2025 COMMUNITY HEALTH NEEDS ASSESSMENT

MORE
COMMUNITY VOICES

IRS Section 501(r)(3) CHNA Compliance Checklist

1) A definition of the community served by the hospital facility and description of how the community was defined.	Page 8	4) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the criteria and process used in identifying certain health needs as significant as well as prioritizing and selecting those significant health needs.	Section IV. and V.
2) A description of the process and methods used to conduct the CHNA, including identification of information gaps that limit the hospital facility's ability to assess the community's health needs.	Section V.	5) A description of the resources potentially available to address the significant health needs identified through the CHNA.	Section IV. A
3) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.	Section IV. B	6) 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).	Page 11

Table of Contents

I. CHNA PURPOSE AND SUMMARY
Adventist Health Land Acknowledgement ... 4
Executive Summary ... 5
Identity of Steering Committee: Hospital & Partner Organizations ... 6
A. CHNA Community Defined ... 7
Getting to Know Our Community ... 7
Defining the Community We Serve ... 8

II. ABOUT US
Adventist Health ... 10
Adventist Health Mendocino Coast ... 10
A Look Back: Activities Since 2022 CHNA ... 11
A Look Forward: After the CHNA Report ... 11

III. HIGH PRIORITY HEALTH NEEDS
A. Access to Care ... 14
B. Financial Stability ... 26
C. Mental Health ... 46

IV. SIGNIFICANT HEALTH NEEDS AND FULL DATA SETS
A. Identified Significant Health Needs ... 56
B. Description of Focus Groups & Key Informant Interviews ... 57
C. Focus Groups & Key Informant Interview Results ... 58
D. Secondary Data Results ... 59
E. Survey Results ... 60

V. PROCESS AND METHODS TO CONDUCT THE CHNA
A. Introduction ... 62
B. Community Impact Framework ... 63
C. Data Overview: Description, Benefits & Limitations ... 64
D. Focus Group & Key Informant Interview Methodology ... 66
E. Survey Methodology ... 66
F. Secondary Data Methodology ... 67
G. Data Analysis & Identification of Significant Health Needs ... 69
H. Criteria & Process Used for Identification & Prioritization of Health Needs ... 70
I. Written Comments for 2025 CHNA ... 71
J. CHNA Team Used to Conduct the Assessment ... 71

VI. APPROVAL PAGE ... 73

APPENDIX:
A. Glossary of Terms and Definitions of Health Needs ... 75
B. Activity Explanation: Focus Group & Key Informant Interview Guides ... 78
C. Survey Questions ... 80
D. Prioritization Tools ... 81

Adventist Health Land Acknowledgement

In the sight of our Creator, we acknowledge and honor that the three Adventist Health hospitals in Mendocino County serve communities residing on the ancestral and present homeland of the Cahto, Central Pomo, Coastal Pomo, Northern Pomo, Southern Pomo, Coast Yuki, Yuki, Huchnom, Sinkyone, and Wailaki people. Additionally, we honor those tribes who were relocated here without choice and are now part of the Round Valley Indian Tribes including the Pit River, Nomlaki, and Concow people.

We thank the Indigenous Peoples of Mendocino County as the original caretakers of these lands, and we honor the land, air, water, plants and animals of this territory as we serve this region. We are committed to creating meaningful relationships and partnerships rooted in respect and will strive to ensure our models of care honor and are respectfully inclusive of indigenous knowledge and cultural practices.

We humbly make this land acknowledgment with gratitude to these sovereign nations and acknowledge that the work guided by our Mission, Vision and Values is delivered on this unceded and ancestral land with the awareness that our words must be consistent with our actions and attitudes.

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public services to help improve the lives of the community members they serve. The Community Health Needs Assessment (CHNA) is conducted every three years to support this calling by helping nonprofit hospitals understand the health needs of the community. The CHNA is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify the health needs of their community. The CHNA process engages communities in identifying high priority health needs, and in aligning the resources of community-based organizations, public health services and Adventist Health to achieve improved health for all. Through this collective effort, communities collect data and identify resources to maximize their focus on meeting the most significant community health needs over the next three years.

For 2025, Adventist Health Howard Memorial, Mendocino Coast and Ukiah Valley collaborated with community partners to create a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. Input was gathered from focus groups and key informants representing the broad interests of the community served by our hospital, and collaborative organizations. We intentionally prioritized gathering insights from local health officials with knowledge and expertise about community health needs, community-based organizations, medical providers, and members of medically underserved, low-income and minority populations.

Scan QR Code to explore the full live data report or visit: cares.page.link/6JEK

Our assessment used a combination of primary and secondary data, providing the greatest understanding of community needs from the broadest range of perspectives. Primary data was collected from focus groups and key informant interviews conducted between May 2024 and July 2024. Nine significant health needs, which focused on the social determinants of health, were identified through in-depth analysis.

The local CHNA Steering Committee reviewed significant health needs, along with corresponding data, and prioritized needs based on severity, prevalence, alignment around common goals, feasibility of potential interventions and opportunities to maximize available resources over a three-year period. This collaborative effort resulted in the identification of the following high priority health needs:

Access to Care

Financial Stability

Mental Health

The following pages share opportunities where you, your family and your community can drive change for improved well-being. We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. In addition to our comprehensive written CHNA report, please explore our living CHNA dashboard below. The entire report is published online and available in print form free of charge by contacting community.benefit@ah.org.

Transforming the health experience of our **communities** by **improving** physical, mental and spiritual **health**.

Identity of Steering Committee Hospital & Partner Organizations

To all that partnered with us, we say THANK YOU. To those now joining, we welcome you. Let's work together to inspire health, wholeness and hope in our community.

We thank the Mendocino County CHNA Steering Committee, who collaborated and partnered to create the 2025 CHNA. Through a series of three collaborative meetings, engagement of community members, and data review, each committee member brought their unique perspective as seen through their job and the work they performed during the CHNA process.

Joseph Aldridge
Fort Bragg Unified School District, Superintendent

Chris Ayeko
Mendocino Community Health Clinic,

Ryan White
Provider

Richard Baker
Willits Senior Center, Executive Director

Mark Beebe
Willits Unified School District, Superintendent

Navin Bhandari
Mendocino County Public Health, QI Manager

Kristy Bowen
Adventist Health Howard Memorial,
Director Quality/Infection Prevention

Neil Cervenka
Fort Bragg PD, Chief of Police

Tiffany Gibson
Chief Community Impact Officer
North Coast Opportunities, Inc. (NCO)

Dan Gjerde
Mendocino County Board of Supervisors,
County Supervisor

Victoria Kelly
Redwood Community Services, CEO

Vicky Klakken
Partnership HealthPlan, Regional Director

Holly Madrigal
North Coast Opportunities,
Leadership Mendocino Program Director

Jeremy Malin
Adventist Health,
Director of Community Health Analytics

Dan McIntire
Rural Communities Housing, CEO

Dr. Jenine Miller
Mendocino County Public Health,
Behavioral Health Director

Dr. Jeff Ribordy
Partnership HealthPlan, Regional Medical Director

Miranda Ramos
Alliance for Rural Community Health, Program Director

Amy Richardson
Adventist Health Mendocino Coast,
Outpatient Practice Manager

Mary Rodin
Ukiah City Council, Councilmember

Townley Saye
First5, Executive Director

Susan Sher
Ukiah City Council, Councilmember

Jayma Spence
Healthy Start Family Resource Center/Family Resource Network, Executive Director

Tina Tyler Oshea
Blue Zones Project, Executive Director

Isaac Whippy
City of Fort Bragg, City Manager

A. CHNA Community Defined

Getting to Know Our Community

Mendocino County is home to spectacular beaches, redwood forests and quaint towns. We are also a world leader in organically grown grapes, home to over ten American Viticultural Areas (AVAs) sprinkled throughout Mendocino County. Located two hours north of San Francisco, Mendocino County is an overnight getaway destination for millions of visitors looking for camping, hiking and other wilderness adventures. With 96 miles of coastline, Mendocino County is home to diverse ocean life and growing local economies. Our natural environment is a community asset and supports the agricultural and tourism industries.

Research suggests that up to 80% of health outcomes can be traced back to social determinants of health (SDOH), the nonmedical factors that influence health outcomes. For additional community context, below are a few SDOH data points:

- Ranked fourth in California for opioid-related overdose deaths (California Overdose Surveillance Dashboard, 2022).
- High school graduation rate of 86.9%.
- 34.66% of the population holds an Associate's level degree or higher, compared to 43.82% in California.
- The unemployment rate is 8.78%.
- Based on the Area Median Income, residents spend 59.98% of their income on housing and transportation alone.

Our community consists of a diverse population, including many Native American tribes and a large Hispanic population. As a rural California county, we recognize the challenges we face and are optimistic about exploring opportunities to improve our community's daily life so we can live the best possible life. In the following pages, we'll review lessons learned and accomplishments from the past three years. We'll dive deeper into the high priority needs, community voices, and data that guided the Community Health Needs Assessment process.

For the purposes of our CHNA, we refer to the following geographic areas throughout the report:

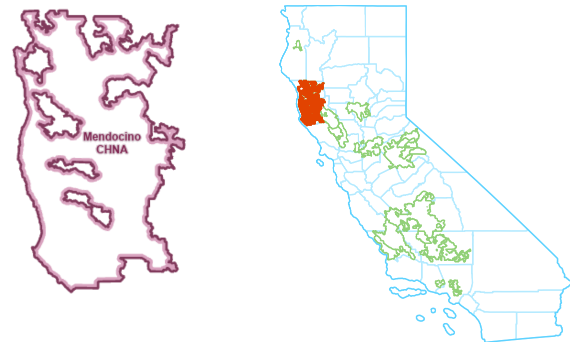
- **Mendocino CHNA** as the full geographic area represented in this report (defined by specific zip codes listed on the following page)
- **Mendocino County** as defined by county boundaries
- **Fort Bragg** as defined by city boundaries
- **Adventist Health Mendocino Coast** as the hospital facility conducting this CHNA report.

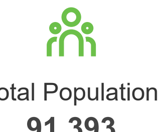
These terms are used for different purposes throughout this report, with the report data being reflective of the most exhaustive "Mendocino CHNA" area. We gathered data and heard voices spanning across all corners of Mendocino County.

Defining the Community We Serve

To define our community, we used the hospital's primary service area and vetted the zip codes with Steering Committee members. We also invited our Steering Committee members to expand the CHNA service area to include zip codes based on the constituents they serve.

The report area is located in the state of California and includes a total population of 91,393 (based on the 2020 Decennial Census). The largest city in the report area is Ukiah city, with a population of 16,607. The report area is comprised of the following ZIP codes: 95410, 95415, 95417, 95420, 95427, 95428, 95429, 95432, 95437, 95445, 95449, 95454, 95456, 95459, 95460, 95463, 95466, 95468, 95469, 95470, 95482, 95488, 95490, 95494, 95585, 95587.

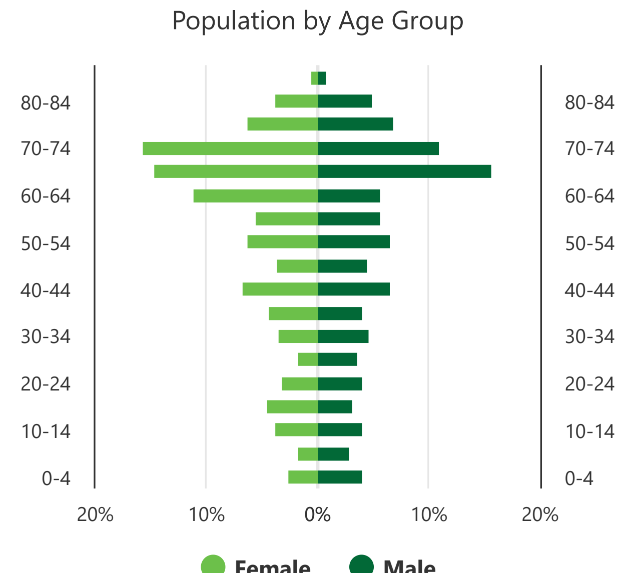


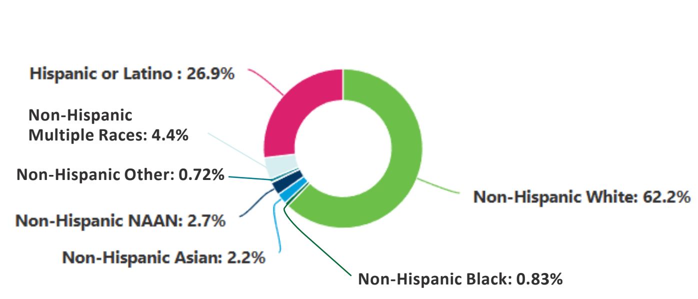


Total Population
91,393

The largest city in the service area is
Ukiah city
with a population of
16,607

Demographic Profile





Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.

Students Experiencing Homelessness, Percent
7.14%
California: 4.25%

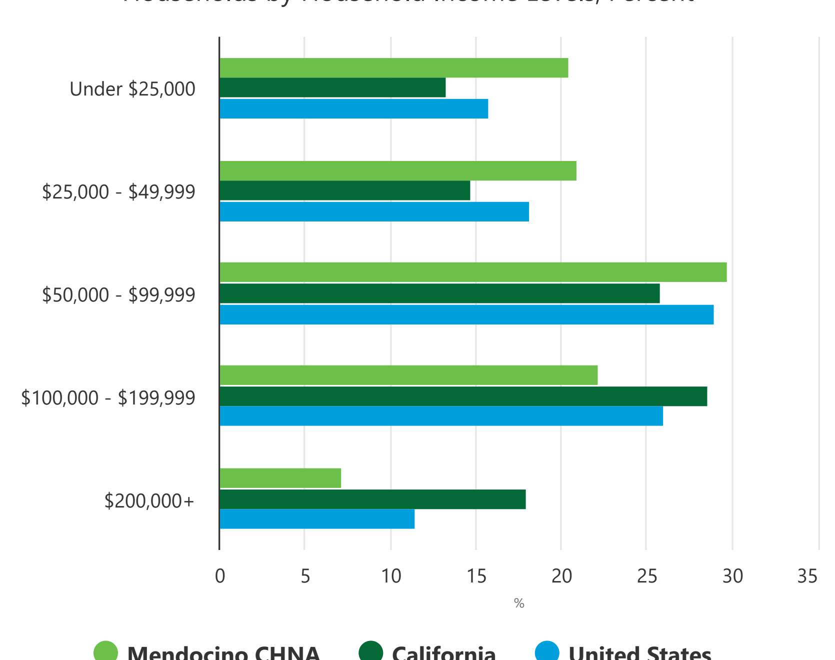
Associate's Degree or Higher
34.66%
California: 43.82%

Labor Force Participation Rate
57.11%
California: 63.82%

60.88%
California: 55.63%
of the population **owns** their home

39.12%
California: 44.37%
of the population **rents** their home

Households by Household Income Levels, Percent



Data Source: US Census Bureau, American Community Survey. 2018-22.

Children in Poverty by Race, Total

Mendocino CHNA

Multiple Race: 33.2%
Non-Hispanic White: 42.5%
Some Other Race: 13.0%
Black or African American: 2.5%
Asian: 0.7%
American Indian or Alaska Native: 8.1%

Childhood Poverty Rate
20.61%
California: 15.61%

II. About Us

Adventist Health

Adventist Health is a faith-based, nonprofit, integrated health system serving more than 100 communities on the West Coast and Hawai'i, with over 440 sites of care, including 27 acute care facilities. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of more than 38,000 includes employees, physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Guided by our mission, Adventist Health supports purposeful work to address the social drivers of health, with a special focus on underserved members of the communities in which we operate. Together, we are transforming the healthcare experience of our communities with a whole-person focus on physical, mental, spiritual and social healing to support well-being.

Adventist Health Mendocino Coast

Adventist Health Mendocino Coast is a 25-bed hospital that has been providing comprehensive healthcare services to the Fort Bragg community since 1971. Our hospital is committed to delivering medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Our continuum of care network of healthcare resources and expertise allows us to provide patients with seamless coordination and access to specialized services.

Services Brought to our Community:

- Behavioral and Mental Health
- Cancer Treatment
- Cardiology
- Ear, Nose & Throat (ENT)
- Family Medicine
- Gastroenterology
- General Surgery
- Hospice & Home Care
- Intensive Care
- Internal Medicine
- Laboratory Services
- Laboratory Outpatient
- Medical Imaging
- Ophthalmology
- Orthopedics
- Physical Therapy
- Podiatry
- Primary Care & Pediatrics
- Rehabilitation Respiratory Therapy
- Surgical Services
- Telehealth
- Urology
- Women's Health
- Wound Care

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the last three years, Adventist Health Mendocino Coast focused on access to care, financial stability and health risk behaviors through community projects and partnerships. To document our impact, we have been monitoring and evaluating progress through annual updates and the Community Health Implementation Strategy (CHIS). In collaboration with the community, we implemented goals, actions, solutions and programs to address each high priority need.

One program that uniquely addressed access to care was the CA Bridge model of care for addiction treatment. The Substance Use Navigator (SUN) provides screening and intervention for people with substance use and behavioral health needs in the emergency department, inpatient setting and community members in need. The SUN team provided navigation 1,282 times, which resulted in 385 referrals to treatment.

We encourage future collaboration with other community organizations to build and scale the work in addressing community health needs. For a full and complete reporting of program and activities since the 2022 Community Health Needs Assessment, please visit this link: https://www.adventisthealth.org/mendocino-coast/about-us/community-benefit

A Look Forward: After the CHNA Report

The next step in our CHNA process is to complete a CHIS. The goal of the CHIS is to strategically implement programs using evidence-informed solutions that address the high priority needs identified in our 2025 CHNA. Together, Adventist Health Mendocino Coast, local public health officials, community-based organizations, medical providers, students, parents, and members of underserved, low-income and minority populations will develop a three-year strategic plan to work towards addressing the needs of our community.

We believe the power of community transformation lies in the hands of the community. We're calling for more collaboration to create intentional strategies that improve health needs for all. Everyone's voice matters, so we want to hear more of your ideas and partner closely with those who want to drive meaningful change. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

AdventistHealth
RALF
SURGERY
RN

The following pages **reflect high priority needs** for our community, as identified by our **diverse** CHNA Steering Committee.

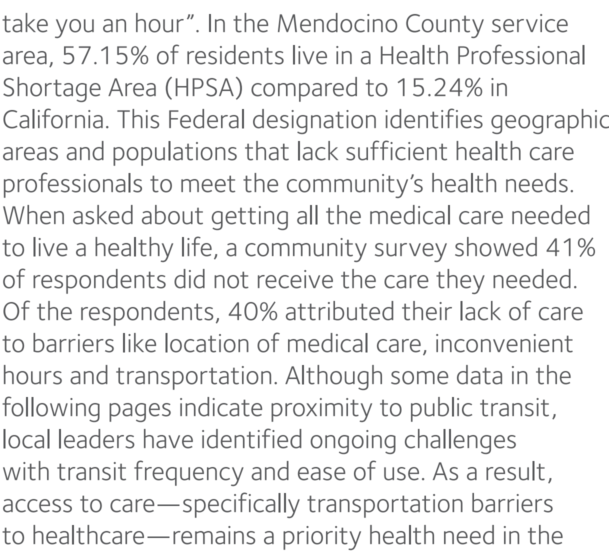
III. High Priority Health Needs

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, and accessibility for all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

In the United States, three in ten people do not have access to a reliable source of primary care (National Association of Community Health Centers) and the American Medical Association projects a shortage of 17,000 – 45,000 primary care doctors over the next decade. Additionally, factors such as being uninsured, lacking access to transportation, limited English proficiency and insufficient provider availability prevent people from receiving the services they need at the right time and place. Mendocino County service area residents face similar limiting factors, often to a greater extent, making access to care a priority need.

Geography in the Mendocino County service area makes accessing healthcare challenging. Key informants referred to the geographic region and remote areas as a barrier to accessing care, and stated the "old logging roads are not transportation roads, so 30 miles can take you an hour". In the Mendocino County service area, 57.15% of residents live in a Health Professional Shortage Area (HPSA) compared to 15.24% in California. This Federal designation identifies geographic areas and populations that lack sufficient health care professionals to meet the community's health needs. When asked about getting all the medical care needed to live a healthy life, a community survey showed 41% of respondents did not receive the care they needed. Of the respondents, 40% attributed their lack of care to barriers like location of medical care, inconvenient hours and transportation. Although some data in the following pages indicate proximity to public transit, local leaders have identified ongoing challenges with transit frequency and ease of use. As a result, access to care—specifically transportation barriers to healthcare—remains a priority health need in the community.



Given that many Mendocino County service area residents live in underserved areas, increasing access and reducing barriers to healthcare in our community can improve health outcomes and reduce disparities. For additional data points, see the following pages.

Scan QR Code to explore the full live data report on Access to Care or visit: cares.page.link/JyNw

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"Trying to find a doctor is really challenging."

"Health insurance can be a barrier...because...folks that just have straight Medicare, they will not go get the testing they need because they do not want to pay that 20% if they don't have the supplemental plan."

"...it's hard to get that durable medical equipment which leads to these mobility issues."

"...long wait times to get an appointment. Doctors not taking new patients."

"I think the lack of specialists in Ukiah drives a lot of people to search for care further south..."

"...I had to wait two years for my neck surgery because nobody wants my [insurance]..."

"There's no urgent care...so you have to either go to the emergency room and wait a few hours to see a doctor or wait two weeks."

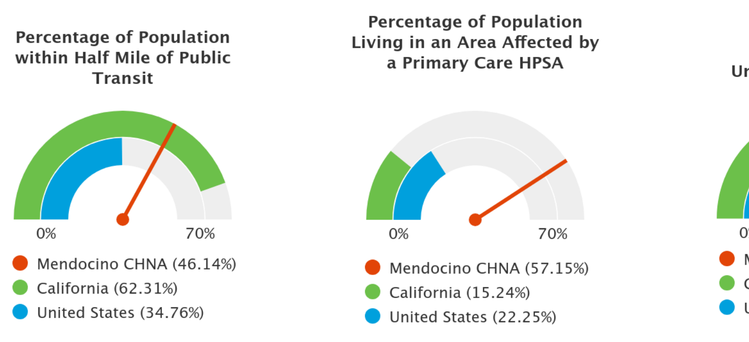
"...our geographic region is very diverse, so there's not a lot of primary care either on the coast or inland. Those gaps tend to be filled by [rural] health clinics which are...overwhelmingly busy when you have 50% of your population on [Medi-Cal]."

"...these remote areas that have poor access to...the internet to check and say...what is this rash?...and they wait too long to come in for care."

"...our roads...they're old logging roads. They're not transportation roads, so 30 miles can take you an hour."

"...there is limited availability of primary care physicians."

"...when you live on the Coast and you don't have a pediatrician and you have a high needs child, you have to figure out how to get inland."



Community Resources

Mendocino Coast Chamber of Commerce
mendocinocoast.com/list/ql/health-care-11
707-961-6300

Mendocino County Social Services
mendocinocounty.gov/departments/social-services
707-463-7700

Multi Senior Services Program Community Care Corp
communitycare707.com/mssp.html

Community Resource Guide for Seniors
seniorresourcedirectory.org

Healthcare Enrollment Services
coveredca.com
800-300-1506

Transportation
seniorresourcedirectory.org/Directory/Transportation.html

Community Health Needs Assessment Full Report

Location

Mendocino CHNA

Health Needs: Access to Care

Availability - Primary Care - Primary Care Shortage Areas

A **Health Professional Shortage Area (HPSA)** is a designation given by the Health Resources and Services Administration (HRSA) in the United States to identify geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types based on the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA**: Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA**: Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA**: Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

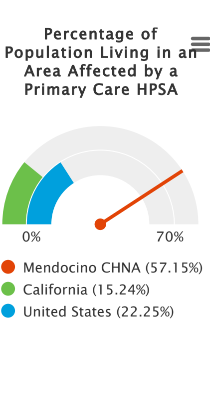
This indicator reports the total population in the report area that is living in a primary care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [HPSA Population] / [Report Area Population] * 100

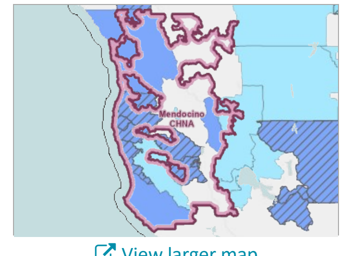
The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates.

Within the report area, there are 52,241 people living in a primary care Health Professional Shortage Area. This represents 57.15% of the total population.

Report Area	Total Population (ACS 2122 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Primary Care HPSA	Percentage of HPSA Population Underserved
Mendocino CHNA	91,403	52,241	57.15%	29.09%
Lake County, CA	64,195	55,947	87.15%	54.02%
Mendocino County, CA	87,224	62,745	71.94%	29.13%
California	39,283,497	5,988,716	15.24%	45.23%
United States	324,697,795	72,230,619	22.25%	51.64%



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.



View larger map

Primary Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Mendocino CHNA

Availability - Mental Health Care - Mental Health Professional Shortage Areas

A **Health Professional Shortage Area (HPSA)** is a designation given by the Health Resources and Services Administration (HRSA) in the United States to identify geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types based on the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA**: Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA**: Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA**: Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

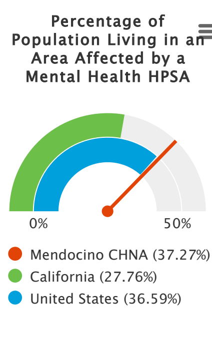
This indicator reports the total population in the report area that is living in a mental health care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [HPSA Population] / [Report Area Population] * 100

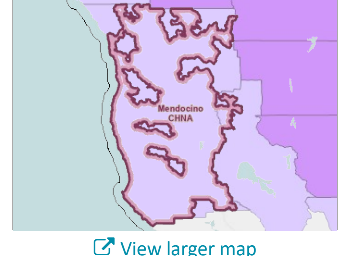
The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Within the report area, there are 34,066 people living in a mental health care Health Professional Shortage Area. This represents 37.27% of the total population.

Report Area	Total Population (ACS 2122 5-Year Estimates)	Population Living in an Area Affected by a HPSA	Percentage of Population Living in an Area Affected by a Mental Health HPSA	Percentage of HPSA Population Underserved
Mendocino CHNA	91,403	34,066	37.27%	100.00%
Lake County, CA	64,195	26,057	40.59%	100.00%
Mendocino County, CA	87,224	34,139	39.14%	100.00%
California	39,283,497	10,907,014	27.76%	69.55%
United States	324,697,795	118,818,005	36.59%	62.78%



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.



View larger map

Mental Health Care HPSA Components, Type and Degree of Shortage by Tract / County, HRSA HPSA Database 2024

- Population Group; Over 20.0 FTE Needed
- Population Group; 1.1 - 20.0 FTE Needed
- Population Group; Under 1.1 FTE Needed
- Geographic Area; Over 20.0 FTE Needed
- Geographic Area; 1.1 - 20.0 FTE Needed
- Geographic Area; Under 1.1 FTE Needed
- Mendocino CHNA

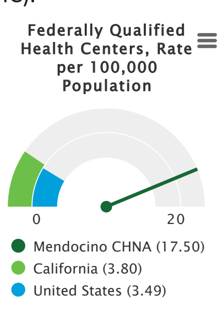
Availability - Hospitals & Clinics - FQHCs, Rate Per Low-Income Population

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

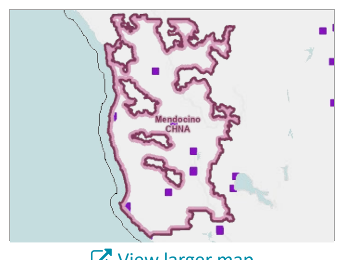
Within the report area, there are 16 Federally Qualified Heath Centers. This means there is a rate of 17.50 Federally Qualified Health Centers per 100,000 total population.

Within the Report area there are SIX (6) Organizations operating 16 Federally Qualified Health Centers (FQHC).

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Mendocino CHNA	91,403	16	17.50
Lake County, CA	68,163	2	2.93
Mendocino County, CA	91,601	16	17.47
California	39,538,223	1,504	3.80
United States	334,735,149	11,680	3.49



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2023.



View larger map

Federally Qualified Health Centers, POS December 2023

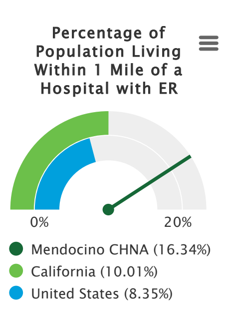
- Federally Qualified Health Centers, POS December 2023
- Mendocino CHNA

Availability - Hospitals & Clinics - Proximity to Hospitals with ER

This indicator reports the percentage of the total population living within 1 mile of a hospital with an emergency room. Having good access to hospitals with an emergency room is important for community health because these hospitals play an important role in rapid and serious medical conditions.

As of 2023, of the report area's 91,403 total population, 14,934 or 16.34% live within 1 mile of a hospital with an emergency room. This is greater than the state's reported rate of 10.01%.

Report Area	Total Population	Population Within 1 Mile of a Hospital with ER	Percent Within 1 Mile of a Hospital with ER
Mendocino CHNA	91,403	14,934	16.34%
Lake County, CA	68,163	5,487	8.05%
Mendocino County, CA	91,601	14,933	16.3%
California	39,538,223	3,959,654	10.01%
United States	334,735,155	27,940,581	8.35%



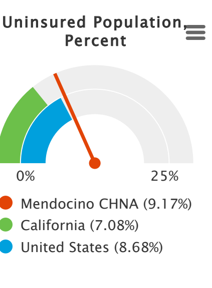
Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2023.

Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.

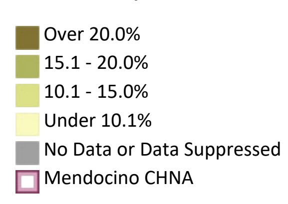
In the report area 9.17% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 7.08%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Mendocino CHNA	90,191	8,270	**9.17%**
Lake County, CA	67,361	4,359	6.47%
Mendocino County, CA	90,359	8,317	9.20%
California	38,874,540	2,752,067	7.08%
United States	326,147,510	28,315,092	8.68%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.

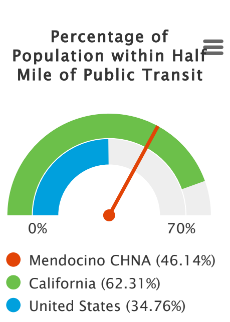
View larger map



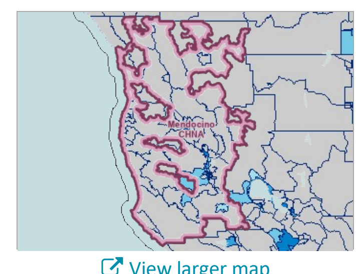
Barriers - Transportation - Distance to Public Transit

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Mendocino CHNA	68,363	31,542	**46.14%**
Lake County, CA	64,148	33,039	51.5%
Mendocino County, CA	87,422	37,191	42.54%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%



Note: This indicator is compared to the state average.
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



View larger map

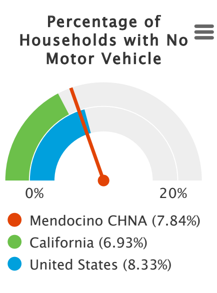
Distance to Nearest Transit Stop, (Meters) by Block Group, EPA SLD 2021

- 800 - 1200 Meters (0.5 - 0.75 Miles)
- 400 - 800 Meters (0.25 - 0.5 Miles)
- 200 - 400 Meters (0.125 - 0.25 Miles)
- Closer than 200 Meters (< 0.125 Miles)
- Further than 1200 Meters (> 0.75 Miles)
- Mendocino CHNA

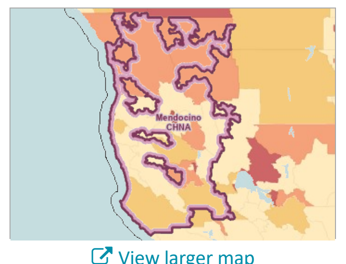
Barriers - Transportation - Households with No Vehicle

This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates. Of the 36,713 total households in the report area, 2,877 or 7.84% are without a motor vehicle.

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Mendocino CHNA	36,713	2,877	**7.84%**
Lake County, CA	26,487	1,485	5.61%
Mendocino County, CA	34,557	2,771	8.02%
California	13,315,822	922,535	6.93%
United States	125,736,353	10,474,870	8.33%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

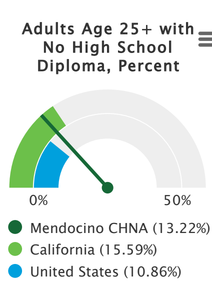
Households with No Vehicle, Percent by Tract, ACS 2018-22

- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed
- Mendocino CHNA

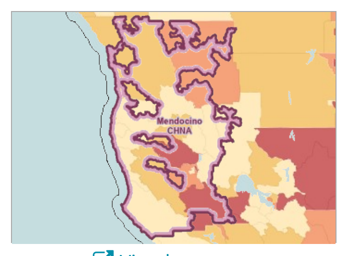
Barriers - Health Literacy - Educational Attainment

Within the report area there are 8,602 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 13.22% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

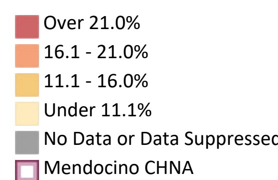
Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
Mendocino CHNA	65,053	8,602	13.22%
Lake County, CA	48,945	6,542	13.37%
Mendocino County, CA	65,163	8,620	13.23%
California	26,842,698	4,185,710	15.59%
United States	226,600,992	24,599,698	10.86%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map



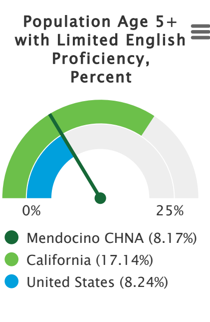
Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2018-22

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Mendocino CHNA

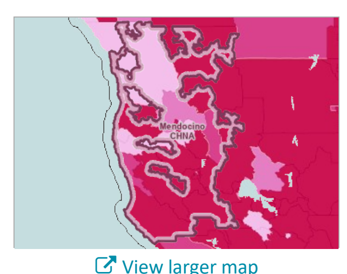
Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 86,033 total population aged 5 and older in the report area, 7,031 or 8.17% have limited English proficiency.

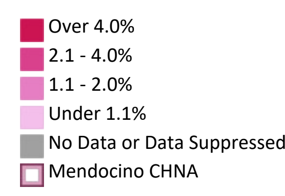
Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Mendocino CHNA	86,033	7,031	8.17%
Lake County, CA	64,191	3,770	5.87%
Mendocino County, CA	86,201	7,066	8.20%
California	37,097,796	6,358,142	17.14%
United States	312,092,668	25,704,846	8.24%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map



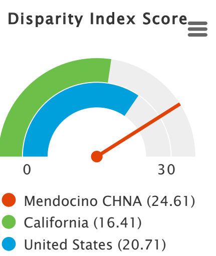
Population with Limited English Proficiency, Percent by Tract, ACS 2018-22

- Over 4.0%
- 2.1 - 4.0%
- 1.1 - 2.0%
- Under 1.1%
- No Data or Data Suppressed
- Mendocino CHNA

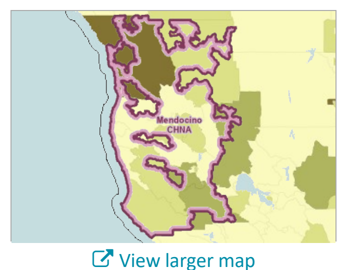
Barriers - Medical Insurance - Health Insurance Disparities

This indicator reports the percentage of the report area population that is uninsured by population race and ethnicity. The disparity index score is a relative measure which expresses the magnitude of disparity across population groups, with a score of 0 representing perfect equality, and a score of 100 representing perfect disparity.

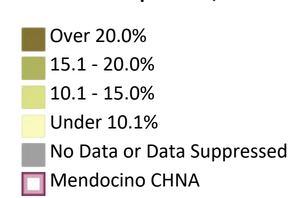
Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Mendocino CHNA	5.69%	14.89%	0.16%	16.70%	24.61
Lake County, CA	4.33%	11.22%	1.19%	11.71%	24.27
Mendocino County, CA	5.70%	14.97%	0.16%	16.70%	24.61
California	3.69%	11.60%	5.75%	8.84%	16.41
United States	5.87%	17.56%	9.76%	13.09%	20.71



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



Uninsured Population, Percent by Tract, ACS 2018-22

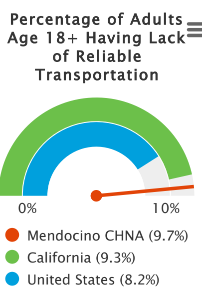


Barriers - Transportation - Lack of Reliable Transportation

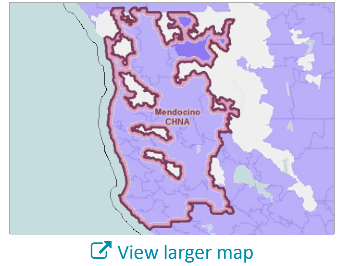
This indicator reports the percentage of adults age 18 and older who report having a lack of reliable transportation in the past 12 months.

Within the report area, there were 9.7% of adults 18 and older who rreport having a lack of reliable transportation in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Lack of Reliable Transportation (Crude)	Adults Age 18+ Having Lack of Reliable Transportation (Age-Adjusted)
Mendocino CHNA	91,403	9.7%	No data
Lake County, CA	68,191	9.3%	10.3%
Mendocino County, CA	89,783	8.9%	10.3%
California	39,029,342	9.3%	9.5%
United States	333,287,557	8.2%	8.7%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.



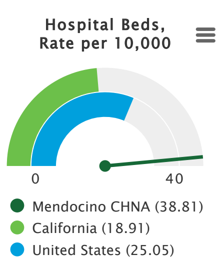
View larger map

Availability - Hospitals & Clinics - Hospital Beds Per Capita

This indicator reports hospital bed availability by estimating the number of hospital beds per 10,000 population. This calculation allocates the number of hospital beds at a given hospital (location) and assigns them to ZIP codes in the hospital service area based on the proportion of patients coming from each ZIP code. This provides an estimation of how hospital capacity (beds) affects the population in ZIP codes served by the hospital.

Report Area	Hospital Beds, Total	Total Population (2020)	Hospital Beds, Rate per 10,000
Mendocino CHNA	354	91,403	38.81
Lake County, CA	174	68,163	25.53
Mendocino County, CA	355	91,601	38.76
California	74,762	39,538,223	18.91
United States	830,171	331,449,281	25.05

Hospital Beds, Rate per 10,000

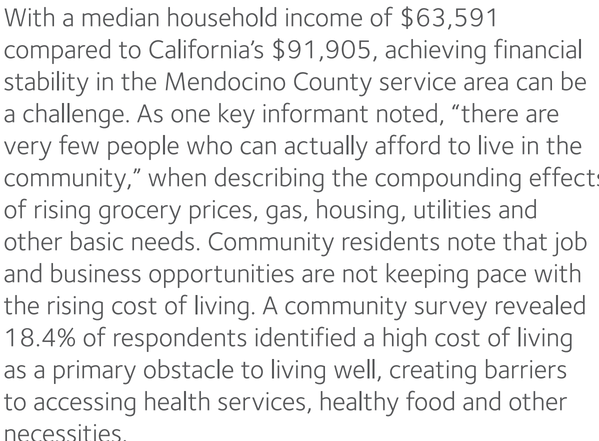


Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Hospital Service Area. 2023.

Finacial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation, while being able to handle unexpected expenses. Financial stability is a critical social determinant of health, as individuals with a steady income are more likely to access preventive care, afford nutritious food, maintain safe living conditions and plan for the future. People with steady jobs are more likely to be healthy and less likely to have an income below the poverty level (Healthy People 2030). However, many people face persistent financial instability which impacts their health and well-being.

In the United States, 36.8 million Americans were living in poverty in 2023 (US Census Bureau), and 28% of adults went without medical care in 2022 because they could not afford it (Federal Reserve). Factors like low-wage jobs, unemployment, poverty and wealth inequality leave millions of families living in a perpetual state of financial instability. Financial instability is linked to higher rates of chronic disease, mental health issues and shorter life expectancy due to limited access to health resources and higher exposure to stressors. In the Mendocino County service area, primary and secondary data confirm that financial stability is a high priority need.



With a median household income of $63,591 compared to California's $91,905, achieving financial stability in the Mendocino County service area can be a challenge. As one key informant noted, "there are very few people who can actually afford to live in the community," when describing the compounding effects of rising grocery prices, gas, housing, utilities and other basic needs. Community residents note that job and business opportunities are not keeping pace with the rising cost of living. A community survey revealed 18.4% of respondents identified a high cost of living as a primary obstacle to living well, creating barriers to accessing health services, healthy food and other necessities.

Financial stability is a social determinant of health that touches all areas of life and enables people to meet their basic needs, health needs and social needs. Interventions may include policies or programs that support employment and boost wages for parents to improve family economic stability. For additional data points, see the following pages.

Scan QR Code to explore the full live data report on Financial Stability or visit: cares.page.link/54Qm

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"I've seen it get a lot worse over the years with the rising costs of living and wages not rising at an equal rate."

"They can't afford housing in that they can't afford to live and they're resorting to crimes."

"...the biggest thing is without good paying jobs, they're not able to take care of their needs. And [the] Native American community...it's important that they're able to pay for their health care..."

"A lot of jobs out there are [part] time, especially at that entry level. [having] jobs that address cost of living are what's really needed."

"...there are very few people who can actually afford to live in the community at this point."

"Homelessness and poverty is so depressing, [it's] so sad that people in the community who aren't experiencing those aren't familiar with the struggles."

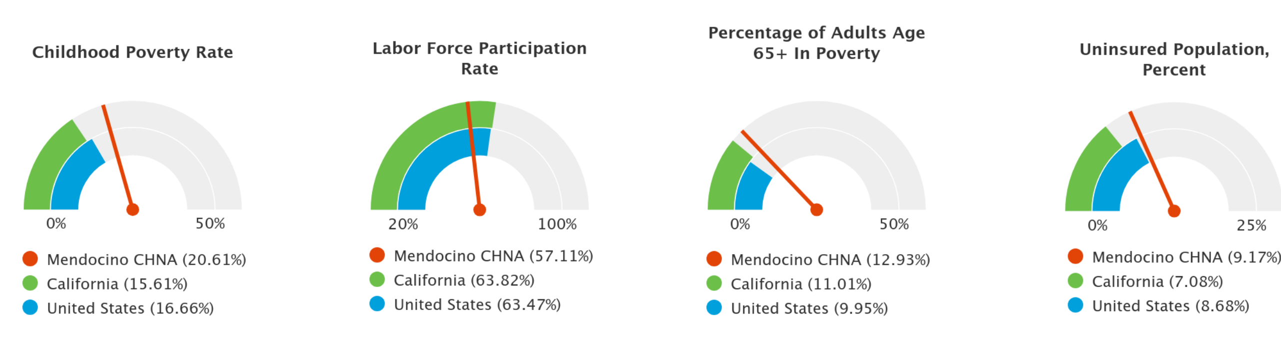
"Fewer business opportunities, lower wages that don't keep up with the cost of living."

"The wages are so low at this point. All of our classified employees [in] their first years at our schools are earning less than they would if they went and did fast food. We're losing amazing teachers at an incredible rate."

"...for this area and our median family income of $48,000 a year, a half a million dollar house is unattainable. So you have people in good jobs that have education that still can't afford houses."

"...the cost of living and the housing affects our ability to recruit and retain professionals...we've had doctors that wanted to come work here and then they couldn't find housing or the cost of housing here compared to somewhere else was so much higher..."

"I still have two full-time jobs, as does my wife."



Community Resources

Finance
seniorresourcedirectory.org/Directory/Finance.html

Mendocino Coast Children's Fund
mccf.info/financial-legal
707-962-8111

Mendocino County General Assistance
mendocinocounty.gov/departments/social-services/adult-aging-services/general-assistance
707-463-7999

Community Health Needs Assessment Full Report

Location

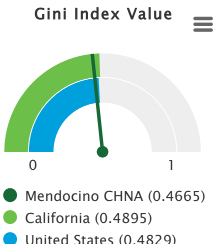
Mendocino CHNA

Basic Needs: Financial Stability

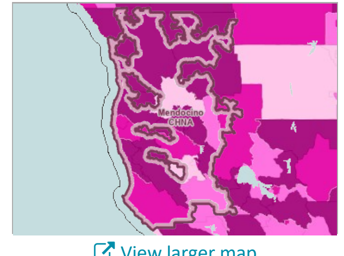
Income - Income Inequality

This indicator reports income inequality using the Gini coefficient. Gini index values range between zero and one. A value of one indicates full inequality where only one household has any income. A value of zero indicates perfect equality, where all households have equal income.
Note: Index values are acquired from the 2018-22 American Community Survey and are not available for custom report areas or multi-county areas.

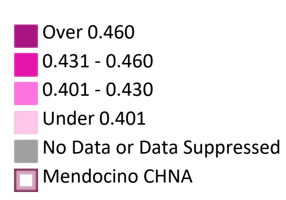
Report Area	Total Households	Gini Index Value
Mendocino CHNA	36,713	0.4665
Lake County, CA	26,487	0.4904
Mendocino County, CA	34,557	0.4805
California	13,315,822	0.4895
United States	125,736,353	0.4829



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map



Income Inequality (GINI Index) by Year

This indicator reports the GINI index from 2012-16 to 2017-21.

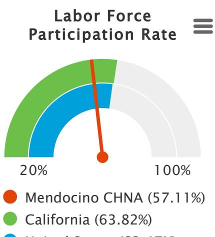
Report Area	2012-16	2013-17	2014-18	2015-19	2016-20	2017-21	2018-22
Lake County, CA	0.4691	0.4691	0.4796	0.4817	0.4946	0.5021	0.4904
Mendocino County, CA	0.4876	0.4942	0.4736	0.4704	0.4714	0.4682	0.4805
California	0.4880	0.4889	0.4891	0.4886	0.4874	0.4874	0.4895
United States	0.4804	0.4815	0.4822	0.4823	0.4817	0.4818	0.4829

Data Source: US Census Bureau, American Community Survey. 2018-22.

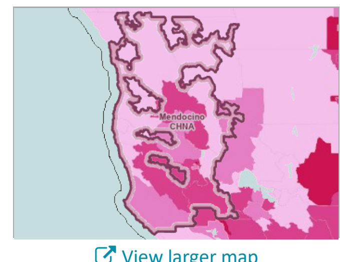
Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2018 – 2022 American Community Survey, of the 78,003 working age population, 44,548 are included in the labor force. The labor force participation rate is 57.11%.

Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Mendocino CHNA	78,003	44,548	57.11%
Lake County, CA	54,938	28,401	51.70%
Mendocino County, CA	74,216	41,923	56.49%
California	31,601,862	20,168,662	63.82%
United States	266,411,973	169,093,585	63.47%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.

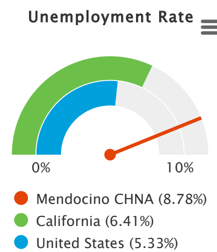


View larger map

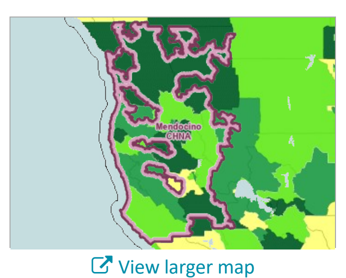
Employment - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 3,913, or 8.78% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Mendocino CHNA	44,548	3,913	8.78%
Lake County, CA	28,401	2,948	10.40%
Mendocino County, CA	41,923	3,811	9.10%
California	20,168,662	1,282,055	6.41%
United States	169,093,585	8,944,003	5.33%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.

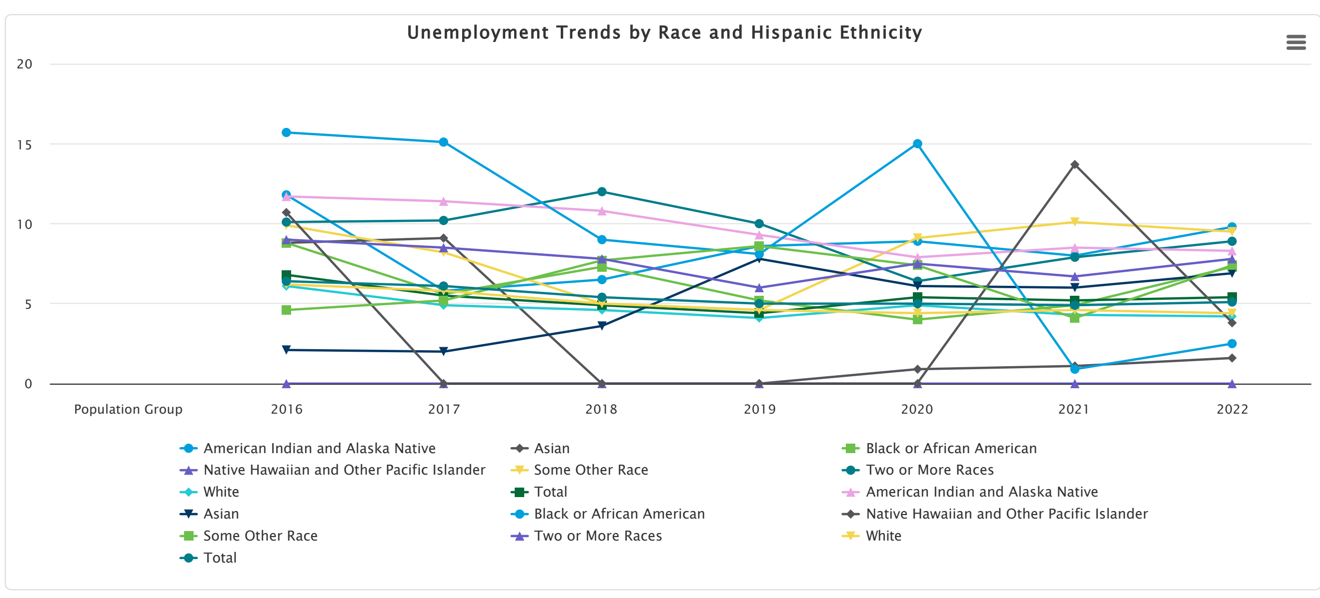


View larger map

Unemployment Trends by Race and Hispanic Ethnicity

Population Group	2016	2017	2018	2019	2020	2021	2022
American Indian and Alaska Native	11.8%	5.8%	6.5%	8.6%	8.9%	8.0%	9.8%
Asian	8.8%	9.1%	0.0%	0.0%	0.9%	1.1%	1.6%
Black or African American	8.8%	5.6%	7.3%	5.2%	4.0%	4.9%	7.3%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Some Other Race	9.9%	8.2%	5.0%	4.6%	9.1%	10.1%	9.5%
Two or More Races	10.1%	10.2%	12.0%	10.0%	6.4%	7.9%	8.9%
White	6.1%	4.9%	4.6%	4.1%	4.9%	4.3%	4.2%
Total	6.8%	5.5%	4.9%	4.4%	5.4%	5.2%	5.4%
American Indian and Alaska Native	11.7%	11.4%	10.8%	9.3%	7.9%	8.5%	8.3%
Asian	2.1%	2.0%	3.6%	7.8%	6.1%	6.0%	6.9%
Black or African American	15.7%	15.1%	9.0%	8.1%	15.0%	0.9%	2.5%
Native Hawaiian and Other Pacific Islander	10.7%	0.0%	0.0%	0.0%	0.0%	13.7%	3.8%
Some Other Race	4.6%	5.2%	7.7%	8.6%	7.4%	4.1%	7.4%
Two or More Races	9.0%	8.5%	7.8%	6.0%	7.5%	6.7%	7.8%
White	6.2%	5.8%	5.0%	4.6%	4.4%	4.6%	4.4%
Total	6.4%	6.1%	5.4%	5.0%	5.0%	4.9%	5.1%

Data Source: US Census Bureau, American Community Survey. 2018-22.

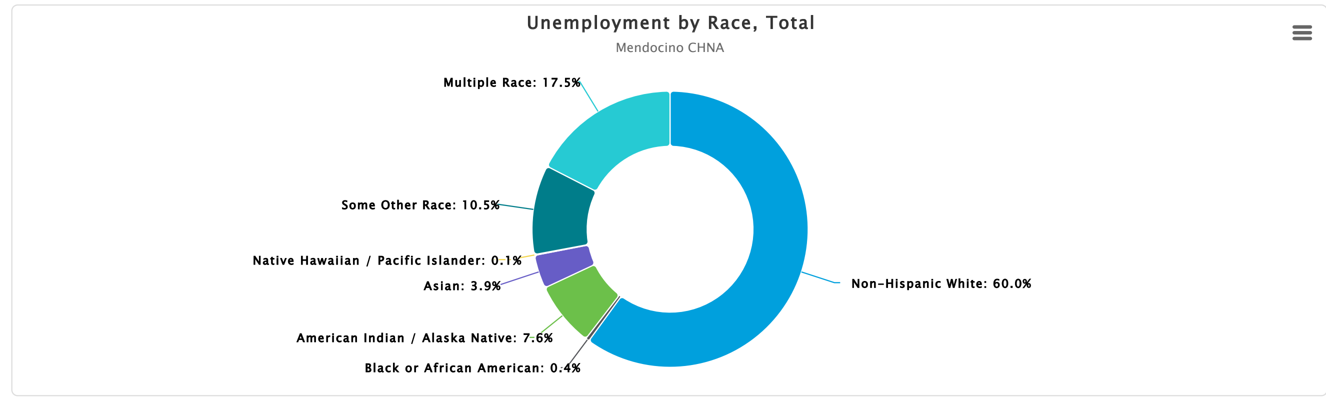


Unemployment by Race, Total

This indicator reports the total count of unemployed population in the report area by race.

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	1,937	14	245	127	3	338	564
Lake County, CA	1,578	86	145	12	0	598	382
Mendocino County, CA	1,937	14	245	127	3	338	564
California	416,299	107,711	17,277	157,482	6,335	223,804	195,450
United States	4,340,546	1,821,110	108,590	455,467	23,416	652,179	928,104

Data Source: US Census Bureau, American Community Survey. 2018-22.

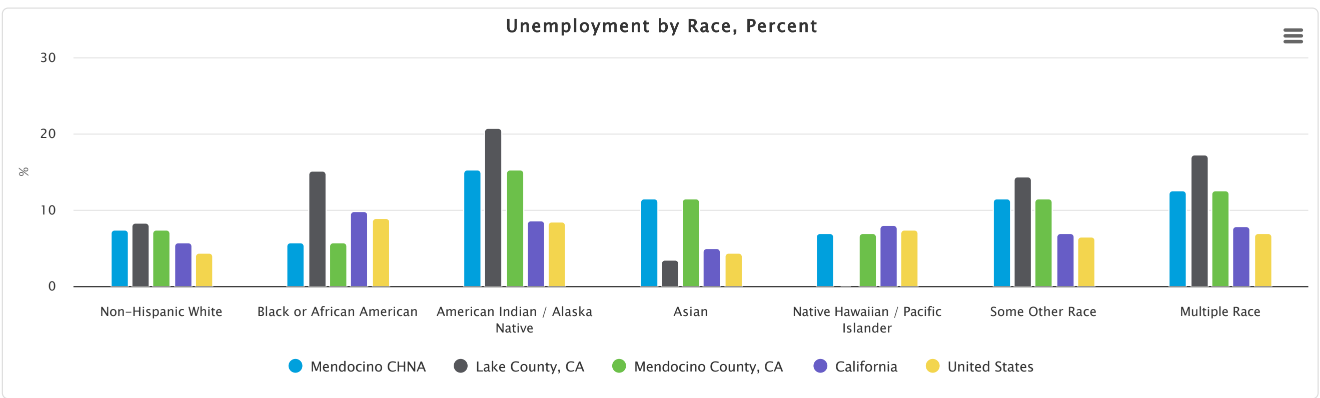


Unemployment by Race, Percent

This indicator reports the percentage of unemployed population in the report area by race. The values could be interpreted as, for example, *"Of all the Non-Hispanic White population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	7.33%	5.65%	15.27%	11.46%	6.82%	11.47%	12.44%
Lake County, CA	8.28%	15.01%	20.63%	3.48%	0.00%	14.27%	17.24%
Mendocino County, CA	7.32%	5.65%	15.27%	11.46%	6.82%	11.47%	12.44%
California	5.71%	9.82%	8.50%	4.90%	7.88%	6.83%	7.78%
United States	4.29%	8.87%	8.42%	4.36%	7.30%	6.37%	6.85%

Data Source: US Census Bureau, American Community Survey. 2018-22.

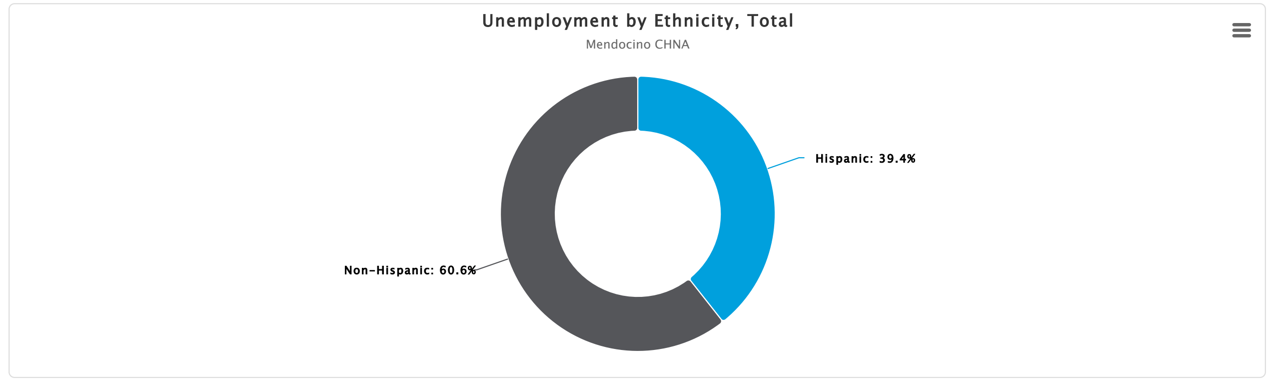


Unemployment by Ethnicity, Total

This indicator reports the total count of unemployed population in the report area by ethnicity.

Report Area	Hispanic	Non-Hispanic
Mendocino CHNA	1,500	2,311
Lake County, CA	1,007	1,941
Mendocino County, CA	1,500	2,311
California	538,085	743,970
United States	1,879,633	7,064,370

Data Source: US Census Bureau, American Community Survey. 2018-22.

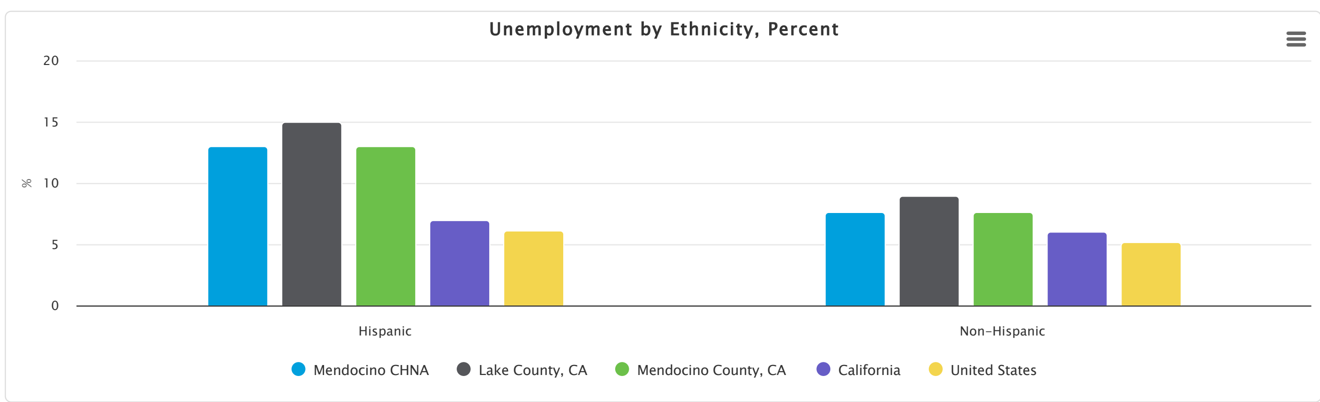


Unemployment by Ethnicity, Percent

This indicator reports the percentage of unemployed population in the report area by ethnicity. The values could be interpreted as, for example, *"Of all the Hispanic population in civilian labor force in the report area, the unemployment rate is (value)."*

Report Area	Hispanic	Non-Hispanic
Mendocino CHNA	12.99%	7.63%
Lake County, CA	14.94%	8.96%
Mendocino County, CA	12.95%	7.62%
California	6.91%	6.01%
United States	6.12%	5.10%

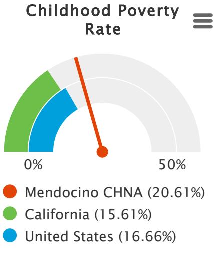
Data Source: US Census Bureau, American Community Survey. 2018-22.



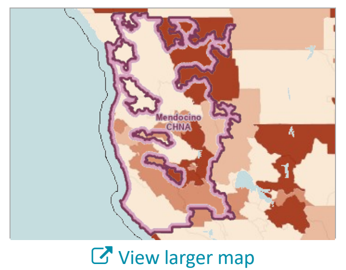
Income - Childhood Poverty Rate

In the report area 20.61% or 3,884 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population < Age 18	Population < Age 18 in Poverty	Childhood Poverty Rate
Mendocino CHNA	89,481	18,845	3,884	**20.61%**
Lake County, CA	66,691	13,783	2,909	21.11%
Mendocino County, CA	89,649	18,899	3,884	20.55%
California	38,643,585	8,636,362	1,347,789	15.61%
United States	323,275,448	72,035,358	12,002,351	16.66%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2018-22

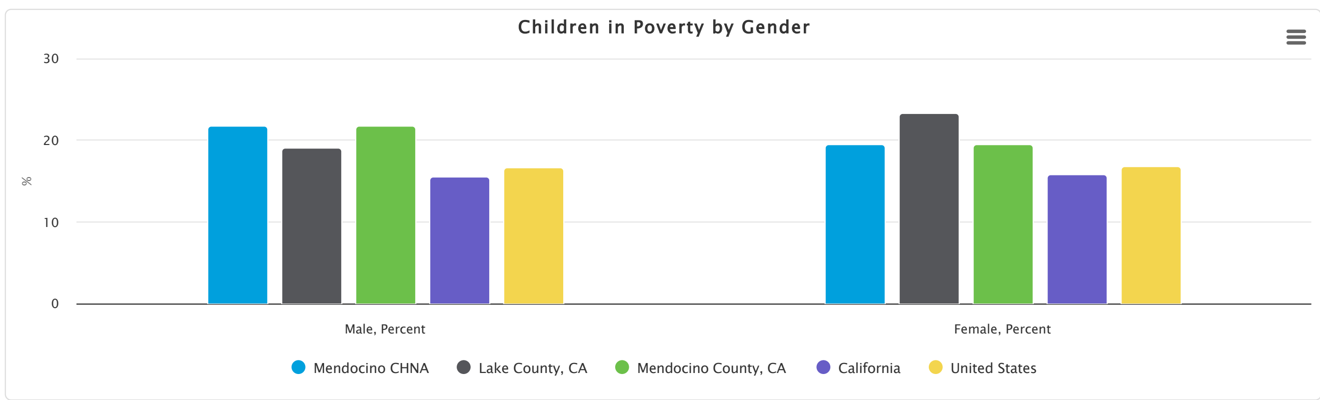
- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Mendocino CHNA

Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender. The percentage values could be interpreted as, for example, *"Of all the boys under age 18 within the report area, the percentage of boys living in households with income below the federal poverty level is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Mendocino CHNA	2,033	1,851	21.76%	19.48%
Lake County, CA	1,364	1,545	19.04%	23.34%
Mendocino County, CA	2,033	1,851	21.70%	19.42%
California	684,184	663,605	15.47%	15.75%
United States	6,124,747	5,877,604	16.61%	16.72%

Data Source: US Census Bureau, American Community Survey. 2018-22.

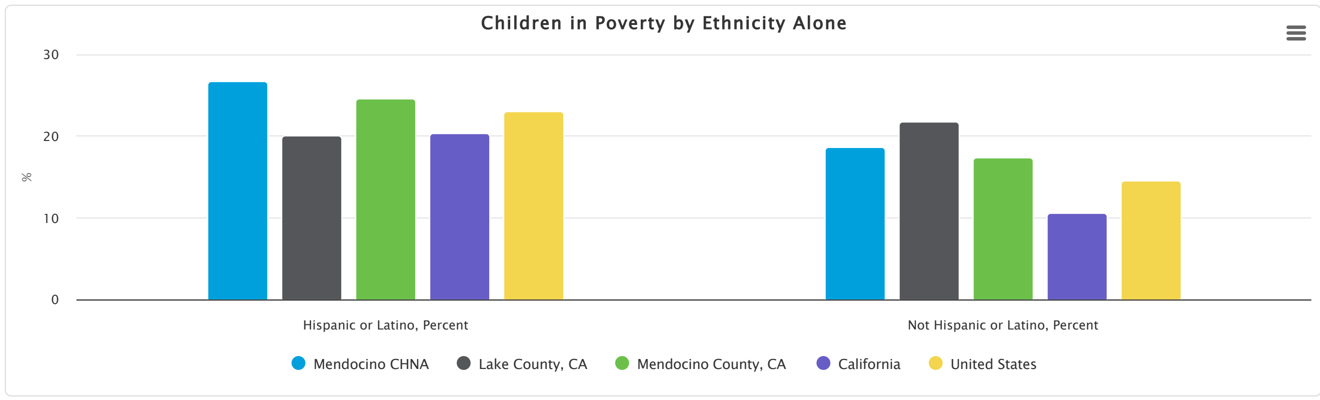


Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone. The percentage values could be interpreted as, for example, *"Of all the Hispanic children under age 18 within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Mendocino CHNA	2,081	1,803	26.64%	18.55%
Lake County, CA	1,046	1,863	20.00%	21.78%
Mendocino County, CA	2,081	1,803	24.56%	17.29%
California	908,098	439,691	20.37%	10.52%
United States	4,231,686	7,770,665	22.95%	14.50%

Data Source: US Census Bureau, American Community Survey. 2018-22.

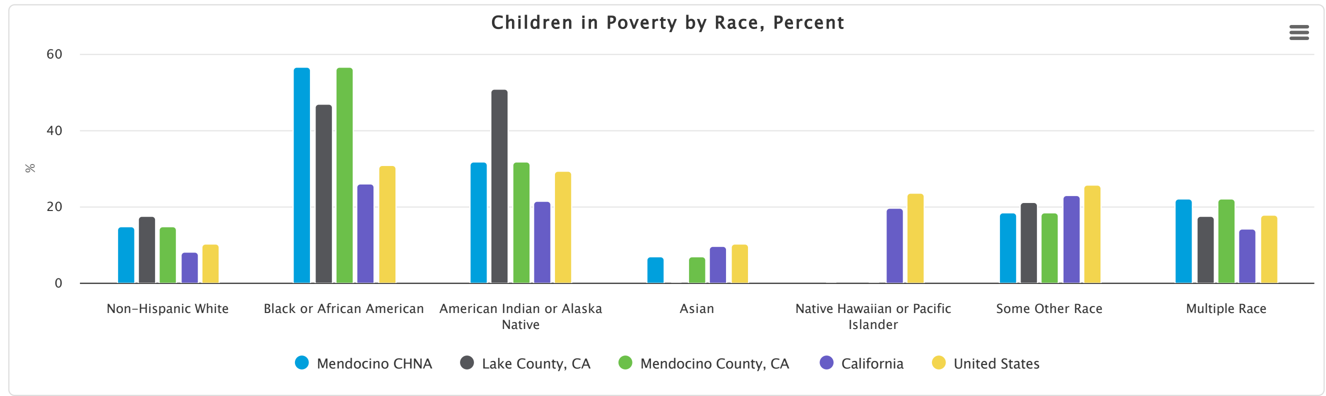


Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race. The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white children under age 18 within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	14.58%	56.52%	31.75%	6.78%	0.00%	18.46%	22.10%
Lake County, CA	17.53%	46.88%	50.62%	0.00%	No data	21.03%	17.48%
Mendocino County, CA	14.58%	56.52%	31.75%	6.78%	0.00%	18.46%	22.10%
California	8.08%	25.76%	21.34%	9.50%	19.55%	22.88%	14.09%
United States	10.21%	30.62%	29.11%	10.17%	23.44%	25.46%	17.68%

Data Source: US Census Bureau, American Community Survey. 2018-22.

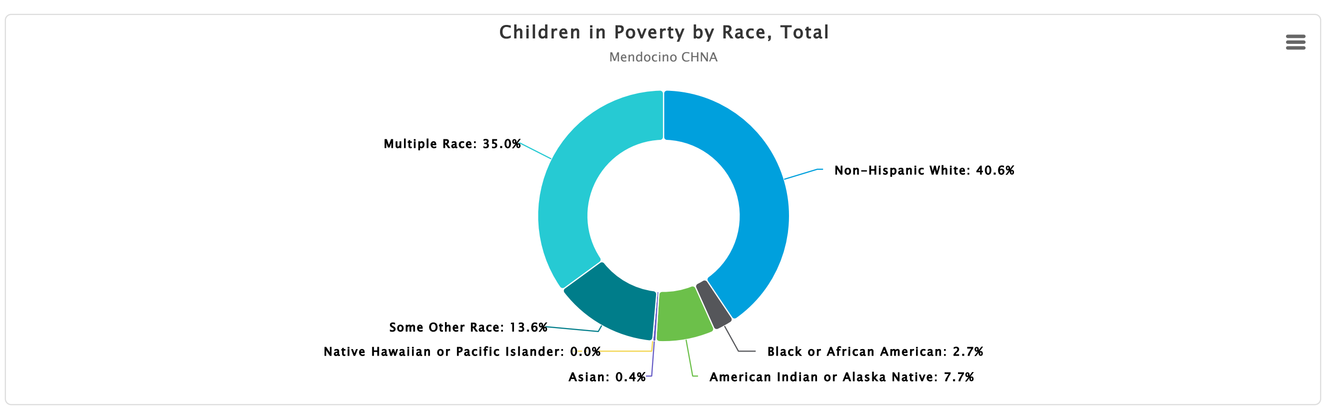


Children in Poverty by Race, Total

This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Mendocino CHNA	1,173	78	221	12	0	392	1,012
Lake County, CA	1,192	195	288	0	0	576	353
Mendocino County, CA	1,173	78	221	12	0	392	1,012
California	167,997	113,370	18,338	102,173	6,128	378,119	245,585
United States	3,577,433	3,006,512	205,808	377,412	35,545	1,385,687	1,767,675

Data Source: US Census Bureau, American Community Survey. 2018-22.

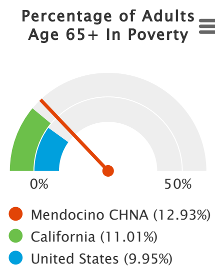


Income - Senior Poverty Rate

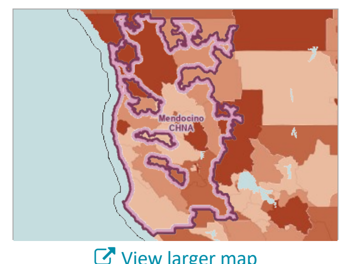
In the report area 12.93% or 2,699 older adults aged 65 or older are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Age 65+	Population Age 65+ in Poverty	Population Age 65+ in Poverty, Percent
Mendocino CHNA	89,481	20,876	2,699	12.93%
Lake County, CA	66,691	15,582	1,571	10.08%
Mendocino County, CA	89,649	20,900	2,702	12.93%
California	38,643,585	5,761,476	634,473	11.01%
United States	323,275,448	53,352,363	5,309,452	9.95%

Percentage of Adults Age 65+ In Poverty



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

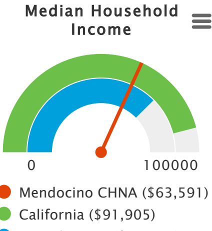
Population Below the Poverty Level, Senior (Age 65+), Percent by Tract, ACS 2018-22

- Over 17.0%
- 12.1 - 17.0%
- 7.1 - 12.0%
- Under 7.1%
- No Population Age 65+ Reported
- No Data or Data Suppressed
- Mendocino CHNA

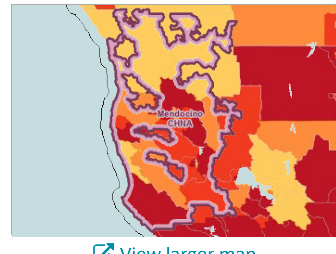
Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 34,477 households in the report area, with an average income of $86,956 and a median income of $63,591.

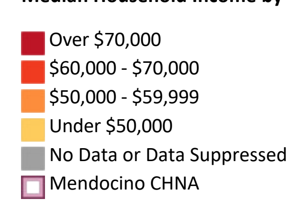
Report Area	Total Households	Average Household Income	Median Household Income
Mendocino CHNA	34,477	$86,956	$63,591
Lake County, CA	26,487	$83,917	$56,259
Mendocino County, CA	34,557	$86,870	$61,335
California	13,315,822	$130,718	$91,905
United States	125,736,353	$105,833	$75,149



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

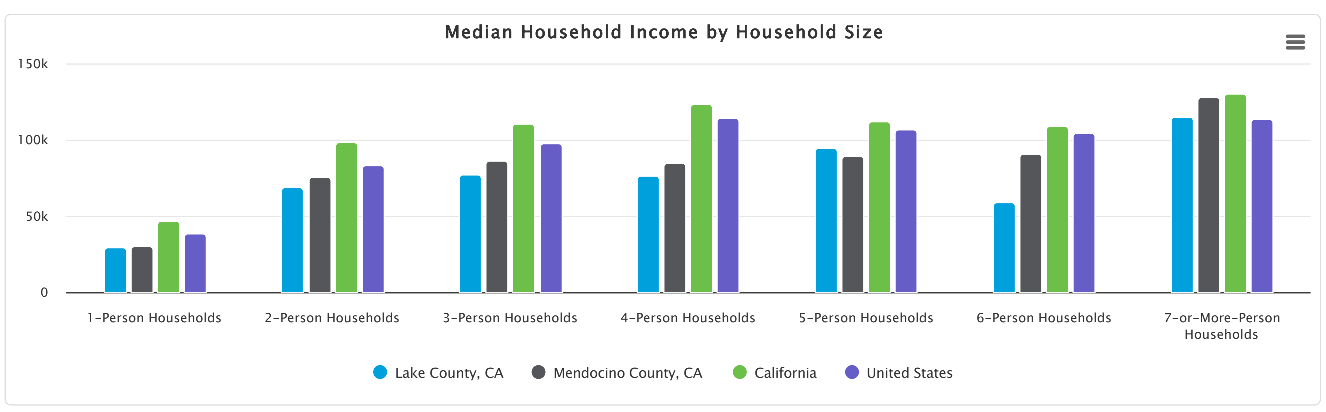


Median Household Income by Household Size

This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Lake County, CA	$29,490	$68,875	$77,054	$76,110	$94,200	$58,438	$115,000
Mendocino County, CA	$29,906	$75,280	$85,758	$84,281	$89,339	$90,547	$127,438
California	$46,740	$98,299	$110,353	$123,339	$111,677	$108,747	$130,288
United States	$38,445	$83,185	$97,644	$113,664	$106,473	$104,420	$113,370

Data Source: US Census Bureau, American Community Survey. 2018-22.

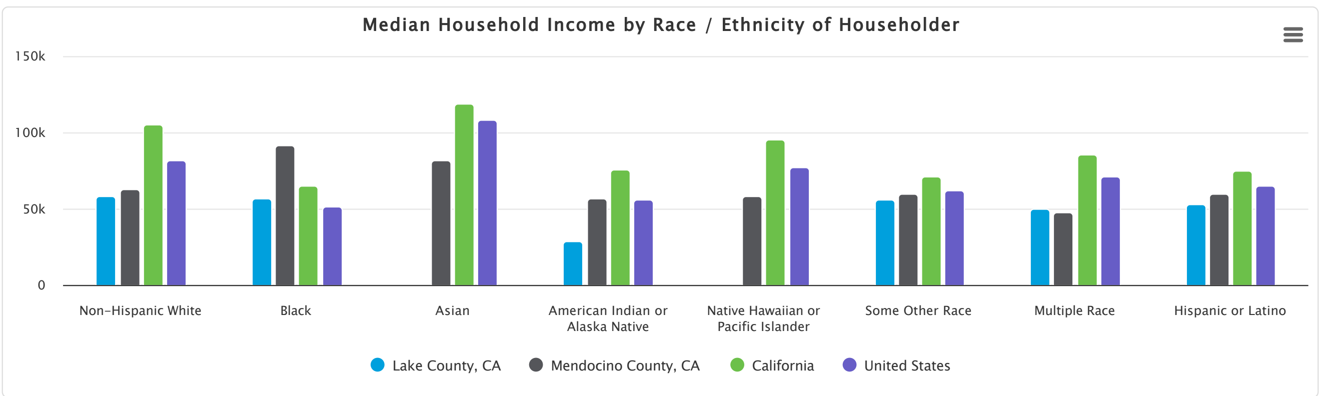


Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Lake County, CA	$58,073	$56,667	No data	$28,777	No data	$55,571	$49,985	$52,917
Mendocino County, CA	$62,870	$91,151	$81,250	$56,371	$57,667	$59,167	$47,021	$59,142
California	$104,752	$64,513	$118,815	$75,076	$95,021	$70,612	$85,219	$74,517
United States	$81,423	$50,901	$107,637	$55,925	$76,568	$61,851	$70,596	$64,936

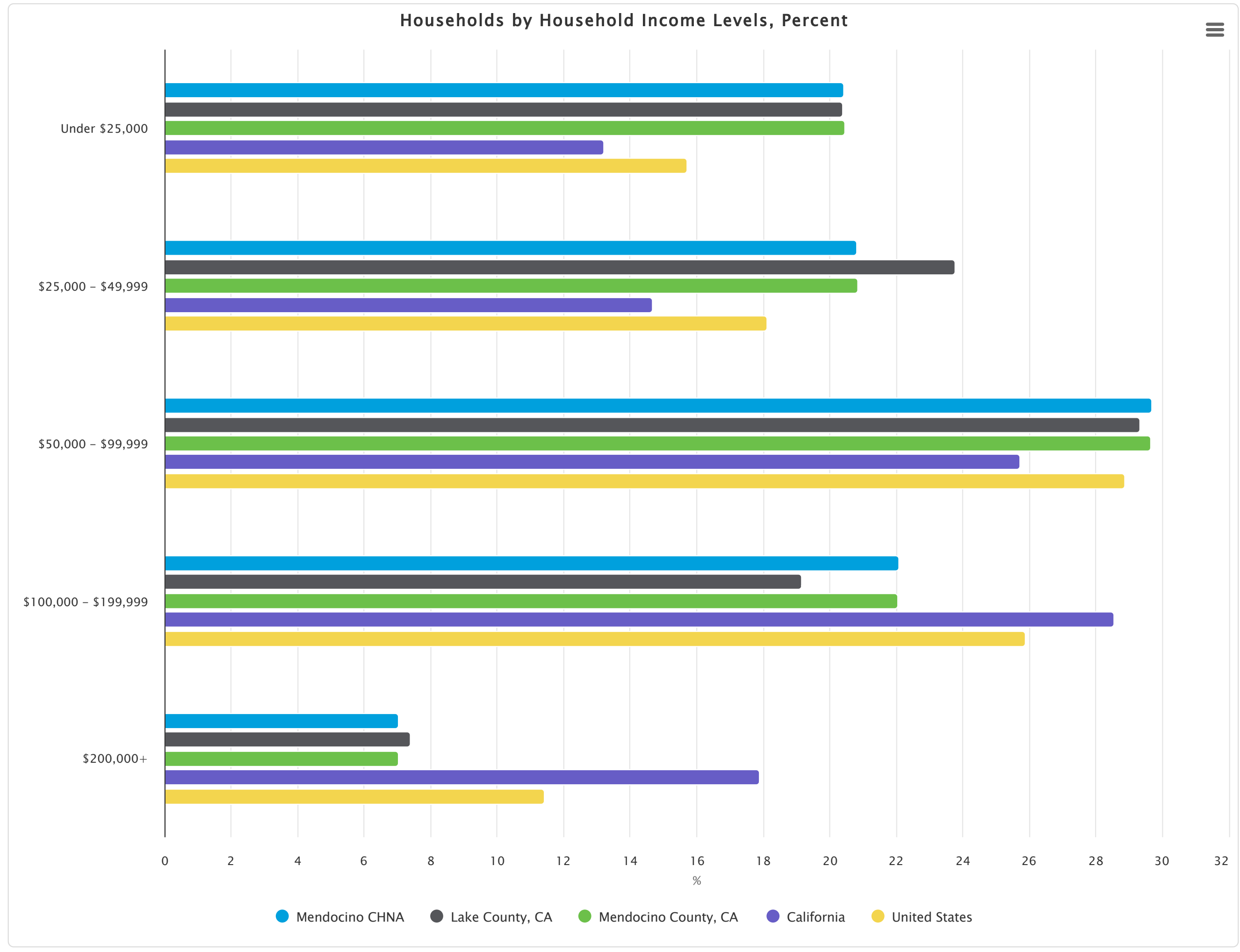
Data Source: US Census Bureau, American Community Survey. 2018-22.



Households by Household Income Levels, Percent

Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Mendocino CHNA	20.41%	20.82%	29.67%	22.06%	7.04%
Lake County, CA	20.38%	23.76%	29.32%	19.15%	7.39%
Mendocino County, CA	20.46%	20.85%	29.64%	22.03%	7.02%
California	13.20%	14.67%	25.72%	28.53%	17.88%
United States	15.71%	18.11%	28.88%	25.88%	11.41%

Data Source: US Census Bureau, American Community Survey. 2018-22.

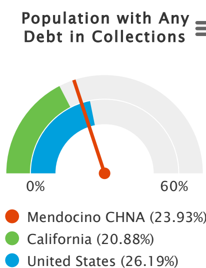


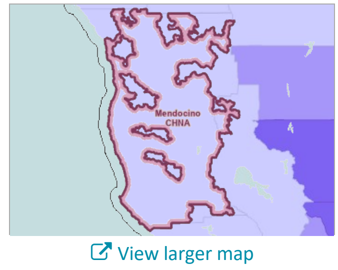
Security - Population with Debt

This indicator reports data from a 2 percent nationally representative panel of deidentified, consumer-level records from a major credit bureau at the national, state, and county levels for the 50 states and Washington, DC, as of 2023, compiled by the Urban Institute. The share with any debt in collections and the median debt in collections within the report area are shown as below. The Share with Any Debt in Collections is defined as the share of people with a credit bureau record who have any debt in collections. This includes past-due credit lines that have been closed and charged-off on the creditor's books as well as unpaid bills reported to the credit bureaus that the creditor is attempting to collect. The Median Debt in Collections is the median amount of all debt in collections among those with any debt in collections.
Note: Credit bureau metrics are not reported when they are based on fewer than 50 people.

Report Area	Share with Any Debt in Collections	Median Debt in Collections
Mendocino CHNA	**23.93%**	No data
Lake County, CA	31.59%	$1,148
Mendocino County, CA	23.92%	$1,089
California	20.88%	$1,824
United States	26.19%	$1,739

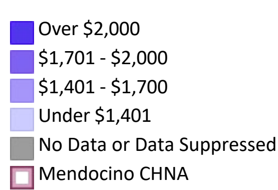
Note: This indicator is compared to the state average.
Data Source: Debt in America, The Urban Institute. 2018-22.





View larger map

Debt in Collections, Median Amount (USD) by County, UI 2023



Share with Any Debt in Collections by Race

The table below reports how debt affects communities across the US in terms of race, i.e., the ratio of people with any debt in collections in white communities and the ratio in communities of color. White communities and communities of color are based on zip codes where most residents are white (at least 60 percent of the population are white) or most residents are people of color (at least 60 percent of the population are of color).

Note: Credit bureau metrics are not reported when they are based on fewer than 50 people. In some cases, values for white communities and communities of color are not reported because there are no zip codes with predominantly white populations or populations of color in the county or state.

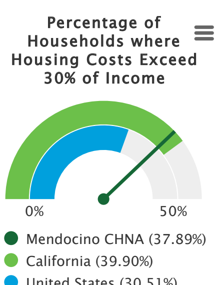
Report Area	Share with Any Debt in Collections, All	Share with Any Debt in Collections, White Communities	Share with Any Debt in Collections, Communities of Color
Lake County, CA	31.59%	27.82%	No data
Mendocino County, CA	23.92%	21.74%	23.53%
California	20.88%	14.78%	24.62%
United States	26.19%	22.07%	35.19%

Data Source: Debt in America, The Urban Institute. 2018-22.

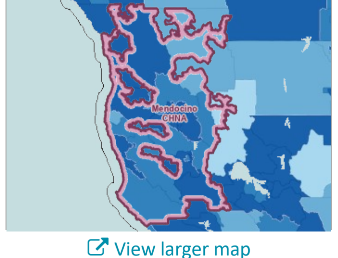
Security - Housing Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. Of the 34,477 total households in the report area, 13,065 or 37.89% of the population live in cost burdened households.

Report Area	Total Households	Cost-Burdened Households	Cost-Burdened Households, Percent
Mendocino CHNA	34,477	13,065	37.89%
Lake County, CA	26,487	9,602	36.25%
Mendocino County, CA	34,557	13,117	37.96%
California	13,315,822	5,312,755	39.90%
United States	125,736,353	38,363,931	30.51%

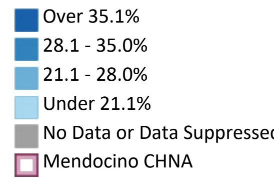


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2018-22

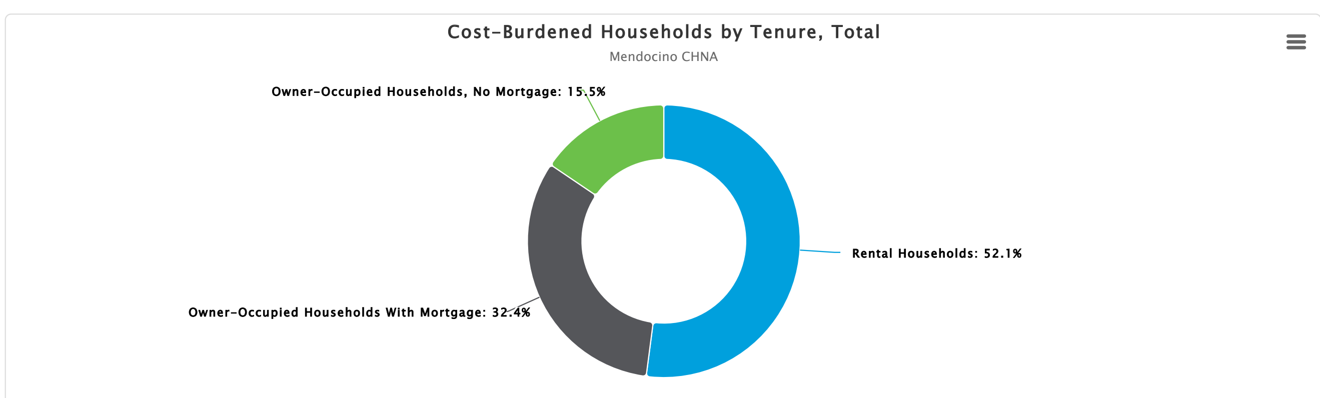


Cost-Burdened Households by Tenure, Total

These data show the number of households that spend more than 30% of the household income on housing costs. In the report area, there were 13,742 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2018-2022 5-year estimates. The data for this indicator is only reported for households where household housing costs and income earned was identified in the American Community Survey.

Report Area	Cost-Burdened Households	Cost-Burdened Rental Households	Cost-Burdened Owner-Occupied Households w/ Mortgage	Cost-Burdened Owner-Occupied Households w/o Mortgage
Mendocino CHNA	13,742	7,156	4,450	2,136
Lake County, CA	9,602	3,832	4,002	1,768
Mendocino County, CA	13,117	6,828	4,266	2,023
California	5,312,755	3,050,389	1,894,888	367,478
United States	38,363,931	20,547,938	13,624,400	4,191,593

Data Source: US Census Bureau, American Community Survey. 2018-22.



ACS Tenure Categories:

Owner-occupied:

The person (or one of the people) living in the unit owns it, either with a mortgage or loan or free and clear.

Renter-occupied:

The person (or one of the people) living in the unit pays rent to occupy it.

Vacant:

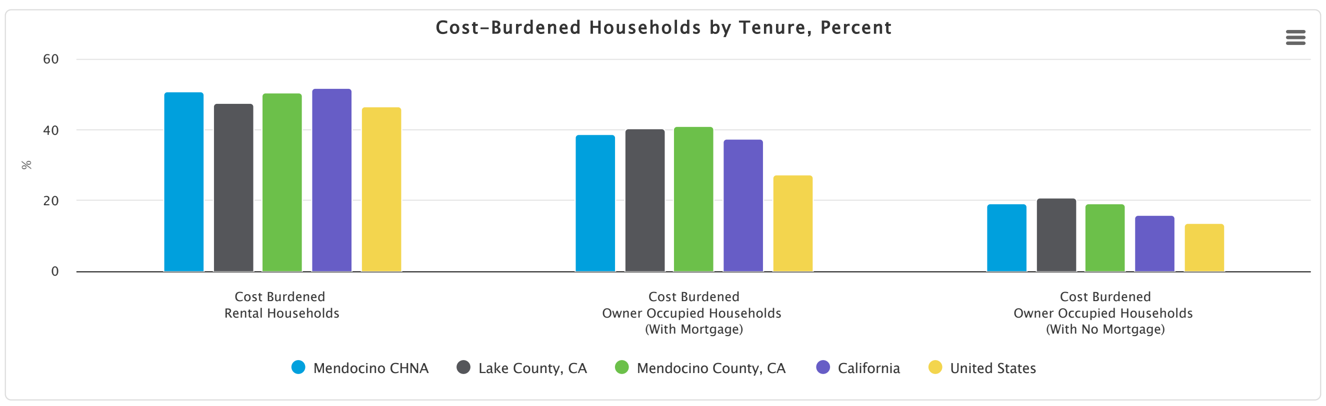
While not part of tenure directly, vacant units are categorized separately in ACS housing data.

Cost-Burdened Households by Tenure, Percent

These data show the percentage of households by tenure that are cost burdened. Cost burdened rental households (those that spent more than 30% of the household income on rental costs) represented 50.86% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2018-2022 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Rental Households	Rental Households Cost-Burdened, Percent	Owner-Occupied Households w/ Mortgage	Owner-Occupied Households w/ Mortgage Cost-Burdened, Percent	Owner-Occupied Households w/o Mortgage	Owner-Occupied Households w/o Mortgage Cost-Burdened, Percent
Mendocino CHNA	14,070	50.86%	11,513	38.65%	11,130	19.19%
Lake County, CA	8,067	47.50%	9,938	40.27%	8,482	20.84%
Mendocino County, CA	13,513	50.53%	10,442	40.85%	10,602	19.08%
California	5,908,461	51.63%	5,067,173	37.40%	2,340,188	15.70%
United States	44,238,593	46.45%	50,148,459	27.17%	31,349,301	13.37%

Data Source: US Census Bureau, American Community Survey. 2018-22.



Mental Health

Mental health is a state of well-being where individuals cope with life's challenges, work productively and contribute to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and social well-being.

Mental health is an important component of overall health and is interdependent with social determinants such as income, education, social support and access to healthcare. Mental health conditions can increase the risk of chronic health conditions such as diabetes, heart disease and stroke. For instance, depression can lead to poor self-care which exacerbates certain health conditions (National Institute of Mental Health). Inversely, the presence of health conditions can increase the risk for mental illness as individuals with one or more chronic illnesses often experience higher levels of stress and anxiety, which can trigger mental health issues. According to the Substance Abuse and Mental Health Services Administration, 23.1% of U.S. adults (59.3 million) experienced a mental health condition in 2022. Living with a mental health condition can vary in severity, causing distress and negatively affecting personal, social and work life. For some, it can significantly impact their ability to carry out daily obligations.

The growing prevalence of mental health as an issue is affecting many community residents. People note a wide variety of factors that contribute to poor mental health, like adverse childhood experiences or poverty. Increased risk factors like stress and trauma due to higher violent crime rates and unemployment, are also linked to mental health outcomes. In the Mendocino County service area, almost one in five adults (17.7%) self-reported as having poor mental health, which can negatively impact overall health outcomes, including a higher rate of deaths of despair at 104.7 compared to California's 47.8 per 100,000 people.

Focus group participants are starting to see mental health as a concern "in our community with depression, anxiety, trauma, especially with our younger people from the schools."

Despite increased risk factors, opportunities to address indicators of mental health do exist. Securing more resources and programming, along with sharing existing opportunities can improve overall health outcomes and reduce disparities. For additional data points, see the following pages.

Scan QR Code to explore the full live data report on Mental Health or visit: cares.page.link/sk32

Data Highlights

Community Voices: *exploring local perceptions, thoughts & beliefs*

"…it doesn't take a whole lot to see the country is suffering from mental health [issues]…"

"I know too many personal friends of mine that have come close to a fatal experience with fentanyl and it's in the community…"

"I see it in our community that depression, anxiety, trauma, especially with our younger people from the schools…"

"…there's not [enough] mental health services, adequate mental health services for the need…"

"…that cycle [drug use] just continues and continues and it goes younger and younger and it becomes normalized…"

"…when you have so much generational trauma, so much poverty…and it's this ongoing cycle and nobody has the skills to deal with it."

"…lots of stress. Lots of stress related illnesses…"

"There's a huge increase in depression, anxiety, trauma, and subsequently that leads to more drug and alcohol use."

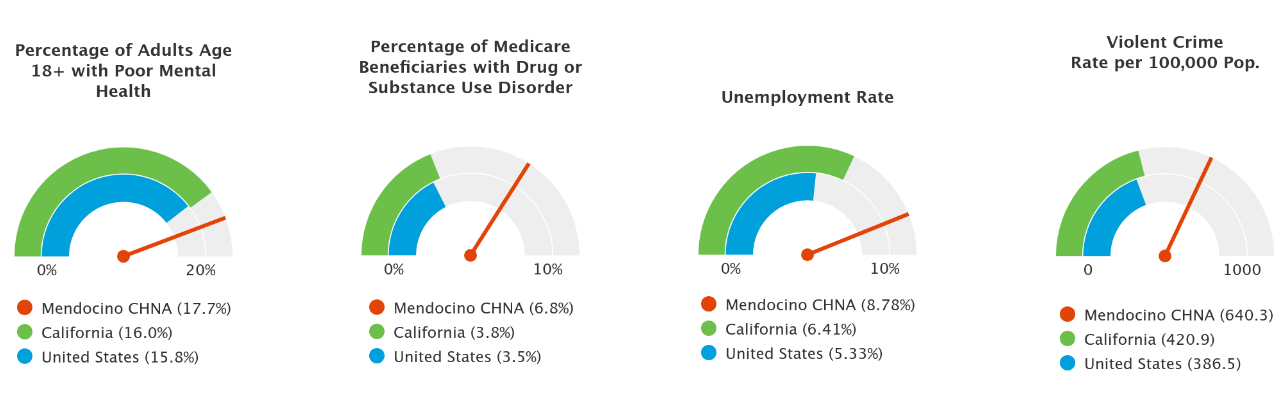
"…there's also the stigma of going to get therapy or counseling or any help…"

"…and again, we don't have a psychologist or psychiatrist in our community at all…"

"We can't get him a bed and it's not because of their insurance. There's no beds accessible in the State of California…"

"…we are in the process of building a psychiatric health facility…"

"The drug and fentanyl problem that's everywhere. It does hit us…hard just because we're a small community and typically know those that are that are impacted."



Community Resources

California Youth Crisis Hotline
800-843-5200

Crisis, Assessment, & Intervention Program (CAIP)
209-533-7000 or
Toll free 800-630-1130

Managing Stress & Depression
calhope.org
833-317-4673 English
833-642-7696 Spanish

Mendocino County Youth Project
mcyp.org
Crisis Line: 707-463-HELP (4357)

Mental Health Services California Youth Crisis Hotline
mendocinocounty.gov/departments/behavioral-health-and-recovery-services/mental-health-services
Crisis Line: 855-838-0404

Mental Wellness & Counseling
seniorresourcedirectory.org/Directory/MentalWellness&Counseling.html

Community Health Needs Assessment Full Report

Location

Mendocino CHNA

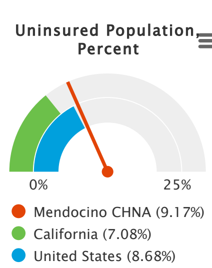
Health Needs: Mental Health

Risk Factors - Access to Care - Medical Insurance

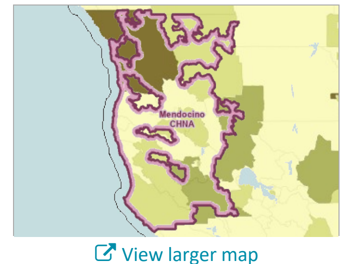
The lack of health insurance is considered a *key driver* of health status.

In the report area 9.17% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 7.08%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Mendocino CHNA	90,191	8,270	**9.17%**
Lake County, CA	67,361	4,359	6.47%
Mendocino County, CA	90,359	8,317	9.20%
California	38,874,540	2,752,067	7.08%
United States	326,147,510	28,315,092	8.68%

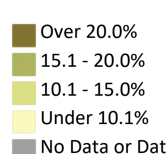


Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

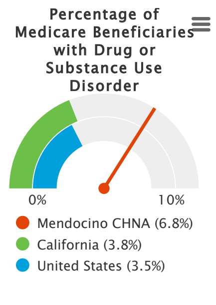
Uninsured Population, Percent by Tract, ACS 2018-22



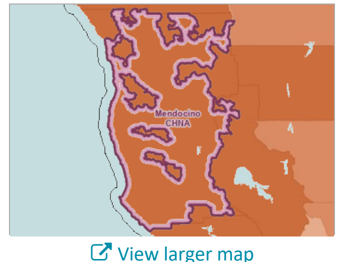
Risk Factors - Drugs & Alcohol - Substance Use Disorder

This indicator reports the percentage of the Medicare Fee-for-Service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program. Within the report area, there are a total of 1,313 beneficiaries with substance use disorder. This represents a 6.8% of the Medicare Fee-for-Service beneficiaries.

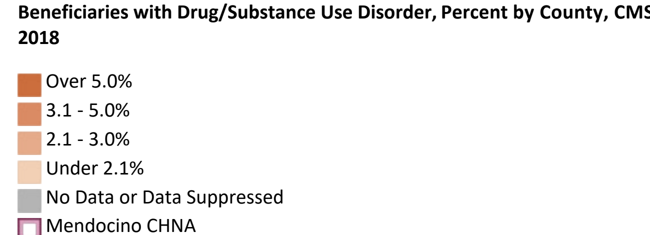
Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
Mendocino CHNA	19,369	1,313	6.8%
Lake County, CA	15,147	1,011	6.7%
Mendocino County, CA	19,410	1,316	6.8%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.



View larger map

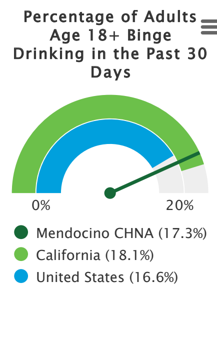

Beneficiaries with Drug/Substance Use Disorder, Percent by County, CMS 2018

Risk Factors - Drugs & Alcohol - Binge Drinking

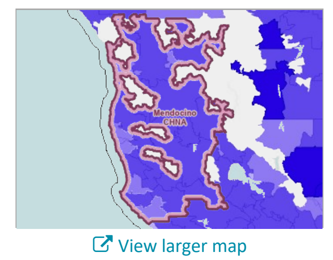
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Within the report area there are 17.3% adults age 18+ who reported having four or more drinks in the last month of the total population age 18+.

Report Area	Total Population	Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)
Mendocino CHNA	91,403	17.3%	No data
Lake County, CA	68,191	16.6%	19.7%
Mendocino County, CA	89,783	16.8%	19.8%
California	39,029,342	18.1%	18.8%
United States	333,287,557	16.6%	18.0%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



View larger map

Binge Drinking, Percent of Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

Over 19.0%
16.1 - 19.0%
13.1 - 16.0%
Under 13.1%
No Data or Data Suppressed
Mendocino CHNA

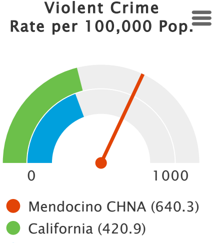
Risk Factors - Stress & Trauma - Violent Crime Rate

This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and 2016 FBI Uniform Crime Reports. This indicator is relevant because it assesses community safety.

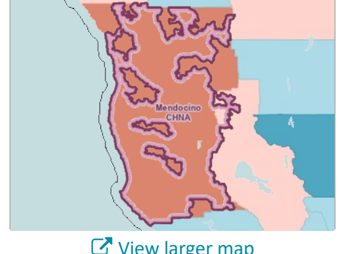
In the report area, 558 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 640.3 per 100,000 residents is higher than the statewide rate of 420.9 per 100,000.

Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Mendocino CHNA	558	640.3
Lake County, CA	343	535.5
Mendocino County, CA	559	640.5
California	164,253	420.9
United States	1,240,534	386.5



Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014&2016.



View larger map

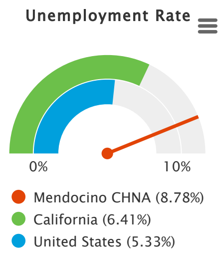
Violent Crime, Rank by County, County Health Rankings 2022

- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed; -1
- Mendocino CHNA

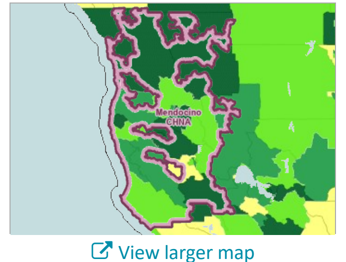
Risk Factors - Stress & Trauma - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 3,913, or 8.78% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Mendocino CHNA	44,548	3,913	8.78%
Lake County, CA	28,401	2,948	10.40%
Mendocino County, CA	41,923	3,811	9.10%
California	20,168,662	1,282,055	6.41%
United States	169,093,585	8,944,003	5.33%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2018-22.



View larger map

Unemployed Workers, Percent by Tract, ACS 2018-22

- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Mendocino CHNA

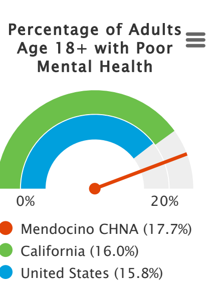
Health Outcomes - Anxiety & Depression - Poor Mental Health

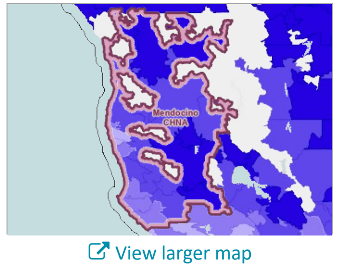
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

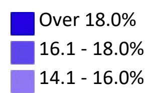
Within the report area, there were 17.7% of adults 18 and older who reported poor mental health in the past month of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ with Poor Mental Health (Crude)	Adults Age 18+ with Poor Mental Health (Age-Adjusted)
Mendocino CHNA	91,403	17.7%	No data
Lake County, CA	68,191	16.6%	19.0%
Mendocino County, CA	89,783	16.5%	18.5%
California	39,029,342	16.0%	16.4%
United States	333,287,557	15.8%	16.4%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .







Frequent Mental Distress, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

- Over 18.0%
- 16.1 - 18.0%
- 14.1 - 16.0%
- Under 14.1%
- No Data or Data Suppressed
- Mendocino CHNA

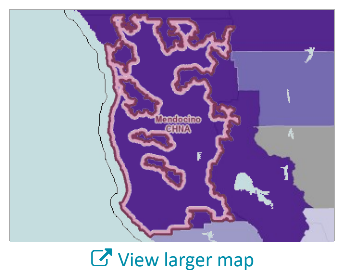
Health Outcomes - Deaths of Despair - Suicide Mortality

This indicator reports the 2018-2022 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Within the report area, there are a total of 100 deaths due to suicide. This represents a crude death rate of 22.7 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

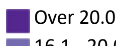
Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Mendocino CHNA	88,111	100	22.7
Lake County, CA	66,041	87	26.4
Mendocino County, CA	88,301	100	22.6
California	39,340,905	21,531	10.9
United States	330,014,476	239,493	14.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2018-2022.



View larger map

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2018-22



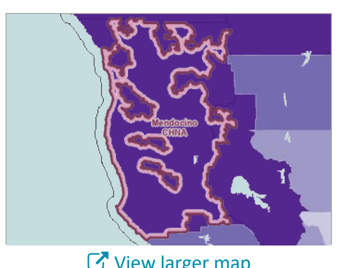
- Over 20.0
- 16.1 - 20.0
- 12.1 - 16.0
- Under 12.1
- Data Suppressed (<10 Deaths)
- Mendocino CHNA

Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.
Within the report area, there were 461 deaths of despair. This represents a crude death rate of 104.7 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Mendocino CHNA	88,111	461	104.7
Lake County, CA	66,041	543	164.4
Mendocino County, CA	88,301	462	104.6
California	39,340,905	93,948	47.8
United States	330,014,476	922,513	55.9

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2018-2022.



View larger map

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2018-22

- Over 70.0
- 50.1 - 70.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<10 Deaths)
- Mendocino CHNA

From the **list** of significant health needs, Steering Committee members **identified** the following as high priorities. The remaining lower priority needs were also identified by **Steering Committee** members as important community needs to address.

A. Identified Significant Health Needs

The following lists all significant health needs identified during the 2025 CHNA process. Also included are links to resources related to each health need.

High Priority Needs

Access to Care

mendocinocoast.com/list/ql/health-care-11

Over half (57.15%) of the service area population lives in a Health Professional Shortage Area (HPSA) compared to 15.24% in California (Health Resources and Services Administration, 2024). Focus group participants mentioned having to travel far to receive specialty care and key informants referred to the geography as a barrier to accessing timely care.

Financial Stability

www.mccf.info/financial-legal

The median household income is $63,591 compared to $91,905 in California (U.S. Census Bureau, 2022). Focus group participants shared that job opportunities are limited but the cost of living continues to rise, while key informants described that without good paying jobs, families cannot afford basic needs.

Mental Health

mendocinocounty.gov/departments/behavioral-health-and-recovery-services/mental-health-services

There is a higher rate of deaths of despair at 104.7 compared to California's 47.8 per 100,000 people (Centers for Disease Control and Prevention, 2022). Focus group participants mentioned how mental health has become a concern especially with the students in school. Key informants highlighted the need for more mental health providers to treat rising depression, anxiety and trauma.

Lower Priority Needs **please note web address leads to multiple 211 resources within each priority need*

Community Infrastructure

mccsd.com/infrastructure-projects

Almost 15% of households live with slow or no high-speed internet access (U.S. Census Bureau, 2022). Key informants described how limited access to resources includes internet access, which is important to carry out everyday activities. Focus group participants noticed the digital divide, but also physical divide in transportation access, walkability and community amenities.

Food Security

mendofood.org/about

Almost three in four (73.5%) students are eligible for free or reduced lunch (National Center for Education Statistics, 2023) and focus group participants noted that the loss of their community grocery store means traveling 50 miles for access to fresh produce. Key informants mentioned that they're seeing how a lack of access to healthy foods causes obesity and other long-term chronic health conditions.

Health Risk Behaviors

mendocinocounty.gov/departments/behavioral-health-and-recovery-services

Almost one in four (23.4%) people self-reported as not engaging in physical activity (CDC, 2022) and based on Medicare enrollment data, 6.8% of beneficiaries has a substance use disorder and 7% of total prescriptions are opioid drug claims (Centers for Medicare and Medicaid Services, 2022). Focus group participants attributed health risk behaviors to substance use disorders across all ages.

Housing

mendocinococ.org

Based on the Area Median Income (AMI), nearly 60% (59.98%) of a household's income is spent on housing and transportation alone (Partnership for Sustainable Communities, 2019). Focus group participants noticed an increase in the homeless population, particularly among seniors with health conditions while key informants pointed out specific needs such as transitional housing, sober housing and multifamily housing.

Social & Economic Context

mendocinocoast.com/list/ql/family-community-civic-organizations-9

Key informants discussed the lack of space to gather and how social disconnection seems to be part of the culture. Almost half (45.51%) of adults 65 and older live alone (U.S. Census Bureau, 2022) and are vulnerable to challenges accessing basic needs. Focus group participants noticed the isolation among seniors and generally attribute alcohol and drug abuse to social isolation.

Scan QR Code to explore the full live data report or visit: cares.page.link/6JEK

B. Description of Focus Groups & Key Informant Interviews

The CHNA Steering Committee identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations — the voices of those with chronic disease, low income and the underserved were heard. See below for more details regarding focus groups and key informant interviews. Themes and quotes from focus groups and key informant interviews are available in Section III. High Priority Health Needs.

Logistics

Eight (8) focus groups with fifty seven (57) people participating. Focus groups were in-person, typically running 90 minutes.

Two (2) key informant interviews. Interviews were conducted virtually, running 60 minutes.

Participating Organizations

Community of Anderson Valley

- Anderson Valley Village, educational representatives, agriculture representative and community members

Communities of Caspar, Fort Bragg and Westport

- Blue Zones Project - Mendocino County
- City of Fort Bragg
- Fort Bragg Police
- Mendocino Coast Health Care District
- Mendocino Community Services

Community of Covelo

- Educational representative, Round Valley Skate Park Project and community members

Communities of Gualala, Mendocino and Point Arena

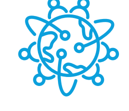
- Action Network, educational representatives (K-8 and HS) and Mendocino Presbyterian Church

Communities of Laytonville and Willits

- Nuestra Allianza, The Ridgewood Ranch/Church of the Golden Rule, Willits volunteer fire department and community members

Mendocino County

- Adventist Health Primary Care Providers
- Building Bridges/RCS
- Consolidated Tribal Health Project
- Leadership Mendocino
- Mendocino Community Health Clinic, Inc.
- North Coast Opportunities
- Mendocino Public Health
- Mendocino County Administration
- Mendocino Sheriff's Office
- Round Valley Indian Health Center



Represented Race/Ethnicity

- American Indian
- Hispanic
- White

Represented Populations

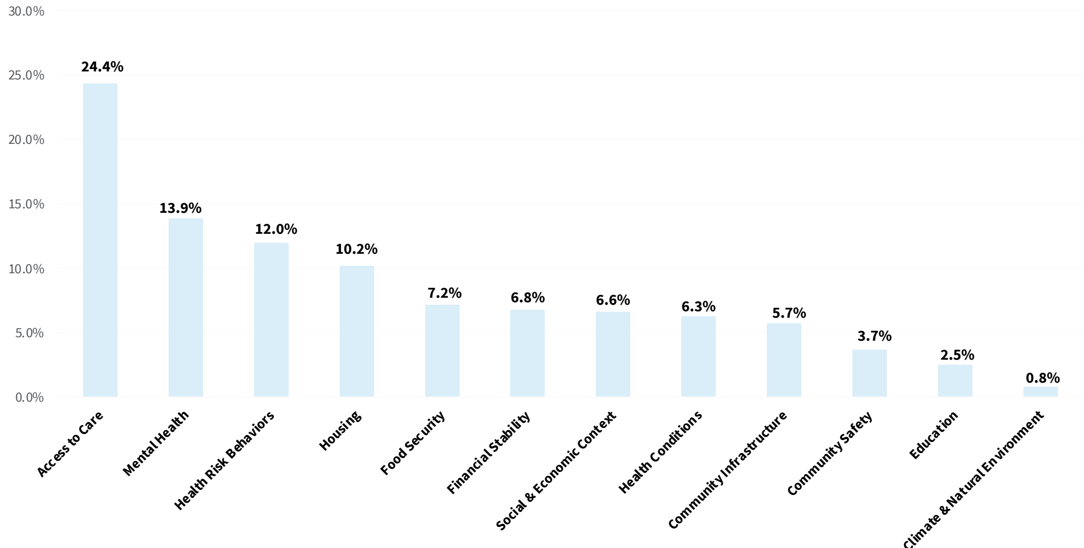
- Agricultural workers
- Healthcare consumer
- Human services
- Labor or workforce reps
- Law enforcement
- Low-income
- Medically underserved
- Older adults
- Substance use disorder
- Unhoused populations
- Individual Tribal healthcare consumers from the following Mendocino County Tribes: Cahto Tribe of the Laytonville Rancheria, Hopland Band of Pomo Indians, Redwood Valley Little River of Pomo Indians of the Redwood Valley Rancheria, Round Valley Indian Tribes and Sherwood Valley Band of Pomo Indians

C. Focus Groups & Key Informant Interviews Results

The focus group and key informant interview charts below highlight the percentage of mentions for each selected need within the Community Impact Framework. For additional details on focus group and key informant interview methodology, see Section V. Process and Methods to Conduct the CHNA.

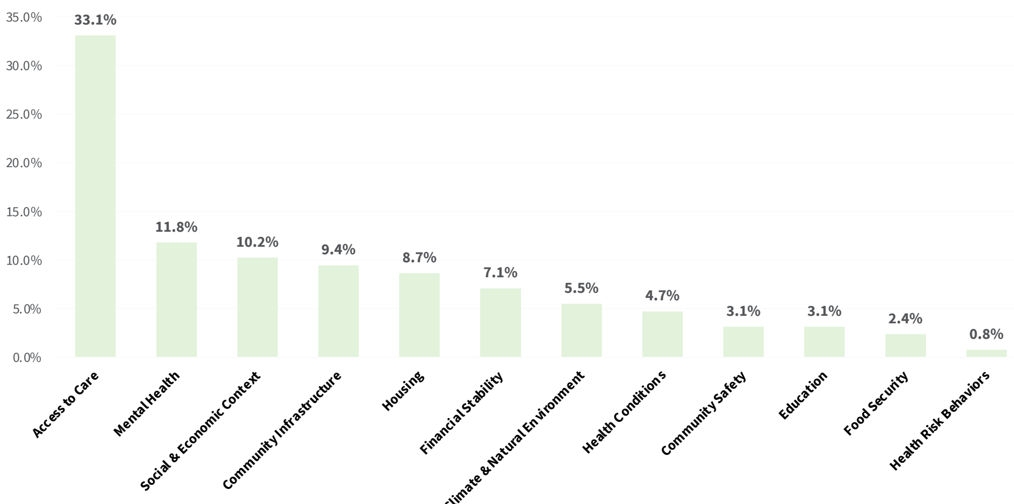
Focus Groups

The following chart details the percentage by which focus group participants mentioned or discussed the 12 categories from our Community Impact Framework.



Key Informant Interviews

The following chart details the percentage by which key informant interviews mentioned or discussed the 12 categories from our Community Impact Framework.



D. Secondary Data Results

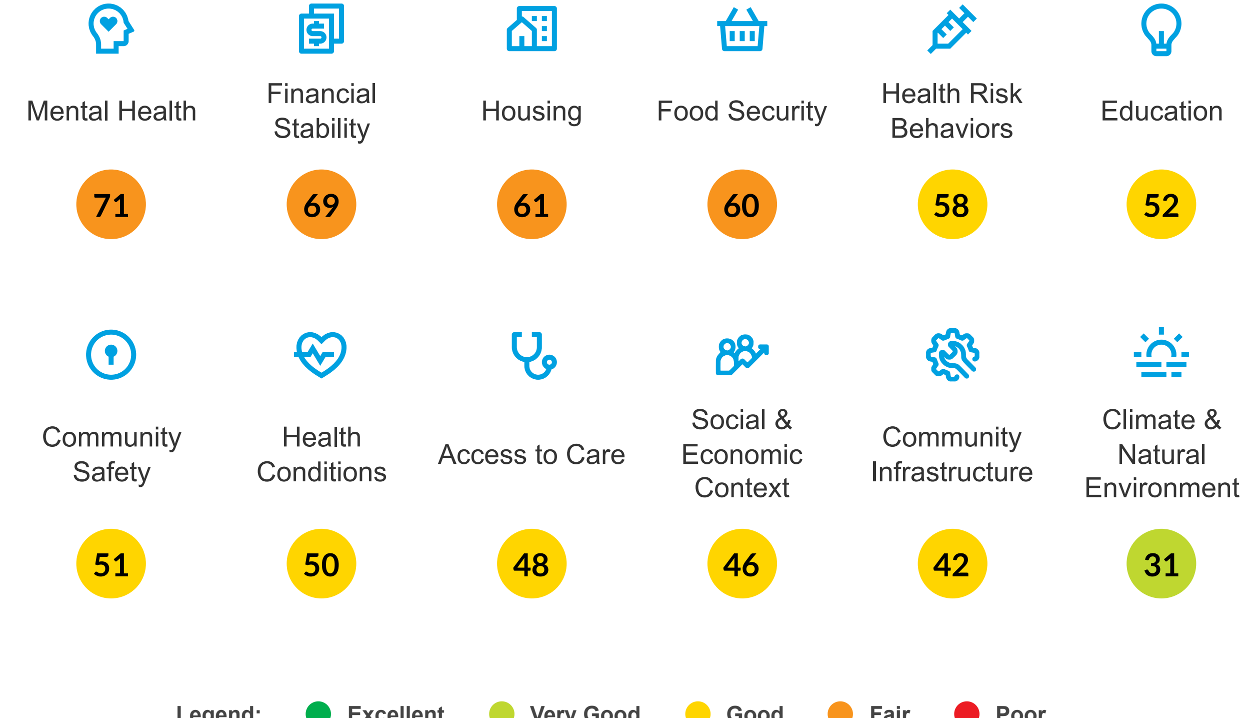
Below are the secondary data results that rank the 12 categories from our Community Impact Framework from 1 to 100. Higher scores have the greatest impact on life expectancy and general health status. For additional information on scoring methodology see Section V. Process and Methods to Conduct the CHNA.

Priority Health Needs

Health needs in Mendocino CHNA were determined using quantitative analysis of data. Needs were identified based on their impact on short-term health (well-being) and long-term health (life expectancy), as well as prevalence in the market relative to state benchmarks. Priority areas are scored on a scale of 1 to 100, with higher scores indicating higher health needs.

Adults Age 18+ with Poor or Fair General Health (Crude)
21.3%
California: 18.8%

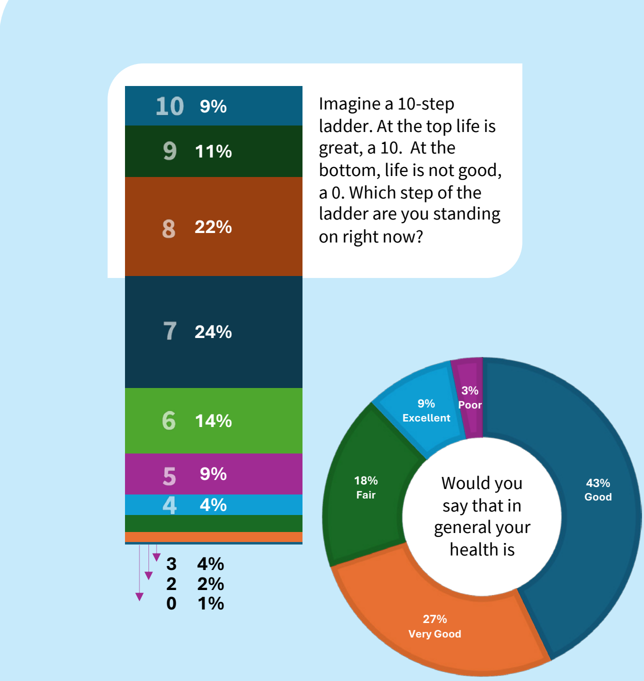
Life Expectancy at Birth (2010-2015)
78.69
California: 80.32



Legend: Excellent, Very Good, Good, Fair, Poor

E. Survey Results

Community surveys collect data from a broad population to understand real-time perspectives on health and well-being. Survey questions focus on gathering data related to major health issues, life satisfaction, access to medical care and community resources.

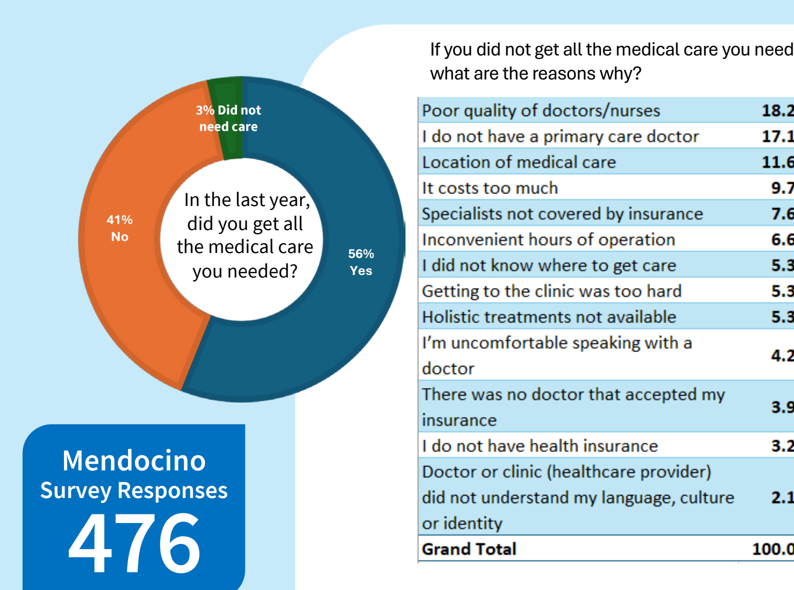


Select 3-5 things that you believe make it hard to live and be well

Lack of affordable housing	18.5%
High cost of living	18.4%
Can't get medical care	15.3%
Not enough good jobs	10.4%
High risk for natural disasters (fire, floods, earthquakes)	6.5%
Access to affordable healthy food	6.0%
Lack of safe roads, sidewalks, bike lanes	4.4%
Unsafe community	3.9%
Lack of transportation	3.7%
No friends or connection to community	2.5%
Limited access to social services for me or my family members	2.5%
Limited childcare options	2.5%
Lack of good schools	2.4%
Racism	2.2%
Bad air and/or water quality	0.8%
Grand Total	**100.0%**

Select 1-5 of the biggest health problems you're

Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	17.2%
Being overweight	12.3%
Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)	9.3%
High blood pressure	8.2%
Teeth problems	7.7%
Vision/hearing problems	6.9%
No health problems	5.9%
Poor eating habits	5.5%
Diabetes/Kidney Disease	4.6%
Heart disease/Stroke	3.7%
Cancer	3.6%
Asthma/COPD	3.4%
Problems with mobility	3.1%
Alcohol and/or drug misuse	2.4%
Illness that spreads (like flu, COVID, TB)	2.3%
Respiratory/Lung Diseases	1.3%
Learning problems	1.2%
Mother-Baby care	0.7%
Child/Partner Abuse	0.5%
Sexually Transmitted Diseases (STDs)	0.2%
Grand Total	**100.0%**



If you did not get all the medical care you needed, what are the reasons why?

Poor quality of doctors/nurses	18.2%
I do not have a primary care doctor	17.1%
Location of medical care	11.6%
It costs too much	9.7%
Specialists not covered by insurance	7.6%
Inconvenient hours of operation	6.6%
I did not know where to get care	5.3%
Getting to the clinic was too hard	5.3%
Holistic treatments not available	5.3%
I'm uncomfortable speaking with a doctor	4.2%
There was no doctor that accepted my insurance	3.9%
I do not have health insurance	3.2%
Doctor or clinic (healthcare provider) did not understand my language, culture or identity	2.1%
Grand Total	**100.0%**

Select the resources that your community needs more of to help you live better.

Housing Options	18.1%
Healthcare & Prescription Costs	17.4%
Childcare or Senior Care	13.3%
Parks, Recreation and Outdoor Activities	9.4%
Managing Stress and Depression	9.4%
Utilities/Internet	8.2%
Social/Community Events	7.4%
Neighborhood Safety	6.4%
Personal Safety	4.4%
Local Food Banks	3.1%
Legal Services	2.9%
Grand Total	**100.0%**

The following pages **reflect** the **process** and **methods** used to **conduct** this CHNA.

V. Process & Methods to Conduct the CHNA

A. Introduction

This Community Health Needs Assessment (CHNA) process aligns with the American Hospital Association Community Health Improvement (i.e. Healthy Communities) guidelines and was designed after an analysis of best practices for CHNAs, as defined by the Centers for Disease Control and Prevention (CDC), Community Commons, and the National Association of County & City Health Officials (NACCHO).

This CHNA was conducted using four distinct sources of primary and secondary data. This mixed methods approach is a preferred practice for needs assessments as it allows for data triangulation, providing the greatest understanding of community needs from the broadest range of perspectives. Having multiple avenues for contributing perspectives has been shown to better include the voices of all community members, particularly vulnerable and disadvantaged groups (Ravaghi et al., 2023).

For this CHNA process, a local Steering Committee was formed to help coordinate the collection of primary data, with an emphasis on incorporating the perspectives of underserved populations. Primary data collection involved focus group interviews, individual key informant interviews and surveys. Secondary data was also collected, involving a review of over 150 metrics from state and national sources which were analyzed to determine factors having the greatest impact on community health. All collected CHNA data was coded and analyzed according to a Community Impact Framework. Framework development, data types, data collection, analysis and prioritization methods are described in the following pages.

B. Community Impact Framework

To organize health findings throughout this CHNA, a multi-tiered Community Impact Framework was used to categorize data into community health needs. To develop the Community Impact Framework, an initial set of 12 conceptual health need areas were identified by reviewing an analysis of past cycle CHNAs, which was conducted by the American Hospital Association, and comparing to existing SDoH frameworks like Well-Being in the Nation (WIN) and Kaiser Family Foundation. After conducting an analysis of appropriate and available public, secondary data to measure each category, a set of sub-categories and subsequent indicators were codified to make up a systematic framework. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well Being
- County Health Rankings and Roadmaps
- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. The final framework consists of more than 150 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022). For a full glossary of terms that include all 12 categories, see Appendix A. Glossary of Terms and Definitions of Health Needs.

Need	Category	Subcategories
Health Needs	Access to Care	Availability - Hospitals & Clinics | Availability - Mental Health Care | Availability - Primary Care Availability - Specialty Care | Barriers - Health Literacy | Barriers - Medical Insurance | Barriers - Transportation
	Health Conditions	Asthma & COPD | Cancers | Chronic Brain Disorders | Heart Disease & Stroke | Kidney & Liver Diseases Obesity & Diabetes | Impairments | Preventable Death Health Status | Aging Conditions
	Health Risk Behaviors	Alcohol | Diet & Nutrition | Illicit Drugs | Physical Inactivity | Preventative Care | Reproductive Health STIs | Tobacco
	Mental Health	Health Outcomes - Anxiety & Depression | Health Outcomes - Deaths of Despair | Risk Factors - Access to Care Risk Factors - Drugs & Alcohol | Risk Factors - Stress & Trauma
Basic Needs	Food Security	Economic Security | Food Access
	Education	Achievement | Attainment | Early Childhood
	Financial Stability	Employment | Income | Security
	Housing	Homelessness | Housing Costs | Housing Quality
Social Needs	Climate & Natural Environment	Physical Environment - Air & Water | Physical Environment - Heat & Climate
	Community Safety	Injuries | Public Safety | Risk Factors
	Community Infrastructure	Access to Childcare | Community Amenities | Internet & Technology | Transportation
	Social & Economic Context	Civic Engagement | Economic Vitality | Place Attachment | Social Inclusion | Socioeconomic Disadvantage

C. Data Overview: Description, Benefits & Limitations

The below information includes context related to each data source, to aid interpretation of the data included in the following sections.

Description

Key Informant Interviews

Qualitative data from semi-structured conversations with community leaders who possess specialized knowledge about a particular community. Key informants are selected based on their firsthand experience, expertise, or position within a specific community.

Focus Group

Qualitative data from structured, but fluid discussions led by a facilitator with a small group of community members who reside in that local area. Participants are chosen for their ability to represent the needs of underrepresented, underserved, or vulnerable populations within the community.

Survey

Quantitative data collected in real time for this report, representing health concerns and priorities across a broad sample of the community and patients. The survey consists of questions related to health status, health needs and resources available to the community.

Secondary Public Data

Quantitative data previously collected by government agencies, research institutions, or other organizations. This report references a pool of 150 data indicators curated by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES).

Benefits

Key Informant Interviews

- **In-depth Insight:** These interviews are designed to gather in-depth insights, perspectives and expertise that may not be readily available through other sources.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting key informant interviews can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs.

Focus Group

- **Interactive and In-depth Insights:** Community members are encouraged to interact with each other, which provides insights and generates discussion that uncover a range of needs and perspectives. Focus groups encourage participants to build on each other's responses, leading to richer, more detailed insights.
- **Contextual Understanding:** The information gathered helps our organization gain an understanding of complex health barriers and sociocultural contexts beyond what is available in quantitative data.
- **Validation:** Conducting focus groups can serve as a means of validating other data sources.
- **Community Engagement:** Supports collaborative efforts to address community health needs. We prioritized engaging underrepresented individuals who face negative socioeconomic or health effects, such as low-income populations, minorities and those with chronic health conditions.

Survey

- **Full Anonymity:** Personally identifiable information is not collected.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.
- **Cost-Effectiveness:** Surveys can be a relatively cost-effective method for reaching a large audience.

Secondary Public Data

- **Public Data:** Data is publicly available and therefore a cost-effective method for assessing health needs.
- **Diverse and Longitudinal Data:** The data includes a diverse set of 150 metrics spanning census data, economic indicators, and health statistics and publicly released survey results, allowing for the ability to conduct comparative analyses over time.
- **Wide Reach and Generalizability:** Data from a large number of respondents makes it possible to generalize findings to a larger community.

Limitations

Key Informant Interviews

- **Subjectivity and Perspective Bias:** Key informants who volunteer to participate may have their own biases or limited perspectives, which can shape their responses.
- **Limited Generalizability:** Informants may lack generalizability to the broader community since informants are selected based on involvement in specific area.

Focus Group

- **Limited Generalizability:** Findings from focus groups may not be broadly representative of the entire community due to the small sample size of volunteers.
- **Social Desirability Bias:** Participants may provide responses that they perceive as socially desirable or acceptable in a group setting, rather than fully disclosing less favorable or controversial information.

Survey

- **Sampling Bias:** Community members who choose to complete the survey may have their own biases or limited perspectives, which can shape their responses.
- **Distribution and Data Collection:** Surveys distributed digitally used a global online translation service, which may present challenges with the quality of understanding cultural nuances and word-for-word translation. Surveys were also distributed in paper form to local organizations who entered results from their constituents, which could affect the accuracy of the information collected.
- **Limited Depth of Responses:** Limited opportunity for participants to elaborate on their answers or provide context can result in responses that do not fully capture the complexities of health barriers.

Secondary Public Data

- **Timeliness:** The most recent public data that met our criteria (available across multiple states and, when possible, at the zip code level) was referenced. However, public data may not always be up-to-date or reflect real-time information.

References

Ravaghi, H., Guisset, A.-L., Elfeky, S., Nasir, N., Khani, S., Ahmadnezhad, E., & Abdi, Z. (2023). A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. BMC Health Services Research, 23, Article 44. https://pmc.ncbi.nlm.nih.gov/articles/PMC9847055/

UCLA Center for Health Policy Research. (2023). Section 2: Focus Groups.

UCLA Center for Health Policy Research. (2023). Section 4: Key Informant Interviews.

Health Research & Educational Trust. (2016). Engaging patients and communities in the community health needs assessment process. Chicago, IL: Health Research & Educational Trust.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. National Institutes of Health. Retrieved from https://obssr.od.nih.gov/research-resources/mixed-methods-research

D. Focus Group & Key Informant Interview Methodology

Primary data collection was designed to gather first-person input on community health needs directly from community members. From May 2024 – November 2024, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides used for both types of interviews were nearly identical. The only variation between the focus group and key informant interview guides was the inclusion of additional prompting questions allowing for key informants to provide a greater depth of response.

The facilitators were a team of Adventist Health system staff who began all focus groups and key informant interviews by having participants identify up to five high priority community health needs from their perspective based on a social determinants of health framework with priority areas and subcategories. The facilitators then moved through a series of questions, focusing on depth of need, barriers, attempts at addressing the need historically, ways that different groups are affected and recent, emerging trends. Focus groups and key informant interviews were conducted in teams of two, with a lead facilitator and a notetaker, and all interviews were recorded. All focus groups were conducted in English or Spanish, with translation services provided as needed. Focus groups and key informant interviews were recorded with the consent of participating interviewees. All recordings were transcribed into English. In the spirit of collaboration, transcripts were shared with other non-profit hospitals within the same service area. To ensure the anonymity of participants was protected, all shared transcripts removed participant names. Remarks that detracted from the scope pertaining to community health needs were also removed.

E. Survey Methodology

A community survey was distributed as a primary data tool to gather real-time, quantitative data about the community's greatest health needs. To reflect the entire community, questions were designed to solicit responses at the individual, interpersonal and community levels. The selection process and criteria for the survey questions involved a rigorous review of other health systems' CHNAs, reputable government organizations such as the National Association of County and City Health Officials (NACCHO), the Centers for Medicare and Medicaid Services (CMS) Health-Related Social Needs Screening Tool, Healthy People 2030, and the Centers for Disease Control and Prevention (CDC). Additionally, the survey design was informed by interviewing techniques, collaboration with Steering Committee members from our previous CHNA cycle, a review of community health improvement toolkits, and the availability of state and national benchmarks.

The community survey comprised seven questions and took approximately five minutes to complete. To ensure accessibility, the questions were written at a fifth-grade reading level and translated into four languages using a global online translation service. The survey was distributed both in paper form and digitally via link, email, text, and QR code. Participation was voluntary, and responses were kept confidential. To maximize reach within the service area, the survey was shared with Steering Committee members, who then distributed it among their stakeholders, community-based organizations that volunteered to share it with their constituents, and patients at Adventist Health hospitals. For the full list of survey questions, see Appendix C.

F. Secondary Data Methodology

Basic Approach

Secondary data scoring comprised development of health needs index scores for each of the 12 categories included in the Community Impact framework. These index scores were determined using quantitative analysis of all secondary data referenced. Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected that best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to life expectancy and quality of life. These criteria include impact on short-term health (well-being), impact on long-term health (life expectancy) and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

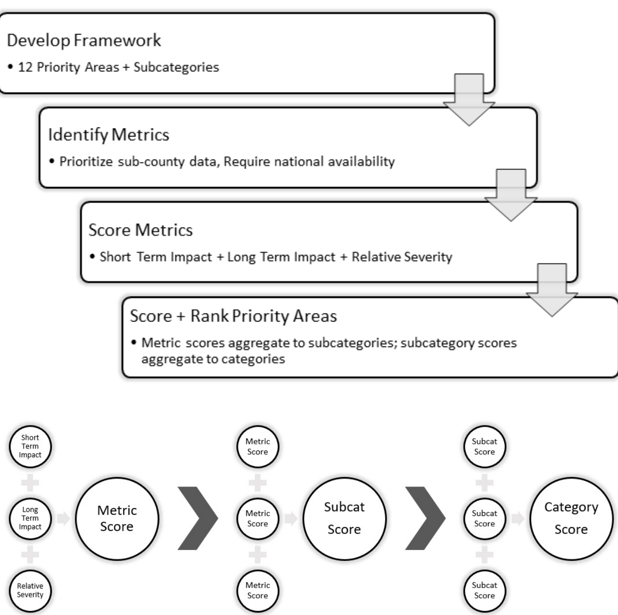


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status) and a long-term goal (length of life, measured by life expectancy at birth).

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework.

To address the third criterion, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values, as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a final score for each metric, we calculate the weighted average of the short-term and long-term

score and apply the z-score as an adjustment factor.

$M_c = (ST_s + LT_s) * Z_{cs}$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities that perform better than average for a metric will see scores adjusted down (lower priority), and communities that perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$SubC_c = \Sigma_c SubC/n$
$Cat_c = \Sigma SubC/n$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and one is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum "real" subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores; category scores may be compared with category scores, however subcategory scores and category scores cannot be compared.

Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are a major driver of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community level, availability of data to represent some priority health need concepts remain limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Work found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or U.S. total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (summer 2024), the latest available data on health behaviors, outcomes, and social determinants represented the 2021 and 2022 calendar years, and in some cases, data were older still. Since the first aim of this work is to measure the relationship between certain factors and well-being and life expectancy, this temporal lag is of less importance. Moreover, we incorporate a mix of other data sources to mitigate the data lag variance to take a standardized approach important for a mixed-methodology analysis.

References

Association for Community Health Improvement. Community Health Assessment Toolkit. 2017. [cited 2018 Oct 28]. Available from: www.healthycommunities.org/assesstoolkit.

Barnett, K. (2012). Best practices for community health needs assessment and implementation strategy development: A review of scientific methods, current practice, and future potential. Atlanta, GA: Centers for Disease Control and Prevention.

Castrucci, B. C., Rhoades, E. K., Leider, J. P., & Hearne, S. (2015). What gets measured gets done: an assessment of local data uses and needs in large urban health departments. Journal of public health management and practice : JPHMP, 21 Suppl 1(Suppl 1), S38–S48. https://doi.org/10.1097/PHH.0000000000000169

Catholic Health Association of the United States. Assessing and Addressing Community Health Needs. 2015. [cited 2018 Oct 28]. Available from: https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs.

Institute of Medicine. For the public's health: the role of measurement in action and accountability. Washington, DC: National Academies Press; 2010.

Stoto, M. A., Davis, M. V., & Atkins, A. (2019). Beyond CHNAS: Performance Measurement for Community Health Improvement. Egems (generating Evidence & Methods to Improve Patient Outcomes), 7(1), 45. DOI: http://doi.org/10.5334/egems.312

Stoto, MA, Davis, MV and Atkins, A. Making Better Use of Population Health Data for Community Health Needs Assessments. eGEMs. 2019; 7(1): 44, pp. 1–9. DOI: https://doi.org/10.5334/egems.305

University of Wisconsin Population Health Institute. County health rankings and roadmaps. 2014. [cited 2018 Oct 28]. Available from: http://www.countyhealthrankings.org/.

G. Data Analysis & Identification of Significant Health Needs

This CHNA deployed a mixed methodology combining the strengths of analyzing primary data with secondary data results. As demonstrated in steps two-four below, several actions were taken to analyze data and produce a list of significant health needs.

Preparation & Data Collection: Adventist Health staff, CARES team and CHNA Steering Committee

STEP 1: FRAMEWORK & CODEBOOK CREATION

- Map focus group and key informant interview questions to framework and codebook.
- Map secondary data indicators to framework.

STEP 2: DATA COLLECTION

- Primary Data: focus groups, key informant interviews and survey.
- Secondary Data: 150 indicators.

Data Analysis & Identification of Significant Health Needs: Adventist Health system staff and CARES team

STEP 3: AGGREGATION

- Code focus group and key informant interview groups to framework.
- Aggregate survey results per community.
- Score Secondary Data Index.

STEP 4: SYNTHESIS

- Identify list of Significant Health Needs based on:
  - Health need identified as top five across any data sources.
  - Health need is identified in two or more data sources.

EVALUATION & HEALTH NEEDS PRIORITIZATION: CHNA Steering Committee

STEP 5: EVALUATION

- Evaluate Significant Health Needs data.

STEP 6: PRIORITIZATION

- Rank "high" and "low" Priority Health Needs based on prioritization criteria.

Data Collection to Aggregation

After primary data collection, Adventist Health staff conducted a deductive coding of all focus group and key informant interview data to the Community Impact framework. Secondary public data was analyzed and index scores were created for ranking, according to the methodology outlined in Section V. Process and Methods to Conduct the CHNA.

To facilitate this coding process for focus groups and key informant interviews, as described in Step 3 of the infographic above, focus group and key informant interview transcript files were uploaded to a Microsoft AI coding solution, along with the Community Impact framework as the reference table. To generate an output, Adventist Health staff provided a written prompt to the AI solution:

You are an AI assistant tasked with analyzing and classifying provided conversational text from interviews conducted with community members regarding what they see as the top health needs in their community. The topics are related to Public Health and Social Determinants of Health (SDOH).

*Each piece of text (or excerpt) relevant to a public health need and/or social determinants of health should be classified into **all applicable** provided SDOH categories, at either the "subcategory" or "codename" levels using the following SDOH reference table: {reference table}.*

For each input text, your goal is:

*1. Identify **all relevant** (either directly or implied) SDOH-related excerpts from the provided text, based on the reference table. Use the excerpt examples, Subcategory and/or Codename Description, and code names from the SDOH reference table to assist in identifying which excerpts are relevant.*

2. Classify the excerpt under the appropriate SDOH categories. Include the entire excerpt text with accompanying context to illustrate how it corresponds with each classified category. If an excerpt cannot be coded to the code and codename level based on the reference table, use the most appropriate subcategory and leave code and codename blank. Excerpts must have two or more sentences. Excerpts must be relevant (direct or implied) to the current health needs/problems in the speaker's community.

*3. **For each classification, assign a confidence score between 0 and 1, where 1 indicates the highest confidence.***

The output was a CSV file with a list of excerpts that were coded to the category and subcategory levels of the Community Impact framework. These category and subcategory references were counted, and a percentage of excerpts coded to each category was generated to establish a ranking of top health need categories for focus groups and key informant interviews.

Data Synthesis and Identification of Significant Health Needs

Staff conducted axial coding by drawing connections between the top health needs across focus groups, key informant interviews and secondary public data. Adventist Health system staff produced a list of significant health needs and presented findings to CHNA Steering Committee, based on the following criteria:

- The health need comes up as a top five for at least one data source.
- The health need is referenced across at least two data sources.
- The health need as represented in the Community Impact framework corresponds with two or more secondary data indicators that perform worse than the CA state benchmark.

In addition to the list of significant health needs and the supporting data from axial coding of focus groups, key informant interviews and secondary public data, survey data was provided to CHNA Steering Committee for evaluation and corroboration before prioritization of significant health needs.

H. Criteria & Process Used for Identification & Prioritization of Health Need

Prioritized Criteria

The local Steering Committee was responsible for identifying and prioritizing the community health needs included in the CHNA. Steering Committee members are community stakeholders who lead and represent sectors such as local government, community-based organizations, health and human services, schools, public health and others. To facilitate the process of prioritizing health needs, Adventist Health system staff led a series of meetings held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

Prioritization Process and Selection of High Priority Needs

Following the identification of significant health needs through the analysis process, Adventist Health system staff conducted a 90-minute presentation to the Steering Committee, revealing primary and secondary data findings that led to the identification of these needs. During the presentation, staff emphasized the top five needs from each data source and the supporting data that justified their inclusion. After the data reveal meeting, Steering Committee members were provided with three prioritization tools, the presentation slides, and a secondary data report for review and discussion with organizational leadership. Additionally, members participated in a poll to identify the three to five needs they considered most critical, utilizing relevant local data sources as available.

The second part of the series involved a prioritization meeting aimed at building consensus around the community health needs identified as most critical by Steering Committee members. Steering Committee members, along with their staff, boards, and constituencies, reviewed and discussed the top five needs from each data source. They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, alignment with common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. The meeting concluded with committee members prioritizing the list of significant identified needs, typically selecting two to four as high-priority. See Appendix D for prioritization tools used.

I. Written Comments for 2025 CHNA

We value your input on our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about the previous CHNA report or adopted implementation strategy were received.

J. CHNA Team Used to Conduct the Assessment

The Adventist Health Community Impact Team coordinates Community Health Needs Assessments for many of the communities we serve. The Community Impact Team convened community experts within each service area's steering committee, coordinated and/or conducted primary data collection, facilitated analysis, and wrote the report content. Team members listed below have diverse and relevant experience in healthcare, philanthropy, government, Medicaid managed care and quality improvement, public health, community health and community benefit reporting. Those team members include:

Amanjit 'Amy' Lasher
Administrative Director, Community Integration

Sarah Clair, MPA
Manager, Public Affairs

Mitchell Iwahiro, MS
Project Manager, Community Integration

Susan Passalacqua
Manager, Community Benefit Compliance

Lisa Wegley
Program Manager, Community Benefits Operations

Additionally, Adventist Health system staff supported the data collection and analysis portion of the report:

Matt Gonzales
Salesforce Administrator

Alex McFadyen, PMP
Manager, Consumer Digital Products

Philip Stanley
Digital Marketing Manager

Aldreen Venzon, Ph.D, MS, RN
Sr. Performance Analyst (System)

Cambria Wheeler
Director, Brand Engagement

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting and collaboration systems that enable public, private and nonprofit sector organizations to effectively address issues across topics like agriculture, environment, business, community, health, safety and youth. The CARES team integrates data, mapping, visualizations and engagement tools to better serve communities and regions across the United States, including vulnerable, rural and underserved populations. CARES' web-based technologies help organizations and policy makers make more informed decisions about access, address issues of equity and support the allocation of public and private resources.

CARES staff has background in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration and web-based content management. Additionally, CARES holds expertise in project management, user training and support, data documentation and client design sessions that directly supports a wide variety of projects.

Angela Johnson, MPH
Assistant Director,
University of Missouri CARES
(johnsonange@missouri.edu)

Zhengting He, MPA
Research Program Analyst,
University of Missouri CARES
(hezhen@missouri.edu)

For more information, please visit
https://careshq.org/about/

You're made for more. We're here to help put more life in your years.

VI. APPROVAL PAGE

This Community Health Needs Assessment was adopted on September 18, 2025 by the Adventist Health System/West Board of Directors. The final report was made widely available to the public on December 31, 2025.

Thank you for reviewing our 2025 Community Health Needs Assessment. We are proud to serve our local community and are committed to making it a healthier place for all.

Eric Stevens
Adventist Health Chief Operating Officer
President, Adventist Health Northern California Network
700 River Drive,
Fort Bragg, CA 95437

Appendix:

A. Glossary of Terms & Definitions of Health Needs

In 2020, Adventist Health analyzed the top priorities from 2019 CHNAs across all hospitals, compared these priorities against language from CHNAs across the country, and created a set of standard nomenclature categories to promote common language, referred elsewhere in this report as "Community Impact Framework". Below is a list of these categories, organized according to this framework, with the accompanying definitions. These categories and definitions are drafted based on context summarized from public health literature, community CHNAs, and national and multi-national healthcare organizations. Sources for definitions are listed below.

Access to Care

Access to care refers to the timely use of personal health services to achieve the best health outcomes. This concept encompasses the availability, affordability and appropriateness of healthcare services, as well as the accessibility of these services to all individuals, regardless of income, location or social standing. Access to care directly affects population health, influencing rates of preventable diseases, overall mortality and quality of life. Ensuring equitable access to healthcare is a central public health goal, particularly in reducing health disparities among underserved populations.

Context/Source

Healthy People 2030. "Health Care Access and Quality"

World Health Organization (WHO). "Access to Care and Financial Protection"

Agency for Healthcare Research and Quality (AHRQ). "Access to Health Care"

Climate & Natural Environment

Climate and natural environment refers to the weather patterns, ecosystems and environmental conditions that impact the health of a community. This includes factors such as air and water quality, temperature extremes, green spaces and the frequency of natural disasters. These environmental elements shape health outcomes directly by influencing respiratory health, heat-related illnesses and exposure to pollutants, and indirectly through their effects on food security, housing stability and economic opportunities, all of which are crucial social determinants of health.

Climate change and environmental degradation can exacerbate existing health disparities, disproportionately affecting low-income communities and communities of color. Public health strategies aimed at addressing climate and environmental challenges focus on building climate resilience, reducing exposure to environmental hazards, and ensuring equitable access to resources like clean air, water and green spaces. By mitigating these environmental health risks and prioritizing sustainable practices, communities can improve both immediate health outcomes and long-term resilience in the face of climate-related impacts.

Context/Source

World Health Organization. "Climate"

National Institute of Environmental Health Sciences. "Climate Change and Human Health"

Centers for Disease Control and Prevention (CDC). "Climate and Health"

Community Infrastructure

Community infrastructure refers to the physical and organizational structures that support and enhance the health, safety and well-being of residents. This includes essential elements that people rely on every day such as transportation systems, internet access, healthcare facilities, schools, parks and water and sanitation systems. When community infrastructure is accessible, safe, and well-maintained, it supports healthier living conditions, reduces health disparities and promotes social determinants of health, such as stable housing, employment opportunities and environmental quality.

Community infrastructure is a foundation for equitable access to services and resources for a healthy lifestyle and to prevent disease. Investments in infrastructure that prioritize public health — like creating walkable neighborhoods, expanding green spaces and ensuring clean drinking water — can reduce chronic illnesses, improve mental health and enhance social connections within a community.

Context/Source

Robert Wood Johnson Foundation. "Infrastructure is Public Health"

American Public Health Association. "Strengthen Public Health Infrastructure and Capacity"

Community Safety

In public health, community safety refers to the protection and well-being of individuals in a community, reducing exposure to violence, crime, environmental hazards and other risks that impact physical and mental health. Within CHNAs, community safety is examined as a determinant of health, affecting overall quality of life and contributing to disparities in health outcomes. Ensuring community safety is seen as essential for fostering environments where individuals can thrive without fear of harm. Community safety includes violence prevention, traffic safety, safe public spaces and youth engagement.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Violence Prevention"

Centers for Disease Control and Prevention (CDC). "About The Public Health Approach to Violence Prevention"

Education

Education refers to the access to quality learning opportunities that shape individuals' knowledge, skills and abilities, impacting their health and well-being. Education is a key social determinant of health because it influences health behaviors, employment opportunities and economic stability. Higher levels of education are associated with better health outcomes, including lower rates of chronic diseases, longer life expectancy and improved mental health. The link between education and health is also seen in the ability to access and understand healthcare information, which can affect decisions about diet, physical activity and preventive care.

Context/Source

American Public Health Association. "Education Health"

Centers for Disease Control and Prevention (CDC). "Education Access and Quality"

Robert Wood Johnson Foundation. "Why Education Matters to Health"

Financial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation. Financial stability is a critical social determinant of health, as individuals with steady income are more likely to access preventive care, afford nutritious food and maintain safe living conditions. Financial instability and poverty are linked to higher rates of chronic disease, mental health issues and reduced life expectancy due to limited access to health resources and higher exposure to stressors.

Context/Source

Centers for Disease Control and Prevention (CDC). "Economic Stability"

Food Security

Food security refers to consistent access to sufficient, safe, and nutritious food that meets the dietary needs necessary for a healthy life. Access to healthy food is fundamental to preventing malnutrition, obesity and chronic diseases such as diabetes and heart disease. When individuals and families have reliable access to affordable, nutritious food, their overall health outcomes and quality of life improve significantly.

Food insecurity, or lack of reliable access to adequate food, disproportionately impacts low-income communities and contributes to health disparities. Public health efforts to improve food security often involve enhancing access to grocery stores, farmers' markets and community gardens, as well as supporting programs like the Supplemental Nutrition Assistance Program (SNAP). By addressing Food Security, public health initiatives aim to reduce health inequities, support economic stability and foster healthier communities.

Context/Source

World Health Organization. "Food Safety"

Centers for Disease Control and Prevention (CDC). "Diabetes and Food Insecurity"

American Public Health Association. "Food and Nutrition"

Health Conditions

Chronic health conditions are defined as long-lasting illnesses that persist for at least one year and require ongoing medical attention, lifestyle adjustments, or both. These conditions include heart disease, diabetes, cancer and chronic respiratory diseases, which are among the leading causes of death and disability worldwide. In the context of CHNAs, identifying and addressing chronic health conditions is crucial for understanding the health status of a population and guiding targeted interventions. Communities with the highest prevalence of chronic health conditions also typically face social, economic and environmental barriers that challenge prevention and management of the chronic condition, requiring interventions that focus on the complex interplay of behavioral and environmental factors described in this framework.

Context/Source

Centers for Disease Control and Prevention (CDC). "About Chronic Diseases"

World Health Organization (WHO). "Noncommunicable Diseases"

Centers for Disease Control and Prevention (CDC). "Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area"

Health Risk Behaviors

Health risk behaviors are actions that increase the likelihood of adverse health outcomes, such as chronic disease, injury or premature death. Common examples include tobacco use, excessive alcohol consumption, physical inactivity, poor diet and risky sexual behaviors. These behaviors are significant focus areas for public health interventions because they are preventable and have broad implications for community health costs, healthcare systems and individual well-being. By identifying and targeting health risk behaviors, public health professionals aim to reduce the prevalence of diseases like heart disease, diabetes and certain cancers, promoting healthier, longer lives for populations.

For CHNAs, health risk behaviors are viewed within the context of social determinants of health, like access to resources, socioeconomic status and educational opportunities. Addressing these behaviors involves considering the social and environmental factors that make certain populations more vulnerable, such as limited access to healthy foods or safe recreational spaces. Community health approaches often implement evidence-based interventions that are culturally tailored and community-specific, recognizing that sustainable behavior change requires supportive environments and policies that mitigate risk factors and empower communities to adopt healthier lifestyles.

Context/Source

Centers for Disease Control and Prevention (CDC). "Behavioral Risk Factor Surveillance System (BRFSS)"

Centers for Disease Control and Prevention (CDC). "Health Risk Behaviors Measure Definitions PLACES: Local Data for Better Health

Centers for Disease Control and Prevention

(CDC). "Sexual Risk Behaviors"

Housing

Housing refers to the availability, affordability, quality and stability of living environments. Safe, stable and affordable housing directly influences health outcomes by providing protection from physical hazards, reducing stress and enabling access to essential services. Poor housing conditions, such as overcrowding, exposure to pollutants and inadequate heating or cooling can lead to respiratory illnesses, injury risks and worsened mental health, especially among vulnerable populations.

Housing instability, including frequent moves, homelessness and the risk of eviction, contributes to health disparities by limiting access to consistent healthcare, educational opportunities and community resources.

Context/Source

Robert Wood Johnson Foundation. "Housing and Health"

American Public Health Association. "Housing and Homelessness as a Public Health Issue"

Centers for Disease Control and Prevention

(CDC). "Homelessness and Health"

Mental Health

Mental health, within public health and community health frameworks, is understood as a state of well-being in which individuals can cope with life's challenges, work productively, and contribute meaningfully to their communities. This concept goes beyond the absence of mental disorders, emphasizing the capacity for resilience, emotional stability and fulfilling social connections. In public health, mental health is integral to overall health and is recognized as a critical factor influencing quality of life and socio-economic productivity, with both individual and social implications.

In the context of CHNAs, mental health is seen as interdependent with social determinants like income, education, social support, and access to healthcare. Health equity approaches prioritize the mental health of underserved communities, focusing on reducing stigma, expanding culturally appropriate services and advocating for policies that remove barriers to mental health resources. This framework recognizes that improving mental health outcomes requires collective action, community engagement and tailored support strategies that reflect the unique needs and values of diverse communities.

Context/Source

World Health Organization (WHO). "Mental Health"

Centers for Disease Control and Prevention (CDC). "Mental Health"

Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health and Wellness"

Social & Economic Context

Social and economic context in this report refers to specific social and economic aspects of an environment that can influence health and well-being of a population-place attachment, civic engagement, social inclusion, and economic vitality. Economic stability and supportive social conditions promote healthier lifestyles, reduce stress and improve access to healthcare, positively impacting health outcomes for individuals and communities.

Social and economic contexts are closely linked to health disparities, as individuals from lower-income or underserved backgrounds often face barriers to achieving home ownership, contributing to economic health, and participating in activities which support social inclusion.

Context/Source

Centers for Disease Control and Prevention (CDC). "Social Determinants of Health (SDOH)"

World Health Organization. "Social Determinants of Health"

B. Activity Explanation: Focus Groups & Key Informant Interviews

- We're going to do a brief exercise to start that will tell us the biggest problems you see related to your and your community's health needs.
    - Then we'll ask you questions about those problems.
    - As you look around the room you'll see three (3) posters on the wall.
    - They show photos of common problems people face, many of them related to health.
    - Please take a few minutes to vote using the five (5) stickers you were given when you walked in.
- Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.
- You can't use all your stickers under one photo but you can use them all in one poster.
- Which of these things causes the most problems for you or others who live here?
- We're interested in learning about things that make it hard for you, your family and friends to have good physical and mental health, and a good quality of life.
    - Some of the descriptions are one word and really meant for you to share more with us.
    - We'll give you 10 minutes to walk around.

Tallying, Engaging & Asking Questions:

- For focus groups, visually tally the votes and clearly call out the top five issues that were identified for the note-taker and audience to hear.
- Spend around 15 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same "Prompting Questions" for each of the five identified issues.

ACTIVITY EXPLANATION – Key Informant Interviews

- We're going to do a brief exercise to start that will tell us what the biggest problems you see are.
    - Then we'll ask you questions about those problems.
    - Here are some photos of common problems people face, many of them related to health.
    - Please take a few minutes to select five (5) problems that you think are the biggest difficulties in your community.
- We're interested in learning about things that make it hard for your organization to provide services and/or for your constituency to have good physical and mental health, and a good quality of life.
    - Some of the descriptions are one word and really meant for you to share more with us.
    - We'll give you a few minutes to make your selection.

Engaging & Asking Questions:

- Spend around 10 minutes going through questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five or so minutes to wrap-up at the end.
- Use the same Prompting Questions for each of the five identified issues.

B. Focus Group & Key Informant Interview: Question prompter

One of the topics that you identified is _____

Questions:

1. Why do you see ___as a problem that's related to your family/community's health?
2. What do you think creates this issue?
3. How do you see the problem affecting your local friends, family or neighbors?
   Who is most affected by this?
4. What have people tried to do to address this problem? What has worked?
   What are the biggest barriers for _______ (policy/program)?
   What makes it hard to fix this problem in your community?
5. What has changed around this concern in the last 2 – 3 years?
   Are there any new emerging trends or areas of concern in the last few years?
6. If this problem got better, how would your community look different?

Closing question:

- Are there other important health needs in your community that we have not already addressed?
- Let the audience introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.

Conclusion:

- Thank you very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- Next year we will publish the Community Health Needs Assessment that will summarize what we found, and that many people in your community will take action on.
  - If you would like us to send you a text or email with a link to that report, just provide us with your information.

Focus Groups Only: As a Thank you to you all we have a gift card for you as you leave.

C. Survey Questions:

1. **Would you say that in general your health is:**
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

2. **Select 3 - 5 things that you believe make it hard to live and be well in this community.**
   - Can't get medical care
   - Not enough good jobs
   - Lack of affordable housing
   - Lack of good schools
   - Access to affordable healthy food
   - High cost of living
   - Unsafe community
   - Bad air and/or water quality
   - No friends or connection to community
   - High risk for natural disasters (fire, floods, earthquakes)
   - Lack of transportation
   - Lack of safe roads, sidewalks, bike lanes
   - Limited childcare options
   - Limited access to social services for me or my family members
   - Racism

3. **Select up to 5 of the biggest health problems you're facing.**
   - Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)
   - Alcohol and/or drug misuse
   - Asthma/COPD
   - Being overweight
   - Cancer
   - Child/Partner abuse
   - Diabetes/Kidney disease
   - Heart disease/Stroke
   - High blood pressure
   - Learning problems
   - Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)
   - Mother-baby care
   - Problems with mobility
   - Poor eating habits
   - Respiratory/Lung disease
   - Sexually transmitted diseases (STDs)
   - Dental problems
   - Vision/Hearing problems
   - No health problems

4. **Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?**
   - 10 (I'm living my best possible life)
   - 9
   - 8
   - 7
   - 6
   - 5
   - 4
   - 3
   - 2
   - 1
   - 0 (I'm living my worst possible life)

5. **In the last year, did you get all the medical care you needed?**
   - Yes
   - No
   - Did not need care

5b. **If you did not get all the medical care you needed, what do you think are the reasons why?**
Check all that apply.
   - Doctor or clinic (healthcare provider) did not understand my language, culture or identity
   - I'm uncomfortable speaking with a doctor
   - I do not have health insurance
   - I do not have a primary care doctor
   - There was no doctor that accepted my insurance
   - I did not know where to get care
   - Getting to the clinic was too hard
   - It costs too much
   - Inconvenient hours of operation
   - Location of medical care
   - Holistic treatments not available
   - Specialists not covered by insurance
   - Poor quality of doctors/nurses

6. **Select the resources that your community needs more of to help you live better.**
   - Childcare or senior care
   - Healthcare and prescription costs
   - Housing options
   - Legal services
   - Local food banks
   - Managing stress and depression
   - Neighborhood safety
   - Parks, recreation and outdoor activities
   - Personal safety
   - Social/Community events
   - Utilities/Internet

7. **Please enter your zip code, if you don't want to share your zip code, enter 00000.**

D. Prioritization Tools:

1. Health Need – Evaluation Worksheet

Addressing the health needs of community members is complex and often requires more than one approach with coordination across multiple sectors.

Based on the primary and secondary data presented select 3 to 5 health needs that you see as needing to be addressed.

Write the name of the need at the top, use the questions to the left to evaluate side-by-side the current resources, political will, infrastructure and shared goals/focus of each need.

Use your findings to identify the needs that, through collaboration, can be thoughtfully and intentionally addressed by multiple community sector partners.

PRIORITY NEEDS COMPARISON	1		2		3		4		5		6		7	
OPERATIONS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Would tracked and shared progress/ data benefit multiple organizations and programs?														
Potentially, could there be 'quick wins' through collaboration and partnerships?														
Is there political willingness to act on this need?														
COMMUNITY PARTNERS/RESOURCES/ ASSETS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are there existing organizations/ programs addressing all or parts of this need?														
Do CBOs' goals/strategic plans list this need as an area of focus?														
Is there community willingness to act on this need?														
FINANCE	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Does this need have government/public funding streams available for those applying collaboratively?														
Are there current grants that could support some or all of this need?														
Does this need meet the vision/ mission of established government or philanthropic partners?														
EQUITY	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are there organizations/programs focused on addressing this need with safety-net, low-income and minority populations?														
Will everyone in the community equally benefit from this need being addressed?														
Would addressing this need lessen absenteeism at work/school for everyone?														
TOTAL YES RESPONSES														

2. Questions to Consider

Do we have any unifying objectives/goals?

What does immediate success look like (1 – 3yrs)?

Is there available funding from grants or Quality Improvement Incentives (Payer) opportunities?

Would addressing this need free up resources for other community-wide needs?

Is this a community-wide or vulnerable population need?

3. Priority Needs Comparison

FEASIBILITY

High feasibility means there's ***alignment*** and/or ***resources*** in place to ***take action***.

	LOW IMPACT	HIGH IMPACT
HIGH FEASIBILITY	Impact: Less | Feasibility: High **Areas for Incremental Gains**	Impact: High | Feasibility: High **Areas for Strategic Action**
LOW FEASIBILITY	**Less Alignment** Impact: Less | Feasibility: Less	**Promising Areas** Impact: High | Feasibility: Less

IMPACT

High impact means the ***most*** community members ***will benefit*** from addressing this Health Need.

AdventistHealth.org

241577-E 0525