible for Free Lunch • Children in Poverty • Median Household Income • Uninsured Population under 64 • Homelessness Rate
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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, focus group participants, and survey respondents:	The following indicators performed worse in the county

Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	when compared to state averages:
<ul style="list-style-type: none"> • Need for increased access to primary, emergent and surgical care throughout the region. • Transportation to main care hubs for rural communities is lacking and/or expensive. • The Karuk tribe clinic has limited services. • Wait times for care are long at area hospitals. • Lack of healthcare staff in the county. • Capacity of area healthcare providers is low in the county. • Culturally competent care for Spanish Speaking and Hmong is lacking in the area. • Hmong travel long distances out of county for care. • Need for liaisons, translators, patient navigators for Hmong in the healthcare system. • High cost of health care in the county. • The county of "revolving doctors" hard to maintain full time medical doctors in the area. • Large shortage of MDs, NPs, clinical nurses, and pediatricians. • Lack of health care access increases the need for preventive services. • Need more vision care providers, especially for Medi-Cal. • Need more after hours urgent care. • Need for more school based health care in county schools. • Only two schools have a school nurse. • Designated Health Provider Shortage Area (HPSA). 	<ul style="list-style-type: none"> • Unable to see doctor in past 12 months • Unable to see doctor, lack of appointments • Prevented from accessing care, doctor availability 	<ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease 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 • Lung Cancer Prevalence • Primary Care Shortage Area • Medically Underserved Area • COVID-19 Cumulative Full Vaccination Rate • Uninsured Population under 64 • Homelessness Rate

5. Access to Specialty and Extended Care

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • Limited access to specialty care in the county. • Need for elderly hospice care. • Need for more in home care option to "age in place." • Need for specialty care physicians. • Primary care providers see many advanced care patients. • Telehealth specialty care availability low due to COVID. • Residents seek care in Oregon, but reimbursement for providers is lacking. 	<ul style="list-style-type: none"> • Prevented from accessing care, doctor availability 	<ul style="list-style-type: none"> • Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • COVID-19 Case Fatality • Alzheimer's Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Lung Cancer Prevalence • Drug Induced Death • Psychiatry Providers • Specialty Care Providers • Homelessness Rate

6. Access to Dental Care and Preventive Services

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • Lack of dental services throughout the county. • Methamphetamine use in the county contributes to the need for dental care. • There aren't enough providers in the area who accept Denti-Cal. • Dental services for kids are lacking • Dental van used to provide services in the area, lack of reimbursement by Denti-Cal. • Need for dental care in rural communities. • The lack of access to dental care here leads to overuse of emergency departments. • People in the area have to travel to receive dental care. • Dental care must meet families where they are in the county. 	<ul style="list-style-type: none"> • Have not seen dentist in over a year 	<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 • Homelessness Rate

7. Active Living and Healthy Eating

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • No key informant data spoke to this PHN 	<ul style="list-style-type: none"> • Access to food limited by transportation • What would help manage chronic illness: eating, lifestyle 	<ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Kidney Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Adult Obesity • Physical Inactivity • Limited Access to Healthy Foods • Food Environment Index • Access to Exercise Opportunities • Homelessness Rate • Access to Public Transit

8. Access to Functional Needs

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

Primary Data Analysis	Secondary Data Analysis
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The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the county when compared to state averages:
Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • Transportation to health care services is lacking. • Happy Camp public transportation provider stopped during COVID. • Transportation to health care services from Happy Camp very limited. • Area needs a creative partnership for transporting to care services in the county. • Tribe has a transit provider for their clinics (Karuk, Anav). • It is difficult to recruit and retain specialists in the area. • The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). • Not all specialty care is covered by insurance. • Increase care for veterans in the county. • Additional hospice and palliative care options are needed. 	<ul style="list-style-type: none"> • Access to food limited by transportation • Have some limitations due to an impairment or health problem. 	<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 • Homelessness Rate • Access to Public Transit

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. Furthermore, 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.⁶

Primary Data Analysis	Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:	The following indicators performed worse in the county when compared to state averages:

⁶ Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

Key Informant, Focus Group, and Community Service Provider Survey Responses	Community Survey Responses	
<ul style="list-style-type: none"> • High number of child abuse cases in the county. 	<ul style="list-style-type: none"> • Feared for safety of self or loved one 	<ul style="list-style-type: none"> • Life Expectancy • Premature Death • Hypertension Mortality • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Physical Inactivity • Access to Exercise Opportunities • Homicide Rate • Firearm Fatalities Rate • Motor Vehicle Crash Death • Disconnected Youth • Homelessness Rate

Other Emerging Health Needs

Two additional emerging health needs were identified through analysis of data from key informant interviews and focus groups. Though the volume of data did not warrant being listed as a significant priority health need, the mention was so pervasive in the data that it is detailed below.

Strengthening Community Relationships

Five of the 11 key informant interviews and focus groups mentioned the need to improve and strengthen community relationships between community members in Siskiyou County. Some of the main themes in this area include:

- There is fear and suspicion of the Hmong community members among some county residents causing increased trouble and crime. Comments heard ““Go back to my country, you aren’t welcome here.”
- The unwelcoming culture leads to deep fear and suspicion among Hmong about others in the community, therefore they rarely seek services or resources.
- People who don’t speak English are afraid to reach out and call for services, community members are fearful and intimidated of who they will talk to.
- Discrimination towards the Hispanic community is ever-present.
- Many community members do not trust area rural health care providers and services agencies due to a history of mistreatment by them.

Improvements to Workforce Infrastructure

Ten of 11 key informant interviews and focus groups mentioned a clear need for improvements to the workforce infrastructure in Siskiyou County related to health and social services. Additionally, six of 11 key informant interviews and focus groups indicated that improvements to the workforce infrastructure was a top 3 priority health need. Some of the main themes in this area include:

- Hard to recruit providers to the area.
- Limited affordable safe housing availability direct impacts recruitment and retainment of health and social service providers in the county.
- County public health has limited staff.
- There's a lack of staffing and consistency in the school system, high turnover of teachers and educational administrators.
- Turnaround of area healthcare providers makes it difficult for some patients (community members) to establish trusting relationships with their health providers.
- There are too few social workers in the county to meet the area demand.
- There is a need for incentive programs focused on the young people of Siskiyou county returning to work after getting their education to help improve the workforce in the area. A direct quote "Having our young people return would also help our economy thrive by building back our tax base."
- Salaries are low in the county which makes retention and recruitment difficult.
- The care system was negatively impacted by COVID-19, there are even less providers than before the pandemic.
- Medical support staff are also limited. A direct quote "We have outstanding good quality practitioners, but it's hard to retain them if you don't have good support staff."
- As a rural county, there is a need for more loan repayment programs and higher salaries for providers to compete with the urban areas.

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.⁷ 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. Fairchild Medical Center requested written comments from the public on their 2019 CHNAs and most recently adopted Implementation Strategies through their respective websites <https://fairchildmed.org/community-health-needs-assessment> ; <https://fairchildmed.org/community-benefit-report-and-plan>.

At the time of the development of this CHNA report, neither hospital had received written comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, and the service provider survey. Both hospitals will continue to use

⁷ Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/>.

its website as a tool to solicit public comments and ensure that these comments are considered as community input in the development of future CHNAs.

Data Used in the CHNA

Data collected and analyzed included both primary (or qualitative) data and secondary (or quantitative) data. Primary data included 9 interviews with 16 community health experts, 2 focus groups conducted with a total of 9 community residents or community-facing service providers, and 5 Service Provider Surveys. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the county 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 county. 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 Siskiyou County service area. This included identifying 12 PHNs in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the county. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

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

Description of Community Served

The definition of the community served was Siskiyou County. Siskiyou County is located in the Northern most part of California, situated along the Interstate 5 corridor bordering the state of Oregon on the north. The County is rural in nature covering 6,347 square miles. The largest city is Yreka, which is also the County Seat with a population of approximately 7,870. The County area has a diverse landscape with high mountain ranges (Mt. Shasta), desert planes, and rivers with magnificent waterfalls and the amazing fishing. The County has a rich history of the Gold Rush Era.

The total population of the Siskiyou County was 43,468 in 2020. Race and ethnicity data for Siskiyou County⁸ are presented in Figure 2 and a map of Siskiyou County is shown in Figure 3.

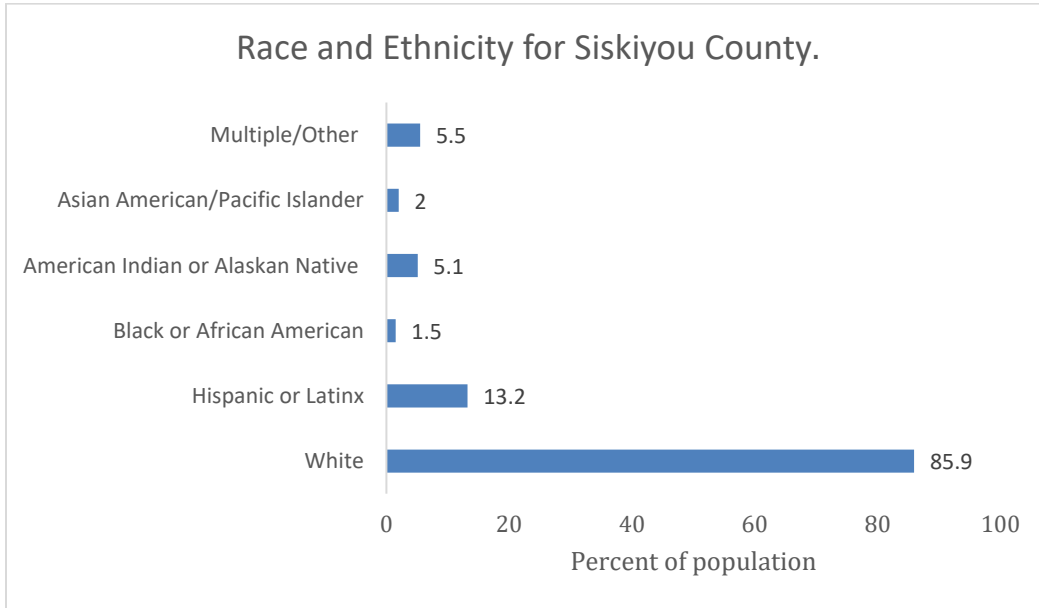


Figure 2: Race and ethnicity for Siskiyou County.

⁸ Race and Ethnicity data for Siskiyou County are based on 2021 Census data as reported here: <https://www.census.gov/quickfacts/fact/table/siskiyoucountycalifornia/INC110219>

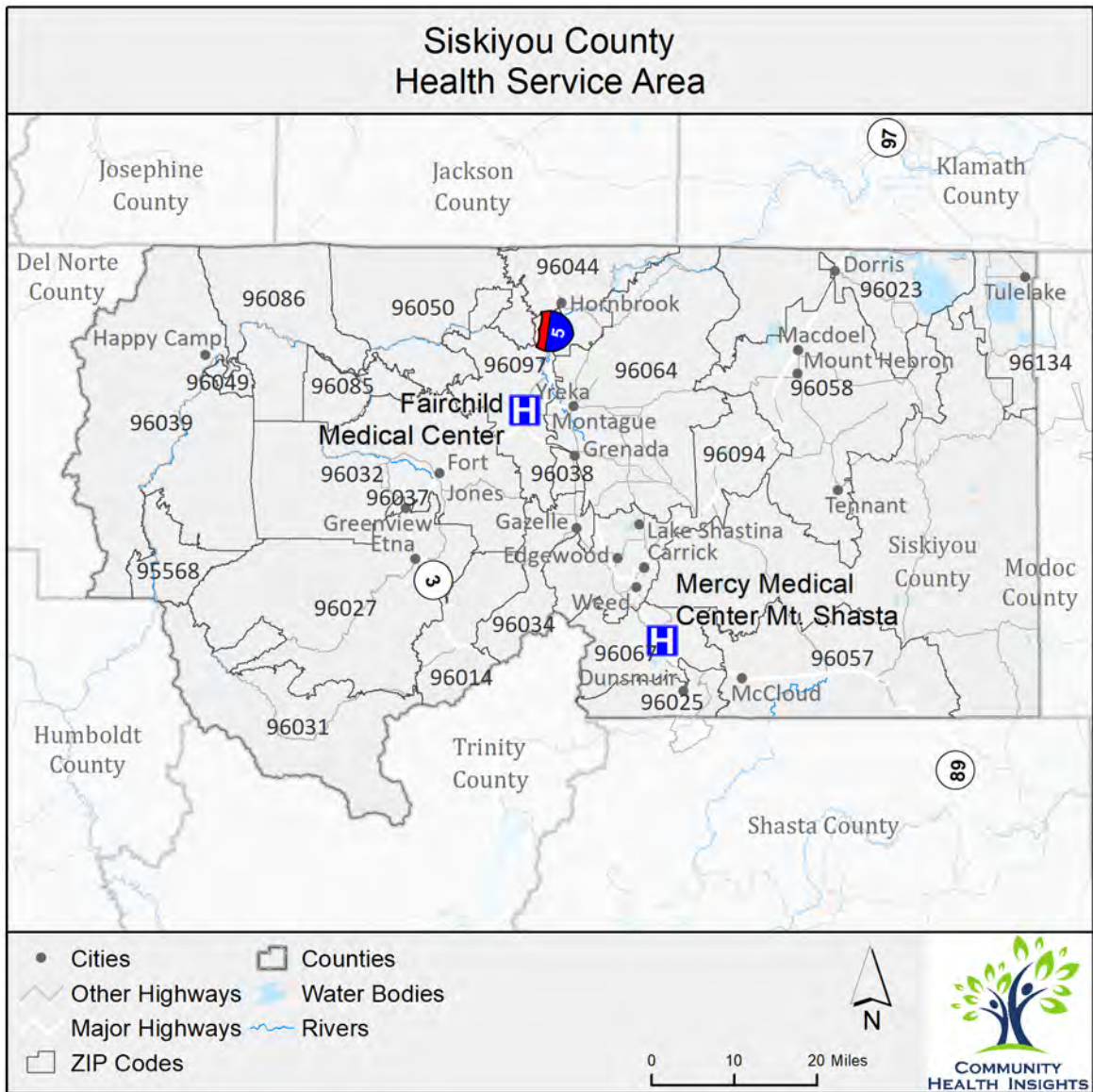


Figure 3: Community served by Siskiyou County.

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

Table 2: Population characteristics for each ZIP Code located in the Siskiyou County 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
95568	274	58.4	52	\$45,104	29.2	21.1	15.7	11.6	14.0	10.6
96014	135	19.3	58	\$33,813	13.3	0.0	5.9	16.1	29.2	13.3
96023	1,184	36.8	40	\$31,322	26.7	11.6	14.9	26.5	22.7	15.6
96025	2,126	22.9	51	\$35,602	20.6	6.1	11.6	6.1	45.8	18.1
96027	2,327	12.8	53	\$64,865	13.4	7.3	2.6	4.7	23.8	22.6
96031	133	31.6	54	\$22,500	37.6	19.4	5.3	7.8	41.7	14.3
96032	2,653	26.8	42	\$48,036	19.0	12.5	6.5	11.2	31.2	21.0
96034	279	18.6	53	\$39,219	23.7	16.5	13.6	12.8	41.9	13.6
96037	279	11.1	59	\$81,394	23.3	14.8	0.0	4.5	47.1	32.3
96038	732	11.5	44	\$54,423	13.0	3.7	5.7	8.3	31.2	19.1
96039	904	48.9	51	\$36,213	30.2	13.1	2.9	18.7	23.5	23.6
96044	963	14.8	59	\$47,228	19.7	8.2	7.0	12.4	24.1	24.1
96049	90	63.3	34		22.2	23.5	0.0	10.5	37.0	17.8
96050	381	10.2	63	\$24,598	37.5	15.1	7.1	12.5	35.0	26.2
96057	1,235	11.8	56	\$36,635	12.8	13.9	5.1	7.8	25.9	24.9
96058	553	55.3	47	\$41,563	10.8	8.6	17.5	29.7	13.3	15.0
96064	4,533	19.1	49	\$49,604	13.9	6.8	6.1	8.7	27.8	21.6
96067	7,094	13.6	53	\$47,150	17.9	3.3	3.6	4.1	42.3	13.4
96085	54	22.2	60		33.3	16.7	18.5	5.7	21.1	5.6
96086	278	23.7	57	\$45,750	29.9	7.8	11.2	21.1	30.9	26.3
96094	6,611	27.1	47	\$51,857	17.0	6.9	5.0	9.0	33.8	18.1
96097	9,746	26.3	40	\$44,782	19.5	6.1	5.2	10.4	32.9	19.0
96134	2,059	54.9	36	\$34,896	29.1	4.2	11.2	37.0	27.7	12.0
Siskiyou	43,468	23.9	48	\$45,241	18.8	7.1	5.9	9.8	33.2	18.6
California	39,283,497	62.8	37	\$75,235	13.4	6.1	7.5	16.7	40.6	10.6

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

Health Equity

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

“Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”⁹

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.”¹⁰

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

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

Health Outcomes - the Results of Inequity

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

Table 3: Health outcomes comparing race and ethnicity in the Siskiyou County 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.	72.1	~	~	82.8	76.3	76.5
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	695.3	~	~	273.4	451.7	445.5
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	~	~	6,270.8	9,995	9,929

⁹ 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 .

¹⁰ 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.

Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	9.9%	~	~	9.7%	8.1%	8.6%
~ Data Not Available							
Data sources included in the technical section of the report.							

Health Outcomes by race and ethnicity show lower life expectancy than Hispanics and Whites, and higher premature age-adjusted mortality for American Indian/Alaska Native community members. Hispanic community members have the highest life expectancy, and lowest premature mortality and the lowest premature death, compared to other groups.

Health Factors - Inequities in the County

Inequalities can be seen in data that help describe health factors in the COUNTY, 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 Siskiyou County 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.	51.9%	38%	69.4%	46.8%	67.9%	64.7%
High School Completion ^a	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	79.6%	66.5%	93.3%	74.5%	93.2%	90.2%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	~	~	2.7	2.8	2.7
Third Grade Math Level	Average grade level performance for 3rd graders on	~	~	~	2.5	2.6	2.6

	math standardized tests						
Children in Poverty	Percentage of people under age 18 in poverty.	29.8%	28.7%	45.8%	33.4%	19.8%	25.5%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$35,938	\$40,875	~	\$39,216	\$47,894	\$45,954
Uninsured Population ^b	Percentage of the civilian non-institutionalized population without health insurance.	6.7%	6.5%	6.7%	10.9%	5%	5.9%

~ Data Not Available

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

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

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

Health inequities in the county show Asians and Hispanics having the lowest percent of county residents completing high school and attending some college. Though data is unavailable for many ethnic and racial groups, Hispanics also show lower third grade reading and math scores compared to Whites. There are more Black families with children living in poverty than any other race or ethnic group, while American Indian/Alaskan Natives have the lowest median household income. In addition, Hispanics have the largest percent of uninsured population in the county.

Population Groups Experiencing Disparities

The figure below describes populations in the Siskiyou County 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 4 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

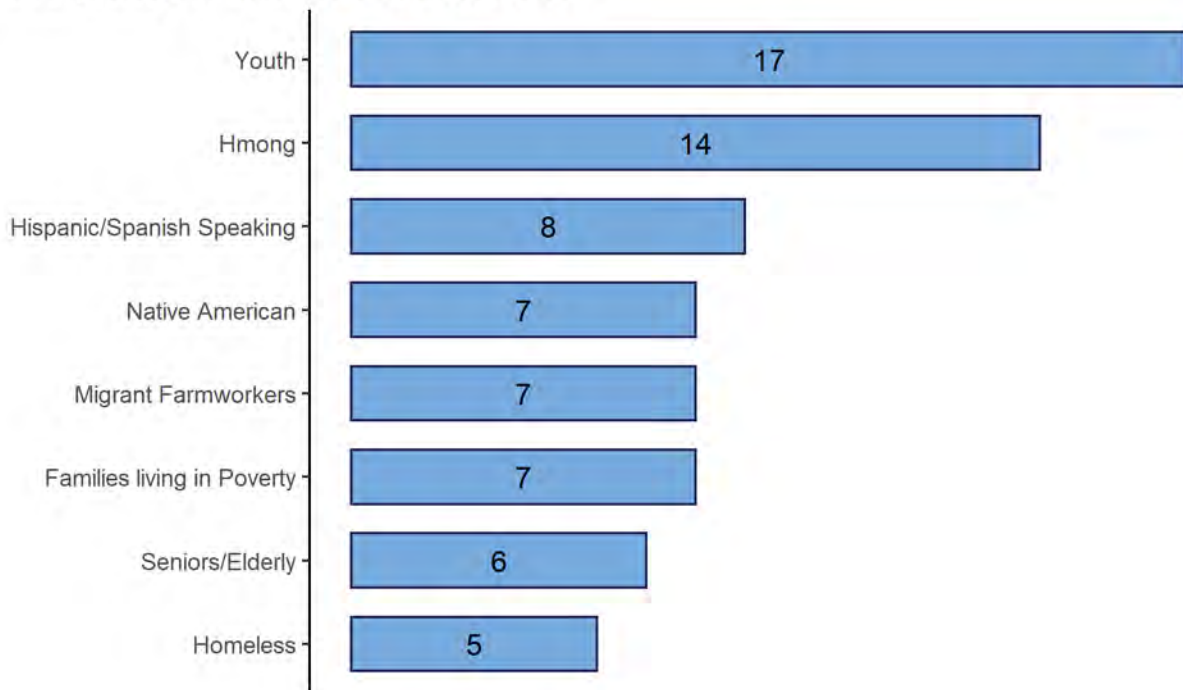


Figure 4: Populations experiencing disparities the Siskiyou County service area.

California Healthy Places Index

Figure 5 displays the California Healthy Places Index (HPI)¹¹ values for the Siskiyou County 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.

¹¹ Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from <https://healthyplacesindex.org/about/>.

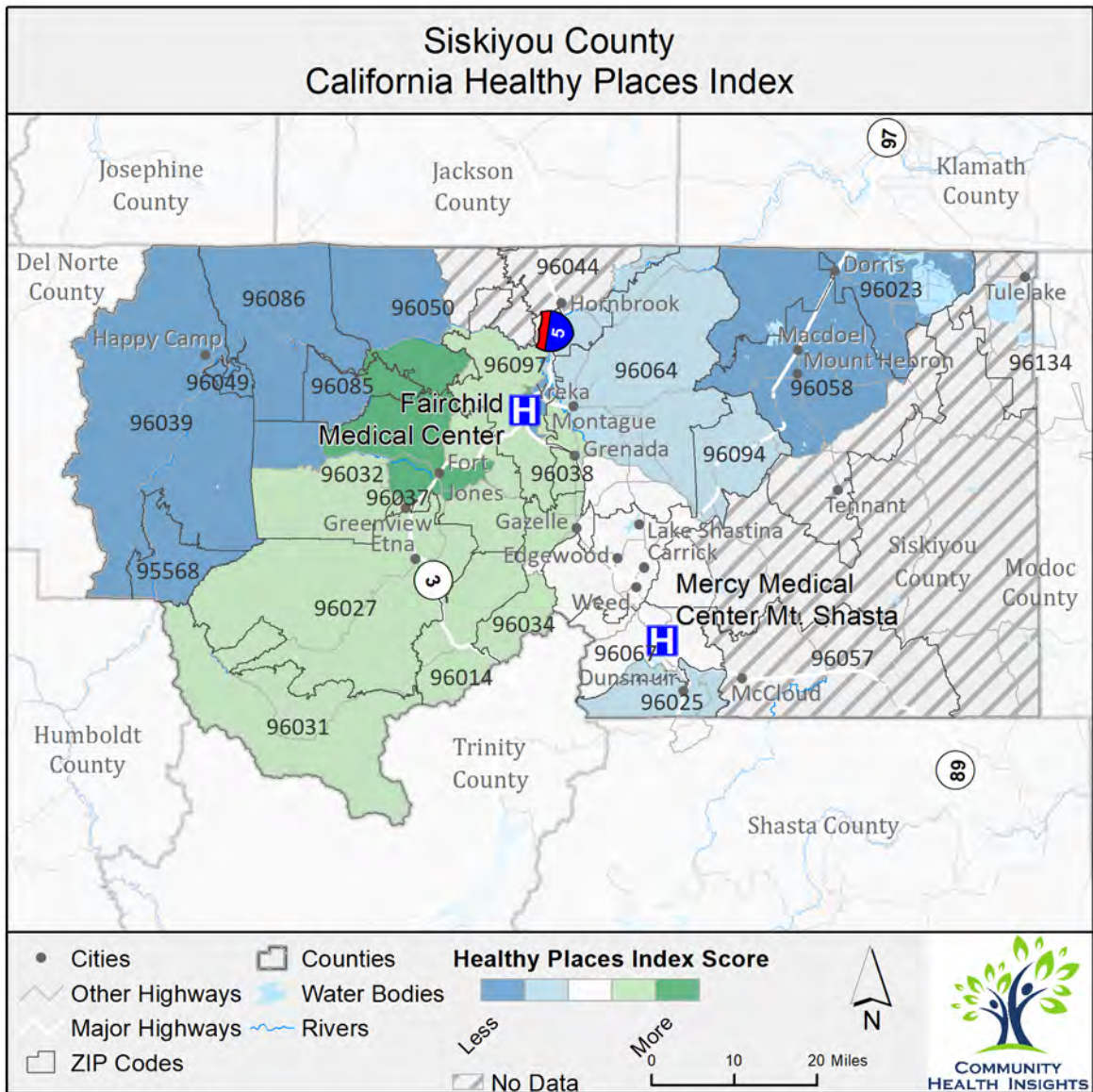


Figure 5: Healthy Places Index for Siskiyou County.

Areas with the darkest blue shading in Figure 5 have the lowest overall HPI scores, indicating factors leading to less healthy social environments. There are likely to be more residents in these locations experiencing health disparities, with a lack of access to health and social service resources.

Communities of Concern

Communities of Concern are geographic areas within the service area that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region likely experiencing the greatest health disparities. Geographic

Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 6 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 5, with the census population provided for each, and are displayed in Figure 6.

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

ZIP Code	Community\Area	Population
Primary		
96097	Yreka	9,746
96039	Happy Camp Area	904
Secondary		
96094	Shasta Valley Area	6,611
96023	Dorris	1,184
96058	Macdoel	553
96134	Tulelake	2,059
<i>Total Population in Communities of Concern</i>		<i>21,057</i>
<i>Total Population in Siskiyou County</i>		<i>44,623</i>
<i>Percentage county population in Communities of Concern</i>		<i>47.2%</i>

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

Figure 6 displays the ZIP Codes highlighted in pink and blue that are primary and secondary Communities of Concern for the Siskiyou County service area.

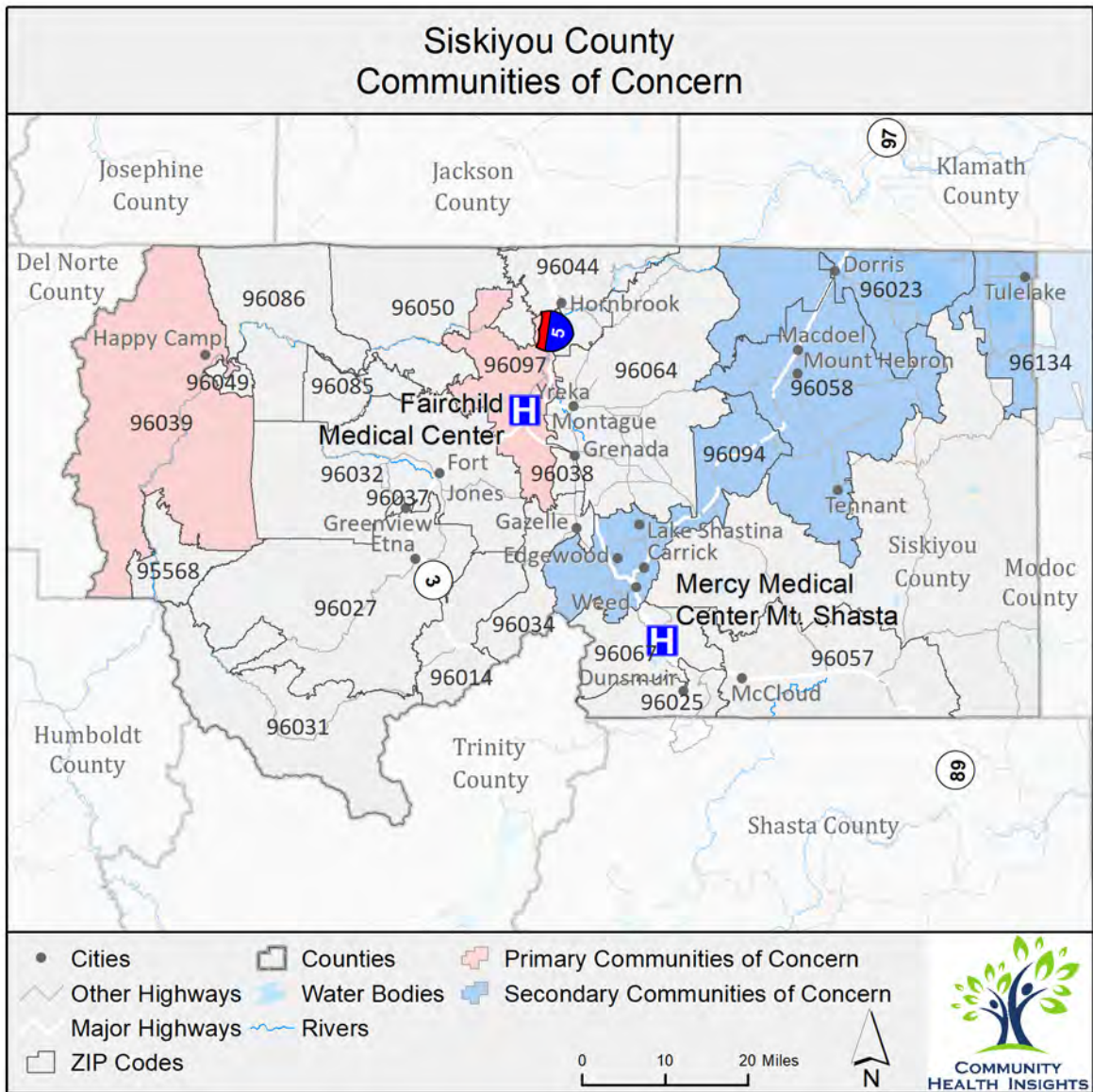


Figure 6: Siskiyou County Communities of Concern.

The primary Communities of Concern, Yreka (96097) and the Happy Camp Area (96039) were chosen due to both primary and secondary data clearly indicating a disproportionate health burden for community members in these areas. The Secondary Communities of Concern consisting of the Shasta Valley Area (96094), Dorris (96023), Macdoel (96058) and Tulelake (96134) were also consistently mentioned by primary data as areas where community members were disproportionately affected by undue health burdens. These areas are listed as secondary Communities of Concern due to the fact that available secondary data may not have flagged it as a priority, however, the voice of area representatives clearly mentioned these areas having disproportionate health impact. The Communities of Concern for Siskiyou County make up 47.2% of the county population. Figure 6 below provides a population density of the county for reference.

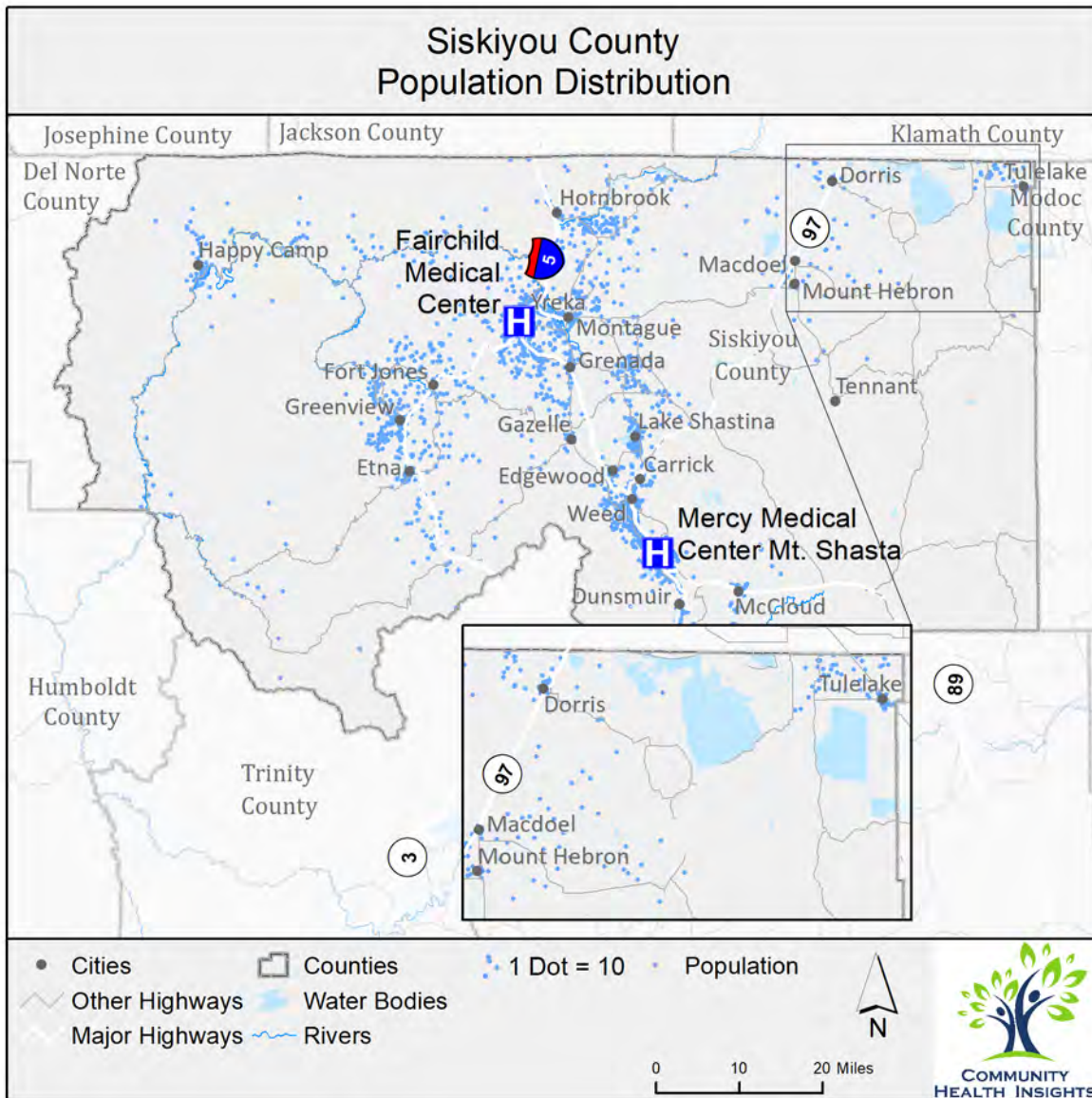


Figure 7: Siskiyou County Population Distribution.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators regard the county are noted in Table 6. Results for the county shows the case fatality rate to be higher than the state rate, coupled with lower full vaccination rates.

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

Indicators	Description	Siskiyou	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	151.8	201.8	Siskiyou: 151.8 California: 201.8

COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID19 cases.	1.6%	1.0%	Siskiyou: 1.6% California: 1%
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	9,291.9	20,055.8	Siskiyou: 9,291.9 California: 20,055.8
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	47,200.2	69,117.9	Siskiyou: 47,200.2 California: 69,117.9

COVID-19 data collected on January 31 2022

Key informants and focus group participants were asked how the COVID-19 pandemic impacted the health needs they described during interviews. A summary of their responses is shown in Table 7.

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

Key Informant and Focus Group Responses
<ul style="list-style-type: none"> • Low vaccination rates coupled with low health care staffing overwhelmed area healthcare systems. A direct quote “Our biggest challenge has been caring for our community with limited staff, limited ventilators, limited ICU beds.” • Government reimbursement for telehealth visits for rural healthcare clinics do not cover the cost to conduct them, limiting rural clinic capacity during COVID-19 stay at home orders. • Many very sick COVID-19 patients that were hospitalized were unvaccinated resulting in very long hospital stays, limiting the capacity of the hospital to serve the other health needs of community members. • COVID-19 exacerbated the limited health and social service workforce shortages. • Area residents experience increase anxiety and depression related to the fear of COVID-19 and related mandates. • Area tribal elders dies as a result of COVID-19. • Many residents have vaccine hesitancy. • COVID-19 has caused the permanent closer of business. • People that got COVID-19 did not want to disclose to others, COVID-19 stigma is high in the county. • Community engagement activities is a central part of the county culture. COVID-19 took that away. • Vaccine mandate has further exacerbated a limited professional healthcare shortage in the county.

Resources Potentially Available to Meet the Significant Health Needs

In all, 112 resources were identified in the Siskiyou County 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 Siskiyou County CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 8.

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

Significant Health Needs (in Priority Order)	Number of Resources
Access to Mental/Behavioral Health and Substance use Services	31
Injury and Disease Prevention and Management	14
Access to Basic Needs Such as Housing, Jobs, and Food	25
Access to Quality Primary Care Health Services	19
Access to Specialty and Extended Care	11
Access to Dental Care and Preventive Services	8
Active Living and Healthy Eating	10
Access to Functional Needs	8
Safe and Violence-Free Environment	10
Total Resources	139

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).”¹² Fairchild Medical Center 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

¹² Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

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.

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Siskiyou County Service Area.

Results of Data Analysis

Compiled Secondary Data

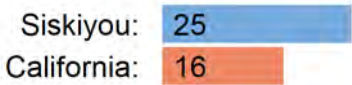
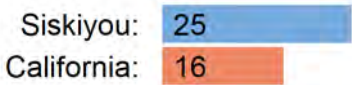
The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. Indicator values for Siskiyou County were compared to the California state benchmark and are highlighted below when performance was worse in the county than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

Length of Life

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

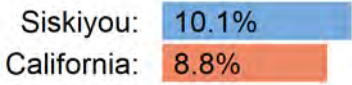
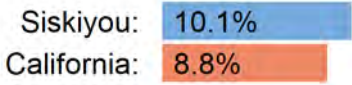
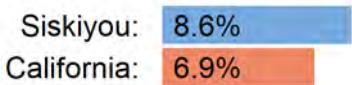
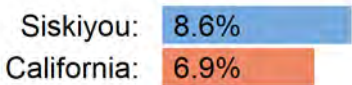
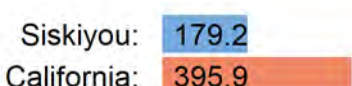
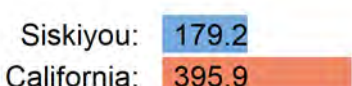
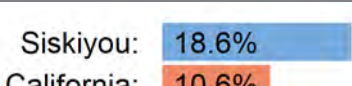
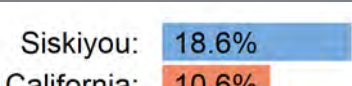
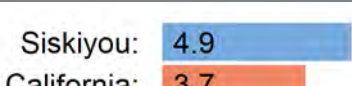
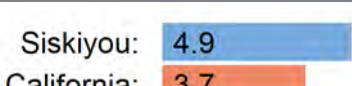
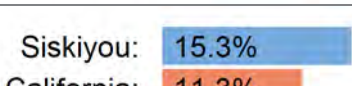
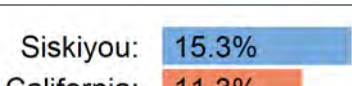
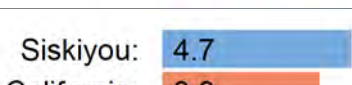
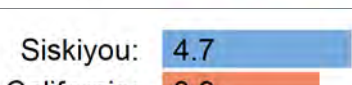




Indicators	Description	Siskiyou	California	
Early Life				
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	6.7	4.2	Siskiyou: 6.7 California: 4.2
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	59.7	36.0	Siskiyou: 59.7 California: 36
Life Expectancy	Average number of years a person can expect to live.	76.5	81.7	Siskiyou: 76.5 California: 81.7
Overall				
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	445.5	268.4	Siskiyou: 445.5 California: 268.4
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	9,929.0	5,253.1	Siskiyou: 9,929 California: 5,253.1
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	59.8	41.2	Siskiyou: 59.8 California: 41.2
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	101.8	34.8	Siskiyou: 101.8 California: 34.8

Indicators	Description	Siskiyou California		
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	34.4	24.1	Siskiyou: 34.4 California: 24.1
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	287.0	159.5	Siskiyou: 287 California: 159.5
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	14.9	13.8	Siskiyou: 14.9 California: 13.8
Cancer, Liver, and Kidney Disease				
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	270.1	152.9	Siskiyou: 270.1 California: 152.9
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	21.2	13.9	Siskiyou: 21.2 California: 13.9
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	14.5	9.7	Siskiyou: 14.5 California: 9.7
Intentional and Unintentional Injuries				
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	18.3	11.2	Siskiyou: 18.3 California: 11.2
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	82.3	35.7	Siskiyou: 82.3 California: 35.7
COVID-19				
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	151.8	201.8	Siskiyou: 151.8 California: 201.8
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID19 cases.	1.6%	1.0%	Siskiyou: 1.6% California: 1%
Other				
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	56.2	41.2	Siskiyou: 56.2 California: 41.2

Indicators	Description	Siskiyou California		
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	25.0	16.0	Siskiyou:  California: 

Quality of Life

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

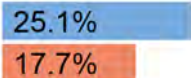
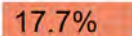
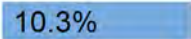



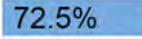
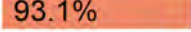

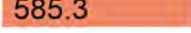



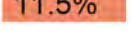
Indicators	Description	Siskiyou California		
Chronic Disease				
Diabetes Prevalence	Percentage of adults ages 20 and above with diagnosed diabetes.	10.1%	8.8%	Siskiyou:  California: 
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	8.6%	6.9%	Siskiyou:  California: 
HIV Prevalence	Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	179.2	395.9	Siskiyou:  California: 
Disability	Percentage of the total civilian noninstitutionalized population with a disability	18.6%	10.6%	Siskiyou:  California: 
Mental Health				
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.9	3.7	Siskiyou:  California: 
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	15.3%	11.3%	Siskiyou:  California: 
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	4.7	3.9	Siskiyou:  California: 
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	14.5%	11.6%	Siskiyou:  California: 
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	18.7%	17.6%	Siskiyou:  California: 
Cancer				

Indicators	Description	Siskiyou California		
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	31.3	34.8	Siskiyou: 31.3 California: 34.8
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	22.0	27.9	Siskiyou: 22 California: 27.9
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	52.4	40.9	Siskiyou: 52.4 California: 40.9
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	72.4	91.2	Siskiyou: 72.4 California: 91.2
COVID-19				
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	9,291.9	20,055.8	Siskiyou: 9,291.9 California: 20,055.8
Other				
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	341.0	422.0	Siskiyou: 341 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).	350.0	601.0	Siskiyou: 350 California: 601

Health Behavior









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

Indicators	Description	Siskiyou California		
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	22.7%	18.1%	Siskiyou: 22.7% California: 18.1%
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	17.7	14.3	Siskiyou: 17.7 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 .	34.5%	24.3%	Siskiyou: 34.5% California: 24.3%

Indicators	Description	Siskiyou California		
Physical Inactivity	Percentage of adults ages 20 and over reporting no leisure-time physical activity.	25.1%	17.7%	Siskiyou:  California: 
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	10.3%	3.3%	Siskiyou:  California: 
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	6.7	8.8	Siskiyou:  California: 
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	72.5%	93.1%	Siskiyou:  California: 
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	303.3	585.3	Siskiyou:  California: 
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	23.1	17.4	Siskiyou:  California: 
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	17.6%	11.5%	Siskiyou:  California: 

Clinical Care

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

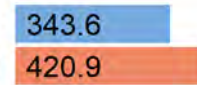

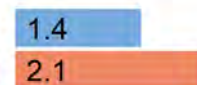

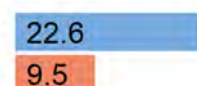

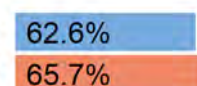
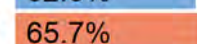
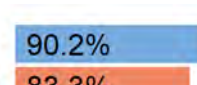
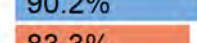
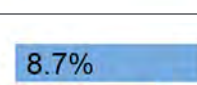






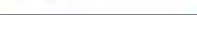
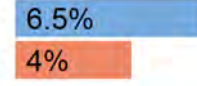

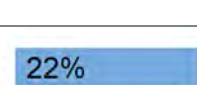
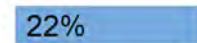
Indicators	Description	Siskiyou California		
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	Yes		Siskiyou:  California: 
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	Yes		Siskiyou: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

Indicators	Description	Siskiyou California		
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	39.0%	36.0%	Siskiyou: 39% California: 36%
Dentists	Dentists per 100,000 population.	68.9	87.0	Siskiyou: 68.9 California: 87
Mental Health Providers	Mental health providers per 100,000 population.	445.6	373.4	Siskiyou: 445.6 California: 373.4
Psychiatry Providers	Psychiatry providers per 100,000 population.	4.6	13.5	Siskiyou: 4.6 California: 13.5
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	64.3	190.0	Siskiyou: 64.3 California: 190
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	155.9	147.3	Siskiyou: 155.9 California: 147.3
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted)	673.8	948.3	Siskiyou: 673.8 California: 948.3
COVID-19				
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	47,200.2	69,117.9	Siskiyou: 47,200.2 California: 69,117.9

Socio-Economic and Demographic Factors

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

Indicators	Description	Siskiyou California		
Community Safety				
Homicide Rate	Number of deaths due to homicide per 100,000 population.	6.9	4.8	Siskiyou: 6.9 California: 4.8
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	19.7	7.8	Siskiyou: 19.7 California: 7.8

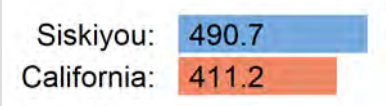
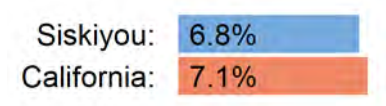

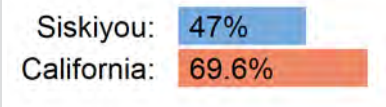
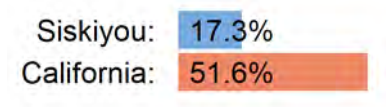

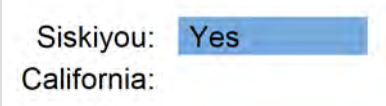
Indicators	Description	Siskiyou	California	
Violent Crime Rate	Number of reported violent crime offenses per 100,000 population.	343.6	420.9	Siskiyou:  California: 
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	1.4	2.1	Siskiyou:  California: 
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	22.6	9.5	Siskiyou:  California: 
Education				
Some College	Percentage of adults ages 25-44 with some post-secondary education.	62.6%	65.7%	Siskiyou:  California: 
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	90.2%	83.3%	Siskiyou:  California: 
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	8.7%	6.4%	Siskiyou:  California: 
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	2.7	2.9	Siskiyou:  California: 
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	2.6	2.7	Siskiyou:  California: 
Employment				
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	6.5%	4.0%	Siskiyou:  California: 
Family and Social Support				
Children in Single-Parent Households	Percentage of children that live in a household headed by single parent.	22.0%	22.5%	Siskiyou:  California: 
Social Associations	Number of membership associations per 10,000 population.	10.5	5.9	Siskiyou:  California: 

Indicators	Description	Siskiyou	California	
Residential Segregation (Non-White/White)	Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.	22.6	38.0	Siskiyou: 22.6 California: 38
Income				
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	65.6%	59.4%	Siskiyou: 65.6% California: 59.4%
Children in Poverty	Percentage of people under age 18 in poverty.	25.5%	15.6%	Siskiyou: 25.5% California: 15.6%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$45,954.0	\$80,423.0	Siskiyou: \$45,954 California: \$80,423
Uninsured Population under 64	Percentage of population under age 65 without health insurance.	8.4%	8.3%	Siskiyou: 8.4% California: 8.3%
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.6	5.2	Siskiyou: 4.6 California: 5.2

Physical Environment


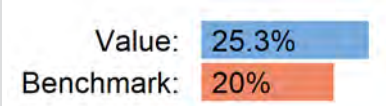
Table 14: County physical environment indicators compared to state benchmarks.

Indicators	Description	Siskiyou	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.	20.1%	26.4%	Siskiyou: 20.1% California: 26.4%
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	15.3%	19.7%	Siskiyou: 15.3% California: 19.7%
Homeownership	Percentage of occupied housing units that are owned.	65.0%	54.8%	Siskiyou: 65% California: 54.8%

Indicators	Description	Siskiyou California		
Homelessness Rate	Number of homeless individuals per 100,000 population.	490.7	411.2	Siskiyou:  Siskiyou: 490.7 California: 411.2
Transit				
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	6.8%	7.1%	Siskiyou:  Siskiyou: 6.8% California: 7.1%
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	22.2%	42.2%	Siskiyou:  Siskiyou: 22.2% California: 42.2%
Access to Public Transit	Percentage of population living near a fixed public transportation stop	47.0%	69.6%	Siskiyou:  Siskiyou: 47% California: 69.6%
Air and Water Quality				
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 3.0 pollution burden score percentile of 50 or greater	17.3%	51.6%	Siskiyou:  Siskiyou: 17.3% California: 51.6%
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	4.9	8.1	Siskiyou:  Siskiyou: 4.9 California: 8.1
Drinking Water Violations	Presence of health-related drinking water violations in the county.	Yes		Siskiyou:  Siskiyou: Yes California:

Community Survey

Table 15: Siskiyou County Community Survey responses compared to selected benchmarks.

Name	Question Number	Question	Value	Benchmark	
Unable to see doctor in past 12 months	16	In the past 12 months, was there a time you wanted to see a doctor, but were unable to?	32%	20%	Value:  Value: 32% Benchmark: 20%
Have not seen dentist in over a year	18	Have not seen a dentist or dental clinic in longer than a year	25.3%	20%	Value:  Value: 25.3% Benchmark: 20%

Name	Question Number	Question	Value	Benchmark	
Unable to access care aligned with identity	22	Answered False to I am able to access care which respects and aligns with my cultural and gender identity.	6.5%	20%	Value: 6.5% Benchmark: 20%
Experienced or witnessed physical or sexual violence or threat	23	Experienced or witnessed actual or threatened physical or sexual violence directed towards self or another person by a significant other in the last 12 months.	12%	20%	Value: 12% Benchmark: 20%
Feared for safety of self or loved one	24	Felt unsafe or feared for the physical safety of self or loved one in the past 24 months.	22.4%	20%	Value: 22.4% Benchmark: 20%
Unable to access desired substance use treatment	25	Sought or desired to seek treatment for a substance use issue, but been unable to access the care needed, in the past 24 months.	2.6%	20%	Value: 2.6% Benchmark: 20%
Felt two or more years of depression	26	Had two years or more in life when felt depressed or sad most days, even if felt okay sometimes.	43.5%	20%	Value: 43.5% Benchmark: 20%
Self or other with suicidal thoughts	29	Self or someone else known has experienced suicidal thoughts or ideation in the past 24 months.	31.4%	20%	Value: 31.4% Benchmark: 20%

Name	Question Number	Question	Value	Benchmark	
Worried about food running out before more money	30	Sometimes or often worried about whether food would run out before more money would be received to buy more within the past 12 months.	17.6%	20%	
Access to food limited by transportation	31	Transportation or distance from a grocery store is sometimes or often a limiting factor in getting to a store which sells healthy, nutritious, and affordable food.	22.5%	20%	
Have some limitations due to an impairment or health problem.	32	Have some limitations due to an impairment or health problem.	32.2%	20%	
Diagnosed with one or more chronic illness	34	Been diagnosed with one or more chronic illness (e.g., arthritis, COPD, diabetes, heart disease, hypertension, high cholesterol, asthma, cancer, etc.).	50.6%	20%	
Unable to see doctor, no health insurance	17a	Unable to see a doctor in the past 12 months because no health insurance	10%	20%	
Unable to see doctor, insurance not accepted	17b	Unable to see a doctor in the past 12 months because health insurance not accepted	5.7%	20%	

Name	Question Number	Question	Value	Benchmark	
Unable to see doctor, lack of transportation	17c	Unable to see a doctor in the past 12 months because of a lack of transportation	3.6%	20%	Value: 3.6% Benchmark: 20%
Unable to see doctor, lack of appointments	17d	Unable to see a doctor in the past 12 months because of a lack of appointments	54.3%	20%	Value: 54.3% Benchmark: 20%
Prevented from accessing care due to beliefs	20a	Prevented from accessing needed care by cultural or religious beliefs.	1.2%	20%	Value: 1.2% Benchmark: 20%
Prevented from accessing care, couldn't find doctor	20b	Prevented from accessing needed care because didn't know how to find doctor.	0.9%	20%	Value: 0.9% Benchmark: 20%
Prevented from accessing care, unaware of need	20c	Prevented from accessing needed care because didn't understand the need to see doctor.	0.6%	20%	Value: 0.6% Benchmark: 20%
Prevented from accessing care, fear	20d	Prevented from accessing needed care by fear.	4.6%	20%	Value: 4.6% Benchmark: 20%
Prevented from accessing care, doctor availability	20e	Prevented from accessing needed care by a lack of availability of doctors.	29.4%	20%	Value: 29.4% Benchmark: 20%
Prevented from accessing care, no time off	20f	Prevented from accessing needed care by a lack of time off work to see doctor.	13.6%	20%	Value: 13.6% Benchmark: 20%
Prevented from accessing care, language barrier	20g	Prevented from accessing needed care by language barriers.	0.3%	20%	Value: 0.3% Benchmark: 20%

Name	Question Number	Question	Value	Benchmark	
Prevented from accessing care, no insurance	20h	Prevented from accessing needed care because of no insurance.	4.6%	20%	Value: 4.6% Benchmark: 20%
Prevented from accessing care, can't pay co-pays	20i	Prevented from accessing needed care because unable to pay co-pays or deductibles.	10.6%	20%	Value: 10.6% Benchmark: 20%
Prevented from accessing care, transportation issues	20j	Prevented from accessing needed care by transportation issues.	3.6%	20%	Value: 3.6% Benchmark: 20%
Prevented from mental/emotional health treatment, didn't know where to seek services	28a	Prevented from seeking desired help from a professional for a mental or emotional problem because didn't know where to seek mental health services.	26.9%	20%	Value: 26.9% Benchmark: 20%
Prevented from mental/emotional health treatment, uncertainty around insurance acceptance	28b	Prevented from seeking desired help from a professional for a mental or emotional problem because do not know who takes insurance.	23.9%	20%	Value: 23.9% Benchmark: 20%
Prevented from mental/emotional health treatment, can't pay co-pays	28c	Prevented from seeking desired help from a professional for a mental or emotional problem because can't afford treatment or co-pay costs.	37.7%	20%	Value: 37.7% Benchmark: 20%

Name	Question Number	Question	Value	Benchmark	
Prevented from mental/emotional health treatment, language, or cultural barriers	28d	Prevented from seeking desired help from a professional for a mental or emotional problem because of language or cultural barriers	0.8%	20%	Value: 0.8% Benchmark: 20%
Prevented from mental/emotional health treatment, stigma	28e	Prevented from seeking desired help from a professional for a mental or emotional problem because of stigma or prejudice.	33.1%	20%	Value: 33.1% Benchmark: 20%
Prevented from mental/emotional health treatment, no time	28f	Prevented from seeking desired help from a professional for a mental or emotional problem because do not feel like there is time.	45.4%	20%	Value: 45.4% Benchmark: 20%
Prevented from mental/emotional health treatment, transportation issues	28g	Prevented from seeking desired help from a professional for a mental or emotional problem because issues with transportation to appointments.	0.8%	20%	Value: 0.8% Benchmark: 20%
What would help manage chronic illness: setting goals	35a	Feels setting health goals would help most in managing chronic illness.	41%	20%	Value: 41% Benchmark: 20%
What would help manage chronic illness: insurance availability	35b	Feels availability of insurance would help most in managing chronic illness.	7.7%	20%	Value: 7.7% Benchmark: 20%

Name	Question Number	Question	Value	Benchmark	
What would help manage chronic illness: learning skills	35c	Feels learning new skills on how to manage their chronic illness would help most in managing chronic illness.	25.7%	20%	Value: 25.7% Benchmark: 20%
What would help manage chronic illness: health screenings	35d	Feels more health screenings related to their chronic illness would help most in managing chronic illness.	14.2%	20%	Value: 14.2% Benchmark: 20%
What would help manage chronic illness: understating how to take medications	35e	Feels understanding how to take their medications would help most in managing chronic illness.	1.6%	20%	Value: 1.6% Benchmark: 20%
What would help manage chronic illness: eating, lifestyle	35f	Feels healthy eating and lifestyle support would help most in managing chronic illness.	45.4%	20%	Value: 45.4% Benchmark: 20%
What would help manage chronic illness: quitting smoking	35g	Feels help quitting smoking would help most in managing chronic illness.	3.3%	20%	Value: 3.3% Benchmark: 20%
What would help manage chronic illness: pain and fatigue management	35h	Feels help developing skills to manage their pain and fatigue would help most in managing chronic illness.	21.9%	20%	Value: 21.9% Benchmark: 20%
What would help manage chronic illness: transportation to appointments	35i	Feels transportation to appointments would help most in managing chronic illness.	2.7%	20%	Value: 2.7% Benchmark: 20%

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 8. 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.

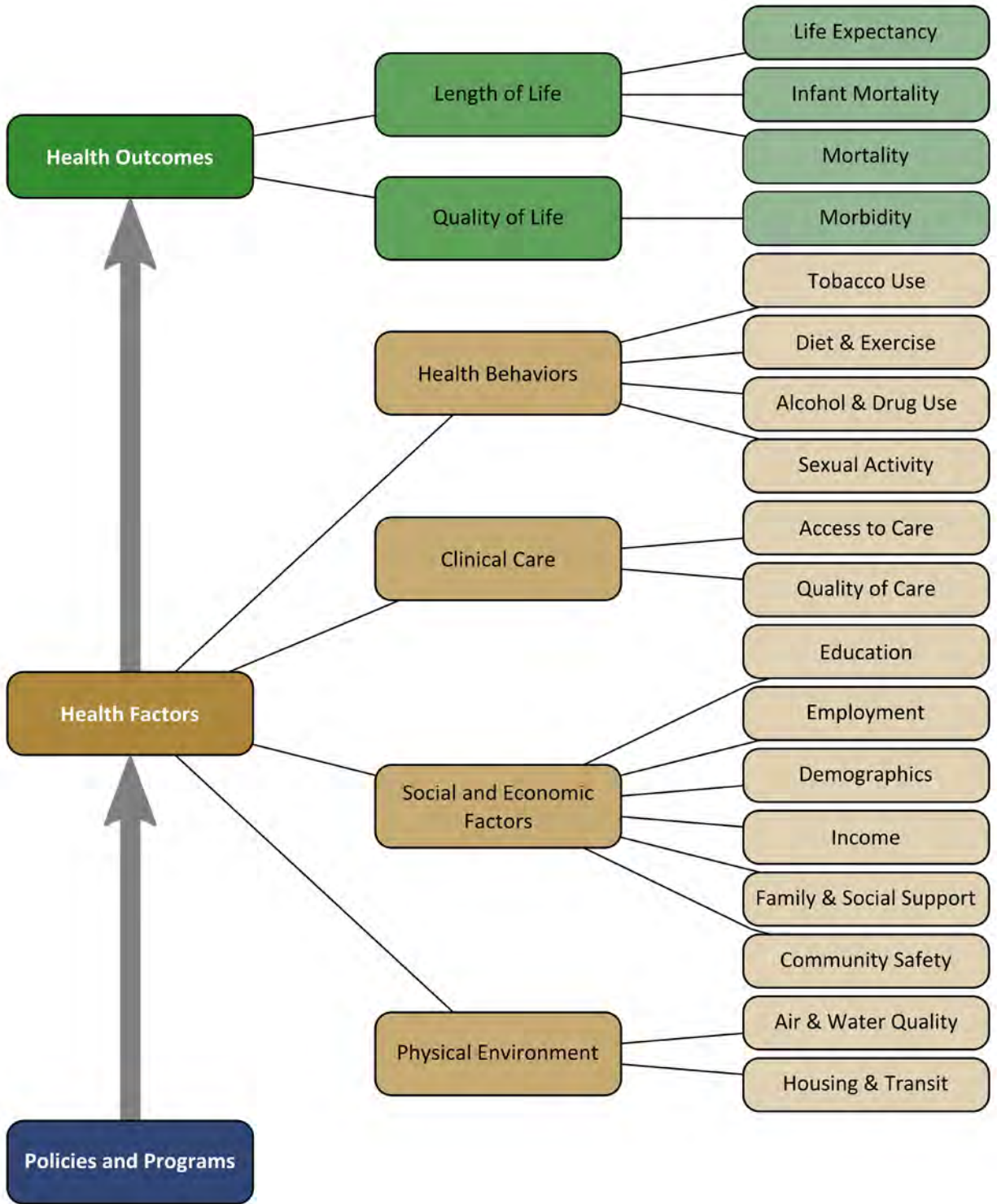


Figure 8: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

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 9 outlines the data collection and analysis stages of this process. The project began by confirming the service area for Siskiyou County 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 Communities of Concern which are areas or population subgroups within the county experiencing health disparities.

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

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

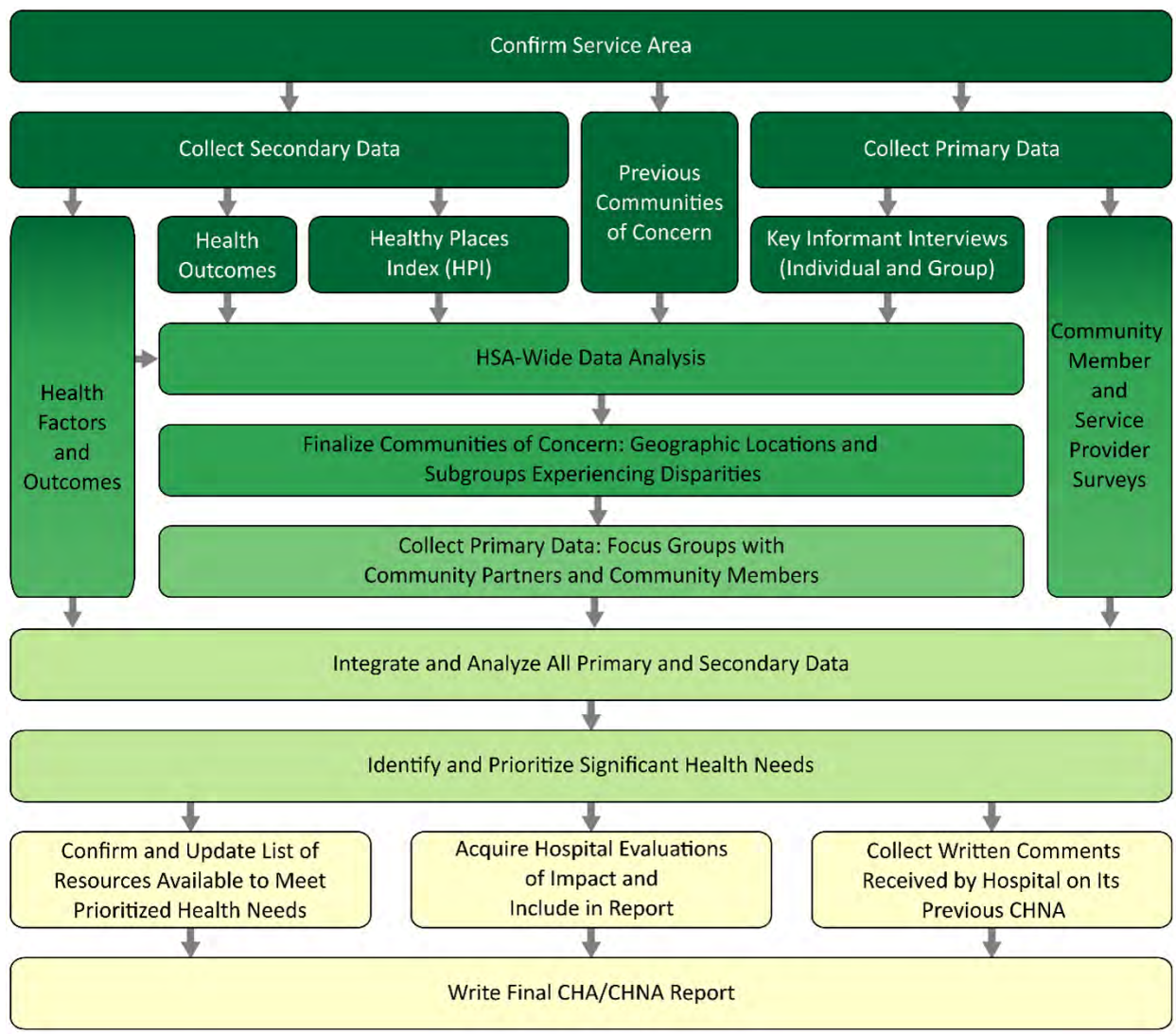


Figure 9: CHNA process model for Siskiyou County.

Primary Data Collection and Processing

Primary Data Collection

Input from the community served by Siskiyou County was collected through three 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 group interviews were conducted with community residents that were identified as populations experiencing disparities. Third, five area service providers completed a service provider survey which were integrated in the primary results.

For interviews, 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 county to directly point to the geographic locations of these vulnerable communities. Additional key informant interviews were focused on the geographic locations and/or subgroups identified in the earlier phase.

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

Table 16: Key Informant List for Siskiyou County.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Fairchild Medical Clinic and Fairchild Medical Center	10/08/2021	5	Healthcare system	Residents of Siskiyou County
Siskiyou County Health & Human Services Agency and Public Health	10/12/2021	2	Public Health, social services, behavioral health	Residents of Siskiyou County
Siskiyou County Office of Education	10/13/2021	2	Education	School age youth
Mountain Valleys Health Centers	10/20/2021	2	Federally Qualified Health Centers; healthcare, prevention, behavioral health	Rural communities; low income
Mercy Medical Center Mt. Shasta	11/08/2021	1	Acute care hospital	Residents of Siskiyou County
Hmong Community Activist in Siskiyou County	01/07/2022	1	Hmong	Hmong residents of Siskiyou County
Northern CA Indian Development Council Inc.	12/01/2021	1	Native American Health	Native Community of Siskiyou County

First 5 Siskiyou	01/19/2022	1	Children 0-5; parents of children 0-17	
Tiny Mighty Strong	01/24/2022	1	Rural youth ages 2 - 18 of Tulelake	

Key Informant Interview Guide

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

2022 CHNA Group/Key Informant Interview Protocol

1. BACKGROUND

- a. Please tell me about your current role and the organization you work for?
 - i. Probe for:
 - 1. Public health (division or unit)
 - 2. Hospital health system
 - 3. Local non-profit
 - 4. Community member
- b. How would you define the community (ies) you or your organization serves?
 - i. Probe for:
 - 1. Specific geographic areas?
 - 2. Specific populations served?
 - 3. Who? Where? Racial/ethnic make-up, physical environment (urban/rural, large/small)

2. CHARACTERISTICS OF A HEALTHY COMMUNITY

- a. In your view, what does a healthy community look like?
 - i. Probe for:
 - 1. Social factors
 - 2. Economic factors
 - 3. Clinical care
 - 4. Physical/built environment (food environment, green spaces)
 - 5. Neighborhood safety

3. HEALTH ISSUES

- a. What would you say are the biggest health needs in the community?
 - i. Probe for:
 - 1. How has the presence of COVID-19 impacted these health needs?
- b. INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live?
 - i. Probe for:
 - 1. What specific geographic locations struggle with health issues the most?
 - 2. What specific groups of community members experience health issues the most?

4. CHALLENGES/BARRIERS

- a. Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?
 - i. Do these inequities exist among certain population groups?
 - ii. Probe for:

1. Health Behaviors (maladaptive, coping)
 2. Social factors (social connections, family connectedness, relationship with law enforcement)
 3. Economic factors (income, access to jobs, affordable housing, affordable food)
 4. Clinical Care factors (access to primary care, secondary care, quality of care)
 5. Physical (Built) environment (safe and healthy housing, walkable communities, safe parks)
5. SOLUTIONS
- a. What solutions are needed to address the health needs and or challenges mentioned?
 - i. Probe for:
 1. Policies
 2. Care coordination
 3. Access to care
 4. Environmental change
6. PRIORITY
- a. Which would you say are currently the most important or urgent health issues or challenges to address (at least 3 to 5) in order to improve the health of the community?
7. RESOURCES
- a. What resources exist in the community to help people live healthy lives?
 - i. Probe for:
 1. Barriers to accessing these resources.
 2. New resources that have been created since 2019
 3. New partnerships/projects/funding
8. PARTICIPANT DRIVEN SAMPLING:
- a. What other people, groups or organizations would you recommend we speak to about the health of the community?
 - i. Name 3 types of service providers that you would suggest we include in this work?
 - ii. Name 3 types of community members that you would recommend we speak to in this work?
9. OPEN: Is there anything else you would like to share with our team about the health of the community?

Focus Group Results

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

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

Table 17: Focus Group List for Siskiyou County.

Hosting Organization	Date	Number of Participants	Populations Represented
Tulelake Family Resource Center; Modoc County Public Health	01/12/2022	3	Latino, low-income, farmworkers
Happy Camp Community Action, Inc.; Happy Camp Ambulance	01/13/2022	6	Native Americans; White low-income

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?

Community Service Provider Survey

A web-based survey was administered to community service providers (CSP) who delivered health and social services to community residents of the county. A list of CSPs affiliated with the nonprofit hospitals included in this report as our initial sampling frame and sent an email recruitment message to these CSPs detailing the survey aims and inviting them to participate. A snowball sampling technique was used, encouraging participants to forward the recruitment message to other CSPs in their networks. The survey was designed using Qualtrics, an online survey platform, and was available for approximately two weeks. Five respondents completed the survey. Survey respondents were also given the opportunity to be acknowledged for their participation in the report and four organizations are listed as follows:

Quartz Valley Indian Reservation / Anav Tribal Health Clinic, Shasta Cascade Health Centers, McCloud Healthcare Clinics Inc, Siskiyou Food Assistance

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

When the survey period was over, incomplete, and duplicate responses were removed from the dataset and the survey responses were double-checked for accuracy. Descriptive statistics and frequencies were run to summarize the health needs. Given the small sample size of five participants for Siskiyou County, each survey entry was coded using the same analytical process as key informant interview and focus groups.

Countywide Health Survey Results

A countywide health survey was distributed from November 8th to December 28th, 2021. The survey was a revised version of the 2019 community health survey which included questions related to both the perceived health of the community as well as personal health and access to care. The survey was developed and revised in partnership with community organizations, including Fairchild Medical Center and Mercy Medical Center Mt Shasta. When revising the questions for the 2021 survey, questions were removed which did not produce actionable data in the original survey cycle, and questions/ answer options were added to attempt to capture the impacts of the COVID-19 pandemic. The intent of the survey is to help inform actions of community organizations over the next three years based on the Siskiyou County residents' perception of health, available resources, and health related factors. In combination with other data collected through the Community Health Assessment process, this survey provides valuable insight and information.

The community health survey was distributed primarily via social media and integration into organizational website through electronic submission link due to the COVID-19 pandemic. Our target sample size was 381 responses (5% margin of error with a 95% confidence level at 44,000 population size). There were a total of 427 responses. A special thank you to everyone who participated in the survey- we appreciate your time and input. The complete survey and results is contained in [Appendix]. The figure below displays the racial/ethnic profile of the survey respondents in comparison to census counts for the county.

Primary Data Processing

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

Secondary Data Collection and Processing

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

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),¹³ derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),¹⁴ health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2015-2019 due to each of the causes listed in Table 18.

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

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

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

ZIP Code Consolidation

The mortality indicators used here included deaths reported for the ZIP Code at the decedent’s place of residence. ZIP Codes are defined by the U.S. Postal Service as a single location (such as a PO Box), or a set of roads along which addresses are located. The roads that comprise such a ZIP Code may not form contiguous areas and do not match the areas used by the U.S. Census Bureau (the main source of

¹³ Public Health Alliance of Southern California. 2021. HPI_MasterFile_2021-04-22.zip. Data file. Retrieved 1 May 2021 from https://healthyplacesindex.org/wp-content/uploads/2021/04/HPI_MasterFile_2021-04-22.zip.

¹⁴ State of California, Department of Public Health. 2021. California Comprehensive Master Death File (Static), 2015-2019.

population and demographic data in the United States) to report population. Instead of measuring the population along a collection of roads, the census reports population figures for distinct, largely contiguous areas. To support the analysis of ZIP Code data, the U.S. Census Bureau created ZIP Code Tabulation Areas (ZCTAs). ZCTAs are created by identifying the dominant ZIP Code for addresses in a given Census block (the smallest unit of census data available), and then grouping blocks with the same dominant ZIP Code into a corresponding ZCTA. The creation of ZCTAs allows us to identify population figures that make it possible to calculate mortality rates for each ZCTA. However, the difference in the definition between mailing ZIP Codes and ZCTAs has two important implications for analyses of ZIP Code level data.

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

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California¹⁵ were compared to ZCTA boundaries.¹⁶ These unique ZIP Codes were then assigned to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

Rate Calculation and Smoothing

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical bayes smoothed rates (EBRs) were created for all indicators possible.¹⁷ Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small-number problem. Empirical bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

Because the EBR were created for all ZCTAs in the state, ZCTAs with small populations that may have unstable high rates had their rates “shrunk” to match the overall indicator rate more closely for ZCTAs in the entire state. This adjustment can be substantial for ZCTAs with very small populations. The difference between raw rates and EBRs in ZCTAs with very large populations, on the other hand, is negligible. In this way, the stable rates in large-population ZIP Codes are preserved, and the unstable rates in smaller-population ZIP Codes are shrunk to match the state norm more closely. While this may not entirely resolve the small-number problem in all cases, it does make the comparison of the resulting

¹⁵ Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from <http://www.Zip-Codes.com>.

¹⁶ US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from <https://www.census.gov/cgi-bin/geo/shapefiles/index.php>.

¹⁷ Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

rates more appropriate. Because the rate for each ZCTA is adjusted to some degree by the EBR process, this also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

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

Significant Health Need Identification Dataset

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

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

Conceptual Model Alignment		Indicator	Data Source	Time Period	
Health Outcomes	Length of Life	Infant Mortality	County Health Rankings	2013 - 2019	
		Life Expectancy	Child Mortality	County Health Rankings	2016 - 2019
			Life Expectancy	County Health Rankings	2017 - 2019
			Premature Age-Adjusted Mortality	County Health Rankings	2017 - 2019
			Premature Death	County Health Rankings	2017 - 2019
			Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019

			Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			COVID-19 Mortality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-01-31
			COVID-19 Case Fatality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-01-31
			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
			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 2022-01-31
			Asthma ED Rates	Tracking California	2018
			Asthma ED Rates for Children	Tracking California	2018
Health Factors	Health Behavior	Alcohol and Drug Use	Excessive Drinking	County Health Rankings	2018
			Drug Induced Death	CDPH 2021 County Health Status Profiles	2017 - 2019
		Diet and Exercise	Adult Obesity	County Health Rankings	2017
			Physical Inactivity	County Health Rankings	2017
			Limited Access to Healthy Foods	County Health Rankings	2015
			Food Environment Index	County Health Rankings	2015 & 2018
			Access to Exercise Opportunities	County Health Rankings	2010 & 2019
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2018
			Teen Birth Rate	County Health Rankings	2013 - 2019
		Tobacco Use	Adult Smoking	County Health Rankings	2018
	Clinical Care	Access to Care	Primary Care Shortage Area	U.S. Health Resources and Services Administration	2021
			Dental Care Shortage Area	U.S. Health Resources and Services Administration	2021
			Mental Health Care Shortage Area	U.S. Health Resources and Services Administration	2021

			Medically Underserved Area	U.S. Health 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 2022-01-31
Socio-Economic and Demographic Factors	Community Safety		Homicide Rate	County Health Rankings	2013 - 2019
			Firearm Fatalities Rate	County Health Rankings	2015 - 2019
			Violent Crime Rate	County Health Rankings	2014 & 2016
			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2015 - 2019
			Motor Vehicle Crash Death	County Health Rankings	2013 - 2019
	Education		Some College	County Health Rankings	2015 - 2019
			High School Completion	County Health Rankings	2015 - 2019
			Disconnected Youth	County Health Rankings	2015 - 2019

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

				TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau	
		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 Rankings¹⁸ dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 20.

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

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

¹⁸ 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>.

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

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

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

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa¹⁹ 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

¹⁹ 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/>.

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

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

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

COVID-19 Data

Data on the cumulative number of cases and deaths²⁰ and completed vaccinations²¹ 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 Profiles²² and report age-adjusted deaths per 100,000.

²⁰ State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved January 31 2022 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

²¹ State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved January 31 2022 from <https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv>.

²² State of California, Department of Public Health, Vital Records Data and Statistics. 2021. County Health Status Profiles 2021: CHSP 2021 Tables 1-29. Spreadsheet. Retrieved 21 Jul 2021 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP_2021_Tables_1-29_04.16.2021.xlsx.

U.S. Health Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration²³ (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

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

Psychiatry and Specialty Care Providers

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

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

California Cancer Registry

Data obtained from the California Cancer Registry²⁴ 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-

²³ 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>.

²⁴ California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from <https://www.cancer-rates.info/ca/>.

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

Tracking California

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California.²⁵ 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 3.0²⁶ 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.²⁷ 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.²⁸ 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

²⁵ Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.

²⁶ California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from <https://oehha.ca.gov/calenviroscreen/maps-data>.

²⁷ 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/>.

²⁸ California Department of Justice, OpenJustice. 2021. Criminal Justice Data: Arrests. Retrieved 17 Jun 2021 from <https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2020-07/OnlineArrestData1980-2019.csv>.

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

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report²⁹ 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,³⁰ so this was the data used to represent the distribution of population for this indicator.

²⁹ 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>.

³⁰ US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from <https://www2.census.gov/geo/tiger/TIGER2010BLKPOP/HU/>.

Transit stop data were identified first by using tools in the TidyTransit³¹ library for the R statistical programming language.³² 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,³³ Transitland,³⁴ Transitwiki.org,³⁵ and Santa Ynez Valley Transit.³⁶ 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 sf³⁷ library in R was then used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

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

³¹ 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>.

³² 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/>.

³³ OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from <https://openmobilitydata.org/l/67-california-usa>.

³⁴ Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from <https://www.transit.land/operators>.

³⁵ 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.

³⁶ Santa Ynez Valley Transit. GTFS Files. Retrieved 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.

³⁷ 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>.

Community of Concern Identification

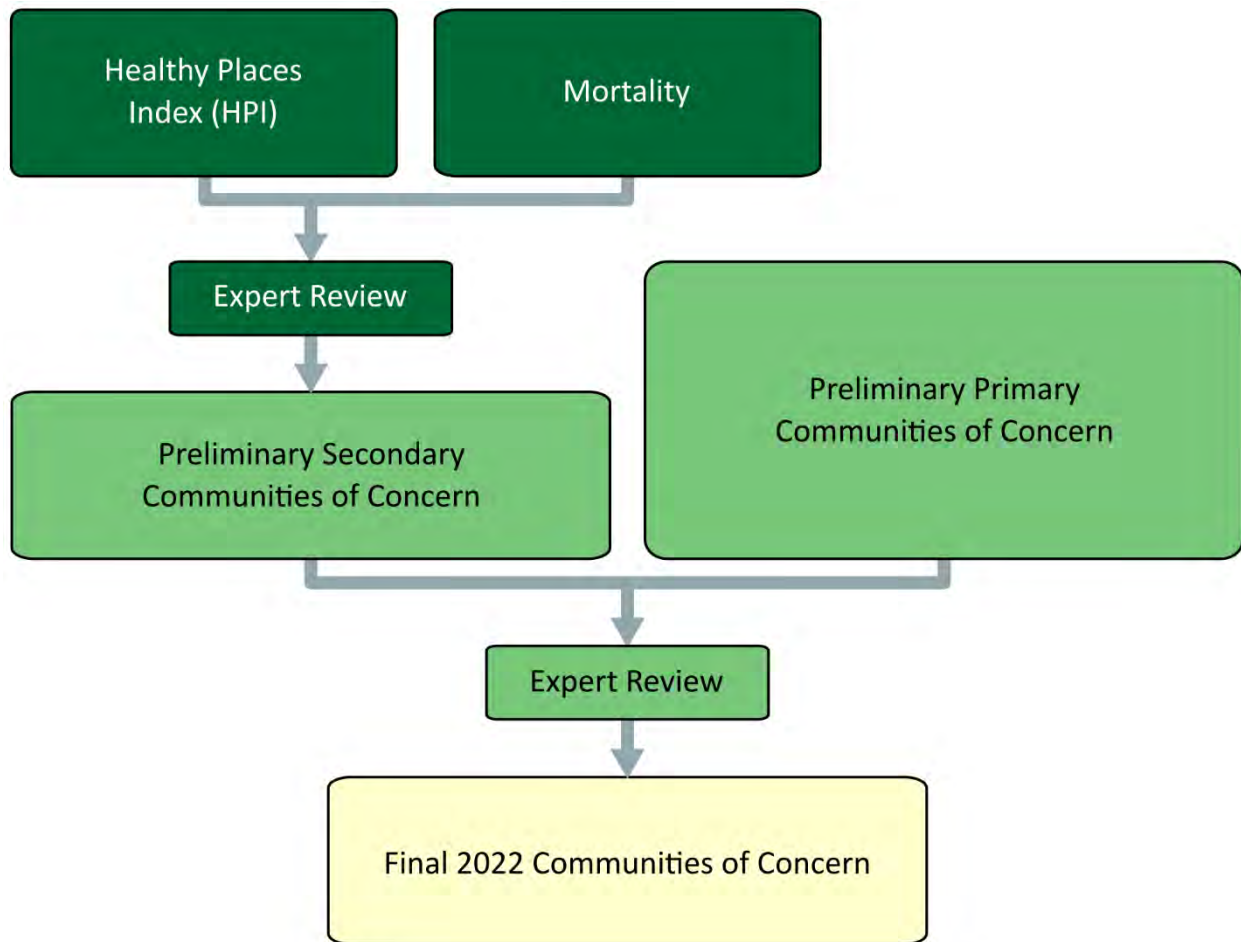


Figure 10: Community of Concern identification process.

As illustrated in Figure 10, 2022 Communities of Concern were identified through a process that drew upon both primary and secondary data. Two main secondary data sources were used in this analysis: the census tract-level California Healthy Places Index (HPI) and the CDPH ZCTA-level mortality data.

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

Healthy Places Index (HPI)

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

CDPH Mortality Data

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

Integration of Secondary Criteria

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

Preliminary Primary Communities of Concern

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

Integration of Preliminary Primary and Secondary Communities of Concern

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

Significant Health Need Identification

The general methods through which significant health needs (SHNs) were identified are shown in Figure 11 and described here in greater detail. The first step in this process was to identify a set of potential health needs (PHNs) from which significant health needs could be selected. This was done by reviewing the health needs identified during prior CHNAs among various hospitals throughout Central and Northern California and then supplementing this list based on a preliminary analysis of the primary qualitative data collected for the current CHNA. This resulted the list of PHNs shown in Table 21.

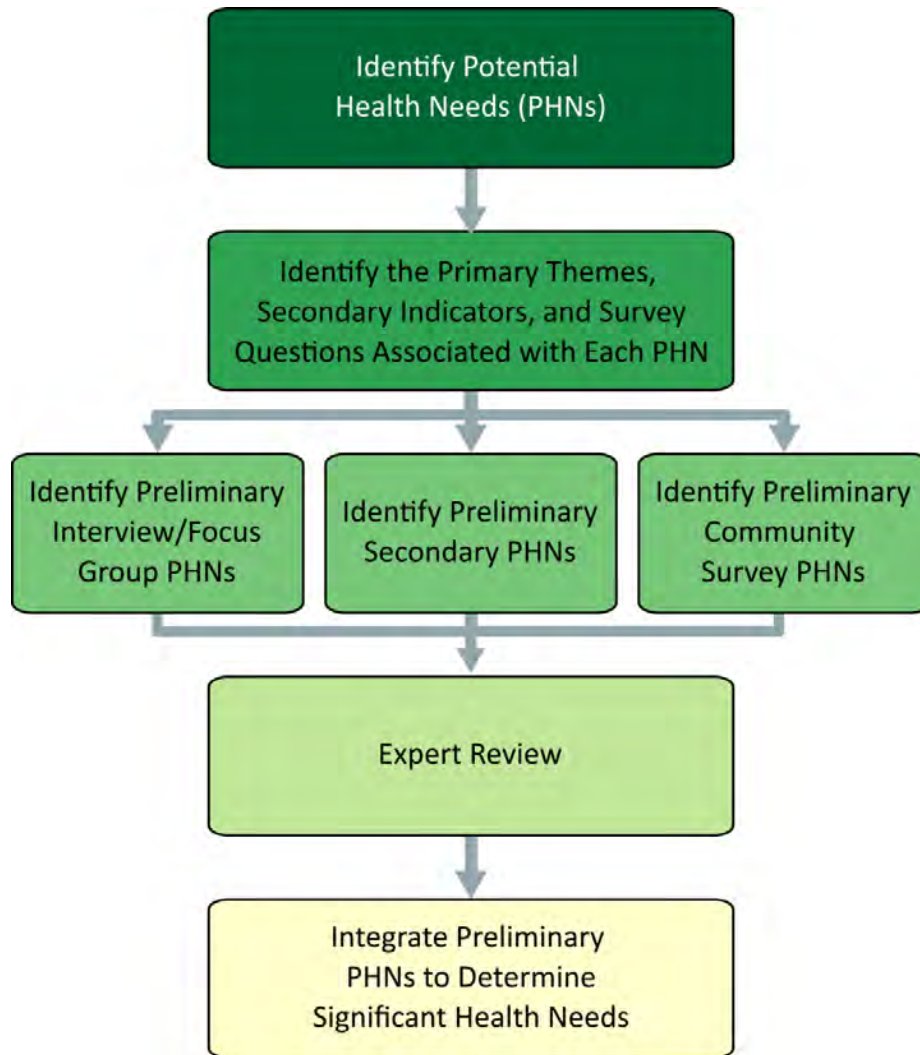


Figure 11: Significant health need identification process.

Table 21: 2022 Potential Health Needs.

Potential Health Needs (PHNs)	
PHN1	Access to Mental/Behavioral Health and Substance use Services
PHN2	Access to Quality Primary Care Health Services
PHN3	Active Living and Healthy Eating
PHN4	Safe and Violence-Free Environment
PHN5	Access to Dental Care and Preventive Services
PHN6	Healthy Physical Environment
PHN7	Access to Basic Needs Such as Housing, Jobs, and Food
PHN8	Access to Functional Needs
PHN9	Access to Specialty and Extended Care
PHN10	Injury and Disease Prevention and Management
PHN11	Increased Community Connections
PHN12	System Navigation

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

Access to Mental/Behavioral Health and Substance use Services

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

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

Access to Quality Primary Care Health Services

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

Primary Themes	Secondary Indicators
Insurance is unaffordable.	Infant Mortality
Wait-times for appointments are excessively long.	Child Mortality
Out-of-pocket costs are too high.	Life Expectancy
There aren't enough primary care service providers in the area.	Premature Age-Adjusted Mortality

Primary Themes	Secondary Indicators
<p>Patients have difficulty obtaining appointments outside of regular business hours.</p> <p>Too few providers in the area accept Medi-Cal.</p> <p>It is difficult to recruit and retain primary care providers in the region.</p> <p>Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).</p> <p>The quality of care is low (e.g., appointments are rushed, providers lack cultural competence).</p> <p>Patients seeking primary care overwhelm local emergency departments.</p> <p>Primary care services are available, but are difficult for many people to navigate.</p>	<p>Premature Death</p> <p>Stroke Mortality</p> <p>Chronic Lower Respiratory Disease Mortality</p> <p>Diabetes Mortality</p> <p>Heart Disease Mortality</p> <p>Hypertension Mortality</p> <p>Cancer Mortality</p> <p>Liver Disease Mortality</p> <p>Kidney Disease Mortality</p> <p>COVID-19 Mortality</p> <p>COVID-19 Case Fatality</p> <p>Alzheimer's Disease Mortality</p> <p>Influenza and Pneumonia Mortality</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>Colorectal Cancer Prevalence</p> <p>Breast Cancer Prevalence</p> <p>Lung Cancer Prevalence</p> <p>Prostate Cancer Prevalence</p> <p>Asthma ED Rates</p> <p>Asthma ED Rates for Children</p> <p>Primary Care Shortage Area</p> <p>Medically Underserved Area</p> <p>Mammography Screening</p> <p>Primary Care Providers</p> <p>Preventable Hospitalization</p> <p>COVID-19 Cumulative Full Vaccination Rate</p> <p>Residential Segregation (Non-White/White)</p> <p>Uninsured Population under 64</p> <p>Income Inequality</p> <p>Homelessness Rate</p>

Active Living and Healthy Eating

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

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

Safe and Violence-Free Environment

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

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

Access to Dental Care and Preventive Services

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

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

Healthy Physical Environment

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

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

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

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

Primary Themes	Secondary Indicators
Lack of affordable housing is a significant issue in the area.	Infant Mortality
The area needs additional low-income housing options.	Child Mortality
Poverty in the county is high.	Life Expectancy
Many people in the area do not make a living wage.	Premature Age-Adjusted Mortality
Employment opportunities in the area are limited.	Premature Death
Services for homeless residents in the area are insufficient.	Hypertension Mortality
Services are inaccessible for Spanish-speaking and immigrant residents.	COVID-19 Mortality
	COVID-19 Case Fatality
Many residents struggle with food insecurity.	Diabetes Prevalence
It is difficult to find affordable childcare.	Low Birthweight
Educational attainment in the area is low.	Poor Mental Health Days
	Frequent Mental Distress

Primary Themes	Secondary Indicators
	Poor Physical Health Days
	Frequent Physical Distress
	Poor or Fair Health
	COVID-19 Cumulative Incidence
	Asthma ED Rates
	Asthma ED Rates for Children
	Drug Induced Death
	Adult Obesity
	Limited Access to Healthy Foods
	Food Environment Index
	Medically Underserved Area
	COVID-19 Cumulative Full Vaccination Rate
	Some College
	High School Completion
	Disconnected Youth
	Third Grade Reading Level
	Third Grade Math Level
	Unemployment
	Children in Single-Parent Households
	Social Associations
	Residential Segregation (Non-White/White)
	Children Eligible for Free Lunch
	Children in Poverty
	Median Household Income
	Uninsured Population under 64
	Income Inequality
	Severe Housing Problems
	Severe Housing Cost Burden
	Homeownership
	Homelessness Rate
	Households with no Vehicle Available
	Long Commute - Driving Alone

Access to Functional Needs

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

Primary Themes	Secondary Indicators
Many residents do not have reliable personal transportation.	Disability
Medical transport in the area is limited.	Frequent Mental Distress
Roads and sidewalks in the area are not well-maintained.	Frequent Physical Distress
The distance between service providers is inconvenient for those using public transportation.	Poor or Fair Health
Using public transportation to reach providers can take a very long time.	Adult Obesity
	COVID-19 Cumulative Full

Primary Themes	Secondary Indicators
The cost of public transportation is too high.	Vaccination Rate
Public transportation service routes are limited.	Income Inequality
Public transportation schedules are limited.	Homelessness Rate
The geography of the area makes it difficult for those without reliable transportation to get around.	Households with no Vehicle Available
Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children).	Long Commute - Driving Alone
There aren't enough taxi and ride-share options (e.g., Uber, Lyft).	Access to Public Transit

Access to Specialty and Extended Care

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

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

Primary Themes	Secondary Indicators
	Income Inequality
	Homelessness Rate

Injury and Disease Prevention and Management

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

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

Primary Themes	Secondary Indicators
	Firearm Fatalities Rate
	Juvenile Arrest Rate
	Motor Vehicle Crash Death
	Disconnected Youth
	Third Grade Reading Level
	Third Grade Math Level
	Income Inequality
	Homelessness Rate

Increased Community Connections

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

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

Primary Themes	Secondary Indicators
	COVID-19 Cumulative Full Vaccination Rate
	Homicide Rate
	Firearm Fatalities Rate
	Violent Crime Rate
	Juvenile Arrest Rate
	Some College
	High School Completion
	Disconnected Youth
	Unemployment
	Children in Single-Parent Households
	Social Associations
	Residential Segregation (Non-White/White)
	Income Inequality
	Homelessness Rate
	Households with no Vehicle Available
	Long Commute - Driving Alone
	Access to Public Transit

System Navigation

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

Primary Themes	Secondary Indicators
<p>People may not be aware of the services they are eligible for.</p> <p>It is difficult for people to navigate multiple, different health care systems.</p> <p>The area needs more navigators to help to get people connected to services.</p> <p>People have trouble understanding their insurance benefits.</p> <p>Automated phone systems can be difficult for those who are unfamiliar with the healthcare system</p> <p>Dealing with medical and insurance paperwork can be overwhelming.</p> <p>Medical terminology is confusing.</p> <p>Some people just don't know where to start in order to access care or benefits.</p>	

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

Table 34: Benchmark comparisons to show indicator performance.

Indicator	Benchmark Comparison Indicating Poor Performance
Infant Mortality	Higher
Child Mortality	Higher
Life Expectancy	Lower
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Stroke Mortality	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Diabetes Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Cancer Mortality	Higher
Liver Disease Mortality	Higher
Kidney Disease Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
COVID-19 Mortality	Higher
COVID-19 Case Fatality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Diabetes Prevalence	Higher
Low Birthweight	Higher
HIV Prevalence	Higher
Disability	Higher
Poor Mental Health Days	Higher
Frequent Mental Distress	Higher
Poor Physical Health Days	Higher
Frequent Physical Distress	Higher
Poor or Fair Health	Higher
Colorectal Cancer Prevalence	Higher
Breast Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
COVID-19 Cumulative Incidence	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher
Excessive Drinking	Higher
Drug Induced Death	Higher
Adult Obesity	Higher
Physical Inactivity	Higher
Limited Access to Healthy Foods	Higher
Food Environment Index	Lower
Access to Exercise Opportunities	Lower

Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Primary Care Shortage Area	Present
Dental Care Shortage Area	Present
Mental Health Care Shortage Area	Present
Medically Underserved Area	Present
Mammography Screening	Lower
Dentists	Lower
Mental Health Providers	Lower
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Primary Care Providers	Lower
Preventable Hospitalization	Higher
COVID-19 Cumulative Full Vaccination Rate	Lower
Homicide Rate	Higher
Firearm Fatalities Rate	Higher
Violent Crime Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Some College	Lower
High School Completion	Lower
Disconnected Youth	Higher
Third Grade Reading Level	Lower
Third Grade Math Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Social Associations	Lower
Residential Segregation (Non-White/White)	Higher
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Median Household Income	Lower
Uninsured Population under 64	Higher
Income Inequality	Higher
Severe Housing Problems	Higher
Severe Housing Cost Burden	Higher
Homeownership	Lower
Homelessness Rate	Higher
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Access to Public Transit	Lower
Pollution Burden Percent	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present

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

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 county. 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 county. To this end, a final round of expert reviews was used to compare the set selection criteria to find the level at which the criteria converged towards a final set of SHNs.

For this report, a PHN was selected as a preliminary quantitative significant health need if 50% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by 40% or more of the primary sources as performing poorly; as a preliminary community survey significant health need if 40% of top priority themes from the survey were associated with the health need; and as a preliminary community survey provider survey significant health need if it was identified by at least 0% of survey respondents. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in two 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 need was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need. Finally, the number of times each health need was selected as one of the top health needs by survey respondents was also included.

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

Detailed List of Resources to Address Health Needs

Table 35: Resources available to meet health needs.

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Anav Tribal Health	96032	www.qvir.com/health-clinic.html	x	x		x		x						
211 NorCal-Siskiyou	96002	211norcal.org/Siskiyou	x		x	x	x	x		x		x		x
Beacon of Hope	96097	beaconofhopemission.org			x									
CASA	96097	yesiskiyou.org/casa	x											
Children First Foster Family Agency	96097	childrenfirstfa.com			x									
Choices Mt. Shasta and Yreka	Siskiyou County	www.facebook.com/choicesmountshasta ; www.facebook.com/choicesyreka			x								x	
Dignity Health Mt. Shasta Community Clinic	96067	www.dignityhealth.org	x	x		x								
Dunsmuir	96025	first5siskiyou.org/family-and-community-resource-centers-projects/dunsmuir/												
Eskaton Washington Manor	96067	www.eskaton.org/affordabl-e-housing					x		x			x	x	

Organization Information			Significant Health Needs								Other Health Needs			
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Fairchild Medical Center	96097	fairchildmed.org	x	x		x		x						x
Fairchild Medical Clinic	96097	fairchildmed.org	x	x		x	x	x						x
Family PACT Providers	96097	familypact.org												x
First 5 Siskiyou	Siskiyou County	first5siskiyou.org									x		x	
Great Northern Services	96094	www.gnservices.org		x	x							x	x	
Great Northern Services- Siskiyou Food Pantry	96094	www.gnservices.org/programs-and-services/community-services/food-banks			x									
Grenada Gardens	96038	grenadagardens.com								x			x	
Habitat for Humanity	96097	www.habitatsiskiyou.org			x									
Happy Camp Ambulance	96039	www.happycampambulance.com					x							
Happy Camp Family Resource Center	96039	first5siskiyou.org/family-and-community-resource-centers-projects			x								x	
Happy Camp Union S.A.F.E. Rockets Programs	96039	happycampca.sites.thrillshare.com/page/safe			x				x		x		x	

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Happy Camp Community Action, Inc	96039	greatnonprofits.org/org/happy-camp-community-action-inc			X									
Heal Therapy, Inc.	96097	www.heal-therapy.com	X											
Karuk Tribe	96039	www.karuk.us	X			X				X			X	X
Karuk Tribal Health	96039, 96097	www.karuk.us	X	X		X		X						
Madrone Hospice	96097	madronehospice.org			X		X			X				
Lake Shastina Clinic	96094	www.dignityhealth.org	X	X		X								
Meals on Wheels	South Siskiyou	www.gnservices.org/programs-and-services/community-services/siskiyou-senior-nutrition-community-cafes			X									
Mercy Medical Center Mt. Shasta	96067	www.dignityhealth.org/north-state/locations/mercy-mtshasta?_ga=2.86918616.1704172004.1640276577-1021042974.1614054006	X			X	X							X
Modoc County Public Health	96101	https://modochealthservices.org/	X	X		X			X			X		
Mountain Valleys Health Centers	Siskiyou County	www.mountainvalleys.org	X			X		X						X
Mountain Valley Clinics	96013	www.mountainvalleys.org/	X	X		X		X						

Organization Information				Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website		Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Mt. Shasta City Parks and Rec.	96067	www.msrec.org				X						X		X	
Mt. Shasta Community Resource Center	96067	mtshastacrc.com		X										X	
Northern California Indian Development Council, Inc	96097	www.ncidc.org/regional-services/siskiyou				X									
Northern Valley Catholic Services-Six Stones Wellness Center	96097	nvcss.org/programs/six-stones-wellness-center		X						X				X	X
Northern Valley Catholic Social Services	96001	nvcss.org		X						X					X
PSA 2 Area Agency on Aging	Siskiyou County	www.psa2.org						X			X	X		X	X
Quartz Valley Indian Reservation	96032	www.qvir.com		X			X				X			X	X
Quartz Valley Indian Reservation - Anav Tribal Health Clinic	96032	www.qvir.com/health-clinic.html		X			X		X						

Organization Information				Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website		Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Remi Vista, Inc.	96001	remivistainc.org		X		X		X							
Scotts Valley Family Resource Center	96032	first5siskiyou.org/family-and-community-resource-centers-projects/				X								X	
Scott Valley Rural Health Clinic	96027	https://scottvalley.fairchildmed.org			X	X	X	X							
Shasta Cascade Health	Siskiyou County	www.shastacascadehealth.org		X	X		X		X						
Siskiyou Child Care Council	96094	www.siskiyouchildcare.org										X	X		
Siskiyou Community Food Bank	96097	www.siskiyoufoodbank.org/home.html				X									
Siskiyou Community Resource Collaborative	Siskiyou County	www.siskiyoucrc.org		X	X	X				X	X			X	X
Siskiyou Community Services Council	Siskiyou County	www.co.siskiyou.ca.us/bc/page/siskiyou-community-services-council		X	X										X
Siskiyou County Behavioral Health	96097	www.co.siskiyou.ca.us		X	X										X
Siskiyou County Child Protective Services	96097	www.co.siskiyou.ca.us/acs/page/child-protective-services-cps		X		X	X					X		X	

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Siskiyou County Health and Human Services	96097	www.co.siskiyou.ca.us/health-humanservices	x	x		x					x			x
Siskiyou County Mobile Health Clinic	96097	www.co.siskiyou.ca.us/publichealth/page/siskiyou-county-public-health-mobile-clinic			x								x	
Siskiyou County Office of Education	96097	www.siskiyoucoe.net												x
Siskiyou County Public Health	96097	www.co.siskiyou.ca.us/publichealth	x	x										x
Siskiyou County Public Health-WIC	96097	www.co.siskiyou.ca.us/publichealth/page/woman-infant-children-wic			x								x	
Siskiyou County Social Services	96097	www.co.siskiyou.ca.us/socialservices					x							x
Siskiyou County Domestic Violence & Crisis Center	96097	sdvcc.org			x						x			
Siskiyou Family/Community Resource Centers		www.siskiyoucoe.net/cms/lib/CA01001605/Centricity/Domain/43/Siskiyou%20Community%20Community-Family%20Resource%20Centers.pdf												

Organization Information			Significant Health Needs								Other Health Needs			
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance use Services	Injury and Disease Prevention and Management	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Dental Care and Preventive Services	Active Living and Healthy Eating	Access to Functional Needs	Safe and Violence-Free Environment	Healthy Physical Environment	Increased Community Connections	System Navigation
Siskiyou Family YMCA	96097	www.siskiyouymca.org	X						X		X		X	
Siskiyou Food Assistance	96094	siskiyoufoodassistance.org			X									
Siskiyou Outdoor Recreation Alliance	96067	siskiyououtdooralliance.org							X				X	
Siskiyou Springs Senior Living	96097	siskiyoussprings-sl.com					X		X	X			X	
The HUB Communities Family Resource Center in Montague	96064	first5siskiyou.org/family-and-community-resource-centers-projects/	X											
Tulelake/Newell Family Resource Center	96134	first5siskiyou.org/family-and-community-resource-centers-projects/	X		X								X	
Yreka Community Resource Center	96097	www.siskiyoucrc.org/yreka	X		X								X	
Yreka VA Rural Clinic	96097	www.va.gov/northern-california-health-care/locations/yreka-va-clinic	X	X		X			X					X

Limits and Information Gaps

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

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

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

Appendix A: Evaluation of the Impact of Actions Taken Since 2019 CHNA for Fairchild Medical Center

Priority One: Access to Healthcare

Fairchild Medical Center had fourteen (14) goals for Access to Healthcare all fourteen (14) goals were met. The three (3) goals that had the most tremendous impact to expand access to healthcare were:

1. Fairchild Clinic expansion
 - a. Expanded Primary Care Capacity in 2020. Remodel Primary Care and built Express Care Clinic suite which added:
 - i. 25 Exam Rooms
 - ii. 3 Procedure Rooms
 - b. Opened Express Care/Urgent Care. Hired two (2) new providers a physician and AHP to staff the Urgent Care seven (7) days a week from 10 am to 6 pm.
2. Expanded Telehealth
 - i. Became a distant site for Telemedicine and offer Virtual Visit from Fairchild Medical Clinic Providers to patients during COVID.
 - ii. Continue to expand originating site telemedicine specialty visits. This allowed patients to access specialty care within the clinic without having to travel to a major city.
3. Became a Joint Commission Primary Stroke Center in November 2020.

Priority Two: Maternal/Child Health

Fairchild Medical Center had five (5) goals for Maternal/Child Health all five (5) goals were met. The two (2) goal that had the most tremendous impact on Maternal/Child Health were:

1. Fairchild Medical Clinic improved all Pre and Post-Partum compliance Measures. Fairchild Clinic Pre and Post-Partum care education remained a priority. This resulted in all Pre and Post-Partum regulatory compliance percentages improved within the clinic.
2. Fairchild increased access to Women's Healthcare services. Fairchild Medical Center remains committed to Woman's Health and recruiting and maintain good providers. As a result, a Women's Health Nurse Practitioner was hired to support clinic volume.

Priority Three: Mental Health

Fairchild Medical Center had three (3) Mental Health goals all three were met. The two (2) goals that had the most tremendous impact to the Behavioral Health Clinic were:

1. Increased number of Substance Use Disorder Services provider. Fairchild Medical Clinic expanded the number of treatment and outpatient counseling providers from two (2) to three (3). As a result, Fairchild Behavioral Health treatment with outpatient counseling service increased 24% from 2019 to 2020.
2. Increased Substance Use Disorder Services: With the additional SUD trained provider FMC

continued to partner with the County for SUD patients. Fairchild Medical Center increased capacity to treat mild/moderate behavioral health patients while referring moderate to severe to Siskiyou County Behavioral Health Program.

Appendix B: Siskiyou County Community Health Status Survey



Siskiyou Well Community Health Survey

Siskiyou County Public Health, Fairchild Medical Center and Mercy Medical Center, Mt Shasta
In collaboration with community partners

Part I: Demographics

1. Zip Code: where you live _____

2. Age: 25 or less
 26 – 39
 40 – 54
 55 - 64
 65 or over

3. Gender _____

4. Ethnicity: Check all you identify with
 African American / Black
 Asian / Pacific Islander
 Hispanic / Latino
 Native American
 White / Caucasian
 Other _____

5. Household Income

- Less than \$20,000
 \$20,000 to \$29,999
 \$30,000 to \$49,999
 More than \$50,000

6. Education

- Less than high school
 High school diploma or GED
 College degree or higher
 Other _____

Part II: Community Health

7. How would you rate the overall health of our community?

Very unhealthy Unhealthy Somewhat healthy Healthy Very healthy

8. How would you rate your own personal health?

Very unhealthy Unhealthy Somewhat healthy Healthy Very healthy

9. Do you feel you are able to access the services you need in order to positively change your health? Such as healthy foods, activity, disease/ pain management services, access to care options and other health services.

No! 1 2 3 4 5 Yes!

10. In the following list, what do you think are **the five most important factors for a “Healthy Community”**? (Factors which would most improve the quality of life in our community). **Check Only Five**

<input type="checkbox"/> Low crime / safe neighborhoods	<input type="checkbox"/> Excellent race/ethnic relations activity	<input type="checkbox"/> Emergency preparedness
<input type="checkbox"/> Low level of child abuse/neglect	<input type="checkbox"/> Good jobs and healthy economy	<input type="checkbox"/> Adolescent health education (nutrition, lifestyle habits, safe sex)
<input type="checkbox"/> Good schools	<input type="checkbox"/> Strong family life	<input type="checkbox"/> Support for caregivers
<input type="checkbox"/> Access to health care	<input type="checkbox"/> Healthy behaviors and lifestyles	<input type="checkbox"/> Other _____
<input type="checkbox"/> Local transportation options	<input type="checkbox"/> Low adult death and disease rates	
<input type="checkbox"/> Clean environment	<input type="checkbox"/> Low infant deaths	
<input type="checkbox"/> Affordable housing	<input type="checkbox"/> Opportunities for physical	
<input type="checkbox"/> Activities for teens/ families		

11. In the following list, what do you think are the five most important “health problems” in our community? Check Only Five

<input type="checkbox"/> Aging problems / support for the elderly	<input type="checkbox"/> Chronic Illness (diabetes, high blood pressure, heart disease, ect)	<input type="checkbox"/> Motor vehicle crash injuries
<input type="checkbox"/> Access to birth control	<input type="checkbox"/> Firearm-related injuries	<input type="checkbox"/> Rape / sexual assault
<input type="checkbox"/> Access to healthy, affordable foods	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Respiratory / lung disease
<input type="checkbox"/> Affordable Housing	<input type="checkbox"/> Homicide	<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Cancers	<input type="checkbox"/> Infant Death	<input type="checkbox"/> Suicide
<input type="checkbox"/> COVID 19	<input type="checkbox"/> Infectious Diseases	<input type="checkbox"/> Teenage pregnancy
<input type="checkbox"/> Child abuse / neglect	<input type="checkbox"/> Mental health (including undiagnosed)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental problems/ Access	<input type="checkbox"/> Behavioral Health	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Chronic stress	

12. In the following list, what do you think are the five most common “risky behaviors” in our community? Check Only Five

<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Not getting vaccines (shots) to prevent disease	<input type="checkbox"/> Unsafe sex
<input type="checkbox"/> Being overweight	<input type="checkbox"/> Racism	<input type="checkbox"/> Unsecured firearms
<input type="checkbox"/> Dropping out of school	<input type="checkbox"/> Tobacco use	<input type="checkbox"/> Other _____
<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Not using birth control	
<input type="checkbox"/> Lack of exercise	<input type="checkbox"/> Not using seat belts / child safety seats	
<input type="checkbox"/> Lack of maternity care		
<input type="checkbox"/> Poor eating habits		

13. What are the top five things you think negatively influence child wellness and safety in our community? Check only 5

<input type="checkbox"/> Limited access to affordable, nutritious food	<input type="checkbox"/> Medicines, drugs, or cleaning supplies are accessible to children in the home	<input type="checkbox"/> Situations (examples: sleeping with soft objects, no hard bed surface, not sleeping alone)
<input type="checkbox"/> Limited physical activity	<input type="checkbox"/> Cigarette smoke exposure	<input type="checkbox"/> Lack of support services for children with special health care needs
<input type="checkbox"/> No safe place to play	<input type="checkbox"/> Parents abuse alcohol & drugs	<input type="checkbox"/> I think generally child wellness and safety in our community is positive
<input type="checkbox"/> Not enough parenting classes	<input type="checkbox"/> Teen drug, alcohol, or tobacco use/abuse	<input type="checkbox"/> Other _____
<input type="checkbox"/> Parents not knowing child safety recommendations	<input type="checkbox"/> Bullying or harassment	
<input type="checkbox"/> Not enough safe sports equipment or not used	<input type="checkbox"/> Not enough adult supervision	
<input type="checkbox"/> Inappropriate use of seat belts or child safety seats	<input type="checkbox"/> Child abuse	
<input type="checkbox"/> Child unable to swim, not using a lifejacket, or needs water safety education	<input type="checkbox"/> Not enough infant safe sleep education for parents and caregivers	
<input type="checkbox"/> Violence in home or community	<input type="checkbox"/> Parents or caregivers put infants in high-risk sleep	

14. What are the top three reasons you think people do not get the mental health services they need?
Please choose only 3.

<input type="checkbox"/> Not enough screenings and referrals for Mental Health	<input type="checkbox"/> Stigma or prejudice	<input type="checkbox"/> Lack of Support (community, family, friends)
<input type="checkbox"/> Not enough Mental Health Providers	<input type="checkbox"/> Lack of coping skills or problem-solving strategies	<input type="checkbox"/> Violence in the home
<input type="checkbox"/> Not enough family, individual, or group therapy services	<input type="checkbox"/> Chronic stress	<input type="checkbox"/> Violence or crime in the community
<input type="checkbox"/> Not understanding Mental Health Disorders	<input type="checkbox"/> Drug or alcohol abuse	<input type="checkbox"/> Financial concerns
<input type="checkbox"/> Multiple mental health disorders	<input type="checkbox"/> Social acceptance of alcohol and/or drug use	<input type="checkbox"/> I think people generally get the mental health services they need
<input type="checkbox"/> Multi-generational mental health issues	<input type="checkbox"/> Untreated substance use problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Language or cultural barriers	<input type="checkbox"/> Not enough substance use screening and treatment	
	<input type="checkbox"/> Not aware of the negative effects of substance use	

15. What would you like to see Public Health and the Hospitals, in collaboration with community partners, focus on over the next three years? Please choose only 3.

<input type="checkbox"/> Help people get to doctors appointments (transportation)	<input type="checkbox"/> and eat more healthy foods	<input type="checkbox"/> child abuse and neglect, or elder abuse and neglect
<input type="checkbox"/> Help people sign up for insurance	<input type="checkbox"/> Help women who are pregnant to have a healthy pregnancy	<input type="checkbox"/> Help people get mental health care
<input type="checkbox"/> Help people get the medicine they need to stay healthy	<input type="checkbox"/> Help people to stay healthy who have a chronic disease like diabetes, heart failure, lung disease, cancer, etc.	<input type="checkbox"/> Help adults and teens to stop using illegal drugs, opioids, alcohol, or tobacco
<input type="checkbox"/> Increase the number of family doctors or increase number of appointments	<input type="checkbox"/> Help prevent teen pregnancy	<input type="checkbox"/> Help support caregivers
<input type="checkbox"/> Increase the number of specialists	<input type="checkbox"/> Help prevent sexually transmitted diseases	<input type="checkbox"/> COVID-19 recovery
<input type="checkbox"/> Help people to lose weight	<input type="checkbox"/> Help stop domestic violence.	<input type="checkbox"/> Other _____

HEALTH CARE ACCESS

16. In the past 12 months, was there a time that you needed to see a doctor, but were unable to?
 Yes No

17. If you answered "yes" to question #19, please specify why:
 I did not have health insurance.
 My health insurance was not accepted.
 Lack of transportation
 Other (please explain briefly) _____

18. About how long has it been since you last were seen by a dentist or dental clinic?
 Within the past year
 More than a year but within the past two years
 Not Sure
 Never

19. Has COVID 19 caused any of the following changes in how you access care? **Check all that apply.**

- Unable to get appointments when I need them
- Avoided seeking medical care when needed
- Unable to schedule medical procedures
- Other _____

20. Do you have any challenges that prevent you from accessing care when you need, unrelated to COVID-19? **Check all that apply.**

- | | |
|--|---|
| <input type="checkbox"/> Cultural/ Religious beliefs | <input type="checkbox"/> No insurance |
| <input type="checkbox"/> Don't know how to find doctor | <input type="checkbox"/> Unable to pay co-pays/ deductibles |
| <input type="checkbox"/> Don't understand the need to see doctor | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Fear | <input type="checkbox"/> I have no issues accessing care |
| <input type="checkbox"/> Lack of availability of doctors | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lack of time off work to see doctor | |
| <input type="checkbox"/> Language barriers | |

21. In the past 24 months, have you used technology as part of your healthcare? **Check all that apply.**

- Online Virtual Care Visit from mobile device or computer
- Hospital or Provider Online Patient Portal
- Telemedicine Visit in the Hospital or Provider's office
- Mobile App
- I have not used any technology as a part of my healthcare
- Other _____

22. True or false: I am able to access care which respects and aligns with my cultural and gender identity

Completely false———Completely True

INJURY and Violence PREVENTION

23. In the last 12 months, was there ever an occasion when you experienced or witnessed actual or threatened physical or sexual violence directed toward you or another person by a significant other?

- Yes No

24. In the past 24 months, I have felt unsafe or feared for the physical safety of myself/a loved one

ALCOHOL/ DRUG USE

25. Have you in the past 24 months sought or desired to seek treatment for a substance use issue, but been unable to access the care you needed?
 Yes No

MENTAL HEALTH

26. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

27. Have you ever sought help from a professional for a mental or emotional problem?

Yes No

28. Have you ever wished to seek help from a professional for a mental or emotional problem, but been prevented for any of the following reasons? **Mark all that apply**

<input type="checkbox"/> I do not know where to seek mental health services	<input type="checkbox"/> Language or cultural barriers
<input type="checkbox"/> I do not know who takes my insurance	<input type="checkbox"/> Stigma or prejudice
<input type="checkbox"/> Can't afford treatment/ co pay costs	<input type="checkbox"/> I feel like I do not have time
	<input type="checkbox"/> Transportation to appointments

29. Have you or somebody you know experienced suicidal thoughts or suicidal ideation in the last 24 months?

Yes No

NUTRITION

30. In the past 12 months, were you worried whether your food would run out before you received money to buy more?

Often true Sometimes true Never true

31. Is transportation or distance from a grocery store a limiting factor in getting to a store which sells healthy, nutritious, and affordable food?

Often true Sometimes true Never true

EXERCISE/PHYSICAL ACTIVITY

32. Are you limited in any way in any activities because of any impairment or health problem?

Yes No (if not skip to #33)

33. If you answered “yes” to question #32, what is the major impairment(s) or health problem(s) that limits you? (please check all that apply)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Heart Problem | |
| <input type="checkbox"/> Back or Neck Problem | <input type="checkbox"/> Hypertension/High Blood Pressure | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung/Breathing Problem | |
| <input type="checkbox"/> Depression, Anxiety, Emotional Problems | <input type="checkbox"/> Stroke Problem | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Walking Problem | |
| <input type="checkbox"/> Eye/Vision Problem | <input type="checkbox"/> Weight/Overweight | |
| <input type="checkbox"/> Fractures, Bone/Joint Injury | <input type="checkbox"/> Amputation | |

CHRONIC DISEASE

34. Have you been diagnosed with one or more chronic illness? (E.g. arthritis, COPD, diabetes, heart disease, hypertension, high cholesterol, asthma, cancer, etc)

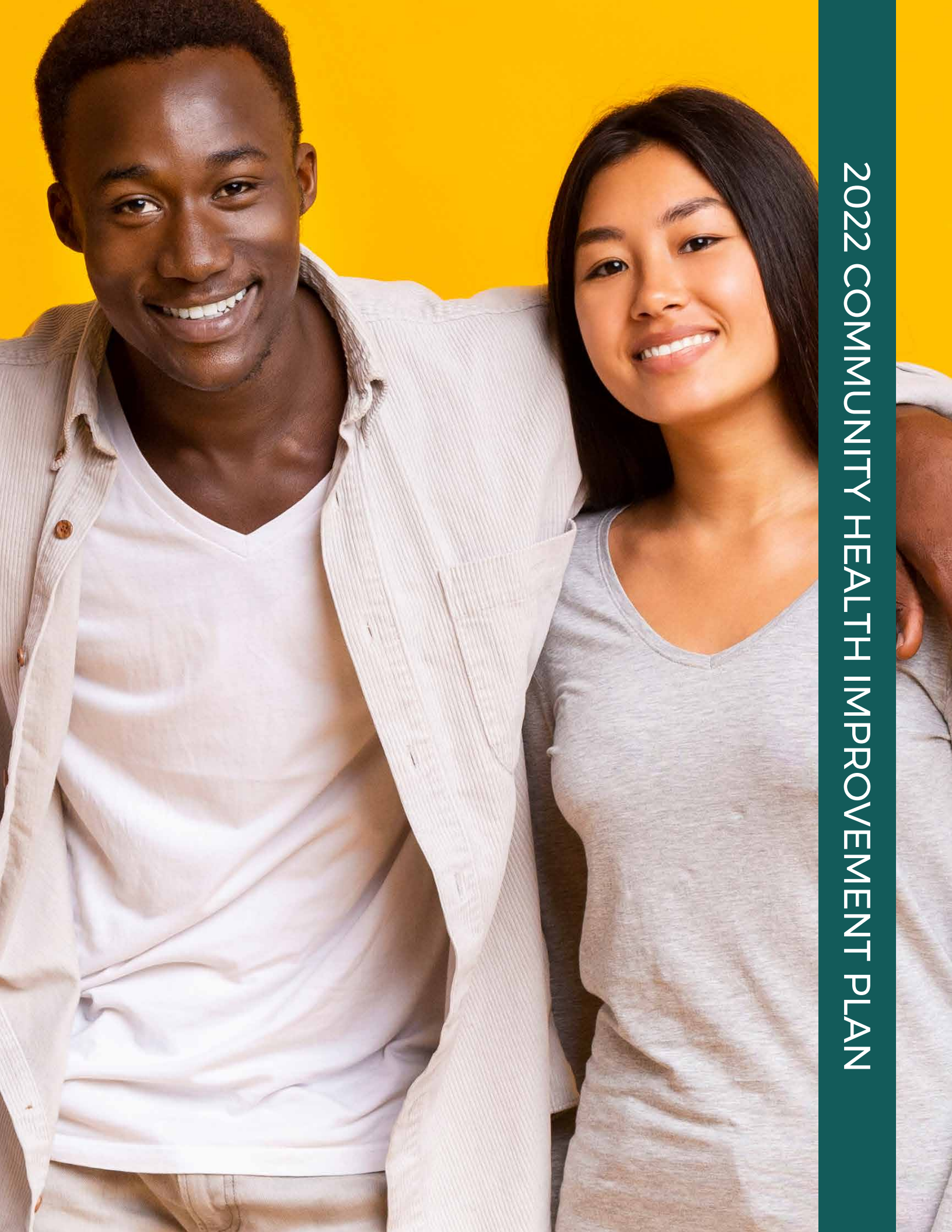
- Yes, one
- Yes, more than one
- No (if no skip to #35)

35. If yes, what do you feel would help you most in managing your chronic illness(s)?

Check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Setting health goals | <input type="checkbox"/> Healthy eating and lifestyle support |
| <input type="checkbox"/> Availability of Insurance | <input type="checkbox"/> Help quitting smoking |
| <input type="checkbox"/> Learning new skills on how to manage my chronic illness | <input type="checkbox"/> Help developing skills to manage my pain and fatigue |
| <input type="checkbox"/> More health screenings related to my chronic illness | <input type="checkbox"/> Transportation to appointments |
| <input type="checkbox"/> Understanding how to take my medications | <input type="checkbox"/> Other _____ |





2022 COMMUNITY HEALTH IMPROVEMENT PLAN

2022 COMMUNITY HEALTH IMPROVEMENT PLAN

The Fairchild Medical Center 2022 Community Health Improvement Plan is currently under development and will be made available to the public in October 2022.

Digital copies will be available beginning October 1, 2022 by visiting fairchildmed.org/community-health-needs-assessment

For a printed copy beginning October 1, 2022 please contact:

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