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COMMUNITY VOICES





Living God's love
by **inspiring**
health, wholeness
and hope.



Adventist Health and Rideout 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 an assessment conducted every three years to support this calling by helping non-profit hospitals understand the health needs of the community.

For 2025, Adventist Health and Rideout jointly conducted the CHNA with Sutter Surgical Hospital North Valley (SSHNV) to create the 2025 CHNA. This collaborative effort resulted in the following high priority health needs:

- Access to Mental/Behavioral Health and Substance Use Services
- Access to Basic Needs Such as Housing, Jobs, and Food
- Access to Quality Primary Care Health Services
- Access to Specialty and Extended Care

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 Rideout

Adventist Health and Rideout is a nonprofit community-based system serving Yuba and Sutter Counties and is comprised of the 221-bed Adventist Health and Rideout acute care hospital; the Heart Center at Rideout; the Cancer Center affiliated with UC Davis Medical Center; outpatient clinics and a wide range of ancillary services. Our continuum of care network of healthcare resources and expertise allows us to provide patients with seamless coordination and access to specialized services..

Specialties Brought to our Community

- Bariatric and Weight Loss Care
- Cancer Care
- Drug Screening
- Emergency Care
- Extended Care Services
- General Medical/Surgical Care
- Heart and Vascular Care
- Intensive Care
- Orthopedic Care
- Senior Living Services
- Urologic Care

A Look Forward: After the CHNA Report

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically identifies and implements evidence-based solutions and programs to address our priority needs.

The CHNA highlights where you, your family and your community can drive change for improved well-being. We hope it is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all.

The full collaborative CHNA report is available in the following pages. It is also published online and available in print form by contacting community.benefit@ah.org

**You're made
for more.**

**We're here to help
put **more** life in
your **years**.**

2025 Community Health Needs Assessment

Conducted on behalf of

**Adventist Health and Rideout
726 4th Street
Marysville, California 95901**

and

**Sutter Surgical Hospital North Valley
455 Plumas Boulevard
Yuba City, California 95991**

Conducted by



January 2025

Acknowledgments

We appreciate the many dedicated individuals who contributed to this community health needs assessment conducted on behalf of Adventist Health and Rideout, and Sutter Surgical Hospital – North Valley. This assessment was enriched by the time and expertise of community health experts and members of various social service organizations serving the most vulnerable members of the community. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights conducted the assessment. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. This joint report was authored by:

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the community served by Adventist Health and Rideout (AHRO) and Sutter Surgical Hospital North Valley (SSHNV). The priorities identified in this report help to guide nonprofit hospitals' community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights.

Community Definition

The definition of the community served was the primary service area jointly shared by AHRO and SSHNV. This area was defined by five ZIP Codes: 95901, 95953, 95961, 95991, and 95993. This service area was designated because the majority of patients served by both AHRO and SSHNV resided in these ZIP Codes. AHRO is located in Marysville, California, and SSHNV is located in Yuba City, California. Separated by the Feather River, these cities are located adjacent to one another and are part of the Yuba City Metropolitan Statistical Area as designated by the US Office of Management and Budget.¹ The service area is home to over 160,000 community residents and encompasses portions of both Sutter and Yuba Counties. The rural community is rich in diversity along a number of dimensions.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.² This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 18 community health experts, social service providers, and medical personnel. Furthermore, 75 community residents or community service provider organizations participated in four focus groups across the service area. Finally, 19 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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

¹ See: <https://www.labormarketinfo.edd.ca.gov/definitions/metropolitan-areas.html>

² Robert Wood Johnson Foundation, and University of Wisconsin, 2024. County Health Rankings Model. Retrieved 18 July 2024 from <https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods>.

Process and Criteria to Identify and Prioritize Significant Health Needs

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

List of Prioritized Significant Health Needs

The following significant health needs identified for the AHRO and SSHNV service area are listed below in prioritized order.

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

Resources Potentially Available to Meet the Significant Health Needs

In all, 254 resources were identified in the service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2022 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2025 CHNA report.

Conclusion

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

Introduction and Purpose

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

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Adventist Health and Rideout (AHRO), located at 726 4th Street, Marysville, California 95901, and Sutter Surgical Hospital North Valley (SSHNV) located at 455 Plumas Boulevard, Yuba City, California 95991. These hospitals’ primary service area includes the communities of the Yuba-Sutter area or the Yuba City Metropolitan Statistical Area which covers both Sutter and Yuba Counties. At the time of this assessment the total population of the service area was 161,183.

AHRO is an affiliate of Adventist Health, a nonprofit healthcare system. SSHNV is an affiliate of Sutter Health, also a nonprofit healthcare system. The CHNA was conducted over a period of six months, beginning in July 2024 and concluding December 2024. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that nonprofit hospitals conduct a community health needs assessment at least once every three years.

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

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. In all, 10 significant health needs were identified. Primary data were then used to prioritize these significant health needs.

Prioritization was based on three measures of community input. The first two measures came from the key informant interviews and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last measure was the percentage of community service provider survey respondents that identified a health need as a top priority. Table 1 shows the value of these measures for each significant health need.

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

Table 1: Health need prioritization inputs for the AHRO/SSHNV service area.

Prioritized Health Needs	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority
Access to Mental/Behavioral Health and Substance Use Services	83%	32%	74%
Access to Basic Needs Such as Housing, Jobs, and Food	92%	12%	89%
Access to Quality Primary Care Health Services	75%	15%	16%
Access to Specialty and Extended Care	83%	8%	26%
Access to Functional Needs	83%	7%	16%
System Navigation	75%	~	26%
Injury and Disease Prevention and Management	50%	12%	11%
Increased Community Connections	58%	10%	5%
Active Living and Healthy Eating	42%	3%	11%
Healthy Physical Environment	8%	~	16%

~ Health need not mentioned

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

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

Sutter and Yuba County 2025 Prioritized Health Needs

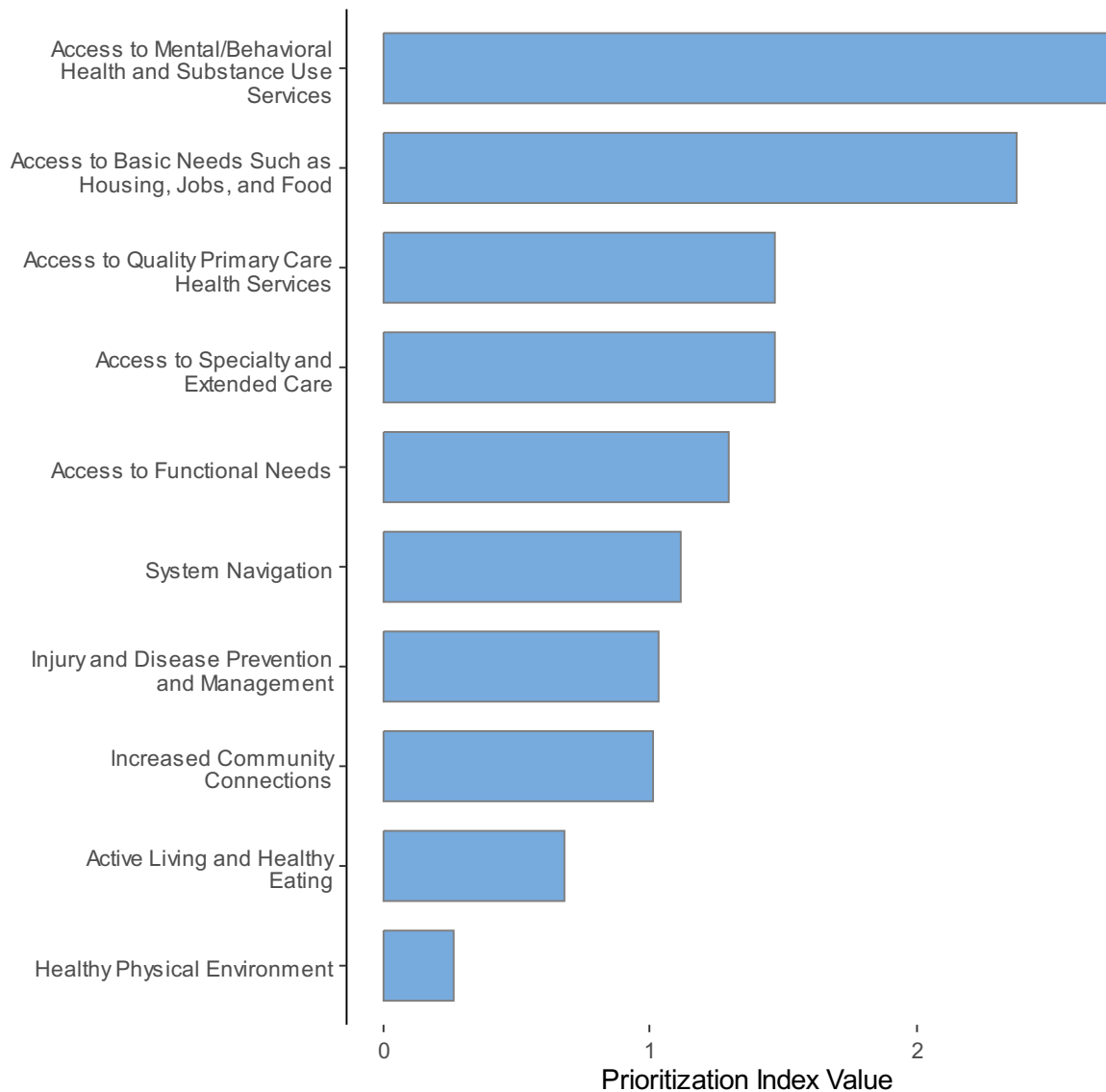


Figure 1: Prioritized significant health needs for the AHRO/SSHNV service area.

These significant health needs are described below. The secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health need ordered by their relationship to the conceptual model used to guide data collection for this report. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of this report).

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

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Limited services for maternal mental health, which is often stigmatized and under-supported. • Parents face social-emotional struggles (anxiety, depression, isolation). • Insufficient focus on early intervention and perinatal mental health disorders. • Shortage of services for children (0-5) and early developmental screenings. • Behavioral health services for youth are at capacity; long wait times and limited resources. • Limited access to therapists, evaluations (e.g., autism spectrum), and non-traditional therapies. • Overwhelmed mental health systems with insufficient providers, especially in rural areas. • Services are often inaccessible without long-distance travel or telehealth. • Lack of affordable care options; many therapists don't accept insurance. • High rates of mental health disorders and substance abuse among unhoused individuals. • Low compliance with treatments and lack of wraparound services for long-term recovery.	• There aren't enough mental health providers or treatment centers (e.g., psychiatric beds, therapists, support groups). • Substance-use is a problem (e.g., use of opiates and methamphetamine, prescription misuse). • There aren't enough services for those who are homeless and dealing with substance-use issues. • There aren't enough substance-use treatment services available (e.g., detox centers, rehabilitation centers). • Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. • There is a lack of infrastructure to support acute mental health crises. • Treatment options for those with Medi-Cal are limited. • It's difficult for people to navigate mental/behavioral healthcare. • Treatment options for those with Medi-Cal are limited. • The stigma around seeking mental health treatment keeps people out of care. • The cost for treatment is too high. • Awareness of mental health issues is low. • The use of nicotine delivery products such as e-cigarettes and tobacco is a problem.	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Suicide Mortality • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Adult Smoking • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Firearm Fatalities Rate • Juvenile Arrest Rate • Disconnected Youth • Social Associations • Homelessness Rate

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Over-reliance on emergency departments for recurring care needs. • Generational trauma and lack of trauma-informed care. • Stigma around seeking mental health help across cultural and societal lines. • Need for integrated care approaches and better training for primary care providers to address mental health in-office. • Increase mental health and substance use service availability, including mobile units and local providers.	• Substance-use is an issue among youth in particular. • Substance-use treatment services are available, but people do not know about them. • Additional services specifically for youth are needed (e.g., child psychologists, counselors and therapists in the schools). • Mental/behavioral health services are available, but people do not know about them.	

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

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

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

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• A large percent of Yuba and Sutter County residents live below the poverty line, with median household incomes lower than state averages. • There is limited access to jobs that provide sustainable incomes, exacerbating financial struggles. • Rental costs often exceed affordability for median earners (\$45,000 annually), leaving little for wellness, mental health, or insurance. • Housing costs range from \$1,000 to \$1,500 per month, with insufficient affordable housing options, including Section 8 and tiny homes. • High numbers of unhoused individuals, limited housing availability, and challenges for single mothers and larger families. • Regulations and norms, such as multigenerational living, complicate housing eligibility. • Marysville lacks affordable grocery stores, and many residents depend on fast food or expensive prepackaged meals. • Difficulties in reaching food distribution centers or grocery stores without reliable transportation. • No food council exists to promote healthy eating or build partnerships for accessible, nutritious food options. • Widespread poverty affects education, community trust, safety, and feelings of scarcity.	• Additional low-income housing options are needed. • Housing is unaffordable. • Many residents struggle with food insecurity. • Poverty is high. • Services for homeless residents are insufficient. • It is difficult to find affordable childcare. • Many people do not make a living wage. • Educational attainment in the area is low. • Employment opportunities are limited. • Services are inaccessible for Spanish-speaking and immigrant residents.	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Hypertension Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Asthma ED Rates • Drug Induced Death • Adult Obesity • Limited Access to Healthy Foods • Food Environment Index • Medically Underserved Area • Some College • High School Completion • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Unemployment • Children in Single-Parent Households • Social Associations • Children Eligible for Free Lunch • Children in Poverty • Median Household Income • Uninsured Population under 64 • Homelessness Rate

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Limited availability of affordable childcare and employment workshops. • Many lack access to showers, proper clothing, and other necessities to secure employment.		• Long Commute - Driving Alone

3. Access to Quality Primary Care Health Services

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Insufficient primary care providers (PCPs), urgent care, and specialists, leading to long wait times (2–6 months) and overuse of emergency departments (EDs). • Providers often choose larger cities (e.g., Roseville, Sacramento) due to better wages, shorter commutes, and more amenities, leaving rural areas underserved. • Lack of after-hours urgent care, in-house pharmacies, and prenatal/pediatric care. • Rural residents struggle to access care due to limited local options and travel difficulties. • Patients report feeling rushed, unheard, and inadequately	• There aren't enough primary care providers. • It's difficult to obtain appointments outside of regular business hours. • Out-of-pocket costs are too high. • Patients seeking primary care overwhelm local emergency departments. • Wait-times for appointments are excessively long. • Primary care services are available, but they	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • Alzheimer's Disease Mortality

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
informed about diagnoses, treatments, or medications. • Patients use EDs as a safety net due to long wait times for PCP appointments or being referred there by providers. • Poor coordination between hospitals and PCPs, limited aftercare instructions, and delayed responses lead to patient frustration and readmissions. • High out-of-pocket costs, lack of insurance, and low reimbursement rates for Medi-Cal deter both providers and patients. • Insufficient translators for languages like Punjabi, ASL, and others, resulting in culturally inappropriate or ineffective communication. • Undocumented immigrants and non-English speakers face systemic barriers, fear of seeking care, and stigma from both the system and community. • Patients lack understanding of when to seek care and how to navigate the healthcare system. • Providers commute, serve loan repayment periods, then leave. Long hours, limited support, and administrative burdens exacerbate burnout. • Patients face challenges with technology access, literacy, and cultural adaptation. • Over-reliance on inadequate translation tools like <i>Google Translate</i> further complicates care.	are difficult to navigate. • Quality health insurance is unaffordable. • The quality of care is low (e.g., providers lack cultural or linguistic competence).	• Influenza and Pneumonia Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Lung Cancer Prevalence • Prostate Cancer Prevalence • Asthma ED Rates • Primary Care Shortage Area • Medically Underserved Area • Mammography Screening • Primary Care Providers • Preventable Hospitalization • Uninsured Population under 64 • Homelessness Rate

4. Access to Specialty and Extended Care

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Delays of up to six months for speech therapy, occupational therapy, and specialty appointments often lead to patients giving up or delaying care. • Shortages of speech pathologists, occupational therapists, ophthalmologists, and other specialists, particularly in rural areas. • Patients must travel to larger cities (e.g., Sacramento, Davis) for specialty services, adding costs for transportation, childcare, and missed work. • Insufficient caregiving and nursing services due to high costs and low Medi-Cal reimbursement rates. • Limited access to assisted living facilities and home healthcare for disabled patients. • Reliance on emergency services (e.g., fire departments) due to lack of other support options. • Struggles with maternal health, including limited prenatal and genetic testing services, which require travel, incurring additional costs and time burdens for families.	• Not all specialty care is covered by insurance. • Wait-times for specialist appointments are excessively long. • More extended care options for the aging population are needed (e.g., skilled nursing homes, in-home care). • Out-of-pocket costs for specialty and extended care are too high. • People must travel to reach specialists. • Additional hospice and palliative care options are needed. • Too few specialty and extended care providers accept Medi-Cal. • It is difficult to recruit and retain specialists. • The area lacks a specific kind of specialist or extended care option: Dementia care and post acute care	• Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • Alzheimer's Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Lung Cancer Prevalence • Asthma ED Rates

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Lack of broadband access prevents effective telehealth services in rural areas. • Local organizations are overextended and can only help a limited number of people.		• Drug Induced Death • Psychiatry Providers • Specialty Care Providers • Preventable Hospitalization • Homelessness Rate

5. Access to Functional Needs

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Limited public transportation options, especially in rural areas, with sparse or non-existent bus routes. • High travel times to medical appointments (30 minutes to 2+ hours). • Lack of affordable transportation for fixed-income and unhoused individuals. • Ride-share options like Lyft/Uber are unreliable or unavailable, and programs like “Dial Rides” exclude many.	• Medical transport is limited or unreliable. • Many residents do not have reliable personal transportation. • The distance between service providers is inconvenient for those using public transportation. • The geography makes it difficult for those without reliable transportation to get around. • Public transportation is more difficult for some residents to use (e.g., non-English speakers, seniors, parents with young children).	• Disability • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Adult Obesity • Homelessness Rate • Long Commute - Driving Alone • Access to Public Transit

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Hospital and service providers rarely offer transportation support. • Cab services are inadequate and often leave people stranded. • Severe weather and poor cellular service further complicate transportation access. • Rural and foothill areas have poor or no broadband access, making telehealth difficult. • Public spaces like libraries lack sufficient broadband services. • Unhoused individuals face intermittent internet access, limiting their ability to coordinate resources and healthcare. • Broadband is expensive and often reloaded monthly, creating further accessibility barriers.	• Public transportation schedules are limited. • Roads and sidewalks are not well-maintained. • Using public transportation to reach providers can take a very long time.	

6. System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems to receive the necessary benefits and supports to improve health outcomes. Research has shown that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.⁷ Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

⁷ Natale-Pereira, A. et. al .2011. The Role of Patient Navigators in Eliminating Health Disparities. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Case management is complex and resource-intensive, requiring follow-ups, documentation, and closed-loop referrals. • Staff are at capacity, making it difficult to manage complex cases, ensure timely referrals, and provide adequate follow-up care. • There's a need for more care navigators to assist families, especially those with children with special needs or dealing with perinatal mood and anxiety disorders. • Low-income families and non-English speakers face difficulties accessing and navigating healthcare resources and systems. • Pharmacy coverage and insurance navigation are confusing, leading to delays and high costs for patients and wasted time for providers. • Residents lack knowledge about health system navigation, insurance, and available benefits, contributing to frustration and isolation. • Local hospitals resist partnerships and innovation due to a "small-town mentality." • Language barriers (notably for Hispanic, Punjabi, and Hmong populations) complicate appointments and understanding of health insurance. • Economic and social challenges exacerbate poor health outcomes	• It is difficult to navigate multiple, different health care systems. • People may not be aware of the services they are eligible for. • Automated phone systems can be difficult for those who are unfamiliar with the healthcare system. • Medical and insurance paperwork can be overwhelming. • More navigators are needed to connect people to services. • People have trouble understanding their insurance benefits. • Some people just don't know where to start in order to access care or benefits. • Medical terminology is confusing. • There aren't enough bilingual navigators.	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • Influenza and Pneumonia Mortality • Poor Mental Health Days • Frequent Mental Distress • Poor or Fair Health • Asthma ED Rates • Primary Care Shortage Area • Dental Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mammography Screening • Dentists • Mental Health Providers • Psychiatry Providers • Specialty Care Providers • Primary Care Providers

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
- for the older population and low-income families. • Medi-Cal providers face delays in referrals due to incomplete approvals. • Administrative burdens, such as fighting insurance denials, consume providers' time.		• Preventable Hospitalization • Uninsured Population under 64

7. Injury and Disease Prevention and Management

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• There is a high prevalence of sexually transmitted infections (STIs), particularly in Sutter County, with a need for collaboration between FQHCs and private health institutions. • Lack of education on health habits, injury prevention, chronic disease management, and distinguishing when to visit the emergency department versus urgent care. • There is limited public health engagement and understanding of holistic medicine, exercise, nutrition, and healthy lifestyles.	• Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). • There isn't a focus on prevention. • Nutrition education opportunities are needed.	• Infant Mortality • Child Mortality • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Liver Disease Mortality • Kidney Disease Mortality • Suicide Mortality

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Poverty and low education levels are fundamental barriers to health improvement. • Many avoid health insurance, believing they don't need it, further limiting access to care. • Preventative care education is scarce for the Punjabi community, with available resources often linguistically or culturally inappropriate. • A shift from a reactive "sick care" model to a proactive prevention model is necessary to build community resiliency and reduce disease burden. • There are pediatric health risks such as cardiac arrest from home substance exposure and limited awareness about sudden infant death syndrome (SIDS).		• Unintentional Injuries Mortality • Alzheimer's Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Asthma ED Rates • Excessive Drinking • Drug Induced Death • Adult Obesity • Physical Inactivity • Teen Birth Rate • Adult Smoking • Firearm Fatalities Rate • Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Homelessness Rate

8. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all." ⁸ Assuring that community members connect with

⁸ Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved 31 Jan 2022 from <https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html>

each other through community opportunities like programs, services, and civic engagement is important to foster a healthy community. Further, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Limited after-school programs due to funding shortages. • Lack of diversity in sports and programs, which are often expensive. • Parents working long hours, limiting their engagement with their children's activities. • Scarcity of mentorship programs for at-risk and previously incarcerated youth. • Limited community engagement activities and insufficient advertising of events. • Social isolation, particularly among younger generations who rely heavily on online interactions. • Lack of a dedicated community center and minimal community-sponsored events. • Language and cultural barriers, exacerbated by varying lengths of residency within the community. • Cultural tendencies in Punjabi, Hispanic, and Black families to handle issues privately, hindering care access. • Lack of partnerships and communication between community organizations and stakeholders.	• Building community connections doesn't seem like a priority. • Relations between law enforcement and the community need to be improved.	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Suicide Mortality • Unintentional Injuries Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Physical Inactivity • Access to Exercise Opportunities • Teen Birth Rate • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Specialty Care Providers • Primary Care Providers • Preventable Hospitalization • Homicide Rate

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
		• Firearm Fatalities Rate • Juvenile Arrest Rate • Some College • High School Completion • Disconnected Youth • Unemployment • Children in Single-Parent Households • Social Associations • Homelessness Rate • Long Commute - Driving Alone • Access to Public Transit

9. Active Living and Healthy Eating

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Parks are far from residential areas, requiring long drives and crossing multiple traffic lanes. • There is a low awareness of accessible parks. • Lack of food education programs.	• Food insecurity is an issue. • Fresh, unprocessed foods are unaffordable. • There are food deserts where fresh, unprocessed foods are not available. • Homelessness in parks or other public spaces deters their use.	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Limited access to affordable, high-nutrition foods. • Reliance on fast-food contribute to poor diets and rising obesity rates. • There's a lack of safe, walkable, and bikeable spaces due to car traffic and limited county support for improvements. • Fixed incomes restrict seniors' access to healthy food options. • A lack of community gardens limits local access to fresh produce.	• Nutrition education programs are needed. • Recreational opportunities are unaffordable (e.g., gym memberships, recreational activity programming). • The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike-friendly, parks are inaccessible). • There aren't enough recreational opportunities (e.g., organized activities, youth sports leagues).	• Kidney Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Prostate Cancer Prevalence • Asthma ED Rates • Adult Obesity • Physical Inactivity • Limited Access to Healthy Foods • Food Environment Index • Access to Exercise Opportunities • Homelessness Rate • Long Commute - Driving Alone • Access to Public Transit

10. Healthy Physical Environment

Individual health is determined by several factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.⁹

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Poor air quality in the area. • There is constant pesticide spraying from farms that back residential housing. • Burn days worsen air quality.	• Low-income housing is substandard. • Heavy traffic harms the air quality. • Residents' use of tobacco and e-cigarettes harms the air quality. • The air quality contributes to high rates of asthma. • Water quality is poor. • Wildfires harm the air quality. • Industrial activity harms the air quality.	• Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Chronic Lower Respiratory Disease Mortality • Hypertension Mortality • Cancer Mortality • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Lung Cancer Prevalence • Prostate Cancer Prevalence • Asthma ED Rates • Adult Smoking • Homelessness Rate • Long Commute - Driving Alone • Pollution Burden Percent • Air Pollution - Particulate Matter • Drinking Water Violations • Drought Frequency • Projected Difference in Extreme Heat Days

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.¹⁰ This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide

¹⁰ Robert Wood Johnson Foundation, and University of Wisconsin, 2024. County Health Rankings Model. Retrieved 18 July 2024 from <https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods>.

the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. Both AHRO and SSHNV requested written comments from the public on its 2022 CHNA and most recently adopted Implementation Strategy through communitybenefit@ah.org (AHRO) and SHCB@sutterhealth.org (SSHNV).

At the time of the development of this CHNA report neither AHRO nor SSHNV had not received written comments. However, input from the broader community was incorporated in the 2025 CHNA through key informant interviews, focus groups, and the service provider survey. Both AHRO and SSHNV will continue to use their websites as tools to solicit public comments and ensure that these comments are considered as community input in the development of future CHNAs.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included seven interviews with 18 community health experts, four focus groups conducted with a total of 75 community residents or community-facing service providers, and 19 responses to the Community Service Provider Survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at sub-county levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures related to issues such as climate, air and water quality, transit and mobility resources, and housing affordability. In all, 85 different health-outcome and health factor indicators were collected for the CHNA.

Data Analysis

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

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

Description of Community Served

The definition of the community served was the primary service area jointly shared by AHRO and SSHNV. This area was defined by five ZIP Codes: 95901, 95953, 95961, 95991, and 95993. This service area was designated because the majority of patients served by both AHRO and SSHNV resided in these ZIP Codes. AHRO is located in Marysville, California, and SSHNV is located in Yuba City, California. Separated by the Feather River, these cities are located adjacent to one another and are part of the Yuba City Metropolitan Statistical Area as designated by the US Office of Management and Budget,¹¹ which is located approximately 40 miles due north of California's capital—Sacramento. The service area total population was 161,183 community residents and encompassed portions of both Sutter and Yuba Counties. The area is a rural community and is rich in diversity along a number of dimensions. The service area is shown in Figure 2.

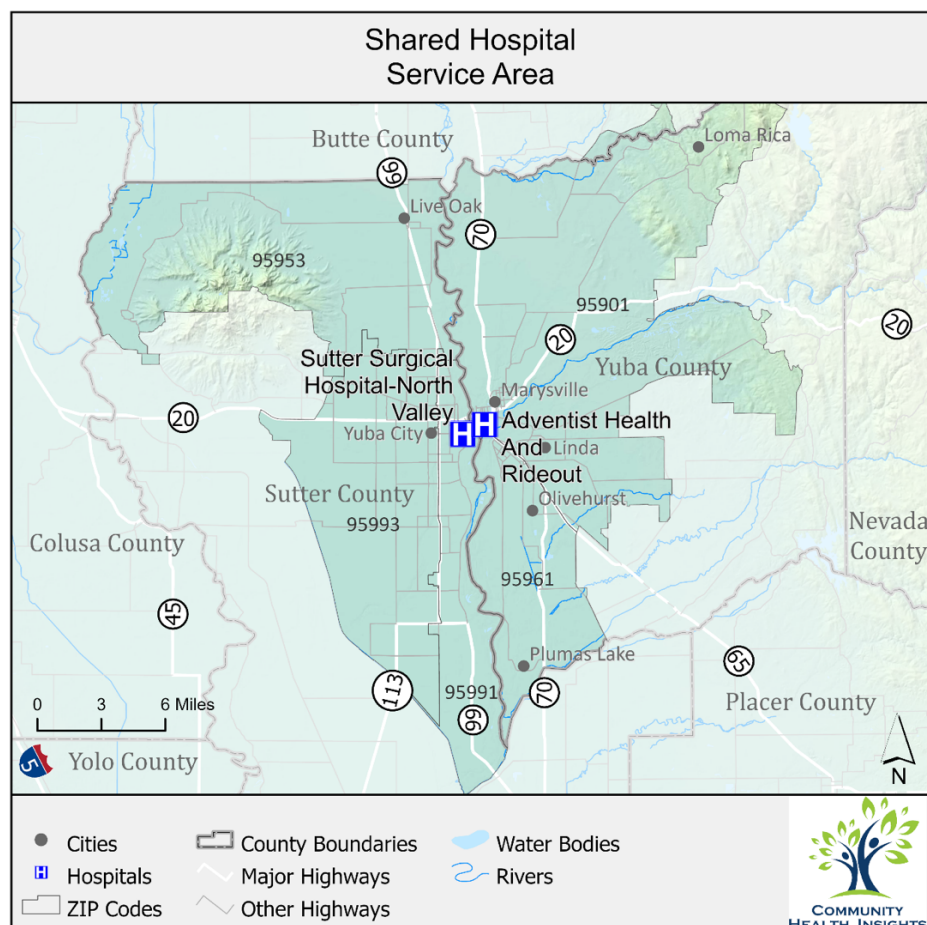


Figure 2: Community served by AHRO and SSHNV.

¹¹See: <https://www.labormarketinfo.edd.ca.gov/definitions/metropolitan-areas.html>

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

Table 2: Population characteristics for each ZIP Code located in the AHRO/SSHNV service area.

ZIP Code	Total Population	% Hispanic/Latinx or Non-White	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95953	11,201	62.7	35.6	\$68,951	16.3	6.9	12.9	27.6	32.5	14.9
95991	43,978	61.6	33.6	\$65,072	15.5	8.9	6.5	21.4	39.6	13.2
95993	37,222	53.9	38.8	\$85,863	10.7	6.3	3.8	18.2	33.6	14.0
<i>Sutter</i>	<i>99,101</i>	<i>56.9</i>	<i>36.0</i>	<i>\$72,654</i>	<i>13.3</i>	<i>7.6</i>	<i>6.2</i>	<i>20.4</i>	<i>35.6</i>	<i>13.8</i>
95901	36,119	48.9	34.4	\$59,378	20.5	7.1	8.5	17.4	38.8	17.8
95961	32,663	57.7	31.0	\$74,819	12.1	8.8	5.0	20.5	38.6	12.6
<i>Yuba</i>	<i>81,705</i>	<i>48.4</i>	<i>33.5</i>	<i>\$66,693</i>	<i>15.4</i>	<i>7.4</i>	<i>6.9</i>	<i>17.3</i>	<i>38.7</i>	<i>16.0</i>
<i>California</i>	<i>39,356,104</i>	<i>64.8</i>	<i>37.3</i>	<i>\$91,905</i>	<i>12.1</i>	<i>6.4</i>	<i>7.1</i>	<i>15.6</i>	<i>39.9</i>	<i>11.0</i>

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Health Equity

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

“Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”¹²

Inequities experienced early and throughout one’s life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation.”¹³

¹² Robert Wood Johnson Foundation. 2017. What is Health Equity? And What Difference Does a Definition Make?. Health Equity Issue Brief #1. Retrieved 18 July 2024 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf.

¹³ Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.

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

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

Health Outcomes - the Results of Inequity

Table 3 below displays disparities among race and ethnic groups for the HSA for life expectancy, mortality, and low birthweight.

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

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Sutter County								
Child Mortality	Number of deaths among residents under age 18 per 100,000 population.	~	~	~	41.8	~	59.5	48.5
Life Expectancy	Average number of years people are expected to live.	~	83.3	78.4	81.1	~	74.7	77.5
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	~	9.8%	8.0%	7.3%	~	5.3%	7%
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	~	276.4	480.5	301.5	~	490.5	392.6
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	6,188.0	~	6,332.8	~	10,456.1	8,068.7
Yuba County								
Child Mortality	Number of deaths among residents under age 18 per 100,000 population.	~	~	~	72.6	~	65.0	64.8

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Infant Mortality Rate	Number of infant deaths (within 1 year) per 1,000 live births.	~	~	~	9.3	~	5.9	7.1
Life Expectancy	Average number of years people are expected to live.	~	77.6	75.1	84.2	~	74.3	75.6
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	~	9.5%	11.4%	6.2%	~	6.3%	6.8%
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	~	403.9	468.9	342.6	~	543.4	487.4
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	8,125.8	~	8,014.8	~	10,431.6	9,598.7

~ Data Not Available

Data sources included in the technical section of the report.

Inequities are apparent when examining data by across race and ethnic categories. For example, in Yuba County life expectancy was significantly higher among Hispanics compared to all other races. In Sutter County, the percent of live births with low birthweight was notably higher among all race and ethnic groups when compared to Whites.

Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the HSA, such as education attainment and income. These health factors are displayed in the Tables 4, 5, and 6 below and are compared across race and ethnic groups.

Table 4: Injury related health factors comparing race and ethnicity in the Yuba service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Sutter County								
Juvenile Felony Arrests	Felony juvenile arrests per 1,000 juveniles	~	~	22.6	1.2	~	1.8	1.6

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Firearm Fatalities	Number of deaths due to firearms per 100,000 population.	~	~	~	6.5	~	13.8	9.5
Injury Mortality ^a	Number of deaths due to injury per 100,000 population.	~	51.0	105.8	47.1	~	101.2	72.7
Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population.	~	17.0	~	15.4	~	22.1	18.3
Homicides ^b	Number of deaths due to homicide per 100,000 population.	~	~	~	7.5	~	4.2	5.0
Drug Overdose Deaths ^d	Number of drug poisoning deaths per 100,000 population.	~	~	~	14.8	~	31.0	20.2

Yuba County

Juvenile Felony Arrests	Felony juvenile arrests per 1,000 juveniles	~	~	7.5	1.2	~	1.8	1.5
Firearm Fatalities	Number of deaths due to firearms per 100,000 population.	~	~	~	10.3	~	19.3	15.6
Injury Mortality ^a	Number of deaths due to injury per 100,000 population.	~	58.9	137.3	67.9	~	110.1	91.6
Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population.	~	~	~	22.8	~	20.3	21.4
Homicides ^b	Number of deaths due to homicide per 100,000 population.	~	~	~	7.6	~	7.4	7.7
Drug Overdose Deaths ^d	Number of drug poisoning deaths per 100,000 population.	~	~	~	16.6	~	28.9	22.7

~ Data Not Available

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

^aFrom County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2017-2021

^bFrom County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2015-2021

^cFrom County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2017-2021

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
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^dFrom County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2019-2021

When comparing health factors across different races and ethnicities, disparities are evident. For example, the juvenile arrest rate among Blacks was 1,800% higher than the group with the lowest rate – Hispanics – in Sutter County. Also, drug overdose deaths among Whites in Yuba County was significantly higher than the group with the lowest rates in the same county – Hispanics.

Table 5: Education and income related health factors comparing race and ethnicity in the Yuba service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Sutter								
High School Completion ^a	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	60.4%	67.3%	90.9%	63.7%	~	91.7%	79.6%
Math Scores	Average grade level performance for 3rd graders on math standardized tests.	~	2.8	2.1	2.3	~	2.6	2.5
Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests.	~	3.1	2.6	2.5	~	2.9	2.8
Some College ^a	Percentage of adults ages 25 and over with some post-secondary education.	43.4%	49.3%	70.9%	38.1%	~	66.1%	55.4%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$67,500	\$83,182	\$71,332	\$61,155	~	\$80,291	\$66,071

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Children in Poverty	Percentage of people under age 18 in poverty.	5.5%	10.9%	51.4%	24.7%	~	12.7%	18.0%
Uninsured Population ^b	Percentage of the civilian non-institutionalized population without health insurance.	6.1%	4.0%	2.9%	10.5%	~	3.8%	6.2%
Homelessness Rate	Number of homeless individuals per 100,000 population.	1,729.7	43.8	1,238.1	269.8	1,027.0	633.1	532.6
Yuba County								
High School Completion ^a	'Percentage of adults ages 25 and over with at least a high school diploma or equivalent.'	64.5%	80.5%	91.2%	67.3%	~	88.3%	82.7%
Math Scores	Average grade level performance for 3rd graders on math standardized tests.	~	2.6	2.3	2.5	~	2.8	2.6
Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests.	~	2.7	2.8	2.4	~	2.9	2.7
Some College ^a	Percentage of adults ages 25 and over with some post-secondary education.	53.1%	49.2%	62.1%	44.1%	~	62.2%	57.3%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$70,938	\$63,015	\$51,893	\$69,681	~	\$66,641	\$63,626

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Children in Poverty	Percentage of people under age 18 in poverty.	26.5%	21.8%	13.6%	25.9%	~	15.2%	19.0%
Uninsured Population ^b	Percentage of the civilian non-institutionalized population without health insurance.	4.5%	10.8%	7.1%	8.7%	~	5.0%	6.9%
Homelessness Rate	Number of homeless individuals per 100,000 population.	1,729.7	43.8	1,238.1	269.8	1,027.0	633.1	532.6

~ Data Not Available

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

^aFrom 2022 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.

^bFrom 2022 American Community Survey 5-year estimates table S2701.

When comparing income among various races and ethnicities, the percent of Hispanic children that lived in poverty was significantly higher than the group with the lowest percentage – Blacks. Further, whereas 91% of Sutter County and 89% of Yuba County White residents completed high school, only 60% of Sutter County and 64% of Yuba County American Indian/Alaskan Native residents did.

Table 6: Clinical related health factors comparing race and ethnicity in the Yuba service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Sutter County								
Preventable Hospital Stays ^a	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	3,924	2,529	~	2,309	~	3,143	2,913
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	35%	27%	43%	27%	~	39%	35%

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	Native Hawaiian\ Pacific Islander	White	Overall County
Teen Births	Number of births per 1,000 female population ages 15-19.	~	~	~	18.3	~	14.1	15.6
Yuba County								
Preventable Hospital Stays ^a	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	7,656	2,332	1,297	3,959	~	3,904	3,939
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	28%	19%	33%	23%	~	32%	30%
Teen Births	Number of births per 1,000 female population ages 15-19.	~	11.7	16.8	22.5	~	20.6	22.0

~ Data Not Available

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

^aFrom County Health Rankings: Mapping Medicare Disparities Tool, 2021

When examining other health factors, disparities are evident among races and ethnicities. For example, in Yuba County 23% of Hispanics received an annual mammography screening, compared to 33% of Blacks.

Population Groups Experiencing Disparities

The figure below describes populations in the shared hospital service area identified through qualitative data analysis that were identified as experiencing health disparities. Interview participants were asked, “What specific groups of community members experience health issues the most?” Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities. Figure 3 displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

Frequency of Mentions in Interviews

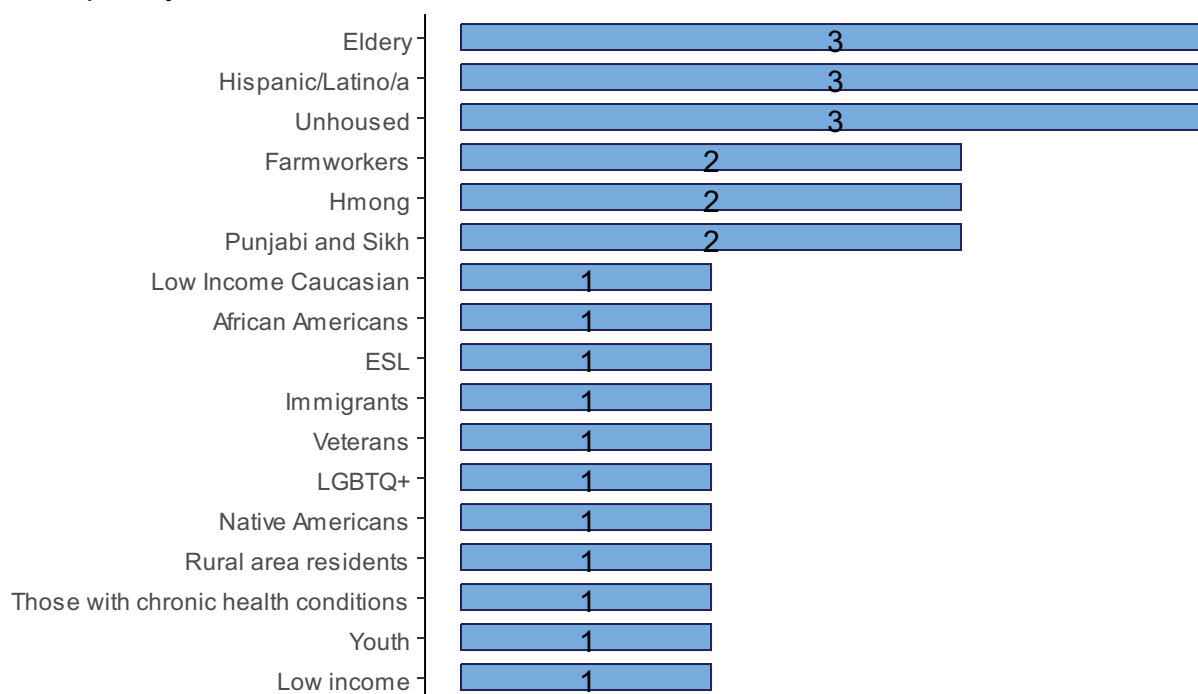


Figure 3: Populations experiencing disparities the AHRO/SSHNV service area.

California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)¹⁴ values for the service area. The HPI is an index based on 23 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

¹⁴ Public Health Alliance of Southern California. 2024. California Health Places Index (HPI): About the HPI. Retrieved 18 July 2024 from <https://www.healthyplacesindex.org/about-hpi>.

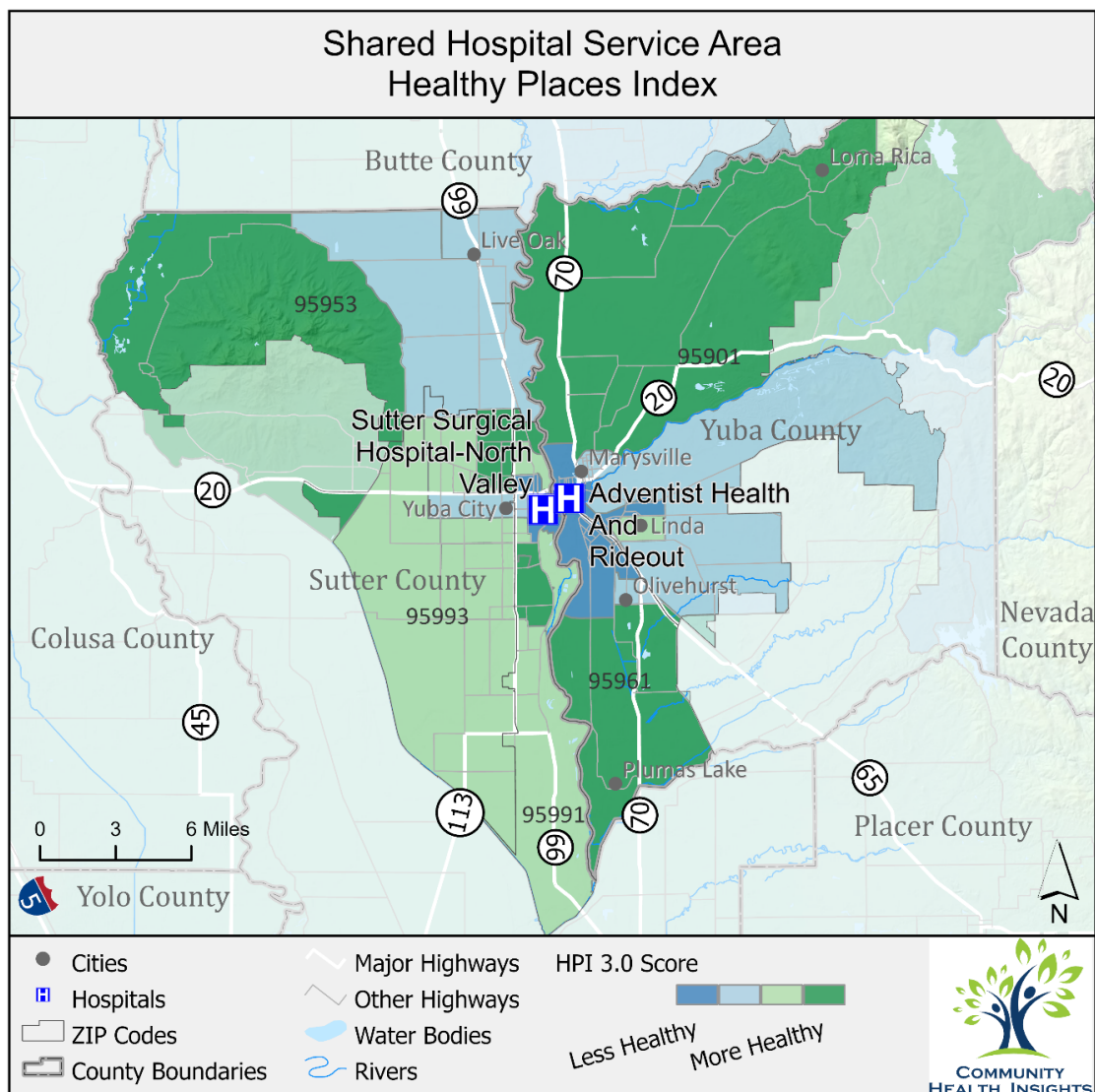


Figure 4: Healthy Places Index for the AHRO/SSHNV service area.

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating less healthy neighborhood conditions. In the AHRO and SSHNV service area, these areas include Marysville, Linda, and the areas south of AHRO hospital, including Olivehurst. Further, the community of Live Oak also has a lower HPI score.

Communities of Concern

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

Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed four ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 7, with the census population provided for each, and are displayed in Figure 5.

Table 7: Identified Communities of Concern for the AHRO/SSHNV service area.

ZIP Code	Community\Area	Population
95901	Marysville, Linda	36,119
95953	Live Oak	11,201
95961	Olivehurst	32,663
95991	South Yuba City	43,978
<i>Total Population in Communities of Concern</i>		<i>123,961</i>
<i>Total Population in Hospital Service Area</i>		<i>161,183</i>
<i>Percentage of Service Area Population in Community of Concern</i>		<i>76.9%</i>

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

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

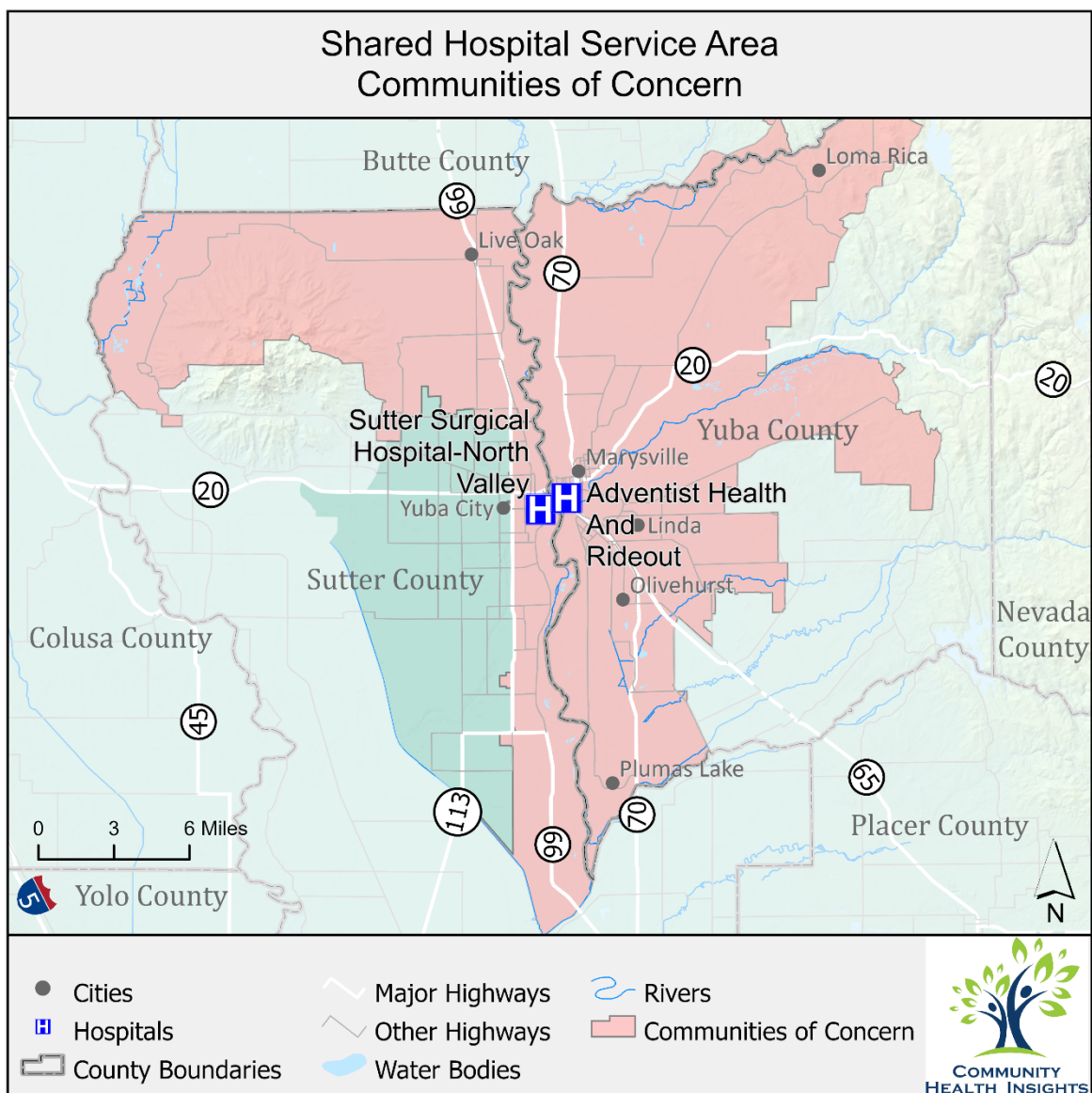


Figure 5: Communities of Concern for the AHRO/SSHNV service area.

In rural communities ZIP Codes often cover large geographical areas. Portions of these areas may be sparsely populated or unpopulated as they are reserved for agricultural use or left undeveloped. This is the case with many of the ZIP Codes identified as Communities of Concern.

As a result, two additional steps were taken to further highlight those portions of these ZIP Code Communities of Concern in which disadvantaged populations were likely to be concentrated. First, the distribution of populations across the county were reviewed to identify areas with a higher population density. Figure 6 shows the distribution of population within the largely rural shared hospital service area. In the figure each gold dot represents 120 residents.

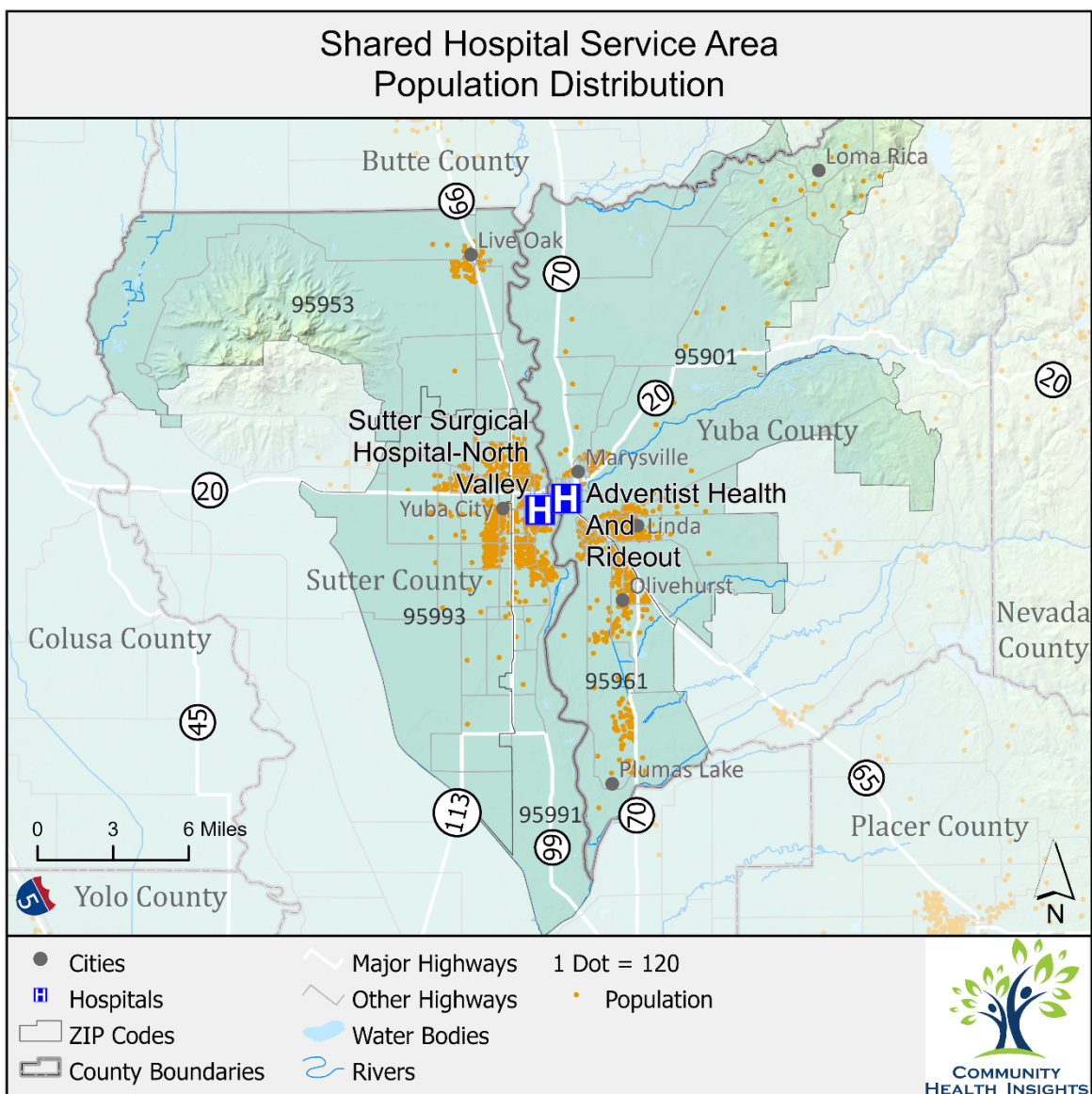


Figure 6: Population distribution in the AHRO/SSHNV service area.

Next, the Census tracts within each ZIP Code Community of Concern that had the highest HPI values were identified. This led to an identification of census tracts that provided a more spatially refined representation of the Communities of Concern within the identified ZIP Codes. Figure 7 displays those census tracts with the greatest concentration of population. These represent tract-level Communities of Concern.

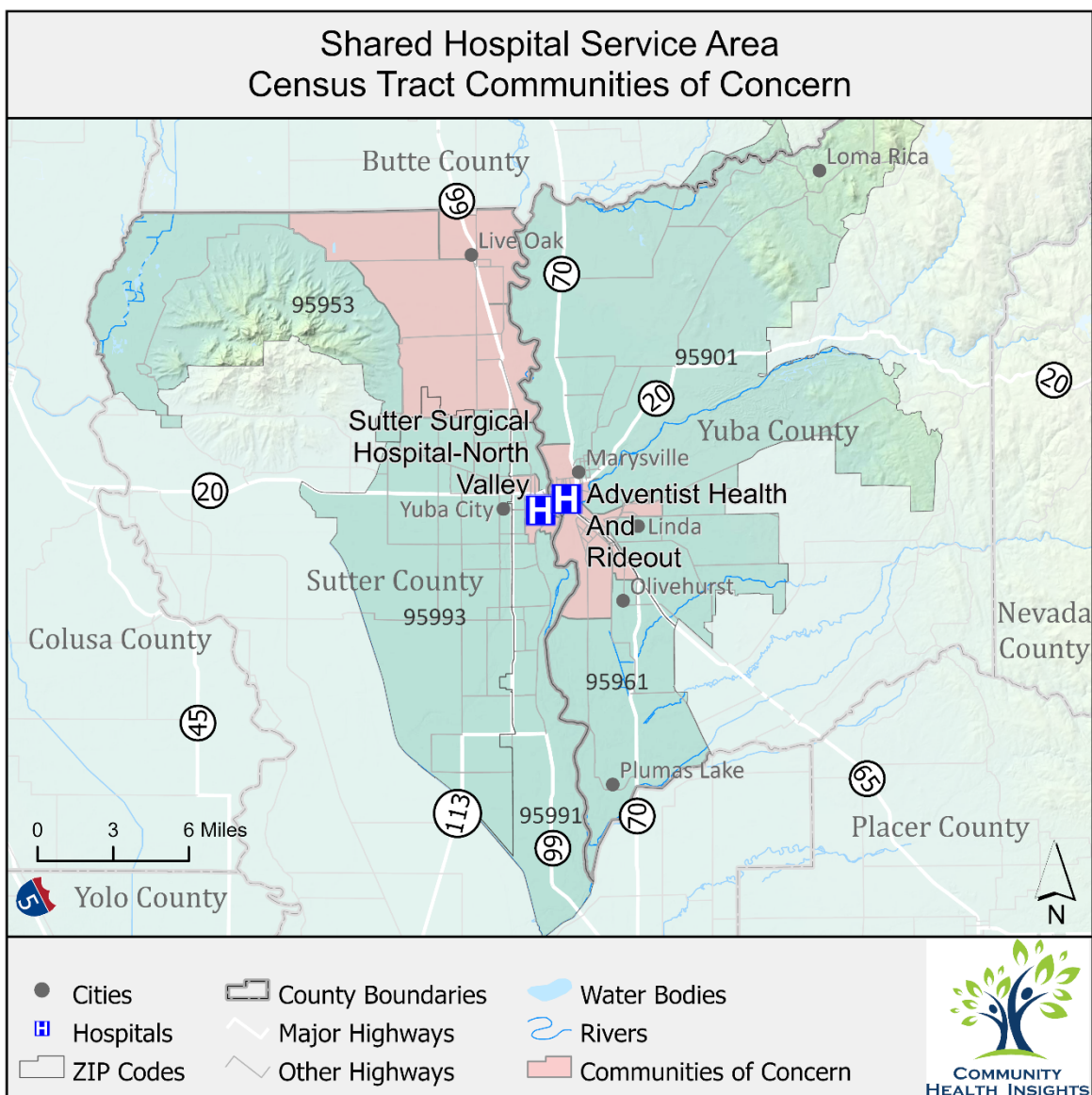


Figure 7: Census Tract Level Communities of Concern for the AHRO/SSHNV service area.

Resources Potentially Available to Meet the Significant Health Needs

In all, 254 resources were identified in the shared hospital service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 89 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2022 Sutter and Yuba County CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2025 CHNA report. Examination of the resources revealed the following number of resources for each significant health need as shown in Table 8.

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

Significant Health Needs (in Priority Order)	Number of Resources
Access to Mental/Behavioral Health and Substance Use Services	37
Access to Basic Needs Such as Housing, Jobs, and Food	33
Access to Quality Primary Care Health Services	29
Access to Specialty and Extended Care	25
Access to Functional Needs	6
System Navigation	31
Injury and Disease Prevention and Management	33
Increased Community Connections	32
Active Living and Healthy Eating	21
Healthy Physical Environment	7
Total Resources	254

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

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital’s CHNA report include “an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility’s prior CHNA(s) (p. 78969).”¹⁵ The hospitals invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of the impact of actions taken by AHRO and Appendix B includes those taken by SSHNV.

Conclusion

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

Please send any feedback about this CHNA report to communitybenefit@ah.org (AHRO) and SHCB@sutterhealth.org (SSHNV)] with “CHNA Comments” in the subject line. Feedback received will be incorporated into the next CHNA cycle.

¹⁵ Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

2025 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Sutter and Yuba Counties Health Service Area (HSA).

Results of Data Analysis

Compiled Secondary Data

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

Length of Life

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

Indicators	Description	Sutter	Yuba	California
Early Life				
Infant Mortality	Number of infant deaths (within 1 year) per 1,000 live births.	5.3	7.1	4.2
				Sutter: 5.3 Yuba: 7.1 California: 4.2
Child Mortality	Number of deaths among residents under age 18 per 100,000 population.	48.5	64.8	37.7
				Sutter: 48.5 Yuba: 64.8 California: 37.7
Life Expectancy	Average number of years people are expected to live.	77.5	75.6	79.9
				Sutter: 77.5 Yuba: 75.6 California: 79.9
Overall				
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	392.6	487.4	318.5
				Sutter: 392.6 Yuba: 487.4 California: 318.5

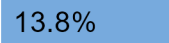
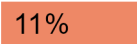
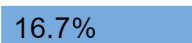
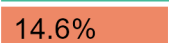
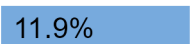
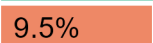
Indicators	Description	Sutter	Yuba	California	
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	8,068.7	9,598.7	6,373.2	Sutter: 8,068.7 Yuba: 9,598.7 California: 6,373.2
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	63.7	54.3	44.7	Sutter: 63.7 Yuba: 54.3 California: 44.7
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	47.2	54.3	32.1	Sutter: 47.2 Yuba: 54.3 California: 32.1
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	26.1	30.4	27.5	Sutter: 26.1 Yuba: 30.4 California: 27.5
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	185.1	187.8	164.4	Sutter: 185.1 Yuba: 187.8 California: 164.4
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	17.1	16.0	15.5	Sutter: 17.1 Yuba: 16 California: 15.5
Cancer, Liver, and Kidney Disease					
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	178.6	170.9	152.0	Sutter: 178.6 Yuba: 170.9 California: 152
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	18.9	20.1	15.7	Sutter: 18.9 Yuba: 20.1 California: 15.7

Indicators	Description	Sutter	Yuba	California	
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	17.9	16.1	11.2	Sutter: 17.9 Yuba: 16.1 California: 11.2
Intentional and Unintentional Injuries					
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	11.6	14.7	11.0	Sutter: 11.6 Yuba: 14.7 California: 11
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	61.9	65.1	46.0	Sutter: 61.9 Yuba: 65.1 California: 46
Other					
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	51.7	37.2	44.0	Sutter: 51.7 Yuba: 37.2 California: 44
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	19.2	15.7	14.5	Sutter: 19.2 Yuba: 15.7 California: 14.5

Quality of Life

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

Indicators	Description	Sutter	Yuba	California	
Chronic Disease					
Diabetes Prevalence	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).	11.0%	10.8%	10.8%	Sutter: 11% Yuba: 10.8% California: 10.8%

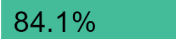
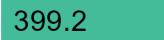
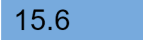
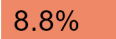
Indicators	Description	Sutter	Yuba	California	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	7.0%	6.8%	7.1%	Sutter:  Yuba:  California: 
HIV Prevalence	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	152.4	154.3	411.4	Sutter:  Yuba:  California: 
Disability	Percentage of the total civilian noninstitutionalized population with a disability	13.8%	16.0%	11.0%	Sutter:  Yuba:  California: 
Mental Health					
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	5.4	5.7	4.7	Sutter:  Yuba:  California: 
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	16.7%	17.6%	14.6%	Sutter:  Yuba:  California: 
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.9	4.1	3.1	Sutter:  Yuba:  California: 
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	11.9%	12.7%	9.5%	Sutter:  Yuba:  California: 

Indicators	Description	Sutter	Yuba	California	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	18.7%	18.9%	15.8%	Sutter: 18.7% Yuba: 18.9% California: 15.8%
Cancer					
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	36.1	42.1	33.9	Sutter: 36.1 Yuba: 42.1 California: 33.9
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	121.3	104.7	122.4	Sutter: 121.3 Yuba: 104.7 California: 122.4
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	50.7	66.9	38.0	Sutter: 50.7 Yuba: 66.9 California: 38
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	105.7	103.5	96.8	Sutter: 105.7 Yuba: 103.5 California: 96.8
Other					
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	187.0	249.0	237.0	Sutter: 187 Yuba: 249 California: 237
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	187.0	152.0	239.0	Sutter: 187 Yuba: 152 California: 239

Health Behavior

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

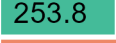
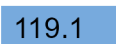
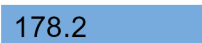
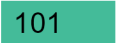
Indicators	Description	Sutter	Yuba	California	
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	16.1%	18.1%	17.2%	Sutter: 16.1% Yuba: 18.1% California: 17.2%
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	19.0	23.7	21.4	Sutter: 19 Yuba: 23.7 California: 21.4
Adult Obesity	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).	31.6%	33.9%	27.8%	Sutter: 31.6% Yuba: 33.9% California: 27.8%
Physical Inactivity	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).	23.7%	22.9%	19.9%	Sutter: 23.7% Yuba: 22.9% California: 19.9%
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	8.1%	10.9%	3.2%	Sutter: 8.1% Yuba: 10.9% California: 3.2%
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.5	7.1	8.6	Sutter: 7.5 Yuba: 7.1 California: 8.6

Indicators	Description	Sutter	Yuba	California	
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	82.0%	84.1%	94.2%	Sutter:  Yuba:  California: 
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	213.0	399.2	488.2	Sutter:  Yuba:  California: 
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	15.6	22.0	12.7	Sutter:  Yuba:  California: 
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	14.4%	15.3%	8.8%	Sutter:  Yuba:  California: 

Clinical Care

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

Indicators	Description	Sutter	Yuba	California	
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	Yes	Yes		Sutter:  Yuba:  California:
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	No	Yes		Sutter: No Yuba:  California:
Mental Health Care Shortage Area	Presence of a mental health professional shortage area	Yes	Yes		Sutter:  Yuba:  California:

Indicators	Description	Sutter	Yuba	California	
	within the county.				
Medically Underserved Area	Presence of a medically underserved area within the county.	Yes	Yes		Sutter:  Yes Yuba:  Yes California:
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	35.0%	30.0%	36.0%	Sutter:  35% Yuba:  30% California:  36%
Dentists	Dentists per 100,000 population.	85.3	29.7	92.9	Sutter:  85.3 Yuba:  29.7 California:  92.9
Mental Health Providers	Mental health providers per 100,000 population.	405.1	253.8	449.8	Sutter:  405.1 Yuba:  253.8 California:  449.8
Psychiatry Providers	Psychiatry providers per 100,000 population.	6.1	2.5	14.0	Sutter:  6.1 Yuba:  2.5 California:  14
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	119.1	36.1	202.7	Sutter:  119.1 Yuba:  36.1 California:  202.7
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	178.2	101.0	167.6	Sutter:  178.2 Yuba:  101 California:  167.6

Indicators	Description	Sutter	Yuba	California	
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted rate)	1,452.6	1,450.9	972.0	Sutter: 1,452.6 Yuba: 1,450.9 California: 972

Socio-Economic and Demographic Factors

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

Indicators	Description	Sutter	Yuba	California	
Community Safety					
Homicide Rate	Number of deaths due to homicide per 100,000 population.	5.0	7.7	5.2	Sutter: 5 Yuba: 7.7 California: 5.2
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	9.5	15.6	8.2	Sutter: 9.5 Yuba: 15.6 California: 8.2
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	1.6	1.5	1.5	Sutter: 1.6 Yuba: 1.5 California: 1.5
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	18.3	21.4	10.4	Sutter: 18.3 Yuba: 21.4 California: 10.4
Education					
Some College	Percentage of adults ages 25-44 with some post-secondary education.	59.5%	61.8%	67.6%	Sutter: 59.5% Yuba: 61.8% California: 67.6%
High School Completion	Percentage of adults ages 25 and over with a high school	79.6%	82.7%	84.4%	Sutter: 79.6% Yuba: 82.7% California: 84.4%

Indicators	Description	Sutter	Yuba	California	
	diploma or equivalent.				
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	9.7%	9.0%	6.6%	Sutter: 9.7% Yuba: 9% California: 6.6%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests.	2.8	2.7	2.9	Sutter: 2.8 Yuba: 2.7 California: 2.9
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests.	2.5	2.6	2.7	Sutter: 2.5 Yuba: 2.6 California: 2.7
Employment					
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	6.6%	5.5%	4.2%	Sutter: 6.6% Yuba: 5.5% California: 4.2%
Family and Social Support					
Children in Single-Parent Households	Percentage of children that live in a household headed by a single parent.	25.2%	22.7%	22.4%	Sutter: 25.2% Yuba: 22.7% California: 22.4%

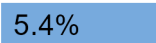
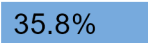
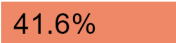
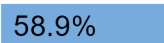
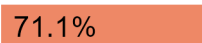
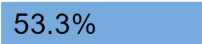
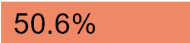
Indicators	Description	Sutter	Yuba	California	
Social Associations	Number of membership associations per 10,000 population.	5.9	3.6	6.0	Sutter: 5.9 Yuba: 3.6 California: 6
Residential Segregation (Black/White)	Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents.	38.3	45.6	58.0	Sutter: 38.3 Yuba: 45.6 California: 58
Income					
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	62.1%	62.8%	57.8%	Sutter: 62.1% Yuba: 62.8% California: 57.8%
Children in Poverty	Percentage of people under age 18 in poverty.	18.0%	19.0%	15.3%	Sutter: 18% Yuba: 19% California: 15.3%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	\$66,071.0	\$63,626.0	\$91,517.0	Sutter: \$66,071 Yuba: \$63,626 California: \$91,517
Uninsured Population under 64	Percentage of adults under age 65 without health insurance.	10.8%	9.1%	9.8%	Sutter: 10.8% Yuba: 9.1% California: 9.8%

Indicators	Description	Sutter	Yuba	California
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.3	4.4	5.2
		Sutter: 4.3 Yuba: 4.4 California: 5.2		

Physical Environment

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

Indicators	Description	Sutter	Yuba	California
Housing				
Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	19.2%	19.4%	25.7%
		Sutter:	19.2%	
		Yuba:	19.4%	
		California:	25.7%	
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	14.3%	16.4%	19.7%
		Sutter:	14.3%	
		Yuba:	16.4%	
		California:	19.7%	
Homeownership	Percentage of owner-occupied housing units.	59.6%	61.4%	55.6%
		Sutter:	59.6%	
		Yuba:	61.4%	
		California:	55.6%	
Homelessness Rate	Number of homeless individuals per 100,000 population.	532.6	532.6	460.9
		Sutter:	532.6	
		Yuba:	532.6	
		California:	460.9	
Transit				

Indicators	Description	Sutter	Yuba	California	
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	5.4%	6.4%	6.9%	Sutter:  Yuba:  California: 
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	35.8%	47.5%	41.6%	Sutter:  Yuba:  California: 
Access to Public Transit	Percentage of population living near a fixed public transportation stop	58.9%	59.4%	71.1%	Sutter:  Yuba:  California: 
Air and Water Quality					
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 4.0 pollution burden score percentile of 50 or greater	53.3%	40.1%	50.6%	Sutter:  Yuba:  California: 
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	8.5	8.7	7.1	Sutter:  Yuba:  California: 
Drinking Water Violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Yes	No		Sutter:  Yuba: No California:
Climate					

Indicators	Description	Sutter	Yuba	California	
Drought Frequency	Percentage of weeks a county was shown as in a moderate or more severe drought by the United States Drought Monitor from 2000-2021.	40.5%	40.8%	40.0%	Sutter:  40.5% Yuba:  40.8% California:  40%
Projected Difference in Extreme Heat Days	Projected difference in extreme heat days as compared to the historical period, 2016-2045, RCP 8.5 emissions scenario, 99th percentile temperature threshold.	10.0	10.0	7.9	Sutter:  10 Yuba:  10 California:  7.9
Projected Difference in Extreme Precipitation Days	Projected difference in extreme precipitation days as compared to the historical period, 2016-2045, RCP 8.5 emissions scenario, 99th percentile precipitation threshold.	0.0	0.0	0.3	Sutter: 0 Yuba: 0 California:  0.3
Wildfire Probability	Mean annual probability of wildfire burning in 30 meter grid cells within the location.	0.0%	0.1%	0.2%	Sutter: 0% Yuba:  0.1% California:  0.2%

CHNA Methods and Processes

Two related models were foundational in this CHNA. The first is a conceptual model that expresses the theoretical understanding of community health used in the analysis. This understanding is important because it provides the framework underpinning the collection of primary and secondary data. It is the

tool used to ensure that the results are based on a rigorous understanding of those factors that influence the health of a community. The second model is a process model that describes the various stages of the analysis. It is the tool that ensures that the resulting analysis is based on a tight integration of community voice and secondary data and that the analysis meets federal regulations for conducting hospital CHNAs.

Conceptual Model

The conceptual model used in this needs assessment is shown in Figure 8. This model organizes populations' individual health-related characteristics in terms of how they relate to up- or down-stream health and health-disparities factors. In this model, health outcomes (quality and length of life) are understood to result from the influence of health factors that describe interrelated individual, environmental, and community characteristics. These health factors are influenced by underlying policies and programs.

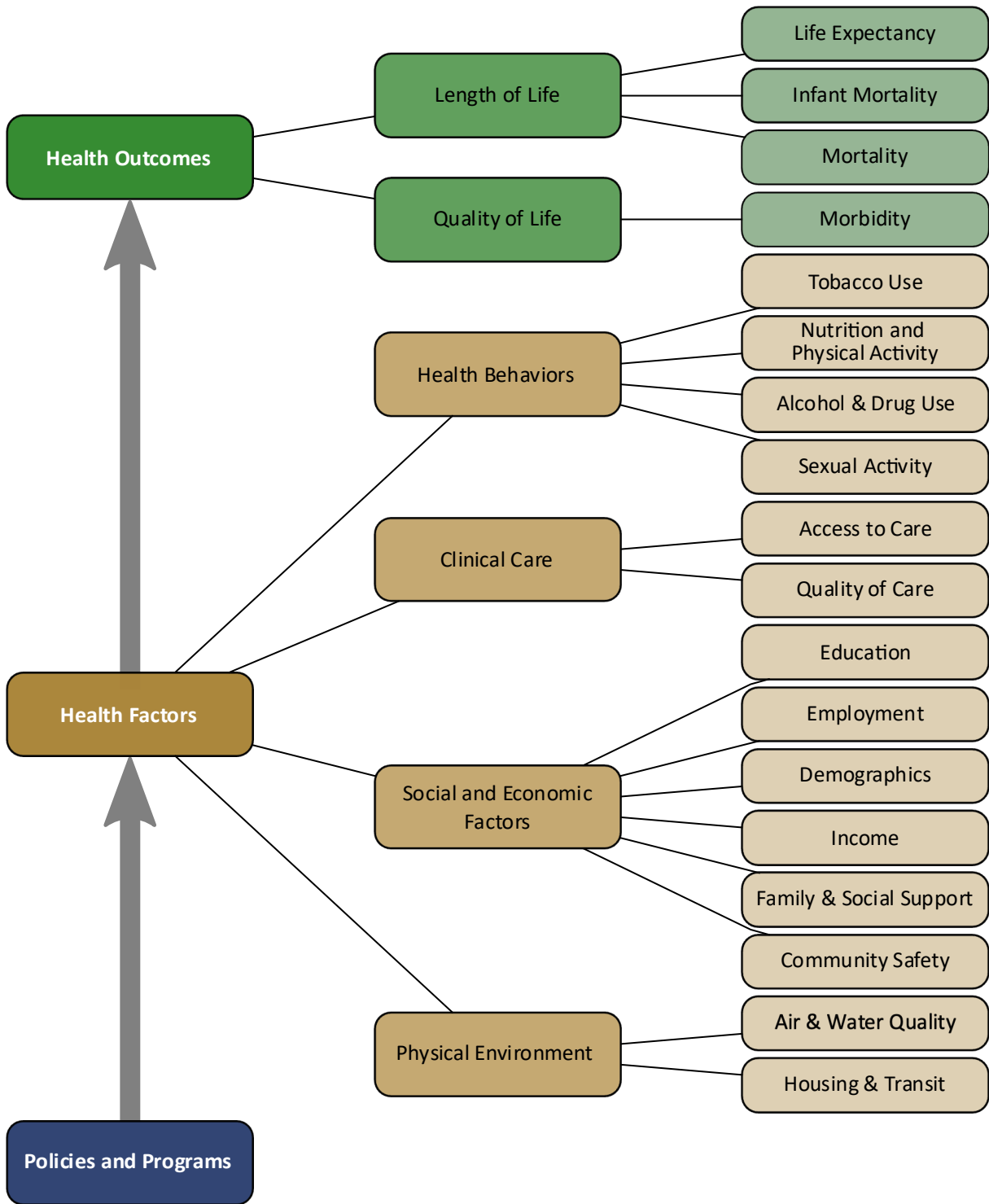


Figure 8: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

This model was used to guide the selection of secondary indicators in this analysis as well as to express in general how these upstream health factors lead to the downstream health outcomes. It also suggests

that poor health outcomes within the service area can be improved through policies and programs that address the health factors contributing to them. This conceptual model is a slightly modified version of the County Health Rankings Model used by the Robert Wood Johnson Foundation. It was primarily altered by adding a “Demographics” category to the “Social and Economic Factors” in recognition of the influence of demographic characteristics on health outcomes.

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

Process Model

Figure 9 outlines the data collection and analysis stages of this process. The project began by confirming the HSA for Sutter and Yuba County for which the CHNA would be conducted. Primary data collection included key informant interviews and focus-groups with community health experts and residents as well as a community service provider survey. Initial key informant interviews were used to identify Communities of Concern, which are areas or population subgroups within the county experiencing health disparities.

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

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

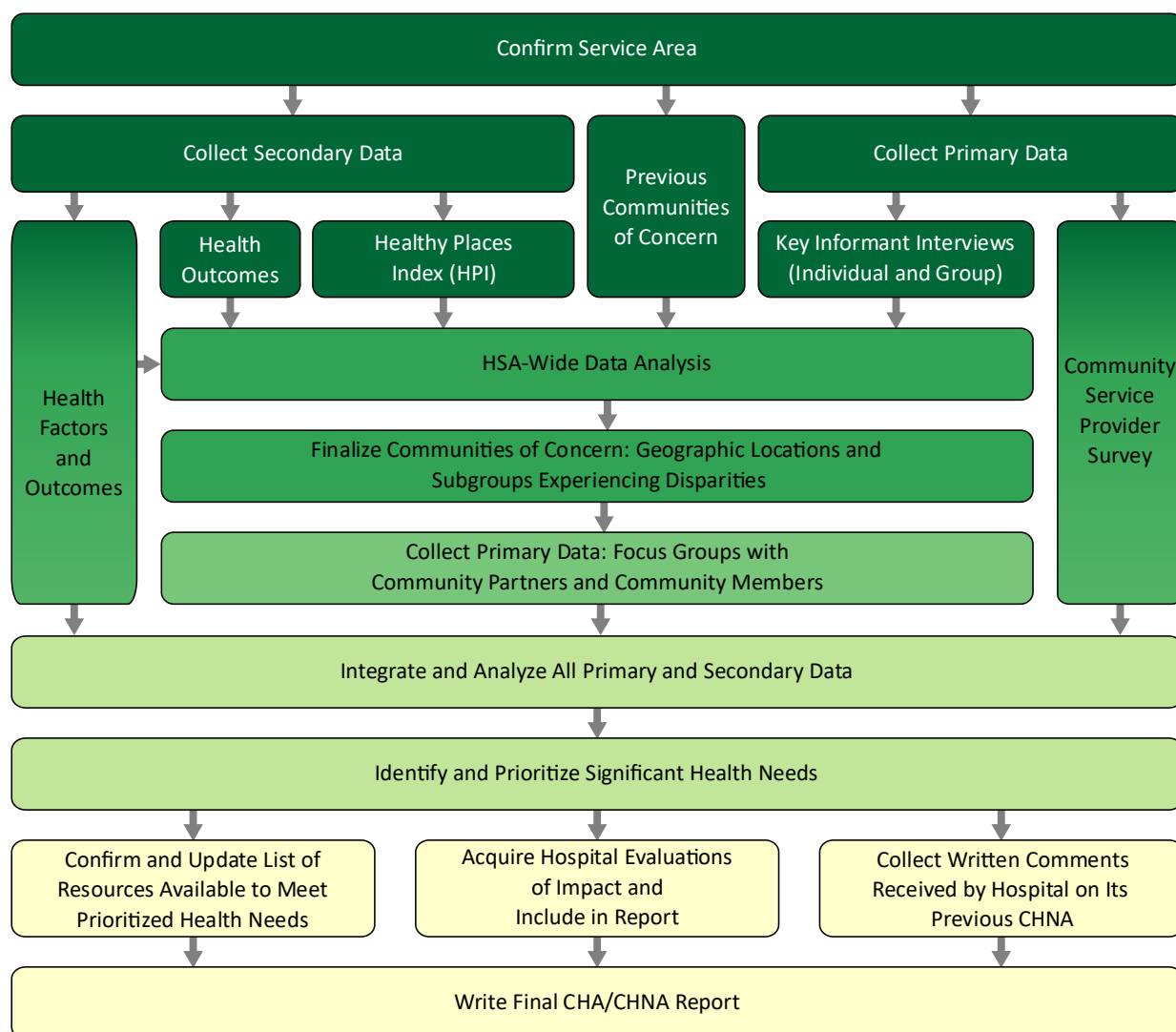


Figure 9: CHNA process model for the CHNA.

Primary Data Collection and Processing

Primary Data Collection

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

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

Key Informant Results

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

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

Table 15 contains a listing of community health experts, or key informants, that contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

Table 15: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Sutter County Department of Public Health and Yuba County Health and Human Services Division	08/09/2024	1	Public Health	Residents of Sutter County and Yuba County
Sutter Care at Home and Sutter Medical Foundation	08/09/2024	2	Home health, hospice, health care provider	Residents of Sutter and Yuba Counties, including children and adolescents
Yuba County Sheriff's Department	08/12/2024	1	Law enforcement	Residents of Yuba County
Partnership HealthPlan of California	08/15/2024	2	Medical coverage	Sutter and Yuba Counties; Medi-Cal recipients
Adventist Health and Rideout Staff	08/16/2024	9	Acute Care Hospital	Residents of Sutter and Yuba Counties
First Five Yuba	08/21/2024	1	Child development	Children, low-income families in Yuba County
Jakara Movement	08/30/2024	2	Education and empowerment	Working class Punjabi Sikhs in Yuba and Sutter Counties

Focus Group Results

Focus group interviews were conducted with community members or service providers living or working in geographic areas of the service area identified as locations or populations experiencing a disparate

amount of poor socioeconomic conditions and poor health outcomes. Recruitment consisted of referrals from designated service providers representing the identified populations, as well as direct outreach to population groups.

Table 16 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table 16: Focus group list.

Hosting Organization	Date	Number of Participants	Populations Represented
Yuba Sutter Healthcare Council	09/13/2024	5	Residents of Yuba and Sutter Counties
Yuba Health Care Townhall	09/30/2024	53	Yuba County Residents
Sutter Yuba Homeless Consortium	10/23/2024	9	Unhoused
Sutter Care at Home	10/23/2024	8	Low-income families, unhoused, elderly, African American

Primary Data Processing

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

Community Service Provider Survey

A web-based survey was administered to community service providers (CSPs) who delivered health and social services to community residents of the HSA. A list of CSPs who have worked with the nonprofit hospitals included in this report was used as an initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey aims and inviting them to participate. Participants were also encouraged to forward the recruitment message to other CSPs in their networks. The survey was designed and distributed using an online survey platform and was available for approximately two weeks. Nineteen completed surveys were received. Survey respondents were asked if they would like the organizations they represented to be acknowledged in the report. The organizations represented by those respondents who requested acknowledgement are as follows. We thank all respondents for their participation in this process:

The Salvation Army - Housing Tenancy Specialist, Yuba-Sutter-Colusa United Way, Sutter Yuba Homeless Consortium, Telecare- iCARE program, Habitat for Humanity Yuba Sutter CALAim, Supportive Services, The Salvation Army, Comfort Keepers #374, Regional Emergency Shelter Team (REST), Hands of Hope: Resources for Homeless Families, Youth For Change, Sutter County Public Health-Homeless Services Unit.

After providing contextual information including the county they served and their affiliated organization(s), survey respondents were shown a list of previously identified potential health needs and asked to indicate which were unmet health needs in their community. In order to reduce any confusion or ambiguity that could introduce bias, participants could scroll over each health need for a definition. Respondents were then asked to select which of the needs they identified as unmet in their community were the priority to address (up to three health needs). Upon selection of these priority unmet health needs, respondents were asked about the characteristics of each as it is expressed in their community. Depending upon the specific health need, respondents were shown a list of between 7-12 characteristics and could select all that applied. Respondents were also offered the opportunity to provide additional information about the health need in their community if it was not provided as a response option. Finally, respondents who provided service in multiple counties were given the opportunity to provide feedback for each county in which they worked.

When the survey period was over, incomplete and duplicate responses were removed from the dataset and the survey responses were double-checked for accuracy. Descriptive statistics and frequencies were used to summarize responses for the health needs. This information was used along with other data sources to identify and rank significant health needs in the community, and to describe how the health needs are expressed. A snapshot of survey results is presented in the following table.

Table 17: Service provider survey results for Sutter and Yuba Counties.

Service Provider Survey Snapshot Yuba/Sutter County (N=19)	
Most Frequently Reported Health Needs	% Reporting
Access to Basic Needs	89.4
Access to Mental/Behavioral Health and Substance-use Services	84.2
Access to Specialty and Extended Care	73.6
A Healthy Physical Environment	73.6
Increased Community Connection	73.6
System Navigation	73.6
Top 4/ Priority (Most Frequently Reported Characteristics)	% Reporting
Access to Basic Needs	89.4
<i>Housing is unaffordable.</i>	
<i>Additional low-income housing options are needed.</i>	
<i>Many residents struggle with food insecurity.</i>	
Access to Mental/Behavioral Health and Substance-Use Services	84.2
<i>There aren't enough mental health providers or treatment centers (e.g., psychiatric beds, therapists, support groups).</i>	
<i>Substance-use is a problem (e.g., use of opiates and methamphetamine, prescription misuse).</i>	
<i>There aren't enough substance-use treatment services available (e.g., detox centers, rehabilitation centers).</i>	
<i>There aren't enough services for those who are homeless and experiencing mental/behavioral health and/or substance-use issues.</i>	
Access to Specialty and Extended Care	26.3
<i>Wait-times for specialist appointments are excessively long.</i>	
<i>Not all specialty care is covered by insurance.</i>	

<i>Out-of-pocket costs for specialty and extended care are too high.</i>	
<i>More extended care options for the aging population are needed (e.g., skilled nursing homes, in-home care).</i>	
System Navigation	
<i>People may not be aware of the services they are eligible for.</i>	
<i>It is difficult to navigate multiple, different health care systems.</i>	
<i>Medical and insurance paperwork can be overwhelming.</i>	
<i>More navigators are needed to connect people to services.</i>	
<i>People have trouble understanding their insurance benefits.</i>	
<i>Automated phone systems can be difficult for those who are unfamiliar with the healthcare system.</i>	
<i>Some people just don't know where to start in order to access care or benefits.</i>	26.3
Open-ended responses: Is there anything else you'd like to tell us about the unmet health needs in Yuba/Sutter Counties?	
• Appointments with FQHC's are scheduled very far out and, to compound the issue, transportation is extremely difficult to obtain. • Individuals don't spend 12-20 years becoming a great specialist and then relocate to work in Yuba/Sutter. Unless you love outdoor activities, we don't have high-end homes, much of a night life, and when you drive to the hospital, you see a very degraded area on the main street of Marysville, not to mention the traffic, compounded by the fire. Our hospital refuses to help with any community "pressure" to help resolve things like traffic and other issues keeping specialists from locating here. We need local specialists, and we lack specialists who will accept Medi-Cal. • For the client demographics that we serve they are alienated and stigmatized because of being homeless. There's not enough facilities for [these] individuals who need post-acute care and they end up back on the streets with nowhere to adequately recover. • There is a significant unmet need for rapidly growing older adult population (aged 60+) on food insecurity. Clearing the Meals-on-Wheels waitlist and providing these seniors with regular, balanced and nutritious meals is crucial for their health, independence, and well-being. Securing Meals-on-Wheels funding is essential to sustain this lifeline, which not only alleviates food insecurity but also reduces healthcare costs and enriches quality of life for our community's most vulnerable. • The base for low-income rental prices exceeds the average income of those in need of housing. It can be perceived as unfair to offer low-income housing without allowing for it to realistically be obtainable by those in need. Ex. \$1350 rent monthly when the average income is \$800-1200 monthly, especially with the high rates PG&E is getting away with. • Assistance [with] paying rent and utilities is limited...because the rates are so high on both, many people are in bigger trouble in making those payments this year. • Like everywhere in California, rent prices in the Yuba-Sutter area are out of control, making affordable housing difficult to obtain. • We received multiple calls every week from families with children and seniors who are in danger of becoming homeless due to the inability to pay rent or their utility bills. We need funding available to help with homeless prevention because once a person becomes homeless it is much harder to secure housing.	

Secondary Data Collection and Processing

We use "secondary data" to refer to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to 1) inform the identification of Communities of Concern, 2) support the identification of health needs within the HSA. This section

details the data sources and processing steps used to obtain the secondary data used in each of these steps and prepare them for analysis.

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),¹⁶ derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),¹⁷ health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2018-2022 due to each of the causes listed in Table 18.

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

Cause of Death	ICD 10 Codes
Alzheimer's disease	G30
Malignant neoplasms (cancers)	C00-C97
Chronic lower respiratory disease (CLRD)	J40-J47
Diabetes mellitus	E10-E14
Assault (homicide)	U01-U02, X85-Y09, Y87.1
Diseases of heart	I00-I09, I11, I13, I20-I51
Essential hypertension and hypertensive renal disease	I10, I12, I15
Accidents (unintentional injuries)	V01-X59, Y85-Y86
Chronic liver disease and cirrhosis	K70, K73-K74
Nephritis, nephrotic syndrome and nephrosis	N00-N07, N17-N19, N25-N27
Pneumonia and influenza	J09-J18
Cerebrovascular disease (stroke)	I60-I69
Intentional self-harm (suicide)	U03, X60-X84, Y87.0

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

ZIP Code Consolidation

The mortality indicators used here included deaths reported for the ZIP Code at the decedent's place of residence. ZIP Codes are defined by the U.S. Postal Service as a single location (such as a PO Box), or a set of roads along which addresses are located. The roads that comprise such a ZIP Code may not form contiguous areas and do not match the areas used by the U.S. Census Bureau (the main source of population and demographic data in the United States) to report population. Instead of measuring the population along a collection of roads, the census reports population figures for distinct, largely contiguous areas. To support the analysis of ZIP Code data, the U.S. Census Bureau created ZIP Code Tabulation Areas (ZCTAs). ZCTAs are created by identifying the dominant ZIP Code for addresses in a

¹⁶ Public Health Alliance of Southern California. 2024. Access the latest HPI data. Data files for individual indicators and HPI score. Retrieved 20 Feb 2024 from <https://api.healthyplacesindex.org/documentation>.

¹⁷ California Department of Public Health. 2024. California Comprehensive Master Death File (Static), 2018-2022.

given Census block (the smallest unit of census data available), and then grouping blocks with the same dominant ZIP Code into a corresponding ZCTA. The creation of ZCTAs allows us to identify population figures that make it possible to calculate mortality rates for each ZCTA. However, the difference in the definition between mailing ZIP Codes and ZCTAs has two important implications for analyses of ZIP Code level data.

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

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California¹⁸ were compared to 2020 ZCTA boundaries.¹⁹ These unique ZIP Codes were then assigned to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

Rate Calculation and Smoothing

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical bayes smoothed rates (EBRs) were created for all indicators possible.²⁰ Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small-number problem. Empirical bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area.

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

EBRs were calculated for each mortality indicator using the total population figure reported for ZCTAs in the 2020 American Community Survey 5-year Estimates table B01001 and retrieved using the

¹⁸ Datasheer, L.L.C. 2024. ZIP Code Database Free. Retrieved 24 Feb 2024 from <http://www.Zip-Codes.com>.

¹⁹ Walker, Kyle. Rudis, Bob. 2024. tigris:Load Census TIGER/Line Shapefiles. <https://doi.org/10.32614/CRAN.package.tigris>.

²⁰ Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 24 Jul 2024 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

tidycensus²¹ R package. Data for 2020 were used because this represented the central year of the 2018-2022 range of years for which CDPH data were collected. The population data for 2020 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

Significant Health Need Identification Dataset

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

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

Conceptual Model Alignment			Indicator	Data Source	Time Period
Health Outcomes	Length of Life	Infant Mortality	Infant Mortality	County Health Rankings	2015-2021
		Life Expectancy	Child Mortality	County Health Rankings	2018-2021
			Life Expectancy	County Health Rankings	2019-2021
			Premature Age-Adjusted Mortality	County Health Rankings	2019-2021
			Premature Death	County Health Rankings	2019-2021
		Mortality	Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022

²¹ Walker, K. Herman, M. 2024. *tidycensus: Load US Census Boundary and Attribute Data as 'tidyverse' and 'sf'-Ready Data Frames*. R package version 1.6.5, <https://walker-data.com/tidycensus/>.

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Influenza and Pneumonia Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
	Quality of Life	Morbidity	Diabetes Prevalence	County Health Rankings	2021
			Low Birthweight	County Health Rankings	2016-2022
			HIV Prevalence	County Health Rankings	2021
			Disability	2022 American Community Survey 5 year estimate variable S1810_C03_001E	2018 - 2022
			Poor Mental Health Days	County Health Rankings	2021
			Frequent Mental Distress	County Health Rankings	2021
			Poor Physical Health Days	County Health Rankings	2021
			Frequent Physical Distress	County Health Rankings	2021
			Poor or Fair Health	County Health Rankings	2021
			Colorectal Cancer Prevalence	California Cancer Registry	2016 - 2020
			Breast Cancer Prevalence	California Cancer Registry	2016 - 2020
			Lung Cancer Prevalence	California Cancer Registry	2016 - 2020
			Prostate Cancer Prevalence	California Cancer Registry	2016 - 2020
			Asthma ED Rates	Tracking California	2020
			Asthma ED Rates for Children	Tracking California	2020
Health Factors	Health Behavior	Alcohol and Drug Use	Excessive Drinking	County Health Rankings	2021

Conceptual Model Alignment			Indicator	Data Source	Time Period
		Diet and Exercise	Drug Induced Death	CDPH 2023 County Health Status Profiles	2019 - 2021
			Adult Obesity	County Health Rankings	2021
			Physical Inactivity	County Health Rankings	2021
			Limited Access to Healthy Foods	County Health Rankings	2019
			Food Environment Index	County Health Rankings	2019 & 2021
			Access to Exercise Opportunities	County Health Rankings	2023, 2022 & 2020
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2021
			Teen Birth Rate	County Health Rankings	2016-2022
		Tobacco Use	Adult Smoking	County Health Rankings	2021
	Clinical Care	Access to Care	Primary Care Shortage Area	U.S. Heath Resources and Services Administration	2024
			Dental Care Shortage Area	U.S. Heath Resources and Services Administration	2024
			Mental Health Care Shortage Area	U.S. Heath Resources and Services Administration	2024
			Medically Underserved Area	U.S. Heath Resources and Services Administration	2024
			Mammography Screening	County Health Rankings	2021
			Dentists	County Health Rankings	2022
			Mental Health Providers	County Health Rankings	2023
			Psychiatry Providers	Area Health Resource File	2021
			Specialty Care Providers	Area Health Resource File	2021
			Primary Care Providers	County Health Rankings	2021; 2023

Conceptual Model Alignment			Indicator	Data Source	Time Period
	Socio-Economic and Demographic Factors	Quality Care	Preventable Hospitalization	Department of Health Care Access and Information Rates of Preventable Hospitalizations for Selected Medical Conditions by County	2022
		Community Safety	Homicide Rate	County Health Rankings	2015-2021
			Firearm Fatalities Rate	County Health Rankings	2017-2021
			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2018 - 2022
			Motor Vehicle Crash Death	County Health Rankings	2015-2021
		Education	Some College	County Health Rankings	2018-2022
			High School Completion	County Health Rankings	2018-2022
			Disconnected Youth	County Health Rankings	2018-2022
			Third Grade Reading Level	County Health Rankings	2018
			Third Grade Math Level	County Health Rankings	2018
		Employment	Unemployment	County Health Rankings	2022
		Family and Social Support	Children in Single-Parent Households	County Health Rankings	2018-2022
			Social Associations	County Health Rankings	2021
			Residential Segregation (Black/White)	County Health Rankings	2018-2022
		Income	Children Eligible for Free Lunch	County Health Rankings	2021-2022
			Children in Poverty	County Health Rankings	2022 & 2018-2022
			Median Household Income	County Health Rankings	2022 & 2018-2022

Conceptual Model Alignment			Indicator	Data Source	Time Period
Physical Environment			Uninsured Population under 64	County Health Rankings	2021
			Income Inequality	County Health Rankings	2018-2022
	Housing and Transit		Severe Housing Problems	County Health Rankings	2016-2020
			Severe Housing Cost Burden	County Health Rankings	2018-2022
			Homeownership	County Health Rankings	2018-2022
			Homelessness Rate	US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report	2023
			Households with no Vehicle Available	2022 American Community Survey 5-year estimate variable DP04_0058PE	2018 - 2022
			Long Commute - Driving Alone	County Health Rankings	2018-2022
			Access to Public Transit	US Department of Transportation Bureau of Transportation Statistics National Transportation Atlas Database: National Transit Map Stops; US Census Bureau	2024; 2020
	Air and Water Quality		Pollution Burden Percent	California Office of Environmental Health Hazard Assessment	2021
			Air Pollution - Particulate Matter	County Health Rankings	2019
			Drinking Water Violations	County Health Rankings	2022
	Climate		Drought Frequency	Centers for Disease Control and Prevention Environmental Public Health Tracking	2021

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Projected Difference in Extreme Heat Days	Centers for Disease Control and Prevention Environmental Public Health Tracking	2016
			Projected Difference in Extreme Precipitation Days	Centers for Disease Control and Prevention Environmental Public Health Tracking	2016
			Wildfire Probability	US Forest Service Research Data Archive	2020

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

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2024 County Health Rankings²² dataset. This was the most common source of data, with 49 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 20.

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

CHR Indicator	Time Period	Data Source
Infant Mortality	2015-2021	National Center for Health Statistics - Natality and Mortality Files
Child Mortality	2018-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Life Expectancy	2019-2021	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program
Premature Age-Adjusted Mortality	2019-2021	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program
Premature Death	2019-2021	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program
Diabetes Prevalence	2021	Behavioral Risk Factor Surveillance System
Low Birthweight	2016-2022	National Center for Health Statistics - Natality Files
HIV Prevalence	2021	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

²² University of Wisconsin Population Health Institute. 2024. 2024 California Data; 2024 Oregon Data. Retrieved 21 Mar 2024 from <https://www.countyhealthrankings.org/health-data>.

CHR Indicator	Time Period	Data Source
Poor Mental Health Days	2021	Behavioral Risk Factor Surveillance System
Frequent Mental Distress	2021	Behavioral Risk Factor Surveillance System
Poor Physical Health Days	2021	Behavioral Risk Factor Surveillance System
Frequent Physical Distress	2021	Behavioral Risk Factor Surveillance System
Poor or Fair Health	2021	Behavioral Risk Factor Surveillance System
Excessive Drinking	2021	Behavioral Risk Factor Surveillance System
Adult Obesity	2021	Behavioral Risk Factor Surveillance System
Physical Inactivity	2021	Behavioral Risk Factor Surveillance System
Limited Access to Healthy Foods	2019	USDA Food Environment Atlas
Food Environment Index	2019 & 2021	USDA Food Environment Atlas; Map the Meal Gap from Feeding America
Access to Exercise Opportunities	2023, 2022 & 2020	ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles
Chlamydia Incidence	2021	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Teen Birth Rate	2016-2022	National Center for Health Statistics - Natality Files; Census Population Estimates Program
Adult Smoking	2021	Behavioral Risk Factor Surveillance System
Mammography Screening	2021	Mapping Medicare Disparities Tool
Dentists	2022	Area Health Resource File/National Provider Identifier Downloadable File
Mental Health Providers	2023	CMS, National Provider Identification
Primary Care Providers	2021; 2023	Area Health Resource File/American Medical Association; CMS, National Provider Identification
Homicide Rate	2015-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Firearm Fatalities Rate	2017-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Motor Vehicle Crash Death	2015-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Some College	2018-2022	American Community Survey, 5-year estimates
High School Completion	2018-2022	American Community Survey, 5-year estimates
Disconnected Youth	2018-2022	American Community Survey, 5-year estimates
Third Grade Reading Level	2018	Stanford Education Data Archive
Third Grade Math Level	2018	Stanford Education Data Archive
Unemployment	2022	Bureau of Labor Statistics
Children in Single-Parent Households	2018-2022	American Community Survey, 5-year estimates
Social Associations	2021	County Business Patterns
Residential Segregation (Black/White)	2018-2022	American Community Survey, 5-year estimates
Children Eligible for Free Lunch	2021-2022	National Center for Education Statistics
Children in Poverty	2022 & 2018-2022	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates

CHR Indicator	Time Period	Data Source
Median Household Income	2022 & 2018-2022	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates
Uninsured Population under 64	2021	Small Area Health Insurance Estimates
Income Inequality	2018-2022	American Community Survey, 5-year estimates
Severe Housing Problems	2016-2020	Comprehensive Housing Affordability Strategy (CHAS) data
Severe Housing Cost Burden	2018-2022	American Community Survey, 5-year estimates
Homeownership	2018-2022	American Community Survey, 5-year estimates
Long Commute - Driving Alone	2018-2022	American Community Survey, 5-year estimates
Air Pollution - Particulate Matter	2019	Environmental Public Health Tracking Network
Drinking Water Violations	2022	Safe Drinking Water Information System

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

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the state²³ and county²⁴ level for the years 2018-2022. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2020 American Community Survey 5-year Estimates table B01001 and retrieved using the tidycensus R package. Data for 2020 were used because this represented the central year of the 2018-2022 range of years for which CDPH data were collected. The population data for 2020 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

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

Next, we applied the state by-cause mortality rate for each cause and year to estimate mortality at the county level if the reported value was masked. This was done by multiplying the cause/year appropriate state-level mortality rate by the 2020 populations of counties with masked values. Resulting estimates

²³ State of California, Department of Public Health. 2024. California Vital Data (Cal-ViDa), Death Query. Retrieved 20 Feb 2024 from <https://cal-vida.cdph.ca.gov/>.

²⁴ California Department of Public Health. 2024. 2014-2022 Final Deaths by Year by County. Data File. Retrieved 20 Feb 2024 from https://data.chhs.ca.gov/dataset/58619b69-b3cb-41a7-8bfc-fc3a524a9dd4/resource/579cc04a-52d6-4c4c-b2df-ad901c9049b7/download/20231206_deaths_final_2014_2022_county_year_sup.csv.

that were less than 1 or greater than 10 were set to 1 and 10 respectively to match the known CDPH masking criteria.

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

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles²⁵ and report age-adjusted deaths per 100,000.

U.S. Health Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration²⁶ (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

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

Psychiatry and Specialty Care Providers

The HRSA's Area Health Resource Files provide information on physicians and allied healthcare providers for U.S. counties. This information was used to determine the rate of specialty care providers and the rate of psychiatrists for each county and for the state. For the purposes of this analysis, a specialty care provider was defined as a physician who was not defined by the HRSA as a primary care provider. This was found by subtracting the total number of primary care physicians (both MDs and DOs, primary care, patient care, and non-federal, excluding hospital residents and those 75 years of age or older) from the total number of physicians (both MDs and DOs, patient care, non-federal) in 2021. This number was

²⁵ California Department of Public Health, Research and Analytics Branch. 2024. County Health Status Profiles 2023: CHSP 2023 Tables 1-29 (Excel). Datafile. Retrieved 20 Feb 2023 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP2023_Table1-29_20230214.xlsx.

²⁶ US Health Resources & Services Administration. 2024. Area Health resource Files; Health Professional Shortage Areas (HPSA). Datafiles. Retrieved on 29 Apr 2024 from <https://data.hrsa.gov/data/download>.

then divided by the 2021 total population given in the 2021 American Community Survey 5-year Estimates table B01001 and retrieved using the tidycensus R package, and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

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

California Cancer Registry

Data obtained from the California Cancer Registry²⁷ includes age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2016 to 2020, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

Tracking California

Data on 2020 emergency department visits rates due to Asthma for all ages as well as children aged 5 to 17 were obtained from Tracking California.²⁸ These data reported age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

US Census Bureau

Data from the US Census Bureau was used for two additional indicators: the percentage of households with no vehicles available (Table DPO4, variable 0058PE), and the percentage of the civilian non-institutionalized population with some disability (Table S1810, variable C03_001E). Values for both of these variables were obtained from the 2022 American Community Survey 5-year Estimates dataset using the tidycensus R package.

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroScreen 4.0²⁹ dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole,

²⁷ California Cancer Registry. 2024. CAL*Explorer Application. Datafiles. Retrieved on 25 Mar 2024 from <https://www.cancer-rates.info/ca/>.

²⁸ Tracking California, Public Health Institute. 2024. Asthma Related Emergency Department & Hospitalization data. Retrieved on 25 Mar 2024 from www.trackingcalifornia.org/asthma/query.

²⁹ California Office of Environmental Health Hazard Assessment. 2023. CalEnviroScreen 3.0. Datafile. Retrieved on 6 Apr 2024 from <https://oehha.ca.gov/calenviroscreen/report/calenviroscreen-40>.

that live in a US Census tract with a CalEnviroScreen 4.0 Pollution Burden score in the 50th percentile or higher.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information.³⁰ These data are reported as risk-adjusted rates per 100,000.

California Department of Justice

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.³¹ This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2018-2022 by the total population under 18 as reported in Table B01001 in the 2020 American Community Survey 5-year Estimates program. Population data from 2020 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2020 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2020 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I respectively. All census population data were retrieved using the tidycensus R package.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development³² were used to calculate homelessness rates for the counties and state. This data reported point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

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

³⁰ California Department of Health Care Access and Information. 2023. Rates of Preventable Hospitalizations for Selected Medical Conditions by County (LGHC Indicator). Data files for Statewide and County. Retrieved 25 Mar 2024 from <https://data.chhs.ca.gov/dataset/rates-of-preventable-hospitalizations-for-selected-medical-conditions-by-county/resource/7c7aed93-3643-43b8-92fc-324bf8fc13f2>.

³¹ California Department of Justice, OpenJustice. 2024. Criminal Justice Data: Arrests. Datafile. Retrieved 25 Mar 2024 from <https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2023-06/OnlineArrestData1980-2022.csv>.

³² US Department of Housing and Urban Development. 2023. PIT and HIC Data Since 2007: 2007 - 2023 PIT Estimates by CoC. Datafile. Retrieved on 17 Apr 2024 from <https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/>.

Population data came from the total population value reported in Table B03002 from the 2022 American Community Survey 5-year Estimates dataset retrieved using the tidycensus R package. Derived rates report cases per 100,000.

Proximity to Transit Stops

The proximity to transit stops variable reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Census block level population data from the 2020 decennial census was obtained from table P1 using the tidycensus R package. Transit stop data were obtained from the US Department of Transportation's National Transportation Atlas Database.³³

The sf³⁴ library in R was used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

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

³³ US Department of Transportation Bureau of Transportation Statistics. 2024. National Transportation Atlas Database: National Transit Map Stops. Datafile. Retrieved on 22 Mar 2024 from <https://geodata.bts.gov/datasets/usdot::national-transit-map-stops/explore?location=41.726443%2C-123.965217%2C10.90>.

³⁴ Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, <https://doi.org/10.32614/RJ-2018-009>.

Community of Concern Identification

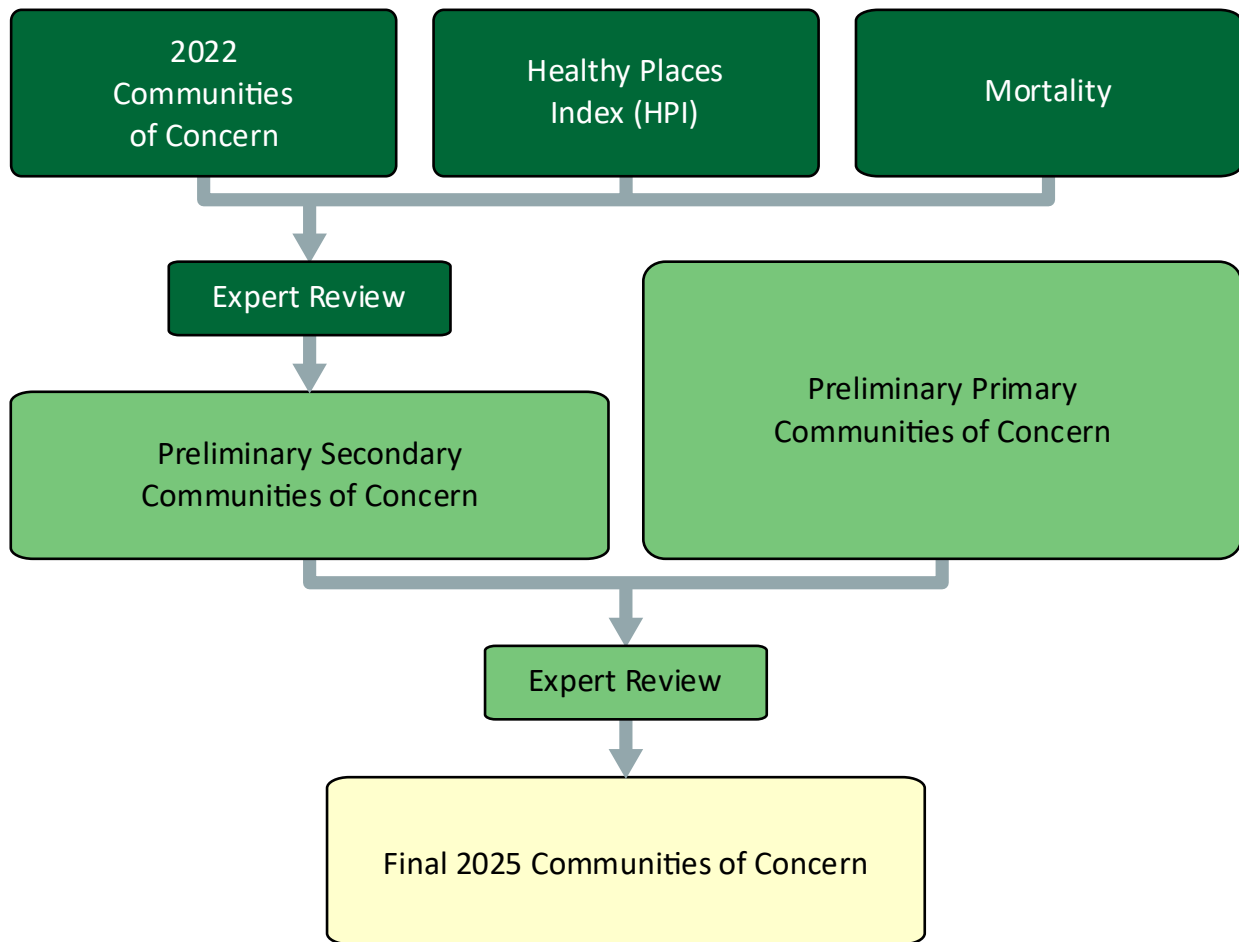


Figure 10: Community of Concern identification process.

As illustrated in Figure 10, 2025 Communities of Concern were identified through a process that drew upon both primary and secondary data. Three main secondary data sources were used in this analysis: Communities of Concern identified in the 2022 CHNA; the census tract-level California Healthy Places Index (HPI); and the CDPH ZCTA-level mortality data.

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

2022 Community of Concern

A ZCTA was included if it was included in the 2022 CHNA Community of Concern list for the HSA. This was done to allow greater continuity between CHNA rounds and reflects the work of the hospital systems oriented to serve these disadvantaged communities.

Healthy Places Index (HPI)

A ZCTA was included if it intersected a census tract whose HPI value fell within the lowest 20% of those in the HSA. These census tracts represent areas with demographic, physical environment, economic, and other characteristics consistently related to poor health outcomes.

CDPH Mortality Data

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

Integration of Secondary Criteria

Any ZCTA that met any of the three selection criteria (2022 Community of Concern, HPI, and Mortality) was reviewed for inclusion as a 2025 Community of Concern, with greater weight given to those ZCTAs meeting multiple selection criteria. An additional round of expert review was applied to determine if any other ZCTAs not thus far indicated should be included based on some other unanticipated secondary data consideration. This list then became the final Preliminary Secondary Communities of Concern.

Preliminary Primary Communities of Concern

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

Integration of Preliminary Primary and Secondary Communities of Concern

Any ZCTA that was identified in either the Preliminary Primary or Secondary Community of Concern list was considered for inclusion as a 2025 Community of Concern. An additional round of expert review was then applied to determine if, based on any primary or secondary data consideration, any final adjustments should be made to this list. The resulting set of ZCTAs was then used as the final 2025 Communities of Concern.

Significant Health Need Identification

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

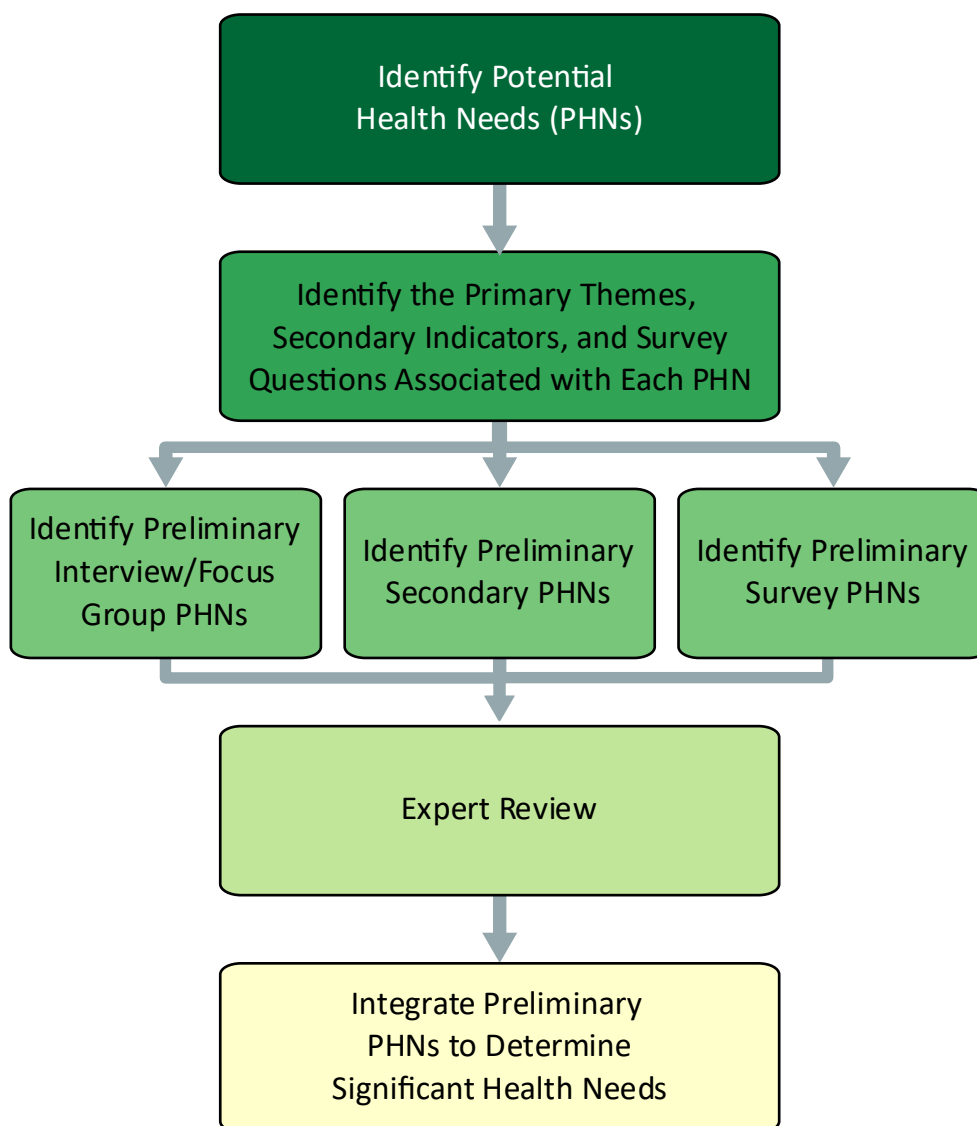


Figure 11: Significant health need identification process.

Table 21: 2025 Potential Health Needs.

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

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

Access to Mental/Behavioral Health and Substance Use Services

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

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

Access to Quality Primary Care Health Services

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

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

Active Living and Healthy Eating

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

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

Safe and Violence-Free Environment

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

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

Access to Dental Care and Preventive Services

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

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

Healthy Physical Environment

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

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

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

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

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

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

Access to Functional Needs

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

Primary Themes	Secondary Indicators
Many residents do not have reliable personal transportation.	Disability
Medical transport in the area is limited.	Frequent Mental Distress
Roads and sidewalks in the area are not well-maintained.	Frequent Physical Distress

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

Access to Specialty and Extended Care

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

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

Primary Themes	Secondary Indicators
	Residential Segregation (Black/White)
	Income Inequality
	Homelessness Rate

Injury and Disease Prevention and Management

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

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

Primary Themes	Secondary Indicators
	Death
	Disconnected Youth
	Third Grade Reading Level
	Third Grade Math Level
	Income Inequality
	Homelessness Rate

Increased Community Connections

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

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

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

System Navigation

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

Primary Themes	Secondary Indicators
People may not be aware of the services they are eligible for.	Infant Mortality
It is difficult for people to navigate multiple, different health care systems.	Child Mortality
The area needs more navigators to help to get people connected to services.	Life Expectancy
People have trouble understanding their insurance benefits.	Premature Age-Adjusted Mortality
Automated phone systems can be difficult for those who are unfamiliar with the healthcare system	Premature Death
Dealing with medical and insurance paperwork can be overwhelming.	Stroke Mortality
Medical terminology is confusing.	Chronic Lower Respiratory Disease Mortality
Some people just don't know where to start in order to access care or benefits.	Diabetes Mortality
	Heart Disease Mortality
	Hypertension Mortality
	Cancer Mortality
	Liver Disease Mortality
	Kidney Disease Mortality
	Influenza and Pneumonia Mortality
	Poor Mental Health Days
	Frequent Mental Distress
	Poor or Fair Health
	Asthma ED Rates

Primary Themes	Secondary Indicators
	Asthma ED Rates for Children
	Primary Care Shortage Area
	Dental Care Shortage Area
	Mental Health Care Shortage Area
	Medically Underserved Area
	Mammography Screening
	Dentists
	Mental Health Providers
	Psychiatry Providers
	Specialty Care Providers
	Primary Care Providers
	Preventable Hospitalization
	Uninsured Population under 64

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

Table 34: Benchmark comparisons to show indicator performance.

Indicator	Benchmark Comparison Indicating Poor Performance
Infant Mortality	Higher
Child Mortality	Higher
Life Expectancy	Lower
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Stroke Mortality	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Diabetes Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Cancer Mortality	Higher
Liver Disease Mortality	Higher
Kidney Disease Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Diabetes Prevalence	Higher
Low Birthweight	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
HIV Prevalence	Higher
Disability	Higher
Poor Mental Health Days	Higher
Frequent Mental Distress	Higher
Poor Physical Health Days	Higher
Frequent Physical Distress	Higher
Poor or Fair Health	Higher
Colorectal Cancer Prevalence	Higher
Breast Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher
Excessive Drinking	Higher
Drug Induced Death	Higher
Adult Obesity	Higher
Physical Inactivity	Higher
Limited Access to Healthy Foods	Higher
Food Environment Index	Lower
Access to Exercise Opportunities	Lower
Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Primary Care Shortage Area	Present
Dental Care Shortage Area	Present
Mental Health Care Shortage Area	Present
Medically Underserved Area	Present
Mammography Screening	Lower
Dentists	Lower
Mental Health Providers	Lower
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Primary Care Providers	Lower
Preventable Hospitalization	Higher
Homicide Rate	Higher
Firearm Fatalities Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Some College	Lower
High School Completion	Lower
Disconnected Youth	Higher
Third Grade Reading Level	Lower
Third Grade Math Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Social Associations	Lower

Indicator	Benchmark Comparison Indicating Poor Performance
Residential Segregation (Black/White)	Higher
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Median Household Income	Lower
Uninsured Population under 64	Higher
Income Inequality	Higher
Severe Housing Problems	Higher
Severe Housing Cost Burden	Higher
Homeownership	Lower
Homelessness Rate	Higher
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Access to Public Transit	Lower
Pollution Burden Percent	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present
Drought Frequency	Higher
Projected Difference in Extreme Heat Days	Higher
Projected Difference in Extreme Precipitation Days	Higher
Wildfire Probability	Higher

Identification of preliminary secondary significant health needs was then based on the percentage of all secondary indicators associated with a given PHN that were identified as performing poorly within the HSA. Identification of preliminary significant health needs interview and focus group health needs were similarly based on the percentage of events in which themes associated with each given PHN were mentioned as priority health needs. Finally, preliminary survey significant health need identification was based on the percentage of survey respondents selecting a particular health need as one of the top health needs in the HSA.

For this report, a PHN was selected as a preliminary quantitative significant health need if 80% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by 50% or more of the primary sources as performing poorly; and as a preliminary community service provider survey significant health need if it was identified by at least 60% of survey respondents. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in two of these three categories.

Health Need Prioritization

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

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health need was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need. Finally, the percentage of times each health need was selected as one of the top three health needs by survey respondents was also included.

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

Detailed List of Resources to Address Health Needs

Table 35: Resources available to meet health needs.

Organization Information			Significant Health Needs									Other Health Needs		
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance Use Services	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
A Woman's Friend	95991	www.awomansfriend.org				x		x	x					
Adventist Health and Rideout	95901	www.adventisthealth.org/rideout	x		x	x				x				
Aegis Medical System	95901	pinnacle-treatment.com/location/california/marysville/aegis-treatment-centers-marysville	x					x						
Agency on Aging\Area 4	95901, 95991	agencyonaging4.org				x	x				x			
Alliance for Hispanic Advancement	95992	aha-ys.org								x				
Ampla Health	95991	www.amplahealth.org	x		x	x		x						x
Ampla Health - Lindhurst	95961	www.amplahealth.org/health-centers/lindhurst-medical-dental	x		x	x		x						x
Ampla Health - Richland	95991	www.amplahealth.org/health-centers/richland-medical	x		x	x		x						x
Ampla Health - Yuba City Medical	95991	www.amplahealth.org/health-centers/yuba-city-medical-xpress-care	x		x	x		x						x
Ampla Health - Colusa	95932	www.amplahealth.org/health-centers/colusa-medical-dental	x		x	x		x						x
Ampla Health- Lindhurst Medical & Dental - Olivehurst Low Cost Clinic	95961	www.amplahealth.org/health-centers/lindhurst-medical-dental			x					x				x
Ampla Health- Yuba County WIC	95901	www.amplahealth.org/wic		x							x			

Organization Information			Significant Health Needs										Other Health Needs	
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
Anthem Blue Cross (Local Medi-Cal Payer)	95901	www.dhcs.ca.gov/individuals/Pages/MCDHealthPlanDir.aspx						x						
Beale Air Force Base-Child Development Center	95903	bealefss.com/child-development-center							x	x			x	
Bible Baptist- Food Pantry	95901	bbc4me.org		x						x				
Bi-County Mental Health (also known as Sutter-Yuba Behavioral Health Services)	95991	www.suttercounty.org/government/county-departments/health-and-human-services/sutter-yuba-behavioral-health	x					x						
Bridges to Housing	95901	www.bridgestohousing.net		x										
Buddy's House	95991	www.buddyshouse.org	x	x				x						
California Tribal TANF	95901	cttp.net/locations		x					x	x				
Casa de Esperanza	95992	casaysc.org		x									x	
Child Care Planning Council of Yuba & Sutter Counties	95901	www.childcareyubasutter.com	x						x	x				
Children Health & Disability Prevention Program (CDPH)	95901	www.dhcs.ca.gov/services/chdp/Pages/default.aspx			x		x	x	x					
Co-Dependents Anonymous for Men & Women (CODA)	95991	coda.org/meeting/twin-cities-co-dependents-anonymous	x							x				
Colusa County Department of Health and Human Services Public Health Division	95932	www.countyofcolusa.org/99/Public-Health	x	x	x	x			x					x

Organization Information			Significant Health Needs									Other Health Needs		
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance Use Services	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
California Children's Services														
Colusa County Senior Nutrition Program	95932	www.countyofcolusa.org/286/Senior-Nutrition		x							x			
Colusa County Veteran Services	95932	www.countyofcolusa.org/180/Veterans-Services		x				x						
Colusa Medical Center	95932	colusamedcenter.com			x	x		x			x			
Comfort Keepers	95901	www.comfortkeepers.com/offices/california/marysville?utm_source=GMBlisting&utm_medium=organic				x	x							
First 5 Colusa	95932	www.countyofcolusa.org/948/First-5	x	x	x				x		x			x
First 5 Yuba County	95901	www.first5yuba.org	x	x	x				x	x	x		x	
FREED Center for Independent Living (Transportation Voucher Program)	95901	freed.org/services/independent-living/senior-transportation-voucher-program	x				x		x					
Habitat for Humanity	95901	yubasutterhabitat.org		x						x				
Hands of Hope	95991	www.ychandsofhope.org		x				x		x				
Harmony Health Medical Clinic & Family Resource Center	95901	www.myharmonyhealth.org	x		x	x			x	x				
Hmong Outreach Center	95961	www.suttercounty.org/government/county-departments/health-and-human-services/adult-services-branch/adult-mental-health-services/hmong-outreach-center	x					x						
Jakara Movement	95901	www.jakara.org		x						x				

Organization Information			Significant Health Needs										Other Health Needs	
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
Latino Outreach Center	95991	www.suttercounty.org/government/county-departments/health-and-human-services/adult-services-branch/adult-mental-health-services/latino-outreach-center	x					x						
Marysville Police Department	95901	www.marysvillepd.org								x			x	
Partnership HealthPlan of CA	Yuba County	www.partnershiphp.org	x		x	x								
Pathways Recovery & Wellness Through Life-long Change, Alcohol Treatment Program	95901	www.yspathways.net	x						x			x		
Peach Tree Health- Linda	95901	pickpeach.org/location/peach-tree-linda	x		x	x		x		x				x
Peach Tree Health- Live Oak Clinic	95953	pickpeach.org/location/peach-tree-live-oak	x		x	x		x		x				x
Peach Tree Health- Marysville Immediate Care Clinic	95901	pickpeach.org/location/marysville-immediate-care	x		x	x		x		x				
Peach Tree Health- Yuba City	95993	pickpeach.org/location/peach-tree-yuba-city	x		x			x	x					x
Peach Tree Pediatrics- Marysville	95991	pickpeach.org/location/marysville-immediate-care/peach-tree-pediatrics-2	x		x	x		x						x
Pick Peach-Peach Tree Health Marysville	95901	pickpeach.org/?gclid=CjwKCAiAo4OQBhBBEiwA5KWu_7iramTLYOuefFxgoaKCxR5mgrKCq33TZyqgNzEuFoa1kWo2JlQkeBoCP6MQAvD_BwE	x		x			x	x					
Planned Parenthood: Yuba City Health Center	95991	www.plannedparenthood.org/health-center/california/yuba-city/95991/yuba-			x	x			x					

Organization Information			Significant Health Needs									Other Health Needs		
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
		city-health-center-2374-90130?utm_campaign=yuba-city-health-center&utm_medium=organic&utm_source=local-listing												
Rotary Club of Yuba City	95991	rotary5180.org								x				
Salvation Army	95991	yubasutter.salvationarmy.org	x	x					x		x	x	x	
St. Andrew Church-Mother Hubbard's Cupboard Food Pantry	95993	standrewpcusa.org/yuba-city-wedding-venue-rental-food-closet		x						x				
St. Isidore Catholic Church- Food Pantry	95991	stisidore-yubacity.org		x						x				
St. John's Episcopal Church	95901	www.saintjohnsmarysville.org		x						x	x			
St. Joseph's Catholic Church	95901	www.stjoseph-marysville.org/index.html		x						x	x			
St. Vincent De Paul-Food Locker	95991	stisidore-yubacity.org/join-serve/community-outreach/society-saint-vincent-de-paul/st-vincent-de-paul-food-locker		x						x				
Sutter Care at Home	95991	www.sutterhealth.org/find-location/facility/sutter-care-at-home-yuba-city-home-health				x		x	x		x	x		
Sutter County Board of Supervisors	95993	www.suttercounty.org/government/board-of-supervisors												
Sutter County Children & Families Commission	95993	sutterkids.org	x	x				x	x	x	x		x	
Sutter County Department of Public Health	95993	www.suttercounty.org/government/county-departments/health-and-human-services/public-health		x	x				x		x	x		x

Organization Information			Significant Health Needs										Other Health Needs	
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
Sutter County- Maternal Child and Adolescent Health	95901	www.suttercounty.org/government/county-departments/health-and-human-services/public-health-branch/maternal-child-adolescent-health				x			x					
Sutter County WIC	95953	www.suttercounty.org/government/county-departments/health-and-human-services/public-health/wic-supplemental-food-program		x				x	x		x			
Sutter Medical Foundation	95991	www.sutterhealth.org/smf	x		x	x			x	x				
Sutter Medical Plaza Brownsville	95919	www.sutterhealth.org/find-location/facility/sutter-medical-plaza-brownsville	x		x	x		x						
Sutter Surgical Hospital North Valley	95991	www.sutterhealth.org/find-location/facility/sutter-surgical-hospital-north-valley				x		x	x					
Sutter Yuba Homeless Consortium	95992	www.syhomelessconsortium.org	x	x				x						
The Liv On Foundation	95993	www.facebook.com/thelivonfoundation.org											x	
Twin City Rescue Mission	95901	www.tcrmission.com		x									x	
United Way/ Yuba-Sutter-Colusa	95901	www.yscunitedway.org		x	x					x				
Victor Community Support Services	95901	victor.org/yuba-city	x						x					
Wellpath	95901	wellpathcare.com	x											
Western Farm Workers Association	95991	labor-organizations.cmac.ws/western-farm-workers-association/1245									x			

Organization Information			Significant Health Needs										Other Health Needs	
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance Use Services	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
Women's Health Specialists- Feminist Women's Health Center	95928	www.womenshealthspecialists.org/				x			x					
Youth for Change	95991	www.youth4change.org	x	x				x		x			x	
Yuba City Police Department	95993	www.yubacity.net/departments/police_department/index.php								x			x	
Yuba City Senior Center	95991	www.yubacity.net/departments/parks_recreation/senior_center.php							x	x	x		x	
Yuba County Adult Services Division	95901			x					x		x		x	
Yuba County Board of Supervisors	95901	www.yuba.org/departments/board_of_supervisors/index.php								x				
Yuba County Children's Services	95901	www.yuba.org/departments/health_and_human_services/index.php	x						x		x	x	x	
Yuba County Family Resource Center	95901	www.yubacoe.org/Page/406			x		x		x	x				
Yuba County Health and Human Services Division	95901	www.yuba.org/departments/health_and_human_services/index.php	x		x			x	x		x	x		x
Yuba County Sheriff's Department	95901	www.yuba.org/departments/sheriff-coroner/index.php											x	
Yuba County WIC	95961	www.amplahealth.org/wic		x					x		x			
Yuba Sutter Healthcare Council	95993	www.yubasutterhealthcarecouncil.org			x				x	x	x	x		
Yuba Sutter Transit	95901	www.yubasuttertransit.com					x							
Yuba/Sutter County Mobile Smiles Dental Van- The Happy	95991, 95901, 95982	pickpeach.org/dental												x

Organization Information			Significant Health Needs										Other Health Needs	
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance Use Services	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	Access to Specialty and Extended Care	Access to Functional Needs	System Navigation	Injury and Disease Prevention and Management	Increased Community Connections	Active Living and Healthy Eating	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services
Toothmobile Dental Office														
Yuba-Sutter Counties Veteran Service Office	95901	www.suttercounty.org/government/county-departments/veteran-services	x		x	x		x	x					
Yuba-Sutter Food Bank	95991	www.feedingys.org		x										
Yuba-Sutter Gleaners Food	95991	www.freefood.org/l/yuba-sutter_gleaners_food_bank_inc		x							x			
Yuba-Sutter- Head Start, WIC	95901	www.ecenter.org		x					x					
Yuba-Sutter Meals on Wheels	95901	www.yubasuttermow.org		x										

Limits and Information Gaps

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

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

Appendix A: Impact of Actions Taken for Adventist Health and Rideout

ADVENTIST HEALTH AND RIDEOUT MEDICAL CENTER

Prior to this CHNA, RRMCM conducted its most recent CHNA in 2022. The 2022 CHNA identified the following nine prioritized health needs:

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

Working within its mission and capabilities, AHRO dedicated efforts to the following prioritized health needs over the last three years.

1. Access to Mental/Behavioral Health and Substance Use Services
2. Access to Quality Primary Care Health & Specialty Care Services
3. Increased Community Connections

Specific outcomes of these efforts are described below.

1. ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE ABUSE SERVICES.

Adventist Health and Rideout initiated several projects to positively impact the access to primary care and prescription medications. Of the initiatives set forth, the following have been most impactful:

SUN/BRIDGE NAVIGATOR PROGRAM: To address the growing opioid problem in the area, Adventist Health and Rideout and Vituity through grants started the SUN/BRIDGE Program. This program offers a patient centered approach to 24/7 access to medication for addiction treatment. Patients are treated with Buprenorphine to ease symptoms of withdrawal and then are connected to outpatient treatment with medications and counseling in the community. This model of addiction treatment with medications plus counseling is called Medication Assisted Treatment (MAT) and has been shown to be the most effective method to treat patients with Opioid Use Disorder (OUD).

Outcomes 2022-2024

- **2022: 809 total opioid use patients**
- **2023: 134 total charted patients**
 - 95 unique patients**
 - 96 28 follow up or treatment appointments made, 7 mental health appointments made**
- **2024: SUN navigator program was paused to investigate alternative funding resources.**

The Behavioral Health Collaborative

The volume of behavioral health patients in the Adventist Health and Rideout Emergency Department has steadily increased in recent years due to the lack of funding for behavioral health services and lack of facilities/providers in our rural area. To deliver the highest quality of care for behavioral health patients in the Emergency Department, Adventist Health and Rideout partnered with county resources to embed county-paid crisis counselors in the Emergency Department 24 hours a day. As a team, the county and hospital have created a process to provide high quality care to the psychiatric patient in the ED. The Behavioral Health Collaborative is made possible through the creation of a robust safety program and discharge plans by our county worker's and tele-psychiatry services. Every patient receives true psychiatric care while they are in the ED and this includes the same type of assessment, medication recommendations, and discharge and safety plans performed by behavioral health experts.

Outcomes 2019-2024: Total patients served: 14,465

- **2019: 2,227 patients served**
- **2020: 2,369 patients served**
- **2021: 2,341 patients served**
- **2022: 2,587 patients served**
- **2023: 2,603 patients served**
- **2024: 2,338 patients served**
- **2025: Data Unavailable**

Street Nursing Program – In 2019, Rideout Health initiated a street nursing program to bring healthcare services to the growing homeless population in Yuba and Sutter Counties. Well over 1,000 people are living in tents or in cars near our river's edge. A social worker and a registered nurse are currently working at both Coordinated Entry sites providing care to the homeless population in our area. The Street Nursing Team consists of two Community Outreach Street Nurses, a nutritionist, and two Community Outreach Social Workers. This team provides medical screenings, tele-doc visits, case management services, and housing navigation to the homeless population in the Yuba and Sutter Communities. The Street Nurse team does outreach with several of the above identified partner agencies in the streets and river bottoms of the Yuba Sutter Communities. Other outreach locations include Hands of Hope, The Life Building Center, Better Ways, and Harmony Village. Due to financial constraints, the program was discontinued in April 2024 with patients transitioned to Harmony Health, a local medical clinic and family resource center. AHRO also donated their van to support the mobile outreach conducted by the team.

Outcomes 2022-2024:

- **2022: 747 Individuals**
- **2023: 1032 individuals**
- **2024: 676 individuals. Program ended in April 2024**

HOUSING NAVIGATOR: In February 2021, to meet the housing needs of the community, the Community Well-Being Unit hired a Social Worker, Housing Navigator. This associate assists with the planning and coordinating of services, identifies individuals who are agreeable and suitable for housing based on income, budget, and compatibility. They will also assist with gathering items such as an ID card, Social Security cards and proof of income. 6 MONTHS of post housing Case Management will then be provided for every housed individual.

Outcomes 2022-2024

- Individuals housed in permanent housing:
2022: 56
2023: 27
2024: 6
- Individuals housed in temporary hotels and or shelters:
2022: 10
2023: 3
2024: 0

Street Nursing Social Worker: In October 2021, the Well-Being (Street Nursing Team) expanded and hired a Social Worker who provides case management in the field. This SW will partner with the RNs to assist in connecting individuals to community resources and to provide emotional support and coping skills.

Outcomes 2022-2024

- Connected to employment
2022: 9
2023: 6
2024: 1
- Connected to transportation
2022: 434
2023: 236
2024: 52
- Assisted with obtaining Medi-Cal:
2022: 0
2023: 8
2024: 8
- Connections to community resources:
2022: 299
2023: 74
2024: 16

Community Outreach Mobile Van: The community outreach van arrived on November 22, 2021. The van will offer basic health care services, triage and screening, checkups, wound care, immunizations,

social services, resources and community referrals to underserved populations. Patients will be provided care regardless of insurance or their ability to pay. Due to some technical challenges with the lift on the van, it has been in and out of the shop for service which has hindered some days of use.

Outcomes 2022-2024.

- Outreach visits:
2022: 88
2023: 46
2024: 1

Project Hope: Project Hope is a two-phase plan with a goal to build infrastructure to support the behavioral health crisis continuum in the bi-county region. Project Hope’s original concept was the development of a behavioral health campus designed to provide a range of services, addressing both clinical and non-clinical needs, covered by MediCal and the CalAIM expansion. Including:

- Medical Recuperative Care
- Short-Term Post-Hospitalization Housing
- Sobering
- Temporary Housing
- Housing Navigation
- Day Habilitation
- Supporting Spaces

Adventist Health + Rideout (AHRO) has made significant progress with “Project Hope Minor,” an estimated 20-22 bed center with limited services providing:

- Medical Recuperative Care
- Short-Term Post Hospitalization Housing
- Enhanced Care Management
- Housing Navigation

Construction will commence in March 2025 and is scheduled to be completed by the end of June 2025.

2. ACCESS TO QUALITY PRIMARY HEALTH & SPECIALTY CARE SERVICES.

Meds to Beds Program – Adventist Health and Rideout is among many hospitals nationwide that has a “Meds-to-Beds” program, in which prescription drugs are given directly to patients just before they are sent home from the hospital or emergency room. This program serves as more than just a convenience; for some patients, this is the only way they will obtain necessary medications for chronic medical conditions and other required treatments. AHRO is not allowed to bill for medications that will be used at home; these drugs must come from an outpatient pharmacy. In order to bridge this gap, AHRO partnered with the Sutter Pharmacy for both discharge counseling and dispensing medications. In

situations where the patient is unable to pay for the critical medications, Adventist Health and Rideout will pay for the medications.

Outcomes 2022-2024:

- **2022: 214 patients served**
- **2023: 150 patients served**
- **2024: 108 patients served**

Continuous Provider Recruitment

Data shows that there are 68.1 providers per 100,000 residents in the Adventist Health + Rideout (AHRO) primary and secondary service area which is well below the national rate of 111.42 providers per 100,000 residents. Additionally, there are 45,198 residents living in a health professional shortage area which represents 24.30% of the total population. Of that percentage, 51.72% are an underserved population.

2023 Recruitment Results:

- Primary Care Advanced Practitioner Providers (2)
- Specialty Advanced Practitioner Providers (Urology, Orthopedics, Trauma, Bariatrics)
- OBGYN (1)
- Interventional Cardiologists (2)

2024 Recruitment Results:

- Cardiothoracic (1)
- General Surgery (1)
- Podiatry (1)
- Obstetrics (1)
- Orthopedics (1)
- Specialty Advanced Practitioner Providers (Cardiology (3), Obstetrics, Hospital Based)

1)

2025 Recruitment Results: Complete list not available at time of published report

Adventist Health and Rideout continues to recruit primary care physicians and advanced practitioner providers (nurse practitioners and physician assistants) to the Yuba-Sutter area

3. **INCREASING COMMUNITY CONNECTIONS** –Adventist Health and Rideout have worked to align focus with community partners to create opportunities for increased, collaborative outreach efforts to maximize collective resources benefitting individuals living in the Yuba Sutter community.

- **2023 - 39 local community events with direct sponsorship of 27.**

- **2024 - 22 local community events with direct sponsorship of 19.**
- **2025 – 7 local community events through March 2025 with an estimated 37 events scheduled throughout the remainder of 2025.**

AHRO also made a dedicated effort to coordinate opportunities to partner with community organizations including Day of the Child, leveraging the collective educational and access resources to meet the needs of the children and their caregivers in the community including 3 FQHCS, Ampla, Harmony Health and Peachtree, Yuba County Health & Human Services, The Community Resource Project, Marysville Kiwanis Club and the American Lung Association. AHRO continued to further the association and alignment with Blue Zones by combining resources at seven local community events serving a broad population including Day of the Child, Yuba Sutter Shines volunteer day, Heart for Kids Walk, Peach Festival, Yuba City Summer Stroll.

Coalition building included participation in Homeless Consortium, law enforcement and city council meetings to leverage and develop new community partnerships to address mutual objectives and reach target audiences.

- **2023 - 92 hours**
- **2024 - 75 hours**
- **2025 metrics not available at time of published report**

Appendix B: Impact of Actions Taken for Sutter Surgical Hospital North Valley

Sutter Health

Sutter Surgical Hospital North Valley

Impact of Actions - Responding to the 2022 Community Health Needs Assessment

Access to Mental/Behavior/Substance-Abuse Services

Name of program/activity/initiative	Fit Quest Program
Description	The Fit Quest Program is a comprehensive children's wellness program focusing on improving nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, teaches students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way. The Fit Quest Program is incredibly impactful, reaching over 40 schools in Yuba and Sutter County, providing school assemblies and an expanded curriculum focus on nutrition, physical activity and mental wellness. The expanded curriculum and role modeling of and interactions with the Naturalists in choosing to drink water, and staying active have impacted over 2,400 students. Specialists have been engaged throughout the process attending assemblies and providing guidance and suggestions at planning meetings for continued enhancements in the Fit Quest Program. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest is to teach children healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 1,945 individuals with 2,009 services. In 2023, the program served 1,793 individuals with 4,370 services.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Fit Quest Family Camp
Description	Fit Quest Family Camp is a fun-filled weekend for the whole family, where both kids and parents experience healthy cooking classes; gardening; low-ropes challenge course; workshops on nutrition, mental wellness and physical activity; naturalist-led hikes and games; swimming; and an evening program. The program is available for up to 24 families annually and has components led by a PE specialist, Registered Dietician, Psychologist and Registered Yoga Therapist. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.

Goals	The goal of Fit Quest Family Camp is to teach children and their families healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 25 families. In 2023, the program served 31 families.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Victim Support Services
Description	The Liv On Foundation seeks to fill gaps for victim services in Yuba-Sutter counties by providing weekly support groups and creating a statewide directory of resources. Barriers for victims to escape unsafe home environments include not having enough time to safely retrieve personal belongings with law enforcement assistance and finding pet-friendly accommodations. Liv On will provide security for safe retrieval of belongings for up to an hour and pet-friendly lodging assistance for victims. Also, as part of an early intervention and prevention, yearly educational workshops will be provided for area youth in partnership with local school districts.
Goals	The goal of the program is to connect victims of domestic violence to support services and remove barriers for victims to seek safe environments. In addition, the program seeks to prevent domestic violence situations through education with youth.
Outcomes	In 2022, the program served 71 individuals with 139 services. This program ended in 2022.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, referral to services, and anecdotal stories.
Name of program/activity/initiative	Counseling for People Experiencing or At-Risk for Homelessness
Description	Funding will allow clients experiencing or at-risk for homelessness, whom do not have California Health and Wellness and Blue Shield to have access to counseling with licensed mental health professionals. Counseling is offered at two locations in a private office allowing clients to work one on one with a counselor. Counselors determine the frequency of counseling services with each client and help to connect them with any needed outside resources the counselor determines is needed.
Goals	The goal is to provide counseling services to all clients requesting assistance who are experiencing or at-risk for homelessness. By providing counseling with licensed mental health professionals, clients can overcome personal concerns and better their quality of life, with the goal of reintegrating into the community.
Outcomes	In 2022, the program served 71 individuals with 139 services. In 2023, the program served 7 individuals with 7 services.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of visits, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Harm Reduction Coalition
Description	The Yuba Sutter Healthcare Council created a Harm Reduction Coalition (HRC) to help with opioid crisis in the community. The HRC is assembled of community stakeholders to develop a plan for addressing opioid usage among clients and reducing deaths related to substance use.

Goals	The goals of the program are to partner with community organizations to develop a response plan and educate the community.
Outcomes	In 2022, the program provided 33 services. In 2023, the program provided 60 services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of community events, and anecdotal stories.
Name of program/activity/initiative	Mobile Medicine
Description	Care-A-Van is a mobile medicine care unit that provides immediate care, primary, pediatric and preventative care, behavioral health services, sexual health services, health education, STI testing, blood sugar and A1C testing, urine and pregnancy testing, blood pressure checks, immunizations, covid testing and much more. The partnership is currently with Marysville Joint Unified School District and rotates services every Wednesday between Kynoch and Dobbins elementary schools. The program is scheduled to start services in Robla School District in November 2024 every Thursday at Robla Elementary.
Goals	The goals of the program are to remove barriers for access to healthcare, behavioral health services, and specialty care.
Outcomes	New program is 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of visits, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	PBIS
Description	Each year of the three year grant, fifty participating schools across seven counties will receive professional development and technical assistance/coaching supports to implement and scale up Positive Behavioral Interventions Supports (PBIS). Participating schools will create a Tier 1 universal (prevention) system by establishing, teaching and reinforcing school wide positive social and behavioral expectations. Participating schools will also adopt evidence-based early intervention behavior supporters such as Check In Check Out and social/emotional/wellness and behavioral supports, and will build a system for identifying and matching students to these supports at Tier 2. Schools will advance into adopting intensive/individualized supports for students in need of Tier 3 intervention.
Goals	The goals of the program are to reinforce school wide positive social and behaviors.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.

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

Name of program/activity/initiative	Prevention and Diversion Program
Description	The Prevention and Diversion program is a collaboration with Sutter Yuba Homeless Consortium, Salvation Army of Yuba City, and Bridges to Housing. The program is designed to assist individuals and families in the Yuba Sutter area not eligible for government eviction assistance. Referrals are received from the Coordinated Entry System managed by

	SYHC or directly to the agencies. These individuals must display financial need through communication by a landlord or utility company. Participants of the program are at risk of being evicted from their current housing the Prevention and Diversion program will provide financial assistance of deposits, rent, utilities, or other costs to keep a client remaining in current housing or when current housing is no longer an option, pay deposit and/or rent to move client to an alternative housing situation.
Goals	The goal of the program is to prevent homeless through connecting individuals with financial assistance or other community resources.
Outcomes	In 2022, the program served 375 individuals with 133 services. In 2023, the program served 101 individuals with 101 services.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served, number of connection to resources, amount of funding distributed, number of individuals successfully housed, and anecdotal stories.
Name of program/activity/initiative	Food Rescue Program
Description	In partnership with Sutter Health, Yuba Sutter Food Bank will expand the food rescue program through replacement of a decommissioned truck. Distribution targets parts of Counties vapid of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. Food is also distributed to over 30 partner agencies who support food access in Yuba and Sutter County through a variety of programs, including food pantries and hot meals.
Goals	The goal of the program is to recover an estimated 83,000 pounds of surplus food for distribution to nearly 8,000 people who have limited access to healthy foods will improve their overall health and well being.
Outcomes	In 2022, the program served 5,689 individuals with 1,002,536 pounds of food. In 2023, the program served 81,696 individuals with 979,311 pounds of food.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, pounds of food recovered and distributed, and anecdotal stories.
Name of program/activity/initiative	Hope Express
Description	The Sutter Yuba Homeless Consortium(SYHC) and it's partner on this project, The Salvation Army Yuba Sutter Corps, have been working together for almost two decades to solve homelessness in Sutter and Yuba Counties. SYHC serves as the area's Continuum of Care, administering State and Federal funds to agencies serving homeless residents, and oversees the local Coordinated Entry Program, which is the connection point for homeless services. The Salvation Army operates two emergency shelters, The Depot and 14 Forward, as well as a comprehensive Rapid Rehousing Program, transitional housing program, prevention services, food pantry, and various seasonal assistance programs. The Salvation Army Hope Express is a mobile street outreach program providing meals to sheltered and unsheltered unhoused persons in Yuba and Sutter Counties.
Goals	The goals of the program are to provide warm meals to unhoused persons in Yuba and Sutter counties.
Outcomes	New program is 2024.

Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.
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Active Living and Healthy Eating	
Name of program/activity/initiative	Fit Quest Program
Description	The Fit Quest Program is a comprehensive children's wellness program focusing on improving nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, teaches students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way. The Fit Quest Program is incredibly impactful, reaching over 40 schools in Yuba and Sutter County, providing school assemblies and an expanded curriculum focus on nutrition, physical activity and mental wellness. The expanded curriculum and role modeling of and interactions with the Naturalists in choosing to drink water, and staying active have impacted over 2,400 students. Specialists have been engaged throughout the process attending assemblies and providing guidance and suggestions at planning meetings for continued enhancements in the Fit Quest Program. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest is to teach children healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 1,945 individuals with 2,009 services. In 2023, the program served 1,793 individuals with 4,370 services.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Fit Quest Family Camp
Description	Fit Quest Family Camp is a fun-filled weekend for the whole family, where both kids and parents experience healthy cooking classes; gardening; low-ropes challenge course; workshops on nutrition, mental wellness and physical activity; naturalist-led hikes and games; swimming; and an evening program. The program is available for up to 24 families annually and has components led by a PE specialist, Registered Dietician, Psychologist and Registered Yoga Therapist. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest Family Camp is to teach children and their families healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 25 families. In 2023, the program served 31 families.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Food Rescue Program
Description	In partnership with Sutter Health, Yuba Sutter Food Bank will expand the food rescue program through replacement of a decommissioned truck. Distribution targets parts of Counties vapid of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. Food is also distributed to over 30 partner agencies who support food access in Yuba and Sutter County through a variety of programs, including food pantries and hot meals.
Goals	The goal of the program is to recover an estimated 83,000 pounds of surplus food for distribution to nearly 8,000 people who have limited access to healthy foods will improve their overall health and well being.
Outcomes	In 2022, the program served 5,689 individuals with 1,002,536 pounds of food. In 2023, the program served 81,696 individuals with 979,311 pounds of food.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, pounds of food recovered and distributed, and anecdotal stories.
Name of program/activity/initiative	Hope Vista Playground
Description	Funding will help the completion of a playground in the neighborhood of Hope Vista, including: naming rights of the park for Sutter Health, a press release and volunteer opportunity for Sutter staff. The Salvation Army purchased a small vacant lot, 5910 Popular Avenue, east of Hope Vista (temporary housing for homeless families and camp fire victims) for construction of a playground/small park. Safety and security plans include the installation of fencing, security cameras and routine onsite staff monitoring. Children residing at Hope Vista and the surrounding neighborhood need a safe place for recreation and play. Hope Vista sits alongside the river bottom of the Feather River, an area filled with homeless encampments and heavy drug use/trafficking. Most parents do not allow their children to play outdoors.
Goals	The goals of the program are to provide a safe space for children to play outdoors and enhance social skills.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.

Access to Specialty and Extended Care

Name of program/activity/initiative	Mobile Medicine
Description	Care-A-Van is a mobile medicine care unit that provides immediate care, primary, pediatric and preventative care, behavioral health services, sexual health services, health education, STI testing, blood sugar and A1C testing, urine and pregnancy testing, blood pressure checks, immunizations, covid testing and much more. The partnership is currently with Marysville Joint Unified School District and rotates services every Wednesday between Kynoch and Dobbins elementary schools. The program is scheduled to start services in Robla School District in November 2024 every Thursday at Robla Elementary.

Goals	The goals of the program are to remove barriers for access to healthcare, behavioral health services, and specialty care.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of visits, anecdotal stories and other successful program impacts.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Women's Health Screenings and Mammograms
Description	In honor of Breast Cancer Awareness month, Sutter Medical Foundation – North offers no-cost mammograms and women's health screenings. This program remains a key initiative for SSHNV and a cornerstone event for the entire Yuba/Sutter community. This program addresses multiple prioritized significant health needs, such as access to disease and injury through knowledge; and access to quality primary care health services.
Goals	The goal of the screening event is to provide no-cost mammograms and health screenings for women who otherwise wouldn't have access to one, due to no insurance or a high, unaffordable deductibles.
Outcomes	In 2022, the program served 67 individuals with 67 services. In 2023, the program served 50 individuals with 50 services.
Metrics Used to Evaluate the program/activity/initiative	SSHNV will continue to evaluate the impact of screenings on an annual basis, by tracking the number of women served. We will also reexamine this program to ensure it evolves with the needs of the community.
Name of program/activity/initiative	Mobile Medicine
Description	Care-A-Van is a mobile medicine care unit that provides immediate care, primary, pediatric and preventative care, behavioral health services, sexual health services, health education, STI testing, blood sugar and A1C testing, urine and pregnancy testing, blood pressure checks, immunizations, covid testing and much more. The partnership is currently with Marysville Joint Unified School District and rotates services every Wednesday between Kynoch and Dobbins elementary schools. The program is scheduled to start services in Robla School District in November 2024 every Thursday at Robla Elementary.
Goals	The goals of the program are to remove barriers for access to healthcare, behavioral health services, and specialty care.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of visits, anecdotal stories and other successful program impacts.

Access to Functional Needs

Name of program/activity/initiative	Create Coalitions for Unmet Community Health Needs
Description	The Yuba Sutter Healthcare Council will create a strategic plan based on Sutter Surgical Hospital North Valley's recent CHNA to identify needs not being met in the community. In partnership with Sutter Health, the Yuba Healthcare Council and Foundation will increase access and organizational capacity in two of the eight significant health needs

	identified in the CHNA. Two cohorts will be identified, coordinated, and assembled to discuss local resources and asset mapping to develop an Access and Capacity Action Plan. Sutter Health will have an advisory role on the committees.
Goals	The goal is to convene key stakeholders in the community develop plans and combine resources to address gaps in community health needs.
Outcomes	In 2022, the program provided outreach to 497 individuals. The Yuba Sutter Healthcare Council board of directors will continue to work through the Next Step Summary report and will continue to develop, coordinate, and implementing the social infrastructure and capacity and delivery of Community Response Teams. In 2023 Yuba Sutter Healthcare Council board of directors continued to work through the Next Step Summary report and continued to develop, coordinate, and implement the social infrastructure and capacity and delivery of Community Response Teams.
Metrics Used to Evaluate the program/activity/initiative	Number of events, number of key stakeholders, and creation of strategic plan.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Victim Support Services
Description	The Liv On Foundation seeks to fill gaps for victim services in Yuba-Sutter counties by providing weekly support groups and creating a statewide directory of resources. Barriers for victims to escape unsafe home environments include not having enough time to safely retrieve personal belongings with law enforcement assistance and finding pet-friendly accommodations. Liv On will provide security for safe retrieval of belongings for up to an hour and pet-friendly lodging assistance for victims. Also, as part of an early intervention and prevention, yearly educational workshops will be provided for area youth in partnership with local school districts.
Goals	The goal of the program is to connect victims of domestic violence to support services and remove barriers for victims to seek safe environments. In addition, the program seeks to prevent domestic violence situations through education with youth.
Outcomes	In 2022, the program served 71 individuals with 139 services. This program ended in 2022.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, referral to services, and anecdotal stories.
Name of program/activity/initiative	Fit Quest Program
Description	The Fit Quest Program is a comprehensive children's wellness program focusing on improving nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, teaches students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way. The Fit Quest Program is incredibly impactful, reaching over 40 schools in Yuba and Sutter County, providing school assemblies and an expanded curriculum focus on nutrition, physical activity and mental wellness. The expanded curriculum and role modeling of and interactions with the Naturalists in choosing to drink water, and staying active have

	impacted over 2,400 students. Specialists have been engaged throughout the process attending assemblies and providing guidance and suggestions at planning meetings for continued enhancements in the Fit Quest Program. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest is to teach children healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 1,945 individuals with 2,009 services. In 2023, the program served 1,793 individuals with 4,370 services.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Fit Quest Family Camp
Description	Fit Quest Family Camp is a fun-filled weekend for the whole family, where both kids and parents experience healthy cooking classes; gardening; low-ropes challenge course; workshops on nutrition, mental wellness and physical activity; naturalist-led hikes and games; swimming; and an evening program. The program is available for up to 24 families annually and has components led by a PE specialist, Registered Dietician, Psychologist and Registered Yoga Therapist. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest Family Camp is to teach children and their families healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 25 families. In 2023, the program served 31 families.
Name of program/activity/initiative	Women's Health Screenings and Mammograms
Description	In honor of Breast Cancer Awareness month, Sutter Medical Foundation – North offers no-cost mammograms and women's health screenings. This program remains a key initiative for SSHNV and a cornerstone event for the entire Yuba/Sutter community. This program addresses multiple prioritized significant health needs, such as access to disease and injury through knowledge; and access to quality primary care health services.
Goals	The goal of the screening event is to provide no-cost mammograms and health screenings for women who otherwise wouldn't have access to one, due to no insurance or a high, unaffordable deductibles.
Outcomes	In 2022, the program served 67 individuals with 67 services. In 2023, the program served 50 individuals with 50 services.
Metrics Used to Evaluate the program/activity/initiative	SSHNV will continue to evaluate the impact of screenings on an annual basis, by tracking the number of women served. We will also reexamine this program to ensure it evolves with the needs of the community.
Name of program/activity/initiative	Food Rescue Program
Description	In partnership with Sutter Health, Yuba Sutter Food Bank will expand the food rescue program through replacement of a decommissioned truck. Distribution targets parts of Counties vapid of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. Food is also distributed to over 30 partner agencies who support food access in

	Yuba and Sutter County through a variety of programs, including food pantries and hot meals.
Goals	The goal of the program is to recover an estimated 83,000 pounds of surplus food for distribution to nearly 8,000 people who have limited access to healthy foods will improve their overall health and well being.
Outcomes	In 2022, the program served 5,689 individuals with 1,002,536 pounds of food. In 2023, the program served 81,696 individuals with 979,311 pounds of food.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, pounds of food recovered and distributed, and anecdotal stories.
Name of program/activity/initiative	Adverse Childhood Experiences
Description	The Sierra Community Medical Foundation, and the Medical Societies new program for Placer, Yuba, Sutter counties has comprehensive education, an expanded health service model and specialty care that will reduce the mental anxiety, stress and depression that is being shown in our communities. Education opportunities include trainings for social, education and health care representatives; webinars for tools and techniques to remedy the stress from the outlook of our social abnormalities due to COVID-19 for families and community-based organizations. The Clinical Service model will be operated and managed by Dr. Craig Corp, MD Sutter Health Pediatrician.
Goals	Through this work, there will be a development of a network of agencies, families, health and social providers that lead to the capitalization of an improved outcome for the family members.
Outcomes	In 2022, the program served 4,605 individuals with 2,932 services. In 2023, the program served 2,648 individuals with 5,590 services.
Metrics Used to Evaluate the program/activity/initiative	Number of community events, number of people reached and anecdotal stories.
Name of program/activity/initiative	Harm Reduction Coalition
Description	The Yuba Sutter Healthcare Council created a Harm Reduction Coalition (HRC) to help with opioid crisis in the community. The HRC is assembled of community stakeholders to develop a plan for addressing opioid usage among clients and reducing deaths related to substance use.
Goals	The goals of the program are to partner with community organizations to develop a response plan and educate the community.
Outcomes	In 2022, the program reached 347 individuals with 33 services. In 2023, the program provided 60 services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of community events, and anecdotal stories.
Name of program/activity/initiative	Mobile Medicine
Description	Care-A-Van is a mobile medicine care unit that provides immediate care, primary, pediatric and preventative care, behavioral health services, sexual health services, health education, STI testing, blood sugar and A1C testing, urine and pregnancy testing, blood pressure checks, immunizations, covid testing and much more. The partnership is currently with Marysville Joint Unified School District and rotates services every Wednesday between Kynoch and Dobbins elementary schools. The

	program is scheduled to start services in Robla School District in November 2024 every Thursday at Robla Elementary.
Goals	The goals of the program are to remove barriers for access to healthcare, behavioral health services, and specialty care.
Outcomes	New program is 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of visits, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Hope Express
Description	The Sutter Yuba Homeless Consortium (SYHC) and its partner on this project, The Salvation Army Yuba Sutter Corps, have been working together for almost two decades to solve homelessness in Sutter and Yuba Counties. SYHC serves as the area's Continuum of Care, administering State and Federal funds to agencies serving homeless residents, and oversees the local Coordinated Entry Program, which is the connection point for homeless services. The Salvation Army operates two emergency shelters, The Depot and 14 Forward, as well as a comprehensive Rapid Rehousing Program, transitional housing program, prevention services, food pantry, and various seasonal assistance programs. The Salvation Army Hope Express is a mobile street outreach program providing meals to sheltered and unsheltered unhoused persons in Yuba and Sutter Counties.
Goals	The goals of the program are to provide warm meals to unhoused persons in Yuba and Sutter counties.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.

Increased Community Connections

Name of program/activity/initiative	Fit Quest Program
Description	The Fit Quest Program is a comprehensive children's wellness program focusing on improving nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, teaches students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way. The Fit Quest Program is incredibly impactful, reaching over 40 schools in Yuba and Sutter County, providing school assemblies and an expanded curriculum focus on nutrition, physical activity and mental wellness. The expanded curriculum and role modeling of and interactions with the Naturalists in choosing to drink water, and staying active have impacted over 2,400 students. Specialists have been engaged throughout the process attending assemblies and providing guidance and suggestions at planning meetings for continued enhancements in the Fit Quest Program. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest is to teach children healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 1,945 individuals with 2,009 services.

	In 2023, the program served 1,793 individuals with 4,370 services.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Fit Quest Family Camp
Description	Fit Quest Family Camp is a fun-filled weekend for the whole family, where both kids and parents experience healthy cooking classes; gardening; low-ropes challenge course; workshops on nutrition, mental wellness and physical activity; naturalist-led hikes and games; swimming; and an evening program. The program is available for up to 24 families annually and has components led by a PE specialist, Registered Dietician, Psychologist and Registered Yoga Therapist. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to disease and injury through knowledge, action and access to resources; and active living and healthy eating.
Goals	The goal of Fit Quest Family Camp is to teach children and their families healthy lessons about the importance of physical fitness, mental wellness and nutritious eating.
Outcomes	In 2022, the program served 25 families. In 2023, the program served 31 families.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Victim Support Services
Description	The Liv On Foundation seeks to fill gaps for victim services in Yuba-Sutter counties by providing weekly support groups and creating a statewide directory of resources. Barriers for victims to escape unsafe home environments include not having enough time to safely retrieve personal belongings with law enforcement assistance and finding pet-friendly accommodations. Liv On will provide security for safe retrieval of belongings for up to an hour and pet-friendly lodging assistance for victims. Also, as part of an early intervention and prevention, yearly educational workshops will be provided for area youth in partnership with local school districts.
Goals	The goal of the program is to connect victims of domestic violence to support services and remove barriers for victims to seek safe environments. In addition, the program seeks to prevent domestic violence situations through education with youth.
Outcomes	In 2022, the program served 71 individuals with 139 services. This program ended in 2022.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, referral to services, and anecdotal stories.
Name of program/activity/initiative	Harm Reduction Coalition
Description	The Yuba Sutter Healthcare Council created a Harm Reduction Coalition (HRC) to help with opioid crisis in the community. The HRC is assembled of community stakeholders to develop a plan for addressing opioid usage among clients and reducing deaths related to substance use.
Goals	The goals of the program are to partner with community organizations to develop a response plan and educate the community.
Outcomes	In 2022, the program provided 33 services.

	In 2023, the program provided 60 services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of community events, and anecdotal stories.
Name of program/activity/initiative	Create Coalitions for Unmet Community Health Needs
Description	The Yuba Sutter Healthcare Council will create a strategic plan based on Sutter Surgical Hospital North Valley's recent CHNA to identify needs not being met in the community. In partnership with Sutter Health, the Yuba Healthcare Council and Foundation will increase access and organizational capacity in two of the eight significant health needs identified in the CHNA. Two cohorts will be identified, coordinated, and assembled to discuss local resources and asset mapping to develop an Access and Capacity Action Plan. Sutter Health will have an advisory role on the committees.
Goals	The goal is to convene key stakeholders in the community develop plans and combine resources to address gaps in community health needs.
Outcomes	In 2022, the program provided outreach to 497 individuals. The Yuba Sutter Healthcare Council board of directors will continue to work through the Next Step Summary report and will continue to develop, coordinate, and implementing the social infrastructure and capacity and delivery of Community Response Teams. In 2023 Yuba Sutter Healthcare Council board of directors continued to work through the Next Step Summary report and continued to develop, coordinate, and implement the social infrastructure and capacity and delivery of Community Response Teams.
Metrics Used to Evaluate the program/activity/initiative	Number of events, number of key stakeholders, and creation of strategic plan.
Name of program/activity/initiative	PBIS
Description	Each year of the three-year grant, fifty participating schools across seven counties will receive professional development and technical assistance/coaching supports to implement and scale up Positive Behavioral Interventions Supports (PBIS). Participating schools will create a Tier 1 universal (prevention) system by establishing, teaching and reinforcing school wide positive social and behavioral expectations. Participating schools will also adopt evidence-based early intervention behavior supporters such as Check In Check Out and social/emotional/wellness and behavioral supports, and will build a system for identifying and matching students to these supports at Tier 2. Schools will advance into adopting intensive/individualized supports for students in need of Tier 3 intervention.
Goals	The goals of the program are to reinforce school wide positive social and behaviors.
Outcomes	New program is 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Hope Vista Playground
Description	Funding will help the completion of a playground in the neighborhood of Hope Vista, including: naming rights of the park for Sutter Health, a press release and volunteer opportunity for Sutter staff. The Salvation Army purchased a small vacant lot, 5910 Popular Avenue, east of Hope Vista

	(temporary housing for homeless families and camp fire victims) for construction of a playground/small park. Safety and security plans include the installation of fencing, security cameras and routine onsite staff monitoring. Children residing at Hope Vista and the surrounding neighborhood need a safe place for recreation and play. Hope Vista sits alongside the river bottom of the Feather River, an area filled with homeless encampments and heavy drug use/trafficking. Most parents do not allow their children to play outdoors.
Goals	The goals of the program are to provide a safe space for children to play outdoors and enhance social skills.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.

Safe and Violence-Free Environment

Name of program/activity/initiative	Victim Support Services
Description	The Liv On Foundation seeks to fill gaps for victim services in Yuba-Sutter counties by providing weekly support groups and creating a statewide directory of resources. Barriers for victims to escape unsafe home environments include not having enough time to safely retrieve personal belongings with law enforcement assistance and finding pet-friendly accommodations. Liv On will provide security for safe retrieval of belongings for up to an hour and pet-friendly lodging assistance for victims. Also, as part of an early intervention and prevention, yearly educational workshops will be provided for area youth in partnership with local school districts.
Goals	The goal of the program is to connect victims of domestic violence to support services and remove barriers for victims to seek safe environments. In addition, the program seeks to prevent domestic violence situations through education with youth.
Outcomes	In 2022, the program served 71 individuals with 139 services. This program ended in 2022.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, referral to services, and anecdotal stories.
Name of program/activity/initiative	Harm Reduction Coalition
Description	The Yuba Sutter Healthcare Council created a Harm Reduction Coalition (HRC) to help with opioid crisis in the community. The HRC is assembled of community stakeholders to develop a plan for addressing opioid usage among clients and reducing deaths related to substance use.
Goals	The goals of the program are to partner with community organizations to develop a response plan and educate the community.
Outcomes	In 2022, the program provided 33 services. In 2023, the program provided 60 services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of community events, and anecdotal stories.
Name of program/activity/initiative	Building Dignity

Description	The objective of this program is to provide DV survivors with an enhanced sense of safety and security in our violence-free environment while also enhancing space for activity and wellness. Over the years, Casa's physical location has become widely known due to its extended operation at the same site. While this familiarity has facilitated victim access to our services, it has also, unfortunately, made it easier for their abusers to locate them, compromising our clients' safety and comfort. Grant funding will be used to complete a fencing structure that will directly contribute to enhancing location safety.
Goals	The goals of the program are to enhance safety for residents escaping domestic violence.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	Number of people served and anecdotal stories.
Name of program/activity/initiative	PBIS
Description	Each year of the three-year grant, fifty participating schools across seven counties will receive professional development and technical assistance/coaching supports to implement and scale up Positive Behavioral Interventions Supports (PBIS). Participating schools will create a Tier 1 universal (prevention) system by establishing, teaching and reinforcing school wide positive social and behavioral expectations. Participating schools will also adopt evidence-based early intervention behavior supporters such as Check In Check Out and social/emotional/wellness and behavioral supports, and will build a system for identifying and matching students to these supports at Tier 2. Schools will advance into adopting intensive/individualized supports for students in need of Tier 3 intervention.
Goals	The goals of the program are to reinforce school wide positive social and behaviors.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.
Name of program/activity/initiative	Hope Vista Playground
Description	Funding will help the completion of a playground in the neighborhood of Hope Vista, including: naming rights of the park for Sutter Health, a press release and volunteer opportunity for Sutter staff. The Salvation Army purchased a small vacant lot, 5910 Popular Avenue, east of Hope Vista (temporary housing for homeless families and camp fire victims) for construction of a playground/small park. Safety and security plans include the installation of fencing, security cameras and routine onsite staff monitoring. Children residing at Hope Vista and the surrounding neighborhood need a safe place for recreation and play. Hope Vista sits alongside the river bottom of the Feather River, an area filled with homeless encampments and heavy drug use/trafficking. Most parents do not allow their children to play outdoors.
Goals	The goals of the program are to provide a safe space for children to play outdoors and enhance social skills.
Outcomes	New program in 2024.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, anecdotal stories and other successful program impacts.

Needs Sutter Surgical Hospital – North Valley Plans Not to Address

All health needs were addressed in 2024.

Approval by Governing Board

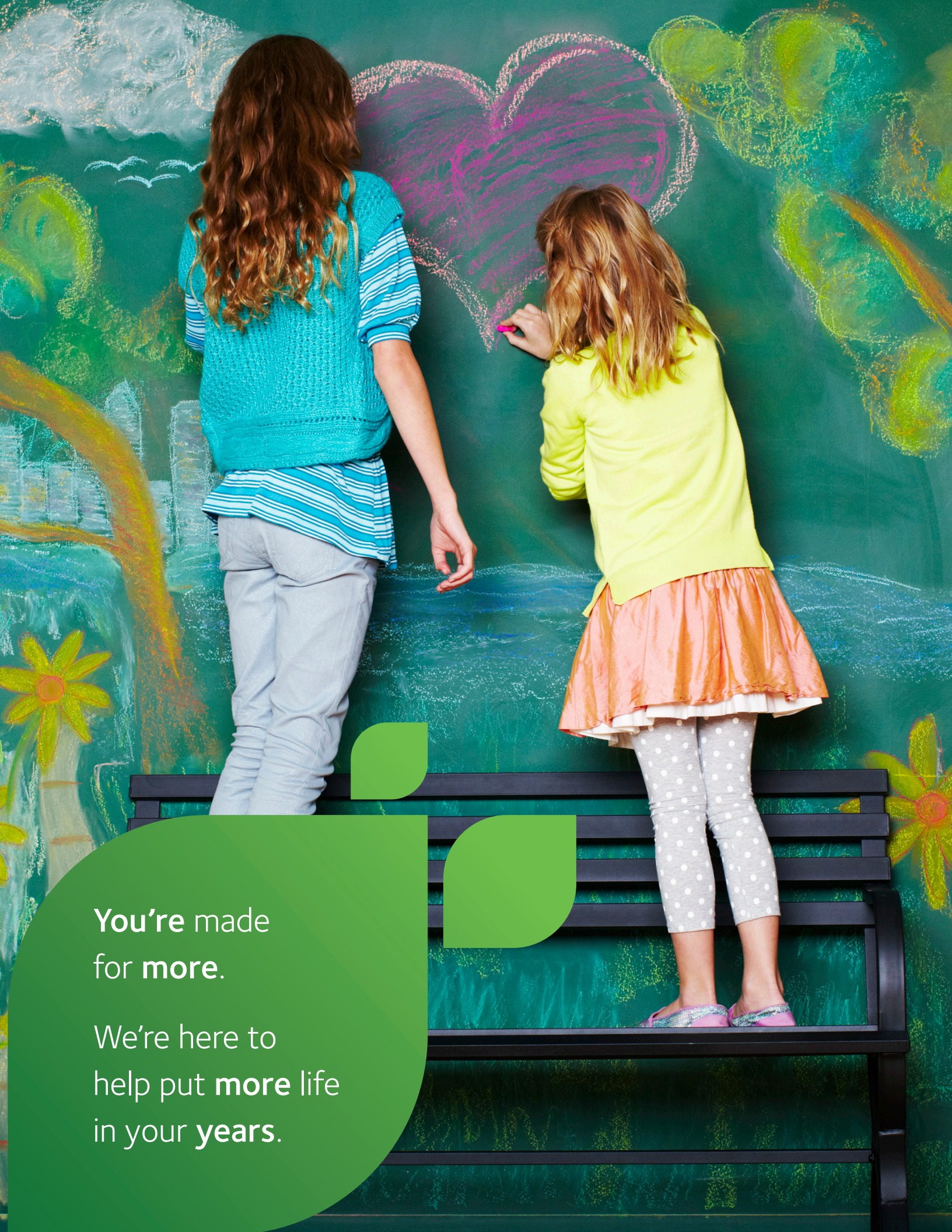
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on July 21, 2022.

2023 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association.

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.

A photograph of two children, a girl and a boy, standing on a black wooden bench and drawing on a large green chalkboard. The girl, on the right, is wearing a bright yellow sweater and an orange skirt, and is actively drawing a large pink heart on the board. The boy, on the left, is wearing a blue and white striped shirt under a blue vest and grey pants, and is looking at the drawing. The chalkboard is covered in colorful chalk drawings, including a cityscape with a rainbow on the left, a large pink heart in the center, and various abstract shapes and flowers on the right. The background is a vibrant green with yellow and orange accents.

You're made
for **more**.

We're here to
help put **more** life
in your **years**.

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.

Chris Champlin

President, Adventist Health and Rideout

726 4th Street.
Marysville, CA 95901

