2016 Community Health Needs Assessment

Kaiser Foundation Hospital Fresno
License #040000384

Approved by KFH Board of Directors
September 21, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

KAISER PERMANENTE®

Authors
Marie Sanchez, Kaiser Permanente, Central Valley Area and Dana Williamson, Kaiser Permanente, Northern California Region, with input from Maria Hernandez, PhD Senior Associate, Scott Ormerod, Founder and Managing Partner, and Susana Morales-Konishi from Leap Solutions LLC.

Acknowledgements
This report was made possible through a partnership with the Hospital Council of Northern and Central California's (HCNCC) Community Benefit Needs Workgroup[1] comprised of 14 hospitals.

Kaiser Foundation Hospital (KFH) Fresno would like to thank the community for their contributions in helping identify the top health needs for the KFH-Fresno service area.

[1] Members of the Community Benefit Needs Workgroup are: Leticia Lopez (Adventist Health/Adventist Medical Center); Tim Curley (Valley Children's Healthcare); Alma Martinez (Community Medical Centers); Rob Veneski (Kaiser Permanente Fresno Medical Center); John Tyndal (Kaweah Delta Health Care District); Mark Foote (Madera Community Hospital); Eric Linville (Saint Agnes Medical Center); Brenda Weyhrauch (Sierra View District Hospital), Sharon Spurgeon (Coalinga Regional District Hospital).

Table of Contents

I. EXECUTIVE SUMMARY 5
- A. Community Health Needs Assessment (CHNA) Background 5
- B. Summary of Prioritized Needs 5
- C. Summary of Needs Assessment Methodology and Process 5

II. INTRODUCTION/BACKGROUND 6
- A. About Kaiser Permanente (KP) 6
- B. About Kaiser Permanente Community Benefit 6
- C. Purpose of the Community Health Needs Assessment (CHNA) Report 6
- D. Kaiser Permanente's Approach to Community Health Needs Assessment 7

III. COMMUNITY SERVED 7
- A. Kaiser Permanente's Definition of Community Served 7
- B. Map and Description of Community Served 7

IV. WHO WAS INVOLVED IN THE ASSESSMENT 9

A. Identity of hospitals that collaborated on the assessment 9
- B. Other partner organizations that collaborated on the assessment 9
- C. Identity and qualifications of consultants used to conduct the assessment 9

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA 10
- A. Secondary data 10
- B. Community input 10
- C. Written comments 11
- D. Data limitations and information gaps 12

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS 12
- A. Identifying community health needs 12
- B. Process and criteria used for prioritization of the health needs 13
- C. Prioritized description of all the community health needs identified through the CHNA 14
- D. Community resources potentially available to respond to the identified health needs 15

VII. KFH FRESNO 2013 implementation strategy Evaluation of Impact 16
- A. Purpose of 2013 Implementation Strategy evaluation of impact 16
- B. 2013 Implementation Strategy Evaluation Of Impact Overview 16
- C. 2013 Implementation Strategy Evaluation of Impact by Health Need 19

VIII. APPENDIX 33

APPENDIX A: Secondary Data Sources and Dates 34

APPENDIX B: Community Input Tracking Form 40

APPENDIX C: Health Need Summary Profiles (Alphabetical Order) 44
APPENDIX D: Primary Data Collection Questions 70
APPENDIX E: Data for Health Need Identification 78
APPENDIX F: KP Fresno Service Area Prioritization Exercise Matrix 97

I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

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

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

B. Summary of Prioritized Needs

Seven health needs were identified through a process that was informed by secondary data, key informant interviews, and community members participating in surveys and focus groups throughout the four counties that comprise the KFH Fresno service area. These health needs were prioritized using a process that included established criteria to assign a score to each health need. The score was then used to establish the priority order for the list of identified community health needs. The resulting order, from highest priority to lowest priority, is as follows:

1. Economic Security
2. Asthma
3. Diabetes
4. Access to Healthcare
5. Obesity
6. Mental Health
7. Substance Abuse

C. Summary of Needs Assessment Methodology and Process

KFH Fresno partnered with the Hospital Council of Northern and Central California's Community Benefit Needs Workgroup[2] comprised of 14 hospitals. Secondary data cited in this CHNA report comes from the Kaiser Permanent CHNA data platform and additional sources (Appendix: A). Potential health needs that benchmarked 2% below state averages were identified as affirming that a health need existed. Primary data collection to provide additional insight into the communities health needs was collected from stakeholder interviews, focus groups and community surveys with community residents, representatives and leaders from Fresno, Kings, Madera, and Tulare counties. Health needs where health disparities exist, were identified through secondary data, and affirmed by 2 out of the 3 primary data sources were then prioritized by the community in numerical order. The next step in this process will be to develop an implementation strategy for addressing selected health needs, which will build on Kaiser Permanente's assets and resources, as well as evidence based strategies.

[2] Members of the Community Benefit Needs Workgroup are: Leticia Lopez (Adventist Health/Adventist Medical Center); Tim Curley (Valley Children's Healthcare); Alma Martinez (Community Medical Centers); Rob Veneski (Kaiser Permanente Fresno Medical Center); John Tyndal (Kaweah Delta Health Care District); Mark Foote (Madera Community Hospital); Eric Linville (Saint Agnes Medical Center); Brenda Weyhrauch (Sierra View District Hospital), Sharon Spurgeon (Coalinga Regional District Hospital).

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must

conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

D. Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

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

In conjunction with this report, KFH-Fresno will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

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

B. Map and Description of Community Served

i. Map

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

The KFH-Fresno service area includes eastern Fresno County, most of Madera County, northeast Kings County, and northwest Tulare County, and the cities and towns of Ahwahnee, Auberry, Bass Lake, Biola, Burrel, Caruthers, Clovis, Coarsegold, Del Rey, Dinuba, Five Points, Fresno, Fowler, Friant, Hanford, Helm, Kerman, Kingsburg, Laton, Madera, North Fork, Oakhurst, O'Neals, Orange Cove, Parlier, Piedra, Prather, Raisin City, Reedley, Riverdale, San Joaquin, Sanger, Selma, Squaw Valley, Sultana, Tollhouse, Tranquillity, Traver, and Wishon.

iii. Demographic profile of community served

Current population demographics and changes in demographic composition over time play a determining role in the types of health and social services needed by communities. This section provides an overview of the demographics of the KFH-Fresno service area.

KFH-Fresno Demographic Data	
Total Population	1,127,410
White	62.86%
Black	4.65%
Asian	8.64%
Native American/ Alaskan Native	1.06%
Pacific Islander/ Native Hawaiian	0.15%
Some Other Race	18.59%
Multiple Races	4.04%
Hispanic/Latino	51.49%

KFH-Fresno Socio-economic Data	
Living in Poverty (<200% FPL)	50.28%
Children in Poverty	37.42%
Unemployed	11.3%
Uninsured	18.16%
No High School Diploma	26.3%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

KFH Fresno conducted portions of this Community Health Needs Assessment (CHNA) in collaboration with other hospitals in the region as part of the Hospital Council of Northern and Central California Community Benefit Needs Work Group. The facilities directly involved in collecting survey data, facilitating focus group participation, identifying key stakeholders in the region, and identifying a list of needs for each of the counties included in the KFH-Fresno service area were:

- Adventist Health/Central Valley Network
- Community Medical Centers
- Coalinga Regional District Hospital
- Kaweah Delta Medical Center
- Madera Community Hospital
- Saint Agnes Medical Center
- Sierra View Medical Center
- Tulare Regional Medical Center
- Valley Children's Hospital

B. Other partner organizations that collaborated on the assessment

Fresno Metro Ministry, a nonprofit established in 1970 with a mission to advocate for the health and well-being of the community, and Centro La Familia Advocacy Services, a nonprofit working to empower low income people to access life sustaining resources through education, training and social services, were contracted to assist with the community outreach efforts. In addition, the Madera County Department of Public Health assisted with the outreach efforts in Madera County.

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

Leap Solutions, LLC facilitated the development of the four county community health needs assessment for the Hospital Council of Northern and Central California. Staff included Maria Hernandez, PhD, Senior Associate, and Scott Ormerod, Founder and Managing Partner, and Consultant Susana Morales-Konishi. All three consultants have prior experience designing community surveys, coordinating community outreach efforts, conducting stakeholder interviews, and facilitating focus groups. In addition to these experiences, all three have done prior work coordinating and facilitating projects in public health departments, hospital systems and nonprofits serving special needs populations. Dr. Maria Hernandez brings unique expertise in upstream community health interventions related to asthma, hospital governance, and population health.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

A. Secondary data

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

KFH-Fresno used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. In addition, several other public health databases and publications were used to review ethnic disparities and child and maternal health indicators. For details on specific sources and dates of the data used, please see Appendix A.

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

In order to understand how the indicators used in the assessment relate to health needs in the community the indicators were organized according to the 14 most commonly identified health needs from the 2013 CHNA. This allowed for easier analysis and interpretation. Data was pulled for each of the four counties within the HCHCC collaborative hospitals' service areas in order to allow each hospital in the collaborative to use the findings relevant to their service area. The data was compared to the state average in order to understand the health needs faced by each county and, when available, data was examined by racial and ethnic groups to examine possible health disparities. The results from the secondary data analysis were used in the identification of health needs, described later.

B. Community input

i. Description of the community input process

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

ii. Methodology for collection and interpretation

Community input was collected through surveys, focus groups, and key informant interviews in each of the four counties that comprise the KFH Fresno service area (Fresno, Kings, Tulare and Madera Counties). The goal of soliciting community input was to gather the community's perspective on the priority health needs for each county and any community assets or resources available to address those needs. All three methodologies focused on the same set of questions which asked about the biggest health, social and economic problems facing the community, obstacles to a healthy environment, behaviors that affect health, and barriers that make it hard to access health care. Community input validated a health need when at least two points were assigned using the criteria outlined for each methodology.

Survey Methodology

The community survey was available on a web platform called Survey Monkey in both Spanish and English and was based on an existing survey developed by Madera County Public Health Department and the Healthy Madera Coalition. Links to the survey were emailed to the community. Responses to the survey were confidential and the survey remained open between July 1 and December 2, 2015. A total of 1,125 surveys were completed across the four county area that

comprises the KFH Fresno service area. Survey data that had been collected as part of a previous effort by the Madera County Department of Public Health was also included in the CHNA analysis.

The survey responses were analyzed by county and the responses to the seven questions most directly relevant to assessing health needs - questions 11-16 (Appendix D) were used in the analysis of health needs. In each county where 20% or more of survey respondents indicated one of the potential health needs as a major concern, that health need received one point in that county. Points were from the survey analysis were eventually tallied with points from other primary data collection analysis and then used as criteria for the identification of the final list of health needs.

Focus Group Methodology

Leap Solutions consultants conducted a total of 15 focus groups, ranging in size from three to twenty eight participants (Appendix D). Participants included representatives from local public health departments as well as leaders, representatives, and members of medically underserved, low-income, and minority populations.

Focus group participants were shown secondary data on the status of health in their county. Participants were also shown preliminary data results from the Health Needs Assessment Survey for the relevant county and then asked to comment on the results and provide their own perspective on community health needs.

Focus group responses were analyzed according to the 14 potential health need categories and a health need got a point if it was identified as a significant issue by the focus groups for that county as illustrated in responses to question 11 that asks "What are the 3 biggest health problems in your county?" on the survey

Stakeholder Interview Methodology

A total of 34 interviews were conducted across all four counties during the months of July - November 2015. The individuals included County Public Health Directors, hospital executives, and nonprofit leaders who serve the community with social, health, or educational support services. A list of individuals interviewed appears in (Appendix B).

Stakeholder interviews followed a similar format to the focus groups. Leap Solutions provided each of the key informants interviewed with a copy of preliminary results from the Community Health Needs Assessment Survey for their county as well as secondary data on the status of health in their county. Each stakeholder was asked to comment on existing results and then provide their own perspective on community health needs in their county.

Stakeholders who were based in a healthcare setting were also asked additional questions about how their organization is addressing the needs of the community. For a complete list of the stakeholder interview questions, see (Appendix B).

Similar to the process for survey results and focus group data, the potential health needs were assigned a point if stakeholders in that county identified that need as a major issue facing the community.

C. Written comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through *CHNA-communications@kp.org.* This website will continue to allow for written community input on the facilities most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH Fresno had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

The KP CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying community health needs

i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

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

In order to determine the significant community health needs for the KFH Fresno service area, KFH Fresno staff examined the data to determine the extent to which the following criteria were met in each individual county:

- The health need was affirmed by secondary data in that county - at least one indicator performed poorly compared to the State
- A health disparity exists
- Community input confirmed the health need - the health need was validated by at least two primary data sources (focus groups, surveys, stakeholder interviews)

Based on this analysis by county, a health heed was then identified as significant for the KFH Fresno service area if all three criteria mentioned above were met in at least two of the four service area counties. (Table A)

Table A: Health Needs by County

Potential Health Needs For Review	Fresno	Kings	Madera	Tulare
	☑ =Secondary Data Worse Than Benchmark by 2% ☒ = Community Identified It as a Health Need ‡ = Health Disparity exists			
Access to Care	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡
Asthma (Breathing Problems)	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡
Cancers	☑‡	☑‡	☑‡	☑‡

Climate & Health	☑ ☒	☑ ☒	☒	☑ ☒
CVD/Stroke (Heart Disease)		☒	☑	
Diabetes	☑ ☒ ‡	☑☒‡	☑ ☒ ‡	☑ ☒ ‡
Economic Security	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡
HIV/AIDS/STDS	☑‡	‡	‡	‡
Maternal /Infant Health	‡	‡		☑ ‡
Mental Health	☑☒ ‡	☑☒ ‡	☑ ☒ ‡	☑ ☒ ‡
Obesity	☑ ☒‡	☑ ☒ ‡	☑ ☒ ‡	☑ ☒ ‡
Oral Health	☑ ‡	☑ ‡	☑ ☒ ‡	☑ ‡
Overall Health	☑	☑		☑
Substance Abuse	☑ ‡	☑ ☒	☑ ☒ ‡	☑ ☒ ‡
Violence/Injury Prevention	☑ ‡	☑‡	☑ ☒ ‡	☒ ‡

Based on the criteria, a total of seven significant community health needs were identified for the KFH-Fresno service area.

- Access to Care
- Asthma
- Diabetes
- Economic Security
- Mental Health
- Obesity
- Substance Abuse

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

The seven identified health needs for the KFH-Fresno service area were prioritized by a group of six individuals that consisted of stakeholders from both Kaiser Permanente and the broader community. Individuals who were invited to participate in the prioritization process were selected because of their experience with and knowledge of the community. The following steps were taken to prioritize the KFH-Fresno community health needs:

Step 1

A prioritization matrix was created (Appendix F) that includes a row for each of the 7 health needs and a column for each of the equally weighted prioritization criteria:

- Severity of Health Need - This need greatly impacts individual quality of life.
- Magnitude/Scale of Need - This need impacts large numbers of residents.
- Clear Disparities or Inequities - This need impacts certain sub-populations more than others

A webinar was scheduled to walk participants through the data that they would use to score each health need. Following the presentation participants were instructed to complete the matrix on their own time and submit the results within 3 days. Participants were instructed to use the matrix to score each health need on a scale of 1-3 (1=criterion not met; 3=criterion met well) for each of the three criteria. Participants were also asked to rank each health need on a scale of 1-7 (1 = Most important; 7 = Least important) based on their ratings across the three criteria.

Step 2

In order to determine the final prioritization results, respondent scores were averaged across the three criteria for each health need (e.g., If a respondent indicated a score of 2 for Severity of Health Need, 1 for Magnitude/Scale of Need, and 3 for Clear Disparities or Inequities, the average score is

2 for the health need). Points were also assigned to each health need based on the rank given by each respondent (7 points for the highest ranked, 1 point for the lowest ranked). These two numbers, the criteria score average and the rank score, were added together across all respondents to determine a total prioritization score for each health need (Table B).

Table B: Prioritization Matrix

	Access to Healthcare	Asthma	Diabetes	Economic Security	Mental Health	Obesity	Substance Abuse
Respondent 1	9	8.66	9.33	10	6.33	7.66	6
Respondent 2	4	8.66	5	10	6	8	2
Respondent 3	1.66	2.33	2	3	2.33	1.66	2.66
Respondent 4	6	5.33	6	2.33	8	4	8
Respondent 5	4	7	6	8	5	2	4
Respondent 6	6	4	5	3	2	7	1
Total Score	30.66	35.98	33.33	36.33	29.66	30.32	23.66
Rank	**4**	**2**	**3**	**1**	**6**	**5**	**7**

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

As a result of the prioritization process, the health needs were prioritized as follows (listed from highest to lowest priority). Additional details about the prioritized health needs are available in (Appendix C).

1. **Economic Security**. The four counties in the service area have concentrated poverty which translates into poor economic security. Black, Native American/Alaska Native and Hispanic/Latino populations are among those most impacted by poverty. The unemployment rate for the four county area is 13.7 well above the California rate of 8.4. In this area 26.3% of adults 25 years and older do not have a high school diploma, which is higher when compared to the state. This indicator is relevant because low levels of education are often linked to poverty and poor health. Community residents consistently identified poverty as one of the top 3 obstacles for creating a healthy community. The need to address the area poor economic conditions was recognized by key stakeholders as key to improve overall health. Several key quantitative data points were reinforced with the community survey. Poverty was seen as key challenge to overall health of the community by survey respondents, focus group participants and key stakeholders.

2. **Asthma.** Asthma is more prevalent in the four county service area than in the state. The hospitalizations rate due to asthma is also greater in all four counties than in the state. Poor air quality, tobacco usage and obesity and overweight adults are related indicators that impact asthma prevalence and hospitalizations in the four county area. The percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard per year exceeds the state percentage in all four counties indicating poor air quality contributing to respiratory issues and overall poor health for the area.

3. **Diabetes** hospitalizations were higher in the four county area when compared to the state. Diabetes prevalence were higher in Fresno, Kings, and Madera counties as compared to the state. Obesity was one of the most frequently cited health concerns among stakeholders and focus groups. Lack of access to affordable healthy food and lack of physical activity due to strenuous multiple jobs and limited time were mentioned as barriers in primary data.

4. **Access to health care.** In the Fresno, Kings, Madera, and Tulare counties, residents have less access to dentists, primary care providers and mental health providers compared to the state. Lack

of access to health care services was frequently cited as a top health issue. Health access is a particular concern for low-income populations and those without health insurance. All four counties have over 80% of the population living in a Health Professional Shortage Area for primary care. Lack of transportation, long wait times, difficulty scheduling appointments, paying for co-payments and medications, language issues, and difficulties navigating the system and transportation barriers were frequently discussed by stakeholders and in the focus groups.

5. **Obesity**. The four counties have high rates of adults and children who are obese or overweight as compared to the state. Ethnic disparities show that that American Indian, Black, Pacific Islander and Latino adults are most likely to be obese. Factors that contribute to this health outcome are linked to limited consumption of wholesome fruits and vegetables and less opportunity to be physically active. Lack of access to healthy food and safe places for physical activity were frequently mentioned as barriers in primary data collection.

6. **Mental disorders.** Access to mental health providers is limited in the four county area. Access to Mental Health providers remains a concern for residents and healthcare workers in the four county area. In Fresno, Kings and Tulare counties adults 18 years and older self-report they receive insufficient social and emotional support all or most of the time which is higher than the state percentage.

7. **Substance abuse**. While only residents in Madera and Tulare counties identified substance abuse as a top health concern statewide data suggest that Tobacco usage in Fresno, Madera, and Tulare counties is above the state average. Alcohol consumption in Tulare County is above the state average for adults who self-report. Substance abuse was identified by the community as a factor that most impacts the overall health of the community.

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

i. Community Resources

- Barrios Unidos
- Farmer's Market
- Fresno County Community Health Improvement
- Fresno Metro Ministry
- Fresno New Connection, Inc.
- Kings Partnership for Prevention
- Off the Front
- San Joaquin Valley PRIME
- Sierra Kings District Hospital Foundation

ii. Health Care Facilities

- Adventist Medical Center – Handford
- Adventist Medical Center – Reedley
- Adventist Medical Center – Selma
- Central Valley General Hospital – Hanford
- Central Valley Indian Health, Inc. – Clovis
- Children's Hospital Central California – Madera
- Clovis Community Medical Center – Clovis
- Coalinga Regional Medical Center – Coalinga
- Community Behavioral Health Center – Fresno
- Community Regional Medical Center – Fresno
- Community Subacute and Transitional Care Center – Fresno
- Crestwood Psychiatric Health Facility-Fresno – Fresno

- Department of State Hospital – Coalinga – Coalinga
- Fresno Surgical Hospital – Fresno
- Kaiser Foundation Hospitals – Fresno
- Kaweah Delta Medical Center – Visalia
- Kaweah Delta Rehabilitation Hospital – Visalia
- Kaweah Delta Skilled Nursing Facility – Visalia
- Madera Community Hospital – Madera
- Porterville Developmental Center – Porterville
- Sierra View District Hospital – Porterville
- St. Agnes Medical Center – Fresno

VII. KFH FRESNO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH Fresno 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH Fresno's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit www.kp.org/chna. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH Fresno in the 2013 Implementation Strategy Report.

1. Obesity/Diabetes
2. Health Access
3. Broader Health Care System Needs in our Communities (Workforce & Research)

KFH FRESNO is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH Fresno tracks outcomes, including behavior and health outcomes, as appropriate and where available.

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

B. 2013 Implementation Strategy Evaluation Of Impact Overview

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

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.

- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH Fresno awarded 145 grants totaling $3,220,203 in service of 2013 health needs. Additionally, KP Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH Fresno service area. During 2014-2015, a portion of money managed by this foundation was used to award 32 grants totaling $360,536 in service of 2013 health needs.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. From 2014-2015, KFH Fresno donated several in-kind resources in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH Fresno engaged in

several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

PRIORITY HEALTH NEED I: ACCESS TO CARE

Long Term Goal:
- Increase the number of low-income and uninsured individuals who have access to and receive appropriate health care services in the KFH-Fresno service area.

Intermediate Goal:
- Increase the number of low-income people who enroll in, or maintain, health care coverage
- Increase access to culturally competent, high-quality health care services for low-income, uninsured individuals

KFH-Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 5,046 Medi-Cal members* • *2015: 4,128 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $5,861,006* • *2014: 7,466 Applications approved* • *2015: KFH - Dollars Awarded By Hospital - $4,194,813* • *2015: 7,356 Applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 3,439 members receiving CHC* • *2015: 3,182 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 42 active KFH grants totaling $944,274 addressing Access to Care in the KFH-Fresno service area.[3] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 15 grants totaling $135,681 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
California School-Based Health Alliance	$35,000 in 2015	Grant will help Fresno Unified School District develop four to six new school-based health centers (SBHCs) in high need schools.	Conduct a feasibility study for building SBHCs to serve 1,500 to 2,000 students and to provide 10 school staff members with trauma informed practice coaching.

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

Camarena Health	$115,000 in 2015 (2 grants: $40,000 & $75,000) $75,000 grant split with Northern California Region	Funding supported 1) the opening of a school-based health center at Madera South High School by Camarena Health, a FQHC, to increase access to care for students and 2) capacity building focused on improved data collection processes that increase data accuracy in order to eventually implement PHASE, a population health management protocol aimed at reducing heart attacks and strokes.	In 2014, Camarena Health improved access to care for 850 individuals through the school based health center. 2015 Funding will allow Camarena to improve data collection for 3,207 patients, including those with diabetes and hypertension, who are eligible for PHASE.
Valley Health Team	$75,000 in 2015 Grant split with Northern California Region	Grant will improve data collection processes to increase accuracy of data used to make patient care decisions, standardize collection and reporting processes, and increase use of evidence-based care to better meet the needs of patients at risk of heart attacks and strokes.	The goal is that San Joaquin Health Center—which serves 3,661 patients, 14.3% of whom are diagnosed with coronary vascular disease—will have improved health outcomes.
Poverello House	$60,000 in 2015	Grant will update technology infrastructure, increasing clients' access to health care and services that are HIPPA compliant.	The goal is that 120 clients in need will gain access to medical care, mental health, housing, and case management services.
Healthcare Foundation of Northern California	$50,000 in 2014	Fresno Medical Respite Center, an 8-bed facility that allows for the safe discharge of homeless patients after hospitalization and provides a safe, temporary place for them to stay as they recover. Grant funding will provide ongoing support for the center, which is the only service of its kind between Bakersfield and Sacramento.	29 patients were admitted, with an average length of stay of 57 days and a minimum cost savings to hospitals of approximately $800,000.
Marjaree Mason Center, Inc.	$100,000 over 2 years	As repercussions from the drought and resulting	The project reached 303 people outcomes included:

	$53,626 in 2014 $46,738 in 2015	unemployment in the Central Valley become more dire, stress levels rise, and unfortunately so do incidents of domestic violence (DV) and other crime indicators. This project will provide prevention, outreach, advocacy, and support services to DV victims, residents, and services providers in the rural communities of Mendota, San Joaquin, and Kerman.	▪ Educational outreach to several neighborhood, parent, and church groups and health, mental health, social, and community providers. ▪ 100% of all residents who call MMC's hotline in crisis received immediate safety planning consultation. ▪ 70% of community awareness presentation participants (n = 168) self-reported an increase in knowledge. ▪ 70% of service provider awareness training participants (n =90) self-reported an increase in knowledge. ▪ 70% of DV victims (n = 20) who attended a group self-reported increased knowledge. ▪ 45 DV victims received legal assistance andreferrals and follow-up services to other health, community, and social services. ▪ 20 DV victims and/or their children received psychological therapy to reduce DV-related trauma.
Central Valley Health Network (CVHN)	$250,000 over 2 years $125,000 in in 2014 & 2015 This grant impacts six KFH hospital service areas in Northern California Region.	Grant will provide funding for CVHN to support core operational functions, and policy and advocacy activities that support CVHN member health centers in their goal of providing quality health care.	• CVHN reached 14 member health centers that serve 687,620 patients • in collaboration with Fresno County and local health care stakeholders, CVHN developed a way to continue funding the county's program to assure health care access for documented and undocumented residents • to increase access to health care services in farmworker communities, CVHN formed a new partnership with National Center for Farmworker Health (NCFH) to bring technical assistance and resources to member centers • 51 staff from CVHN member health centers were trained on the intake/policy implications of registering farmworkers • CVHN coordinated Growing Health Leaders youth conferences in Merced and Fresno counties, and the two conferences drew more than 500 students

Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Medical Respite Center (MRC) Advisory Committee	The MRC Advisory Committee convenes representatives from the area's three primary hospitals, FQHC nurses and case workers, and MRC leadership to provide technical assistance and referral updates on challenges and gaps.	KFH-Fresno's Social Services manager and Utilization Management assistant manager share responsibilities as committee members and participate in the continuous improvement process for patient referral.

The Children's Movement (TCM)	TCM is a nonpartisan, multi-issue advocacy organization dedicated to promoting children's issues in Fresno.	KFH-Fresno's CB Manager participates on TCM's Leadership Council, which convened 420 people from various sectors in Fresno County to begin alignment around grade-level reading. TCM's health action team is designing an expanded version of the vision clinic to include health and dental services to reach more students in five school districts.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Fresno Unified School District	Kaiser Permanente physicians provided free vision screenings to students at Gaston Middle School and free sports physicals to more than 200 students at Roosevelt High School, McLane High School, and Sunnyside High School.

PRIORITY HEALTH NEED II: HEALTHY EATING ACTIVE LIVING

Long Term Goals:

- Increase healthy eating with special emphasis on African American, Latino, and Hmong populations
- Increase physical activity with special emphasis on low-income neighborhoods

Intermediate Goals:

- Increase access to healthy food options in schools and youth-based programs
- Increase awareness of the importance of healthy eating in at-risk schools
- Increase healthy eating among youth and adults in community settings
- Increase opportunities for physical activity in community settings through education and environmental changes (e.g., safe walking and biking routes, parks and hiking trails, joint use agreements)
- Increase physical activity in institutional settings (e.g. schools, after-school programs, worksites)

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 85 active KFH grants totaling $1,784,408 addressing Healthy Eating and Increased Exercise and Activity in the KFH-Fresno service area.[4] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 9 grants totaling $149,476 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Central Unified School District (CUSD)	$150,000 $90,000 in 2015 $60,000 in 2014 (split with Northern California Region)	In 2014 funding supported Creating Healthy Kids = A Healthy Community initiative by providing aides and additional equipment, and by helping to expand the initiative into the community to increase physical activity and healthy nutrition. In 2015 funding supported a districtwide CUSD project	In 2014, 14 schools received new equipment to support enhanced physical education curriculum, six teachers and six aides were hired, and 58 middle school students were recruited as student health mentors. With 2015 funding three more middle schools will get additional social and emotional support. Students in grades 5, 7, and 9

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

		focused on three key areas: social-emotional, student physical health, and staff wellness.	will participate in a healthy kids survey to identify opportunities for improvement.
City of Clovis	$40,000 in 2015	Installation of par course exercise equipment along existing walking trail to encourage increased physical activity and improved community health.	The goal is for an estimated 25,000 people to use the equipment for strength and cardiovascular training.
Foundation for Clovis Schools	$90,000 in 2015	A tiered opportunity that exposes students to high-quality wellness, healthy living and prevention messages, and training, ending in a grant opportunity for schools.	Mini grants will be awarded to Clovis Unified School district schools to support increased access to health and fitness while stressing the importance of physical activity and healthy eating in at-risk settings.
*KaBoom	$500,000 in 2015	KaBOOM! will partner with Kaiser Permanente and a community partner to create kid-designed, community-built playgrounds in three KP service areas. Each site will incorporate the unique KaBOOM! community build process to ensure community engagement and support.	Expected reach is 8,100 children and family members, and expected outcomes include: • three playgrounds designed by community residents and built by volunteers at organizations or in community settings serving high-need youth. • high need communities have increased access to safe public spaces for recreation and physical activity
Madera County Department of Public Health	$105,000 over 2 years $75,000 in 2014 $30,000 in 2015	Madera County Public Health Department will improve access to healthy food and physical activity by making improvements to school meals, developing joint use agreements with schools, and conducting education and promotion activities	Over this 2 year grant period, CX^3 (communities of excellence in nutrition, physical activity, and obesity) assessment was conducted to decide the best location for enhancing fruit and vegetable retail options. More than 55 community members, including parents and local government leaders, took part in educational forums on the health consequences of sugary beverages and the benefits of healthy food and physical activity. Beverage standards related to procurement, vending, and publically-sponsored events for all Madera County public agencies have been drafted and are under review

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Central Unified School District – Teague Elementary	More than 200 students and their family members attended a performance of Kaiser Permanente Educational Theater's *The Best Me*, a production that teaches kids and families about the importance of healthy eating, active living, and other health behaviors.
Marjaree Mason Center	A KFH-Fresno LCSW gave an introduction to meditation and mindfulness practices to 11 MMC staff. She covered the

(MMC)	emotional/physical benefits of focused meditation; how to identify/manage daily stress; and how to relax body and mind by changing behavior. MMC's wellness newsletter now includes links to the LCSW's podcasts and deskercise tips, and to healthy, seasonal recipes and other sources available on Kaiser Permanente's Food for Health website. Kaiser Permanente provided yoga mats for a kids' yoga program. KFH-Fresno's area finance officer is an active MMC board member, providing finance-related TA.	
Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Alliance for a Healthier Generation (AHG)	Kaiser Permanente supports AHG's Healthy Schools, which serves student populations that are disproportionately at risk for childhood obesity.	In Fresno, AHG works with Central and Kerman USDs to support work related to obesity prevention. To date, four core workshops at CUSD have given school leads TA for successful program implementation.
Impact of Regional Initiatives		

Parks Initiative:

The physical and mental health benefits of experiencing nature and outdoor physical activity are well-documented. Kaiser Permanente's investments in parks focus on increasing access to and use of safe parks and open spaces by low-income, underserved populations that have historically faced significant obstacles in accessing parks. By connecting people to parks, creating infrastructure enhancements in parks, and supporting policies to advance sustainability and improve culturally available services within park departments, we also aim to increase the competencies of local, regional, state, and national parks to effectively engage diverse communities. In addition to our monetary contributions, we are expanding volunteer opportunities in parks for Kaiser Permanente physicians and employees.

PRIORITY HEALTH NEED III: DIABETES

Long Term Goals:

- Increase the number of diabetics whose disease is well-managed

Intermediate Goals:

- Increase screening and access to culturally competent, high-quality diabetes management education for low-income individuals who encounter barriers such as a lack of a primary care provider or medical home, lack of health insurance coverage, or language barriers
- Decrease structural barriers to diabetes self-management education (e.g., transportation, cultural competency, cultural practices, hours of service, administrative procedures, residency documentation, etc.) for low-income individuals

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 4 active KFH grants totaling $208,362 addressing Diabetes in the KFH-Fresno service area.[5]

Grantee	Grant Amount	Project Description	Results to Date

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

California Healthcare Collaborative	$171,087 $80,000 in 2015 $91,087 in 2014 (split with Northern California Region)	Help diabetic African American and Latino residents in Kerman and West Fresno manage their condition by making healthy lifestyle changes and help high-risk residents prevent the onset of the disease.	In 2014 the project developed and implemented a series of classes for African American and Latino residents in West Fresno and Kerman on managing/preventing diabetes. There were 25 participants per class in each community (for a total of 50) who received direct education. Four community health leaders (CHLs) were identified and trained to lead classes. 2015's Expected outcomes include: • four community health leaders are identified/ trained to lead diabetes classes • 200 African American and Latino residents participate in this series of management and prevention classes
Sanger Unified School District (SUSD)	$90,000 in 2015	SHARPEN (student health, activity, recreation, physical education, nutrition) addresses low California State Physical Fitness Standards rates, especially in the area of body composition and aerobic capacity, among 11,200 SUSD students at 14 elementary schools, one middle school, and one comprehensive high school.	The goal is to improve body composition and aerobic capacity by increasing physical activity; integrating movement into classroom instruction; and hosting physical fitness events for students, families, and the community. At least two additional schools will implement the Walk For Health Program.
West Care – LiveSMART	$41,200 in 2014	Supports a program that engages/empowers low-income families living at a housing complex to make healthful food choices, increase fruit and vegetable consumption, and learn important food safety practices.	In association with Fresno Housing Authority (FHA), West Care used LiveSMART served 165 people through providing evidenced-based nutrition education and physical activity to low-income and medically underserved residents at Parc Grove Commons. Participants attended classes that teach them how to make tasty, healthy meals; shop on a stringent budget; plan healthy meals using WIC and food stamp purchases; and read labels at the grocery store. It is expected that West Care will complete four 12-week cycles during the project period, resulting in 48 weeks of education programming.
Buddhist Tzu Chi Medical - Diabetes Management	$35,000 in 2014	Grant will support health outreach through monthly health clinics throughout KFH-Fresno service area, glucose testing costs, mobile units, diabetes training modules, and annual Healthy Fresno outreach event. A portion of the grant funded a pilot vision care project in Fresno Unified School	Nearly 5,000 patients were screened for diabetes, and just over 100 patients with uncontrolled blood sugar levels were identified and referred to health education sessions offered by Tzu Chi and community partners. 75 students received screenings and 35 received eyeglasses.

		District. Volunteer physicians from KP and other clinics provided optometry services and Tzu Chi's mobile clinic provided free eyeglasses onsite.	
Food, Inc. (dba The Community Food Bank)	$300,000 over 2 years $150,000 in 2014 & 2015	Food, Inc. will provide access to and increase consumption of lean protein and fresh produce in drought-impacted communities in Fresno County.	Expected reach is 2,500: outcomes to date: • 8,000 families (32,000 individuals), were served in the first year • each family received approximately 25 lbs. of produce and one whole chicken

In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
Tzu Chi Medical	32 physicians and employees provided more than 400 volunteer hours of medical services and support at monthly free health clinics, including Healthy Fresno. KFH-Fresno CB manager sat on Healthy Fresno planning committee, linked in community partners, and helped recruit Kaiser Permanente volunteers. Two Shop KP representatives distributed information to parents of KPCHP-eligible children.

PRIORITY HEALTH NEED IV: ASTHMA

Long Term Goals:

- Improve asthma management to decrease asthma complications for low-income, high-risk individuals.

Intermediate Goals:

- Increase asthma screening and effective follow-up education for individuals who encounter barriers such as a lack of a primary care provider or medical home, lack of health insurance coverage, or language barriers
- Decrease structural barriers to asthma self-management training (e.g., transportation, cultural competency, cultural practices, hours of service, administrative procedures, residency documentation, etc.) for low-income individuals
- Increase awareness of the impact of air pollution and asthma triggers to decrease asthma complications

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 2 active KFH grants totaling $109,225 addressing Asthma in the KFH-Fresno service area.

Grantee	Grant Amount	Project Description	Results to Date
Central California Asthma Collaborative	$89,225 $59,225 in 2015 $30,000 in 2014	Optimize existing AIM (asthma impact model) program, which provides access to high-quality health care, promotes the spread of health knowledge, improves management of asthma and other	Expectations are to serve a minimum of 200 people with home assessments, asthma education, home remediation, and connections to a primary care provider. Grant will help extend services to those who are ineligible for Medi-Cal

		respiratory conditions, and widens scope of services by making them available to a greater proportion of the community.	because of their immigration status.
Camarena Health - Chronic Disease Management	$40,000 in 2014	Program provides effective disease management for patients with chronic conditions. Camarena will use a chronic disease self-management program (CDSMP) to provide one-on-one and group health education sessions to empower patients, resulting in decreased complications and increased health.	There were 2,410 individual case management interventions, five community health education classes, 1,625 nutrition case management interventions, and three six-week CDSMP workshops.
Fresno Unified School District (FUSD) Asthma Program	$50,000 in 2014	Asthma is the leading cause of school absenteeism, impacting student learning and performance. FUSD aims to improve asthma prevention and management within its student population. Grant supports asthma prevention and symptom control by identifying students who need services and providing asthma management plans for them, using effective school-based strategies.	FUSD worked with American Lung Association (ALA) to provide Open Airways training and Kickin' Asthma train-the-trainer programs for 15 nurses and 40 university interns. 129 school staff received asthma training through the CPR curriculum.128 parents attended asthma basics training sessions held at the schools and 37 adults and children were screened for asthma and given referrals as needed at the Healthy Fresno Fair.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Fresno Unified School District (FUSD)	KPET provided performances at eight FUSD schools, including four elementary, three middle, and one high school. Performances included: • *The Best Me* encourages healthy eating and an active lifestyle. *Peace Signs* promotes conflict resolution and violence prevention. Both target elementary school students. • *Nightmare on Puberty Street*, a humorous yet serious show about the joys and angst of adolescence for middle school students. • *Secrets*, a powerful drama about teens, their relationships, and their sexual and mental health for high school students.

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Promotores de Salud	Through continuing education opportunities and in-kind support/TA, Kaiser Permanente Northern California Region supported the work of local promotores who work to promote healthy eating and active living in Madera.	To date, Promotores de Salud have received English classes, CDSMP Stanford Model training, opportunities to attend the 2014 Vision y Compromiso conference, and physical activity leader training provided by California Department

		of Education. KFH-Fresno's CB Manager provides TA and feedback on community work and sits on the Promotores Advisory Committee.
Fresno Area Strive	Fresno Area Strive seeks to improve student academic success and better prepare them for higher education/training and careers. Action Teams work to facilitate students' academic success and to provide student and family support as outlined by key indicators.	KFH-Fresno's CB Manager is a member of the Action Team that identified interagency support agencies for Connectedness, Safety and Attendance. And along with KFH-Fresno's Community Relations Manager, the CB Manager served on the Healthy Lifestyles Action Team that identified six areas of emphasis to improve student success.

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE

KFH Workforce Development Highlights

Long Term Goal:

- To address health care workforce shortages and cultural and linguistic disparities in the health care workforce

Intermediate Goal:

- Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care

Summary of Impact: During 2014 and 2015, Kaiser Foundation Hospital awarded 12 Workforce Development grants totaling $173,934 that served the KFH-Fresno service area.[6] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $44,037 that address this need. In addition, KFH Fresno provided trainings and education for 56 residents in their Graduate Medical Education program in 2014 and 37 residents in 2015, 53 nurse practitioners or other nursing beneficiaries in 2014 and 30 in 2015, and 48 other health (non-MD) beneficiaries as well as internships for 14 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
*Vision Y Compromiso	$98,093 in 2015	The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotora model.	Anticipated outcomes include: • increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities • increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities

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

			• increased knowledge of community resources, increased networking, and social support as measured by an increased number of agencies involved in the regional Networks
UCSF Fresno Health Careers Opportunity Program	$50,000 This grant impacts three KFH hospital service areas in Northern California Region.	This Kaiser Permanente Northern California Region grant supports HCOP (Healthy Careers Opportunity Program), which addresses the shortage of health professionals in the Central Valley by providing an educational pipeline for qualified disadvantaged California State University, Fresno students who are interested in pursuing a health professional career.	It is expected that 95 HCOP students will receive at least two individual advising sessions per semester to help them select the required health professions courses and to assess their academic performance. They will have access to tutoring services for core courses in math and science. Upper division HCOP students will visit UCSF's Medicine, Dentistry, and Pharmacy schools to learn about admissions and financial aid and gain a better understanding of program requirements.
Fresno Health Community Access Partners	$100,000 in 2014	Support for recruiting family medicine faculty members (both hire and contract) to train residents in the Sierra Vista Family Medicine Residency Program.	Program will recruit one core family medicine faculty or two part-time faculty; contract temporary family medicine physician services; and provide faculty development such as seminars and CME activities for incoming and existing faculty.

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH

KFH Research Highlights

Long Term Goal:

- To increase awareness of the changing health needs of diverse communities

Intermediate Goal:

- Increase access to, and the availability of, relevant public health and clinical care data and research

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
UCLA Center for Health Policy Research	$2,100,000 over 4 years 1,158,200 over 2014 & 2015 This grant impacts all KFH hospital	Grant funding during 2014 and 2015 has supported The California Health Interview Survey (CHIS), a survey that investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and management, the health of	CHIS 2013-2014 was able to collect data and develop files for 48,000 households, adding Tagalog as a language option for the survey this round. In addition 10 online AskCHIS workshops were held for 200 participants across the state. As of February 2016, progress on the 2015-2016 survey included completion of the CHIS 2015 data collection that achieved the adult target of 20,890

	service areas in Northern California Region.	children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic levels, allowing users to visualize the data at a sub-county level.	completed interviews. CHIS 2016 data collection began on January 4, 2016 and is scheduled to end in December 2016 with a target of 20,000 completed adult interviews. In addition, funding has supported the AskCHIS NE tool which has allowed the Center to: • Enhance in-house programming capacity for revising and using state-of-the-science small area estimate (SAE) methodology. • Develop and deploy AskCHIS NE. • Launch and market AskCHIS NE. • Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.

In addition to the CHIS grants, two research programs in the Kaiser Permanente Northern California Region Community Benefit portfolio – the Division of Research (DOR) and Northern California Nursing Research (NCNR) – also conduct activities that benefit all Northern California KFH hospitals and the communities they serve.

DOR conducts, publishes, and disseminates high-quality research to improve the health and medical care of Kaiser Permanente members and the communities we serve. Through interviews, automated data, electronic health records (EHR), and clinical examinations, DOR conducts research among Kaiser Permanente's 3.9 million members in Northern California. DOR researchers have contributed over 3,000 papers to the medical and public health literature. Its research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. Primary audiences for DOR's research include clinicians, program leaders, practice and policy experts, other health plans, community clinics, public health departments, scientists and the public at large. Community Benefit supports the following DOR projects:

DOR Projects	Project Information
Central Research Committee (CRC)	Information on recent CRC studies can be found at: **http://insidedorprod2.kp-dor.kaiser.org/sites/crc/Pages/projects.aspx**
Clinical Research Unit (CCRU)	CCRU offers consultation, direction, support, and operational oversight to Kaiser Permanente Northern California clinician researchers on planning for and conducting clinical trials and other types of clinical research; and provides administrative leadership, training, and operational support to more than 40 regional clinical research coordinators. CCRU statistics include more than 420 clinical trials and more than 370 FDA-regulated clinical trials. In 2015, the CCRU expanded access to clinical trials at all 21 KPNC medical centers.
Research Program on Genes, Environment and Health (RPGEH)	RPGEH is working to develop a research resource linking the EHRs, collected bio-specimens, and questionnaire data of participating KPNC members to enable large-scale research on genetic and environmental influences on health and disease; and to utilize the resource to conduct and publish research that contributes new knowledge with the potential to improve the health of our members and communities. By the end of 2014, RPGEH had enrolled and collected specimens from more than 200,000 adult KPNC members, had received

	completed health and behavior questionnaires from more than 430,000 members; and had genotyped DNA samples from more than 100,000 participants, linked the genetic data with EHRs and survey data, and made it available to more than 30 research projects

A complete list of DOR's 2015 research projects is at **http://www.dor.kaiser.org/external/dorexternal/research/studies.aspx**. Here are a few highlights:

Research Project Title	Alignment with CB Priorities
Risk of Cancer among Asian Americans (2014)	Research and Scholarly Activity
Racial and Ethnic Disparities in Breastfeeding and Child Overweight and Obesity (2014)	Healthy Eating, Active Living
Transition from Healthy Families to Medi-Cal: The Behavioral Health Carve-Out and Implications for Disparities in Care (2014)	Access to Care Mental/Behavioral Health
Health Impact of Matching Latino Patients with Spanish-Speaking Primary Care Providers (2014)	Access to Care
Predictors of Patient Engagement in Lifestyle Programs for Diabetes Prevention – Susan Brown	Access to care
Racial Disparities in Ischemic Stroke and Atherosclerotic Risk Factors in the Young – Steven Sidney	Access to care
Impact of the Affordable Care Act on prenatal care utilization and perinatal outcomes – Monique Hedderson	Access to care
Engaging At-Risk Minority Women in Health System Diabetes Prevention Programs – Susan Brown	HEAL
The Impact of the Affordable Care Act on Tobacco Cessation Medication Utilization – Kelly Young-Wolff	HEAL
Prescription Opioid Management in Chronic Pain Patients: A Patient-Centered Activation Intervention – Cynthia Campbell	Mental/Behavioral Health
Integrating Addiction Research in Health Systems: The Addiction Research Network – Cynthia Campbell	Mental/Behavioral Health
RPGEH Project Title	**Alignment with CB Priorities**
Prostate Cancer in African-American Men (2014)	Access to Care Research and Scholarly Activity
RPGEH high performance computing cluster. DOR has developed an analytic pipeline to facilitate genetic analyses of the GERA (Genetic Epidemiology Research in Adult Health and Aging) cohort data. Development of the genotypic database is ongoing; in 2014, additional imputed data were added for identification of HLA serotypes. (2014)	Research and Scholarly Activity

The main audience for NCNR-supported research is Kaiser Permanente and non-Kaiser Permanente health care professionals (nurses, physicians, allied health professionals), community-based organizations, and the community-at-large. Findings are available at the Nursing Pathways NCNR website: https://nursingpathways.kp.org/ncal/research/index.html,

Alignment with CB Priorities	Project Title	Principal Investigator
Serve low-income, underrepresented, vulnerable populations located in the	**1.** *A qualitative study: African American grandparents raising their grandchildren: A service gap analysis.*	**1.** Schola Matovu, staff RN and nursing PhD student, UCSF School of Nursing

Northern California Region service area	**2.** *Feasibility, acceptability, and effectiveness of Pilates exercise on the Cadillac exercise machine as a therapeutic intervention for chronic low back pain and disability.*	**2.** Dana Stieglitz, Employee Health, KFH-Roseville; faculty, Samuel Merritt University
Reduce health disparities.	**1.** *Making sense of dementia: exploring the use of the markers of assimilation of problematic experiences in dementia scale to understand how couples process a diagnosis of dementia.* **2.** *MIDAS data on elder abuse reporting in KP NCAL.* **3.** *Quality Improvement project to improve patient satisfaction with pain management: Using human-centered design.* **4.** *Transforming health care through improving care transitions: A duty to embrace.* **5.** *New trends in global childhood mortality rates.*	**1.** Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City **2.** Jennifer Burroughs, Skilled Nursing Facility, Oakland CA **3.** Tracy Trail-Mahan, et al., KFH-Santa Clara **4.** Michelle Camicia, KFH-Vallejo Rehabilitation Center **5.** Deborah McBride, KFH-Oakland
Promote equity in health care and the health professions.	**1.** *Family needs at the bedside.* **2.** *Grounded theory qualitative study to answer the question, "What behaviors and environmental factors contribute to emergency department nurse job fatigue/burnout and how pervasive is it?"* **3.** *A new era of nursing in Indonesia and a vision for developing the role of the clinical nurse specialist.* **4.** *Electronic and social media: The legal and ethical issues for health care.* **5.** *Academic practice partnerships for unemployed new graduates in California.* **6.** *Over half of U.S. infants sleep in potentially hazardous bedding.*	**1.** Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center **2.** Brian E. Thomas, Informatics manager, doctorate student, KP-San Jose ED. **3.** Elizabeth Scruth, critical care/sepsis clinical practice consultant, Clinical Effectiveness Team, NCAL **4.** Elizabeth Scruth, et al. **5.** Van et al. **6.** Deborah McBride, KFH-Oakland

VIII. APPENDIX

A. Secondary Data Sources and Dates
B. Community Input Tracking Form
C. Health Need Profiles (see www.chna.org/kp for Health Need Profile Templates)
D. Primary Data Collection Questions
    I. Community Survey Questions and Responses
    II. Focus Group Questions and Responses
    III. Stakeholder Survey Questions and Responses
E. Data for Health Need Identification
F. KP Fresno Service Area Prioritization Exercise Matrix

APPENDIX A: Secondary Data Sources and Dates

1. California Department of Education. 2012-2013.
2. California Department of Education. 2013.
3. California Department of Education, FITNESSGRAM®; Physical Fitness Testing. 2013-2014.
4. California Department of Public Health, CDPH – Birth Profiles by ZIP Code. 2011.
5. California Department of Public Health, CDPH – Breastfeeding Statistics. 2012.
6. California Department of Public Health, CDPH – Death Public Use Data. University of Missouri, Center for Applied Research and Environmental Systems. 2010-2012.
7. California Department of Public Health, CDPH – Tracking. 2005-2012.
8. California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.
9. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
10. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
11. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
12. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
13. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
14. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
15. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
16. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
17. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
18. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
19. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
20. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
21. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
22. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
23. Centers for Medicare and Medicaid Services. 2012.
24. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
25. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
26. Environmental Protection Agency, EPA Smart Location Database. 2011.
27. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
28. Feeding America. 2012.
29. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
30. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
31. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
32. New America Foundation, Federal Education Budget Project. 2011.
33. Nielsen, Nielsen Site Reports. 2014.
34. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.

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

OTHER SOURCES OUTSIDE THE CHNA PLATFORM

60. 2003 and 2011-12 California Health Interview Surveys Cited in: Wolstein, J. Babey. S. and A. Diamant Obesity in California 2015 UCLA Center for Health Policy Research.
61. 2014 California Health Interview Survey
62. Babey, S. H., et al. (2011). A patchwork of progress: Changes in overweight and obesity among California 5th-, 7th-, and 9th-graders, 2005-2010. UCLA Center for Health Policy Research and California Center for Public Health Advocacy. Funded by RWJF; California Department of Education, Physical Fitness Testing Research Files.
63. Bosworth, B. and K. Burke "Differential Mortality and Retirement in the Retirement Benefits in the Health and Retirement Study. Brookings Institute, 2014. See http://www.brookings.edu/~/media/research/files/papers/2014/04/differential-mortality-retirement-benefits-bosworth/differential_mortality_retirement_benefits_bosworth_version_2.pdf
64. Booske, B. , Athens, J., Kindig, D., Park, H., and P. Remington. County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health" February 2010 See: http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf
65. California Breathing County Profiles 2012

66. California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).
67. California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). Definition Percentage of public school students in grades 7, 9, 11, and non-traditional students reporting whether they used alcohol or any illegal drug (excluding tobacco) in the past 30 days, by race/ethnicity.
68. California Department of Health Care Services- Mental Health Services Division Involuntary Detention Data, 2011-12
69. California Department of Public Health, Immunization Branch, Kindergarten Assessment Results (Feb 2015) http://www.cdph.ca.gov/programs/immunize/pages/immunizationlevels.aspx
70. California Department of Public Health, Safe and Active Communities Branch. Report generated from http://epicenter.cdph.ca.gov on: January 21, 2016
71. California Dept. of Education, Physical Fitness Testing Research Files. Accessed at http://www.cde.ca.gov/ta/tg/pf/pftresearch.asp (Jan. 2015).
72. California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; California Dept. of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control & Prevention, Natality data on CDC WONDER; Martin et al. (2015), Births: Final Data for 2013. National Vital Statistics Reports, 64(1) (Mar. 2015).
73. California Office of Statewide Health Planning and Development, Inpatient Discharge Data
74. California's Acute Psychiatric Bed Loss. California Hospital Association, 2012
75. California Healthcare Almanac: Mental Health Care in California-Painting a Picture, 2013. See www.chcf.org
76. Center for Disease Control and Prevention: Reproductive Health and Birth Outcomes-Exposure and Risks. See: http://ephtracking.cdc.gov/showRbPrematureBirthEnv.action#exposure
77. Center for Disease Control: Final Data for 2009. See: www.cdc.gov/nchs/data/nvsr60n/nvsr60_o3.pdf
78. Center for Disease Control. Heart Disease see: http://www.cdc.gov/heartdisease/facts.htm
79. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County
80. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County
81. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-09. Source geography: County
82. Centers for Disease Control. Suicides – United States, 2005 – 2009. In CDC health disparities and inequities report – United States, 2013. MMWR 2013;62(No. Suppl 3):177-81.
83. Centers for Disease Control. Coronary heart disease and stroke deaths – United States, 2009. In CDC health disparities and inequities report – United States, 2013. MMWR 2013;62(No. Suppl 3):155-8.
84. Centers for Disease Control. Climate and Health. See: http://www.cdc.gov/climateandhealth/default.htm
85. Centers for Disease Control. U.S. Centers for Disease Control and Prevention. Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants, Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services, 2013.
86. Centers for Disease Control and Prevention. Social Determinants of Health: Know What Affects Health. See: http://www.cdc.gov/socialdeterminants/
87. Child and Teen 2011 -2012 Health Profiles UCLA Center for Health Policy Research California Health Interview Survey.
88. County Health Rankings Cite 2015 Data
89. County Health Rankings See: http://www.countyhealthrankings.org/
90. CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.
91. Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012. Source geography: County

92. Defining Adult Overweight and Obesity. CDC Division of Nutrition, Physical Activity, and Obesity. See: http://www.cdc.gov/obesity/adult/defining.html
93. Ethnicity and Health Disparities in Alcohol Research, Chartier and Caetano http://pubs.niaaa.nih.gov/publications/arh40/152-160.htm
94. Everhart, R., Kobel, S., McQuad, E., Salcedo, L., York, D., Potter, C. and D. Koinis-Mitchell "Differences in Environmental Control Asthma Outcomes Among Urban Latino, African American and Non-Latino White Families. Pediatric Allergy, Immunology, and Pulmonology, Vol 24. No 3, 2011.
95. Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12. Source geography: County
96. Federal Register Vol 79. No 250 26 Wednesday December 31, 2014. Part 2 26 IRS 26 CFR Parts, 1, 53, 602 additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the return; Final Rule.
97. Feeding America. 2013. Source geography: County
98. Freeman, R. E. Strategic Management: A Stakeholder Approach. Boston, MA: Pitman, 1984.
99. Hacker, J., The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream, rev. and exp. ed., New York: Oxford University Press, 2008 See
100. Health People 2020 Central Valley Health Policy Institute 2009 Data and The American Community Survey 2013 Data and US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014. (communitycommons.org)
101. Healthy People 2020 http://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders
102. Healthy People 2020 Topics and Objectives: Diabetes See http://www.healthypeople.gov/2020/topics-objectives/topic/diabetes
103. Healthy People 2020 Topics. See: http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Substance-Abuse
104. Healthy People 2020, www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
105. Hill, L. and H. Johnson "Unauthorized Immigrants in California: County Estimates" Public Policy Institute of California July 2011 See: http://www.ppic.org/content/pubs/report/R_711LHR.pdf
106. Key Facts on Health Coverage for Low Income Immigrants Today and Under the ACA, Kaiser Commission on Key Facts Medicate and the Uninsured, Kaiser Family Foundation, March 2013 See: https://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf
107. KidsData.org
108. Lessard, L. Alcala, E. and J. Capitman. Pollution, Poverty, and Potentially Preventable Childhood Morbidity in Central California. The Journal of Pediatrics 2016; 168: 198 – 204.
109. Lieberman, T. Why Low-Income Seniors Fail to Get Help Paying for Health Care, Center for Advancing Health Prepared Patient Blog, February 11, 2014
110. Issue Brief 5: Exploring the Social Determinants of Health: Education and Health. Robert Wood Johnson Foundation, April 2011 Accessed here: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447
111. Institute of Medicine. Leading Health Indicators for Healthy People 2020 Letter Report. Report Brief March 2011 See: http://www.integration.samhsa.gov/images/res/Leading%20Health%20Indicators%20for%20Healthy%20People%202010.pdf
112. MacQueen, K., McLellan, E., Metzger, D., Kegeles, S., Straauss, R., Scotti, R., Blanchard, L., and Trotter, R., What Is Community? An Evidence-Based Definition for Participatory Public Health. American Journal of Public Health. 2001 December; 91(12): 1929–1938.

113. Marmot. D. The Status Syndrome: How your social standing directly affects your health and life expectancy. 2015
114. Mental Health and Substance Use Disorders See: http://www.mentalhealth.gov/what-to-look-for/substance-abuse/
115. National Cancer Institute. What is Cancer? See: http://www.cancer.gov/about-cancer/what-is-cancer
116. National Institute on Alcohol Abuse and Alcoholism 2009-2013 Health Disparities Strategic Plan, p.4
117. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2008-12. Source geography: County
118. Obesity: Prevalence and Risk Factors Cleveland Clinic, March 2013 See: http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/endocrinology/obesity/
119. Pabayo, R. , Kawachi, I. and S. Gilman. “Income Inequality Among American States and the Incidence of Major Depression”, Journal of Epidemiology and Community Health. September 2013
120. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
121. Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files (Dec. 2014).
122. Rivero, E. Rate of Latino physicians shrinks, even as Latino population swells. UCLA Newsroom. February 10, 2015 See: http://newsroom.ucla.edu/releases/rate-of-latino-physicians-shrinks-even-as-latino-population-swells
123. SB535 List of Disadvantaged Communities California Communities Environmental Health Screening Tool, 2014. Average of percentiles from the Pollution Burden indicators (with a half weighting for the Environmental Effects indicators).
124. Special tabulation by the State of California, Office of Statewide Health Planning and Development (Sept. 2015); California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2010, 2010-2060 (Sept. 2015).
125. Special tabulation by the State of California, Office of Statewide Health Planning and Development (Sept. 2015). Cited at Kidsdata.org
126. Struggling to Get By: The Real Cost Measure in California 2015 by United Ways of California in partnership with B3 Consults. See: http://unitedwaysca.org/realcost
127. Syed, S., Gerber, B. and L. Sharp. “Traveling towards disease: transportation barriers to health care access”. Journal of Community Health. 2013 Oct;38(5):976-93
128. Syme SL. Social determinants of health: the community as an empowered partner. Preventing Chronic Disease 2004 Jan. Available from: URL: http://www.cdc.gov/pcd/issues/2004/jan/03_0001.htm
129. The Economic Security Index: A New Measure for Research and Policy Analysis. The San Francisco Federal Reserve Bank Working Paper Series. See: http://www.frbsf.org/economic-research/files/wp12-21bk.pdf
130. Torrey, E. F., Entsminger, K., Geller, J., Stanley, J. and Jaffe, D. J. (2008). “The Shortage of Public Hospital Beds for Mentally Ill Persons.”
131. U.S. Census Bureau, American Community Survey (Sept. 2014).
132. UCLA Center for Health Policy Research, California Health Interview Survey. Accessed at http://www.chis.ucla.edu/ (Aug. 2013).
133. University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.Source geography: County (Grouping)
134. University of Wisconsin Population Health Institute, County Health Rankings 2014 Source Geography: County
135. University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2008-10. Source geography: County

136. Virginia Commonwealth University Center on Society and Health. Education: It Matters More to Health Than Ever Before. January 2014. Available at the Robert Wood Johns Library See: http://www.rwjf.org/en/library/research/2014/01/education--it-matters-more-to-health-than-ever-before.html?cid=XEM_A7864
137. World Health Organization Information, Education and Communication: Lessons from the Past; Perspectives for the Future. Department of Reproductive Health, WHO, Geneva, 2001.

APPENDIX B: Community Input Tracking Form

A. Focus Group Tracking

	FOCUS GROUP LOCATION	TYPE OF FOCUS GROUP	TOTAL	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE
	Location	**Respondent's title/role and organization or focus group name**		**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
1.	*Children's Hospital*	Healthcare providers	*9*	Hospital senior staff	*Healthcare providers*	*7/20/15*
2.	*Madera County Camarena Health Oakhurst*	Community Focus Group	*3*	Minority, medically underserved, low-income Intended to be patients and staff; however, due to unforeseen circumstances it was only moms and F5 staff	*Community members and Healthcare provider*	*8/24/15*
3.	Madera Community Hospital Madera	Health Care Providers	*7*	Hospital senior staff	*Healthcare providers*	*7/20/15*
4.	Madera County	Community Leaders	*18*	Public Health staff, Madera County elected officials, hospital staff, and nonprofit leaders	*Community Leaders and Community Representatives*	*8/24/15*
5.	Fresno County Fresno Pacific North Campus Fresno	Community Leaders Focus Group	20	Nonprofit community group leaders, health care providers	*Community Leaders and Community Representatives*	8/25/15
6.	Fresno County Helm home Fresno	Community Focus Group Latina moms, 2 young people	12	Minority, medically underserved, low-income	*Community Members*	8/25/15
7.	Fresno County Saint Agnes Medical Center Fresno	Hospital Staff Focus Group	10	-hospital staff, health providers	*Healthcare provider*	8/26/15
8.	Fresno County FPNC Fresno	Community Leaders Focus Group	15	Community members	*Community Leaders and Community Representatives*	8/26/15
9.	Fresno County Selma	Community Focus Group	12	Residents, Spanish speakers	*Community Members*	11/12/15
10.	Tulare County Sierra View	Community Focus Group	23	Young HS students, community members,	*Community Members*	8/26/15

	FOCUS GROUP LOCATION	TYPE OF FOCUS GROUP	TOTAL	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE
	Location	**Respondent's title/role and organization or focus group name**		**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
	Medical Center Potterville			community members, nonprofit leader		
11.	Tulare County Kaweah Delta Visalia	Hospital Staff Focus Group	27	Health providers	*Healthcare providers*	8/27/15
12.	Tulare County The Lifestyle Center Visalia	Community Leaders Focus Group	11	Community members, nonprofit leaders, county health department staff	*Community Leaders and Community Representatives*	8/27/15
13.	Kings County Kings County Behavioral Health Hanford	Community Leaders Focus Group	28	Health providers	*Community Leaders and Community Representatives*	8/27/15
14.	Tulare County Viscava Gardens Dinuba	Community Leaders Focus Group	11	Residents and community members	*Community Leaders and Community Representatives*	8/27/15
15.	Tulare County Tule River Nation	Tribal Leaders	3	Tule River Nation Elders and Tribal Council Members	*Community Leaders and Community Representatives*	8/27/15

B. Stakeholder Interviews Tracking

	Name	Institution	Sourcing:	Date of Interview
1.	Program Manager	Madera Public Health Department	Public Health/Latino Community Expertise	7/20
2.	Service Provider	Camarena Health	Service Provider (healthcare)	7/20
3.	Director DOH	Fresno Department of Public Health	Public Health	7/21
4.	YLI Specialist	Youth Leadership Institute	Latino Community	7/21
5.	Executive Director	Poverello House	Service Provider (homeless)	7/21
6.	Executive Director	Stone Soup	Service Provider (Hmong Community)	7/21
7.	Director Health Svcs,	Visalia Unified	Service Provider (healthcare)	7/21
8.	Executive Director	Every Neighborhood Partnership	Community Member (	7/21
9.	Community Member	Center for New Americans	Community Member (Latino)	
10.	CEO	Clovis Community Medical Center	Service Provider (healthcare)	7/31
11.	CMO	Saint Agnes Medical Center	Service Provider (healthcare)	7/22
12.	CEO	Saint Agnes Medical Center	Service Provider (healthcare)	7/22
13.	CAO	Saint Agnes Medical Center	Service Provider (healthcare)	7/22
14.	CNO	Saint Agnes Medical Center	Service Provider (healthcare)	7/22
15.	COO	Saint Agnes Medical Center	Service Provider (healthcare)	7/22
16.	CEO	Fresno Heart & Surgical	Service Provider (healthcare)	7/23
17.	VP Pt Care	Sierra View Medical Center	Service Provider (healthcare)	7/23
18.	VP Phys Recruit	Sierra View Medical Center	Service Provider (healthcare)	7/23
19.	Director Soc. Svs	Sierra View Medical Center	Service Provider (healthcare)	7/23
20.	Executive Director Clinical Mgr	Sierra View Medical Center	Service Provider (healthcare)	7/23
21.	CEO	Sierra View Medical Center	Service Provider (healthcare)	7/23
22.	County Health Officer	Tulare County HHSA	Service Provider (healthcare)	7/23
23.	Director of Infection Prevention	Sierra View	Service Provider (healthcare)	7/23
24.	Instructor	PVHS Health Academy, Pathways	Community Member	7/23
25.	Vice President of Patient Care Services	Adventist Health	Service Provider (healthcare)	7/24
26.	Public Health Director	Kings County Public Health Department	Public Health	7/24
27.	CEO	Kaweah Delta	Service Provider (healthcare)	7/24

	Name	Institution	Sourcing:	Date of Interview
28.	Community Member	Kings County Action Org	Community Member	7/24
29.	Social Worker	Board Member, Stone Soup	Community Member (Hmong Community)	8/25
30.	Director	Central California Children's Institute	Community Member (children & youth)	8/25
31.	CEO	Adventist Health	Service Provider (healthcare)	9/2
32.	MD Physician in Chief	Kaiser Permanente	Service Provider (healthcare)	9/3
33.	Director	Director of Behavioral Health at County of Fresno	Service Provider (Mental Health)	9/8
34.	Director	Director of Behavioral Health at County of Fresno	Service Provider (Mental Health)	9/9

APPENDIX C: Health Need Summary Profiles (Alphabetical Order)

ACCESS TO CARE

Definition: Access to health care is defined as "the timely use of personal health services to achieve the best health outcomes"[7]. There are four essential elements of access to care: coverage, services, timeliness, and workforce. As the diversity of our patient populations continues to grow the importance of a healthcare workforce that is culturally effective is essential to achieve access and health equity. The barriers to obtain health care services include: a lack of availability, high cost of care, and lack of insurance coverage. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills".

Relevant Health Access Data (Secondary Data)

Health Indicators

The absence of care impacts a myriad of health outcomes that define good health. The following table summarizes just a few health indicators related to access to care: residents with a regular primary care physician, preventable ED visits, percent of mothers receiving prenatal care, infant mortality, and premature death (years of potential life lost).

Indicator	CA Average	Fresno	Kings	Madera	Tulare
Preventable Hospitalizations: Discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive[8]	45.3	53.1	62.6	49	59.1
Percentage Mothers with Late or No Prenatal Care[9]	18.1%	13.7%	26.29%	26.29%	26.04%
Infant Mortality Rate per 1,000 Births[10]	5	6.3	5.7	5.2	5.6
Percent of Children Without Insurance[11]	7.89%	6.9%	8.1%	9.27%	7.39%
Years of Potential Life Lost, Rate per 100,000 Population[12]	5,594	7,009	6,372	6,693	7,367
Population Living within a HPSA[13]	25.18%	81.67%	100%	100%	100%
Population with No Insurance -Adults	23.91%	26.96%	24.61%	29.78%	28.95%
Percent Adults without Regular Doctor[14]	27.13%	25.05%	27.42%	29.92%	33.48%
Rate of Primary Care Physicians per 100,000 residents	72.2	64.0	37.7	46.0	42.5

The data above highlight that the region has very few indicators that consistently outperform the state averages across all four counties. Most residents live in a Health Professional Shortage Area, and over a quarter of the adults have no insurance nor a regular doctor.

---

[7] See Healthy People 2020 http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

[8] Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2012. Source geography: County

[9] Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2007-10. Source geography: County

[10] Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2006-10. Source geography: County

[11] D*ata Source: US Census Bureau, Small Area Health Insurance Estimates. 2013. Source geography: County*

[12] Data Source: University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National. Accessed via CDC WONDER. 2008-10. Source geography: County

[13] Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. March 2015. Source geography: HPSA

[14] *Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County*

Poverty

In each county nearly a quarter of the populations live in poverty. Unemployment in the Central Valley, unlike other areas of the State, remain at double digits which also contributes to broad level of financial stress in many households. Per capita income ranges from $17,887 in Tulare County to $20,230 in Fresno County and all are substantially lower than the California figure of $29,906.

Poverty	CA Average	Fresno	Kings	Madera	Tulare
Percent of Households Where Costs Exceeds 30% of Income[15]	44.99%	43.33%	37.35%	41.02%	41.51%
Percent of Families with Income Over $75,000	47.06%	32.6%	32.61%	29.71%	28.08%
Per Capita Income	$29,906	$20,230	$18,517	$17,797	$17,887
Percent of Households with Public Assistance Income	3.99%	8.2%	4.88%	5.78%	10.29%
Percent of Population Under 18 Living in Poverty	22.7%	37.56%	33.06%	32.88%	37.28%
Percent of Population Under 18 Living 200% below the Federal Poverty Level (FPL)	46.42%	64.36%	60.95%	64.79%	67.74%

Health Access As Perceived by Community Members (Primary Data)

Our community survey revealed two key factors that respondents felt made it hard to get health care: In Fresno and Kings counties, the **waiting time to see the doctor is too long**. The length of time to see a doctor is largely driven by the limited number of primary care physicians and specialists in the region as indicated by the designation of an HPSA.

In Madera and Tulare counties, **no health insurance** was mentioned as the top issue. Lack of access to insurance was further linked to the cost of insurance on the exchange—even with subsidies-- and the challenge of **undocumented residents who cannot apply for insurance**. Based on 2008 projections from the Public Policy Institute, the following table shows that undocumented immigrants, who would not have access to health insurance, represent between 5% and 7.7% of the region's population[16].

	Total Population	Number of Undocumented Immigrants	Percent of County Total Population
Fresno	909,000	49,000	5%
Kings	150,000	9,000	5.8%
Madera	149,000	12,000	7.7%
Tulare	426,000	29,000	6.8%

During our focus group sessions and stakeholder interviews, the challenges in access to care reinforced the concerns listed in the survey and surfaced additional issues:

1. Lack of doctors in the region who are a cultural fit with the population in the region (i.e. native Spanish speakers)
2. Difficulty of paying co-payments or the affordability of medicines
3. Medi-Cal and Medicare are too hard to use or navigate
4. Transportation from rural areas of each county in the region continues to remain a challenge

Since 100% of the residents in Kings, Madera or Tulare counties and 81.67% of Fresno County's residents live in a Health Professional Shortage Area (HPSA) the challenge of finding a primary care physician is all the more clear. The following table highlights the number of health professionals per 100,000 residents and the percent of adults without any regular doctor. For patients seeking a physician with similar linguistic or cultural background, the quest for care can be especially challenging. Among Latinos, for example, the number of Latino physicians in the state has actually declined in the last 10

[15] *Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: Tract*

[16] Hill, L. and H. Johnson "Unauthorized Immigrants in California: County Estimates" Public Policy Institute of California July 2011 See: http://www.ppic.org/content/pubs/report/R_711LHR.pdf

years. In 1980, there were 135 Latino physicians for every 100,000 Latinos in the U.S.; by 2010, that figure had dropped to just 105 per 100,000. In California Latinos make up only 4.8 percent of all physicians[17]

The affordability of receiving health care services or paying for medications is impacted by the level of poverty in the region. Over half of the population throughout all four counties lives at 200% below the Federal Poverty Level. Recent reports suggest that affordability of copays or medications is a factor for Medicaid and Medicare recipients across the nation[18].

Research on the impact of poor or limited transportation in access to care confirms that the poor and underinsured are the most impacted[19]. Approximately 8.1% of households throughout the region have no family car[20].

The Sub Populations Experiencing Greatest Impact:

The high number of residents living in poverty within the region and the challenge of being undocumented makes the poor undocumented resident the most impacted in accessing health care services. The Kaiser Family Foundation has found that nationwide the median household income for undocumented residents is $27,400, half of the amount for documented residents in the US as a whole. Among undocumented immigrants, 46% are uninsured. Nationally 71%% of undocumented residents versus 87% of citizens receive preventive services. Further 16% of undocumented residents delay or go without health care due to cost versus 11% of citizens. [21] In a study by the Public Policy Institute of California in 2009, the number of residents who live 2 - 15 miles away from any Emergency Department was found to be influenced by their legal, income and insurance status[22].

Area	Total % Safety Net Users in County Living 2 – 15 Miles Away from ED	Percent of Safety Net User who Are Unauthorized Immigrants	Percent of Low Income Residents 200%FPL	Percent of Non-Citizens	Percent of Medi-Cal Recipients
Fresno	73%	63%	74%	67%	75%
Kings	26%	17%	22%	16%	22%
Madera	62%	86%	73%	85%	79%
Tulare	58%	58%	56%	57%	56%
CA Average	64%	59%	61%	59%	62%

SUMMARY:

The region's high concentration of poverty coupled with the majority of residents living in a Health Professional Shortage Area make access to care highly problematic for residents as a whole. For those who are low income and lack easy access to transportation, access to care is a substantial challenge. In California's Central Valley when the poor live in a rural area or have no family car, regular checkups or follow-up care is even more difficult. Based on the unique demographics of the region, this population is largely Latino.
Available data supports the stress and the decline on health outcomes due to the lack of economic security, such as:

Poverty
Poverty is viewed as a significant social determinant of health because the absence of economic resources impacts housing

---

[17] Rivero, E. Rate of Latino physicians shrinks, even as Latino population swells. UCLA Newsroom. February 10, 2015 See: http://newsroom.ucla.edu/releases/rate-of-latino-physicians-shrinks-even-as-latino-population-swells
[18] Lieberman, T. Why Low-Income Seniors Fail to Get Help Paying for Health Care, Center for Advancing Health Prepared Patient Blog, February 11, 2014
[19] Syed, S., Gerber, B. and L. Sharp. "Traveling towards disease: transportation barriers to health care access". Journal of Community Health. 2013 Oct;38(5):976-93
[20] Data Source: US Census Bureau, American Community Survey. 2009-13. Source geography: Tract
[21] Key Facts on Health Coverage for Low Income Immigrants Today and Under the ACA, Kaiser Commission on Key Facts Medicate and the Uninsured, Kaiser Family Foundation, March 2013 See: https://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf
[22] Lee, H. Hill, L., and S. McConville Access to the Healthcare Safety Net in California. Public Policy Institute of California, Oct 2012. See: http://www.ppic.org/content/pubs/report/R_1012HLR.pdf

choices, food options, and overall lifestyle choices. Within the four counties a disproportionate number of residents live in poverty. In each county nearly a quarter of the populations live in poverty. Unemployment in the Central Valley, unlike other areas of the State, remain at double digits which also contributes to broad level of financial stress in many households. Per capita income ranges from 17,887 in Tulare County to 20,230 in Fresno County and all are substantially lower than the California figure of $29,906.

Poverty	CA Average	Fresno	Kings	Madera	Tulare
Percent of Households Where Costs Exceeds 30% of Income	45.89%	43.78%	38.48%	43.15%	42.43%
Percent of Households Where Costs Exceeds 30% of Income[23]	44.99%	43.33%	37.35%	41.02%	41.51%
Percent of Families with Income Over $75,000	47.06%	32.6%	32.61%	29.71%	28.08%
Per Capita Income	$29,906	$20,230	$18,517	$17,797	$17,887
Percent of Households with Public Assistance Income	3.99%	8.2%	4.88%	5.78%	10.29%
Percent of Population Under 18 Living in Poverty	22.7%	37.56%	33.06%	32.88%	37.28%
Percent of Population Under 18 Living 200% below the Federal Poverty Level (FPL)	46.42%	64.36%	60.95%	64.79%	67.74%
Percent of Total Population Living in Poverty	16.38%	27.36%	22.73%	23.16%	27.42%
Percent of Total Population Living 200% below the FPL	36.37%	50.9%	49.23%	51.19%	55.22%
Percent Total Population with Income at or Below 50% FPL	7.08%	12.1%	9.55%	9.66%	10.85%
Unemployment Rate	7.08%	11%	11.5%*	13.5%*	12.2%
Households with No Motor Vehicles	7.81%	9.24%	6.9%	6.7%	6.95%

Those living in poverty vary greatly among race/ethnic groups throughout the KFH Fresno region.

Percent Living in Poverty by Ethnicity[24]	Fresno	Kings	Madera	Tulare
White	22.25	22.54	23.23	27.02
Black, African American	39.61	27.56	39.91	39.87
Native American/Alaska Native	30.51	39.13	21.98	35.73
Asian	27.79	8.83	13.51	19.18
Native Hawaiian/Pacific Islander	50.62	3.77	2.75	38.56
Latino	34.86	29.67	29.1	34.43
Other	37.94	26.36	21.94	30.21
Two or More Races	28.53	18.5	18.69	28.15

Children Living in Poverty

While data for children in each demographic group in every county is not available, existing data indicates substantial disparities exist for children living in poverty when compared to state averages in every ethnic group[25].

[23] *Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: Tract*

[24] Data Source*:* *U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).*

[25] Source: www.KidsData.org

Children living in poverty	CA Average	Fresno	Kings	Madera	Tulare
	2011-2013	2011-2013	2011-2013	2011-2013	2011-2013
African American/Black	35.4%	56.5%	-	-	-
American Indian/Alaska Native	33.9%	38.3%	-	-	-
Asian American	12.7%	39.6%	-	-	-
Hispanic/Latino	31.4%	45.1%	38.1%	39.4%	42.9%
Native Hawaiian/Pacific Islander	22.2%	68.2%	-	-	-
White	11.0%	16.6%	15.0%	-	20.5%
Multiracial	17.1%	34.4%	-	-	-

Percent of income spent on housing
Estimated percentage of households that spend 30% or more of household income on housing costs. The U.S. Dept. of Housing and Urban Development considers housing "affordable" if total expenses (rent or mortgage payments, taxes, insurance, utilities, and other related payments) account for less than 30% of total household income.

Households with a High Housing Cost Burden[26]	CA Average	Fresno	Kings	Madera	Tulare
Housing cost burden	44.7%	44.0%	-	43.7%	44.7%

Unemployment
Unemployment is an important indicator because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Unemployment	CA Average	Fresno	Kings	Madera	Tulare
Unemployment Rates[27]	8.5	13.8	14.6	12.5	15.5

Food Security
Food insecurity is defined as the inability to obtain adequate nutritional food or the lack of sufficient food consumption over a sustained period of time. Despite being home to some of the nation's largest farms for fruits and vegetables in the Central Valley, residents in all but Madera County experience greater food insecurity than the California average of 14.95%. All four counties however, have a larger percentage of residents who live with limited access to healthy food than the California average of 3.4%. These range as high as 7.62% for Kings and 6.87% Tulare County and 4.77% in Madera County, respectively.

Food insecurity in the region[28]	CA Average	Fresno	Kings	Madera	Tulare
Percent Students Eligible for Free School Lunch	58.13%	72.35%	65.72%	76.6%	74.53%
Percent of Population with Food Insecurity	14.95%	16.56%	16.17%	13.83%	15.05%
Percent of Households Receiving Supplemental Nutrition Assistance Program Benefits	8.74%	19.45%	15.26%	17.78%	22.88%

[26] U.S. Census Bureau, American Community Survey (Sept. 2014).
[27] US Department of Labor, Bureau of Labor Statistics. 2015 - November. Source geography: County
[28] *Data Source: Feeding America. 2013. Source geography: County*

Grocery Store Establishments, Rate per 100,000 Population	21.7	25.26	18.30	24.53	26.01
Percent **Low Income** Population with Low Food Access	3.4%	6.75%	7.62%	4.77%	6.87%
Percent of **Total Population** with Low Food Access	14.31%	16.99%	33.22%	12.28%	14.84%
Percent Population in Tracts High Healthy Food Access[29]	3.29%	1.67%	3.73%	2.76%	6.59%
SNAP-Authorized Retailers, Rate per 100,000 Population	63.93	103.93	79.09	98.1	103.58
WIC-Authorized Food Store Rate (Per 100,000 Pop.)	15.8	31	18.2	22.9	24

Education

Education or educational attainment is strongly linked to health outcomes. People with more education live longer, experience better health outcomes and tend to practice health-promoting behaviors (i.e. getting regular exercise, refraining from smoking, or getting timely medical checkups, immunizations or screenings).[30] Unfortunately, over a quarter of the population in each county of the region, does not have a high school diploma. Within each county, less than 20% of the population has a bachelor of arts compared to 30% of California as a whole.

Educational Attainment[31]	CA Average	Fresno	Kings	Madera	Tulare
On Time Graduation Rate	85.7	85	75.2	87.9	87.8
Percent Population Age 25 with Associate's Degree or Higher	38.43%	27.9%	20.42%	21.56%	21.06%
Percent of Population without a High School Diploma	18.51%	26.78%	29.06%	30.54%	31.95%
Persons with a Associates Degree or Higher (age 25 and over)	38.78%	27.47%	20.66%	21.45%	20.8%

Approximately 29% of Fresno's population is under the age of 18. In Kings and Madera County, that number is 27% but in Tulare County that number jumps to 32%. The largest ethnic group represented among these children is Latino. Table 9.3.1 below highlights key leading indicators associated with child and maternal health. **Approximately a fourth of all infants born in Kings, Madera and Tulare Counties are born to mothers with either no or late prenatal care.** Over a third of children in each county live in poverty and the majority are eligible for a reduced price for lunch. Children in the region have higher rates of uninsured status in Kings, Madera and Tulare counties—particularly among Latino residents where documentation status may be in question. Three alarming health factors for children in the region is their overall fitness levels at grade 9, the percent who are overweight or obese children and the high rate of teens having children. None of the counties in the region match California rates of fitness among 9th graders and throughout all four counties 2 out 5 children is overweight or obese. **While the teen birth rate in California stands at 23.2 per 1,000 women aged 15 – 19, the rate of teen births in Kings, Madera and Tulare County is almost double that rate.** Despite these challenges, high school graduation rates in the region are close to or above the state average.

[29] *Data Source: Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. 2011. Source geography: Tract*

[103] Data Source: Socioeconomic Status and Health: The Challenge of the Gradient. Adler, N. Boyce, T. Chesney, M. Cohen, S. Folkman, S. Kahn, R. and S. L Syme. American Psychologist Vol 49. No. 1. 15 – 24, 1994

[31] *Data Source: US Department of Education, EDFacts. Accessed via DATA.GOV. Additional data analysis by CARES. 2013-14. Source geography: School District*

Child and Maternal Health	California Average	Fresno	Kings	Madera	Tulare
Infant Mortality Rate (Per 1,000 Births)	5	**6.3**	**5.7**	**5.2**	**5.6**
Percent of Mothers with No or Late Prenatal Care	18.1%	**13.7%**	**26.22%**	**26.29%**	**26.04%**
Teen Birth Rate (Per 1,000 Population) for women age 15 - 19	23.2	**39.0**	**41.2**	**41.8**	**43.5**
Percent of Preterm Births	8.8%	**10.2%**	**8.0%**	**8.1%**	**9.9%**
Percent Low Birth Weight Births	6.8%	**8.0%**	**6.3%**	**5.7%**	**6.8%**
Kindergartners with all required Vaccinations/Immunizations	90.4%	**95.2%**	**96.7%**	**93.0%**	**96.5%**
Percent of children living below100% FPL	22.7%	**39.1%**	**33.06%**	**32.88%**	**37.28%**
Percent of children living in food insecurity	26.3%	**32.3%**	**31.1%**	**30.6%**	**32.7%**
Percent of children eligible for reduced price lunch	59.2%	**73.1%**	**66.8%**	**77.2%**	**75.6%**
Percent of Children Physically Fit at Grade 9	37.6%	**36.0%**	**29.6%**	**30.4%**	**34.2%**
Percent of Children Overweight or Obese at Grade 9	36.0%	**42.3%**	**42.0%**	**42.8%**	**41.6%**
Percent of Children Uninsured	7.89	**6.9%**	**8.1%**	**9.27%**	**7.39%**
Percent of Children Diagnosed with Asthma	15.4%	**21.3%**	**22.3%**	**11.5%**	**10.3%**
Substantiated Cases of Child Abuse and Neglect per 1,000	8.7	**8.4**	**10.9**	**8.4**	**8.1**
Median Number of Months in Foster Care	15.2	**17.5**	**13.6**	**8.6**	**13.4**
Percent of Children Completing High School On Time	71%	**66.9%**	**70.3%**	**75.3%**	**75%**

SUMMARY

The four counties in the region have concentrated poverty which translates into poor economic security. The stress and challenge of living in poverty has direct health consequences for residents. Coupled with income disparities and racial and ethnic discrimination there is evidence that reduced life span, poor general health, and poor mental health exists among different racial and ethnic groups. Healthcare workers and residents consistently identified poverty as one of the top 3 obstacles for creating a healthy community. The need to address the regions poor economic conditions was recognized by key stakeholders as key to improve overall health. Several key quantitative data points were reinforced with the community survey. Poverty was seen as key challenge to overall health of the community by survey respondents, focus group participants and key stakeholders. Furthermore, when asked what one step they would take to improve the health of the community, stakeholders suggested that addressing poverty and job growth was an essential step.

Data Source: California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; California Dept. of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control & Prevention, Natality data on CDC WONDER; Martin et al. (2015), Births: Final Data for 2013. National Vital Statistics Reports, 64(1) (Mar. 2015).

Data Source California Department of Public Health "Teen Births in California: A Resource for Planning and Policy, 2005
Data Source: California Department of Public Health, Immunization Branch, Kindergarten Assessment Results (Feb 2015) http://www.cdph.ca.gov/programs/immunize/pages/immunizationlevels.aspx Data Source: UCLA Center for Health Policy Research, California Health Interview Survey. Accessed at http://www.chis.ucla.edu/ (Aug. 2013).
Data Source: California Dept. of Education, Physical Fitness Testing Research Files (Dec. 2015).
Data Source: Babey, S. H., et al. (2011). *A patchwork of progress: Changes in overweight and obesity among California 5th-, 7th-, and 9th-graders, 2005-2010*. UCLA Center for Health Policy Research and California Center for Public Health Advocacy. Funded by RWJF; California Department of Education, Physical Fitness Testing Research Files.

ASTHMA (BREATHING PROBLEMS)

Definition: Asthma is a chronic lung disease that inflames and narrows the airways. It causes recurring periods of wheezing, chest tightness, shortness of breath, and coughing which often occurs at night or early in the morning.

Relevant Health Outcome Data

Indicator	CA Average	Fresno	Kings	Madera	Tulare
Asthma Prevalence (Adults)[32]	14.2%	15.8%	17.3%	16.7%	14.6%
Asthma Diagnoses (Children age 1 – 17)[33]	15.4%	21.3	22.3%	11.5%	10.3%

The high rates of asthma translate in to high rates of ED visits and Hospitalizations per 10,000 residents across our region among adults and children[34].

	ED Visits Children		Hospitalizations Children		ED Visits Adults	Hospitalizations Adults
	0 - 4	5 - 17	0 -4	5 – 17	18 – 64	18 - 64
Fresno	226.0	100.5	42.8	15.4	51.3	8.1
Kings	206.1	116.0	36.9	9.9	73.8	9.7
Madera	248.8	121.4	29.9	9.9	46.2	2.3
Tulare	117.1	57.4	21.8	6.1	41.5	6.5
CA Average	113.2	67.1	22.1	7.8	39.8	5.4

Drivers of Health Related to Rates of Asthma—Focus Group and Stakeholder Themes **(Primary Data)**

Survey respondents identified Breathing Problems as one of the top four health concerns in Fresno, Kings, Madera and Tulare Counties. When asked what are the three biggest obstacles to having a healthy environment, air pollution was raised as a core concern. This was the same response in our focus groups and stakeholder interviews. In addition, focus groups participants in rural settings raised pesticide use as a specific contributing factor. Stakeholder interviews also raised the issue of poor housing stock in their region where housing in low income neighborhoods has a tendency to exhibit some of the known triggers for Asthma (i.e. dust, mold, pest infestation).

Passage of SB535 The Global Warming Solutions Act required the reporting and verification of emissions of greenhouse gases and monitoring of these key data in the region. The California Office of Environmental Health Hazard Assessment (OEHHA) has identified communities in the Central Valley as those most impacted by pollution, pesticides and heat exacerbated by climate change that contributes to childhood morbidity[35]. The following table highlights the level of air pollution, pesticides and diesel fuel matter that impacts the four counties in our region.

	Cal Environ Screen 2.0 Score	Age Adjusted Asthma related ED visits	Total pounds of selected active pesticide ingredients	Diesel PM emissions from on-road and non-	**Pollution Burden Score[36]**

[32] *Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County*

[33] *Data Source: UCLA Center for Health Policy Research, California Health Interview Survey. Accessed at http://www.chis.ucla.edu/ (Aug. 2013).*

[34] Source California Breathing County Profiles 2012

[35] Lessard, L. Alcala, E. and J. Capitman. Pollution, Poverty, and Potentially Preventable Childhood Morbidity in Central California. The Journal of Pediatrics 2016; 168: 198 – 204.

[36] Average of percentiles from the Pollution Burden indicators (with a half weighting for the Environmental Effects indicators). Data Source: SB535 List of Disadvantaged Communities California Communities Environmental Health Screening Tool,2014

	Range **(CES 2.0 Score)**	**(Asthma Pctl)**	**(Pesticides)**	road sources **(Diesel PM)**	
FRESNO (130 census tracts)	Range: 89.72 – 37.52 Average: **54.03**	Range: 132.4 – 33.30 Average: **74.99**	Range: 96,414.46 - 23.70 Average: **3,507.57**	Range: 60.37 – 2.45 Average: **27.69**	Range 9.58 – 5.34 Average: **6.92**
KINGS (14 census tracts)	Range: 68.62 - 36.64 Average: **46.77**	Range 92.57 – 37.91 Average: **74.09**	Range: 328.00 – 68.40 Average: **103.44**	Range: 22.41 – 2.38 Average: **10.74**	Range: 7.38 – 4.9 Average: **6.25**
MADERA (12 census tracts)	Range: 58.46- 37.97 Average: **49.64**	Range: 86.24 - 51.70 Average: **78.37**	Range: 512.11 - 75.8 Average: **265.45**	Range: 20.84 – 3.1 Average: **11.80**	Range: 7.49 – 5.58 Average: **6.86**
TULARE (49 census tracts)	Range: 63.46 - 37.13 Average: **47.02**	Range: 67.61 – 30.48 Average: **49.09**	Range: 704.51 – 1.28 Average: **129.03**	Range: 24.64- 2.01 Average: **8.9**	Range: 7.76-4.87 Average: **6.23**
FOR COMPARISON ONLY Santa Barbara County (1 census tract)	***37.34***	***28.76***	***23.9***	***8.7***	***5.6***

In addition to outdoor air quality factors, the region also has a high rate of adults who are smokers. Smoking and exposure to second hand smoke are also factors that exacerbate asthma. The following table shows the percent of adults who are smokers and the percent of children who are exposed to second hand smoke by county. In addition, this table includes the percent of children living in crowded households. A growing body of work suggests that asthma can be exacerbated by poor and overcrowded housing where pet dander, dust, mold, and pest infestations exist.

Risk Factors for Asthma	**CA Average**	**Fresno**	**Kings**	**Madera**	**Tulare**
Percent of adults who are current smokers[37]	12.8%	13.5%	12.6%	13.6%	14.3%
Households with children (age 0 – 17) where smoking is permitted[38]	1.3%	1.1	1.4%	1.3%	1.3%
Children Living in Crowded Households[39]	28.0%	35.5%	LNE	LNE	27.4%

The Sub Populations Experiencing Greatest Impact

Adults across the region are experiencing higher rates of asthma prevalence than the state average. A lower percent of children has been diagnosed with Asthma in Madera and Tulare counties but both adults and children have high rates of hospitalizations and ED visits in the region. The one exception is in Tulare County. There is some evidence of a greater

[37] Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County
[38] Data Source: Child and Teen 2011 -2012 Health Profiles UCLA Center for Health Policy Research California Health Interview Survey.
[39] **Data Source:** Population Reference Bureau, analysis of data from the U.S. Census Bureau's American Community Survey microdata files (Dec. 2014).

risk for asthma morbidity among Latinos and African American children compared to non-Latino White children[40].

SUMMARY

Asthma continues to be a chronic condition that impacts the entire region. Adults and children are both experiencing high prevalence rates that lead to high rates of ED visits and hospitalizations. Pollution and poor housing conditions, and high rates of smoking contribute to the prevalence of Asthma.

[40] Everhart, R., Kobel, S., McQuad, E., Salcedo, L., York, D., Potter, C. and D. Koinis-Mitchell "Differences in Environmental Control Asthma Outcomes Among Urban Latino, African American and Non-Latino White Families. Pediatric Allergy, Immunology, and Pulmonology, Vol 24. No 3, 2011.

Diabetes

Definition: Diabetes occurs when the body cannot produce sufficient insulin, a hormone that the body needs to absorb and use blood glucose—the body's primary source of energy. Diabetes will result in elevated blood glucose levels and other metabolic abnormalities that can lead to lowered life expectancy, heart disease, kidney failure, amputations of legs and adult onset blindness.[41]

Relevant Health Outcome Data

Indicator	CA Average	Fresno	Kings	Madera	Tulare
Percent Adults with Diabetes	8.05%	9.0%	8.7%	8.0%	7.4%
Percent of Medicare Beneficiaries with Diabetes	26.64%	31.37%	32.52%	30.37%	31.83%
Youth Diabetes Hospitalization	1.3%	1.1%	LNE	1.2%	1.3%
% of Hospitalizations Due to Adult Diabetes	31.0%	35.1%	29.3%	33.3%	34.4%

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County
Data Source: Centers for Medicare and Medicaid Services. 2012. Source geography: County
Data Source: Special tabulation by the State of California, Office of Statewide Health Planning and Development (Sept. 2015). Cited at Kidsdata.org
Data Source: UCLA Center for Health Policy Research Diabetes Tied to A Third of CA Hospital Stays, Driving Health Care Costs Higher May 15, 2014

Drivers of Health Related to Rates of Diabetes—Focus Group and Stakeholder Themes **(Primary Data)**

1. Lack of access to affordable healthy foods—food prices are high at major outlets but some are using local "farmer's markets" to access fresh food at reasonable prices and some use WIC payments at authorized local farmer's markets and fruit stands
2. Lack of physical activity due to multiple work roles and limited time available to exercise or the work done daily is so strenuous that it's unlikely they have energy left to exercise
3. Lack of access to healthcare professionals-- specifically those who are a cultural fit with the population (i.e. native Spanish speakers)—limits early diagnosis
4. High cost of care—copayments and medications are seen as too expensive given other cost of living factors (i.e. rent, transportation, food, etc.)

Drivers of health related outcomes regarding Access—**Secondary Data**

Indicator	CA Average	Fresno	Kings	Madera	Tulare
Health Outcomes					
Percent of Population Obese (Adult)	22.3%	28.3%	24.8%	26.6%	29.4%
Health Behaviors					
Percent of Population Physically Inactive	16.6%	19.1%	19.0%	19.3%	18.3%
Physical Environment	74.9%	63.73	55.56	55.02	52.02

---

[41] Healthy People 2020 Topics and Objectives: Diabetes See http://www.healthypeople.gov/2020/topics-objectives/topic/diabetes

Fast Food Establishments, Rate Per 100,000					

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County
Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013. Source geography: County

The Sub Populations Experiencing Greatest Impact:

The population with the highest rate of diabetes in California are Latinos. Within the region, over half of the population is Latino (53.94%). More of the Latino population in the region is male (51.31%) and of the Latino population in the region, 41.35% are between the ages of 18 and 44. The following table summarizes the percent of hospitalizations for patients aged 35 or older by race in California:

Racial/Ethnic Group	Percent of Hospitalizations for Patients with Diabetes
White	27.5%
Latino	43.2%
African American	39.3%
Asian American/Pacific Islander	38.7%
American Indian/Alaska Native	40.3%
Other	37.7%

Source: Source: *Office of Statewide Health and Planning Development, 2011* Note: Patients whose racial/ethnic designations are not known are not shown in the table. Patients' racial/ethnic designation was considered unknown if it was not noted in their records, or if the racial/ethnic designation was removed from the data set to protect patient anonymity. Cited from UCLA Center for Health Policy Research, May 2014

SUMMARY:
Diabetes is a health need in the Fresno service area as evidenced by the high rates of the disease among adults –especially older adults enrolled in Medicare—and the high rates of hospitalization seen among adults. This health outcome is likely driven by several leading indicators: high rates of obesity and high rates of physical inactivity.

ECONOMIC SECURITY

COUNTY RANKINGS: N/A

Definition: Economic security is defined as "the degree to which individuals are protected against hardship causing economic losses"[42]. The long term stress of poverty or economic insecurity is associated with a shorter life span[43], chronic disease, and mental health[44]. Continued work on the rise of income inequality in the US have further focused on two dimensions of economic insecurity that are of key concern for public health: "the risk of large, involuntary expenditures—such as medical out-of-pocket (MOOP) expenditures —and the capacity of individuals or households to use their wealth to reduce the effect of income changes on consumption"[45].

Quantitative Data:
Available data supports the stress and the decline on health outcomes due to the lack of economic security, such as:

Poverty
Poverty is viewed as a significant social determinant of health because the absence of economic resources impacts housing choices, food options, and overall lifestyle choices. Within the four counties a disproportionate number of residents live in poverty. In each county nearly a quarter of the populations live in poverty. Unemployment in the Central Valley, unlike other areas of the State, remain at double digits which also contributes to broad level of financial stress in many households. Per capita income ranges from 17,894 in Tulare County to 20,208 in Fresno County and all are substantially lower than the California figure of $29,527.

Poverty	California Average	Fresno	Kings	Madera	Tulare
Percent of Households Where Costs Exceeds 30% of Income	45.89%	**43.78%**	**38.48%**	**43.15%**	**42.43%**
Percent of Families with Income Over $75,000	46.75%	**32.98%**	**31.11%**	**29.2%**	**28.37%**
Per Capita Income	$29,527	**$20,208**	**$18,429***	**$17,847***	**$17,894**
Percent of Households with Public Assistance Income	3.97%	**7.88%**	**5.32%**	**5.77%**	**9.1%**
Percent of Population Under 18 Living in Poverty	22.15	**37.05%**	**30.32%**	**32.94%**	**35.83%**
Percent of Population Under 18 Living 200% below the Federal Poverty Level (FPL)	45.95%	**63.13%**	**60.84%**	**65.48%**	**66.64%**
Percent of Total Population Living in Poverty	15.94%	**25.96%**	**21.0%***	**22.8%***	**26.18%**
Percent of Total Population Living 200% below the FPL	35.91%	**50.05%**	**48.13%**	**51.01%**	**53.98%**
Percent Total Population with Income at or Below 50% FPL	6.91	**11.33%**	**9.54%**	**9.29%**	**10.55%**

[42] "The Economic Security Index: A New Measure for Research and Policy Analysis" The San Francisco Federal Reserve Bank Working Paper Series See: http://www.frbsf.org/economic-research/files/wp12-21bk.pdf
[43] Bosworth, B. and K. Burke "Differential Mortality and Retirement in the Retirement Benefits in the Health and Retirement Study. Brookings Institute, 2014. See http://www.brookings.edu/~/media/research/files/papers/2014/04/differential-mortality-retirement-benefits-bosworth/differential_mortality_retirement_benefits_bosworth_version_2.pdf
[44] Pabayo, R. , Kawachi, I. and S. Gilman. "Income Inequality Among American States and the Incidence of Major Depression", Journal of Epidemiology and Community Health. September 2013
[45] Hacker, J., The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream, rev. and exp. ed., New York: Oxford University Press, 2008 See:

Unemployment Rate	7.2%	11%	11.5%*	13.5%*	12.2%
Households with No Motor Vehicles	7.77%	9.25%	6.7%	5.86%	6.73%

Those living in poverty vary greatly among race/ethnic groups throughout the KFH Fresno region.

Percent Living in Poverty by Ethnicity	**California Average**	**Fresno**	**Kings**	**Madera**	**Tulare**
White	14.7%	16.3	20.7	22.8	25.5
Black, African American	24.7%	31.9	21.1	33.9	40.3
Native American/Alaska Native	25.2%	23.0	34.0	21.8	29.3
Asian	12%	22.6	8.0	14.2	20.9
Native Hawaiian/Pacific Islander	16.9%	40.1	2.8	1.1	20.9
Latino	23.1%	30.1	29.0	28.9	32.9
Other	25.3%	32.7	27.7	24.9	30.9
Two or More Races	16%	20.4	15.2	17.8	26.6

Children Living in Poverty
While data for children in each demographic group in every county is not available, existing data indicates substantial disparities exist for children living in poverty when compared to state averages in every ethnic group[46].

Children living in poverty	**CA**	**Fresno**	**Kings**	**Madera**	**Tulare**
	2011-2013	2011-2013	2011-2013	2011-2013	2011-2013
African American/Black	**35.4%**	**56.5%**	-	-	-
American Indian/Alaska Native	**33.9%**	38.3%	-	-	-
Asian American	12.7%	39.6%	-	-	-
Hispanic/Latino	**31.4%**	45.1%	38.1%	39.4%	42.9%
Native Hawaiian/Pacific Islander	22.2%	68.2%	-	-	-
White	11.0%	16.6%	15.0%	-	20.5%
Multiracial	17.1%	34.4%	-	-	-

Percent of income spent on housing
Estimated percentage of households that spend 30% or more of household income on housing costs. The U.S. Dept. of Housing and Urban Development considers housing "affordable" if total expenses (rent or mortgage payments, taxes, insurance, utilities, and other related payments) account for less than 30% of total household income.

Households with a High Housing Cost Burden[47]	**California Average**	**Fresno**	**Kings**	**Madera**	**Tulare**
Housing cost burden	44.7%	44.0%	-	43.7%	44.7%

Unemployment
Unemployment is an important indicator because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Unemployment	**California Average**	**Fresno**	**Kings**	**Madera**	**Tulare**

[46] Source: KidsData.org

[47] U.S. Census Bureau, American Community Survey (Sept. 2014).

Unemployment Rates[48]	7.1	11.3	11.4	11.4	12.4

Food Security

Food insecurity is defined as the inability to obtain adequate nutritional food or the lack of sufficient food consumption over a sustained period of time49. Despite being home to some of the nation's largest farms for fruits and vegetables in the Central Valley, residents in all but Madera County experience greater food insecurity than the California average of 16%. All four counties however, have a larger percentage of residents who live with limited access to healthy food than the California average of 3%. These range as high as 8% for Madera and Tulare County and 6% and 5% for Kings and Fresno counties, respectively.

Food insecurity in the region	**California Average**	**Fresno**	**Kings**	**Madera**	**Tulare**
Percent Students Eligible for Free School Lunch	56.33%	**74.53%**	**65.72%**	**76.6%**	**72.74%**
Percent of Population with Food Insecurity	16.24%	**18.91%**	**18%***	**16%***	**17.71%**
Percent of Households Receiving Supplemental Nutrition Assistance Program Benefits	8.07%	**18.15%**	**13.82%**	**15.71%**	**21.42%**
Grocery Store Establishments, Rate per 100,000 Population	21.7	**25.26**	**18.30**	**24.53**	**26.01**
Percent **Low Income** Population with Low Food Access	3.4%	**6.75%**	**7.62%**	**4.77%**	**6.87%**
Percent of **Total Population** with Low Food Access	14.31%	**16.99%**	**33.22%**	**12.28%**	**14.84%**
Limited Access to Healthy Food	3%	**5%**	**6%**	**8%**	**8%**
SNAP-Authorized Retailers, Rate per 100,000 Population	63.93	**103.93**	**79.09**	**98.1**	**103.58**
WIC-Authorized Food Store Rate (Per 100,000 Pop.)	15.8	**30.97**	**18.2**	**22.9**	**24**

Education

Education or educational attainment is strongly linked to health outcomes. People with more education live longer, experience better health outcomes and tend to practice health-promoting behaviors (i.e. getting regular exercise, refraining from smoking, or getting timely medical checkups, immunizations or screenings).[50] Unfortunately, over a quarter of the population in each county of the region, does not have a high school diploma. Within each county, less than 20% of the population has a bachelor of arts compared to 30% of California as a whole.

Educational Attainment	**California Average**	**Fresno**	**Kings**	**Madera**	**Tulare**
Cohort High School Graduation Rates	83.8%	**83.4%**	**83.32**	**86.36**	**84.37%**
On Time Graduation Rate	71%	**66.9%**	**70.3**	**75.3**	**75%**
Percent Population Age 25 with Associate's	38.43%	**27.9%**	**20.42%**	**21.56%**	**21.06%**

[48] US Department of Labor, Bureau of Labor Statistics. 2015 - November. Source geography: County

Degree or Higher					
Percent of Population without a High School Diploma	18.76%	**26.94%**	**29%***	**31.5%***	**31.99%**
Persons with a Bachelor's Degree or Higher (age 25 and over)	30.7%	**19.6%***	**12.9%***	**13.6%***	**13.3%***

SUMMARY

The four counties in the region have concentrated poverty which translates into poor economic security. The stress and challenge of living in poverty has direct health consequences for residents. Coupled with income disparities and racial and ethnic discrimination there is evidence that reduced life span, poor general health, and poor mental health exists among different racial and ethnic groups. Healthcare workers and residents consistently identified poverty as one of the top 3 obstacles for creating a healthy community. The need to address the regions poor economic conditions was recognized by key stakeholders as key to improve overall health. Several key quantitative data points were reinforced with the community survey. Poverty was seen as key challenge to overall health of the community by survey respondents, focus group participants and key stakeholders. Furthermore, when asked what one step they would take to improve the health of the community, stakeholders suggested that addressing poverty and job growth was an essential step.

Mental Health

Definition: Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death.[51]

Relevant Health Outcome Data

If we look at the percent of adults reporting that they have felt the need to see a mental health professional during the last 12 months, two of the four counties standout as seen in the table below. We also can see that the region has high rates of mentally unhealthy days.

	CA Average	Fresno	Kings	Madera	Tulare
Percent of Adults Reporting Poor Mental Health[52]	15.9%	13.6%	10.9%	18.6%	16.4%
Average Mentally Unhealthy Days[53]	3.6	3.7	4.3	4.6	4.6

There is also evidence of higher rates of treatment activity in two of the counties within our region. Both Fresno and Tulare Counties have large numbers of 72 Hour Evaluations and Treatment (51/50 holds) for adults compared to Kings and Madera County as seen in the following table[54].

	CA Average	Fresno	Kings	Madera	Tulare
72 Hour Eval & Treatment (CHILD)	16,115	0	0	0	0
72 Hour Eval & Treatment (ADULT)	109,583	2,656	0	0	1,562
14 Day Intensive Treatment	51,948	368	0	0	1,307
Additional 14 Day Intensive Treatment (Suicidal)	2013	0	0	0	4
30 Day Intensive Treatment	3,461	34	0	0	77
180 Day Post Certification Intensive Treatment	13	1	0	0	0
Temporary Conservatorships	4,191	0	10	10	19
Permanent Conservatorships	7,121	0	69	47	89

The rate of youth who report needing help for Emotional or Mental Health Problems suggests Fresno county has an elevated number than the state as a whole. However, the rate of hospitalizations (per 1,000) for mental health issues among children age 5 – 19 shows that the region does not exceed the rate for California as a whole as seen as the table below[55]:

	CA Average	Fresno	Kings	Madera	Tulare
Percent of Youth Reporting Needing Help for Emotional/Mental Health Problems	19.2%	32.5%	8.7%	LNE	LNE
Hospitalization Rate Per 1,000 of Youth ages 5 – 19 for mental health issues	5.1	2.9	5.2	2.0	2.2

---

[51] Healthy People 2020 http://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

[52] Data Source: University of California Center for Health Policy Research, California Health Interview Survey. 2013-14.Source geography: County (Grouping)

[53] Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12. Source geography: County

[54] Source: California Department of Health Care Services- Mental Health Services Division Involuntary Detention Data, 2011-12

[55] Special tabulation by the State of California, Office of Statewide Health Planning and Development (Sept. 2015); California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2010, 2010-2060 (Sept. 2015).

Drivers of Health Related to Mental Health—Focus Group and Stakeholder Themes **(Primary Data)**

Residents pointed to the lack of access to mental health professionals and services in their own communities as one of the factors that posed a key challenge. Some described having the personal experience or knowing a family who had a child placed in a treatment facility as far away as Santa Barbara or Los Angeles.

According to the California Hospital Association, the estimated target number for psychiatric beds is a ***minimum*** of 1 public psychiatric bed for every **2000** people with serious psychiatric disorders.[56] None of the counties in the region have a sufficient number of psychiatric beds. In the table below we summarize the number of beds available in the region.

	CA Average	**Fresno**	**Kings**	**Madera**	**Tulare**
Total Psychiatric Beds Available[57]	17.21	8.13	0	6.12	13.97

In addition, when we look at the availability of mental Health providers in each county, there is further evidence of limited resources[58].

	CA Average	**Fresno**	**Kings**	**Madera**	**Tulare**
Mental Health Care Provider per 100,000 people	157	119.8	56.8	70.2	123.9

Our focus groups and stakeholder interviews revealed that mental health is viewed as one of the top four concerns throughout all four counties. The table below shows the percent of respondents (both health care workers and community members) who selected mental health issues as a concern in each county.

Mental health issues (example: depression or schizophrenia)	Health Care Workers	Community Members
Fresno	40.7%	43.7%
Kings	37.5%	43.6%
Madera	38.1%	28.6%
Tulare	39.8%	50.0%

Our community survey also found that the mental health issues were seen often as a key behavioral concern that children and youth face in their community. The table below shows the percent of respondents who selected mental health as one of the greatest behavioral concerns for youth.

Mental health seen as the greatest behavioral concerns for children and adolescents	Health Care Workers	Community Members
Fresno	33.2%	39.1%
Kings	37.5%	32.7%
Madera	23.8%	4.5%
Tulare	35.5%	44.4%

The Sub Populations Experiencing Greatest Impact

Within each county, the percent of different ethnic groups who have taken prescription medicine for emotional/mental health

---

[56] *Torrey, E. F., Entsminger, K., Geller, J., Stanley, J. and Jaffe, D. J. (2008). "The Shortage of Public Hospital Beds for Mentally Ill Persons."*

[57] Source: "California's Acute Psychiatric Bed Loss" California Hospital Association, 2012

[58] Data Source: University of Wisconsin Population Health Institute, County Health Rankings 2014 Source Geography: County

issues in the past year varies substantially.[59] Of the available data, American Indian have the greatest likelihood of having taken medication to address mental health needs.

	CA Average	Fresno	Kings	Madera	Tulare
Latino	6.7%	9.0%	3.2%	6.0%	12.5%
American Indian/Alaska Native	20.2%	56.9%	NA	81.7%	NA
Asian	4.7%	1.1%	NA	NA	NA
African American/Black	9.2%	2.5%	19.1%	NA	NA
White	13.9%	17.0%	21.1%	11.6%	5.8%
Other Single/Two or More Races	9.2%	NA	NA	10.2%	50.1%

While there is no county specific data available on mental health status of racial and ethnic youth across our region, there is evidence to suggest that Native Hawaiian/Pacific Islanders, Latinos, and Multi-racial youth self-report particularly higher rates of depressed feelings than other racial/ethnic groups:

Percent of Youth Who Self Report Depressed Feelings[60]	
African American/ Black	27.9%
American Indian/Alaskan Native	27.9%
Asian	27.5%
Hispanic/Latino	31.7%
Native Hawaiian/Pacific Islander	35.0%
White	27.8%
Multiracial	30.0%
Other	26.2%

SUMMARY

Mental Health remains a concern for residents and healthcare workers in the region. While the secondary data suggests youth are not necessarily experiencing higher rates of hospitalizations for mental health conditions, children in Fresno report feeling the need for help for emotional problems at a higher rate of children in California as a whole. Contributing to our community's concern is the reality that few options exist for those seeking mental health professionals or services related to acute care.

[59] Data Source: Source: 2014 California Health Interview Survey

[60] Data Source: California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).

Obesity

Definition: Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese. An individual's Body Mass Index, or BMI, is used as a screening tool for overweight or obesity.[61] It is estimated that there are roughly 30 comorbid conditions associated with severe obesity. These include diabetes mellitus (occurs in 15% to 25% of obese patients), heart disease, gastroesophageal reflux, stress urinary incontinence, abdominal hernia, nonalcoholic steatohepatitis (NASH) and debilitating joint disease. Obesity is also associated with an increased incidence of uterine, breast, ovarian, prostate, and colon cancer, and with skin infections, urinary tract infections, migraine headaches, depression, and pseudotumor cerebri.[62]

Relevant Health Outcome Data

The percent of adults with a BMI over 30 in California is 22.3%. All four counties in our region exceed that rate by 2 – 7%. The percent of obese or overweight youth is even higher than the overall percent of California youth who are obese or overweight:

	CA Average	Fresno	Kings	Madera	Tulare
Percent of adults with BMI over 30[63]	22.3%	28.7%	24.8%	26.6%	29.4%
Percent of Children Overweight or Obese[64]	38.0%	42.7%	43.5%	44.1%	43.8%

Drivers of Health Related to Obesity—

Community members and stakeholders tended to view obesity and diabetes as the same health need and these were consistently called out as one of the top five health needs facing the community. In addition to the concentrated poverty that exists throughout the region, participants in focus groups also pointed out two factors that they believe contribute to high rates of diabetes and obesity: access to healthy food at reasonable prices and limited places to exercise safely. The following table shows the challenges of both limited physical activity and poor consumption of fresh fruits and vegetables and the percent of population living in "food deserts"—census tracts with low access to a large grocery store:

Key Health Drivers	CA Average	Fresno	Kings	Madera	Tulare
Percent Population with no Leisure Time Physical Activity[65]	16.6%	19.1%	19%	19.3%	18.3%
Percent Adults with Inadequate Fruit / Vegetable Consumption[66]	71.5%	71.8%	75.3%	76.5%	76.1%

---

[61] Defining Adult Overweight and Obesity. CDC Division of Nutrition, Physical Activity, and Obesity See: http://www.cdc.gov/obesity/adult/defining.html

[62] Obesity: Prevalence and Risk Factors Cleveland Clinic, March 2013 See: http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/endocrinology/obesity/

[63] Source: Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

[64] Data Source: Babey, S. H., et al. (2011). A patchwork of progress: Changes in overweight and obesity among California 5th-, 7th-, and 9th-graders, 2005-2010. UCLA Center for Health Policy Research and California Center for Public Health Advocacy. Funded by RWJF; California Department of Education, Physical Fitness Testing Research Files.

[65] Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

[66] Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2005-09. Source geography: County

Percent of Population with Low Food Access[67]	14.3%	17.0%	33.2%	12.3%	14.8%

The Sub Populations Experiencing Greatest Impact

In California there is evidence that obesity disproportionately affects low income individuals and people of color. The following table shows the prevalence of **obesity by income** (as a percent of FPL) for adults in 2003 and 2011-12[68]

	0% - 199% FPL	200% - 399% FPL	400% FPL and Above
2003	24.4%	20.8%	17.0%
2011-12	30.5.%	23.8%	20.2%

Obesity also has racial and ethnic disparities in California. The table below shows American Indians, Blacks, Pacific Islanders and Latinos have higher rates of obesity and that the trend for increased obesity throughout the state continues among all ethnic groups[69].

Ethnicity	Obesity Prevalence	
	2001	2011-2012
Overall	19.3%	24.8%
White	17.5%	21.9%
Asian	5.3%	9.7%
Latino	25.4%	32.6%
Black	31.0%	36.1%
American Indian	31.0%	36.2%
Pacific Islander	36.5%	37.1%
Two or More Races	23.1%	23.4%

If we look at the patterns of children among all racial groups in grade 9 who are at a healthy weight or underweight, it becomes clearer that a smaller percent of Latinos, American Indian/Alaska Native and African Americans are at a healthy weight[70]:

Children in grade 9 who are at a healthy weight or underweight

Ethnic Group	CA Average	Fresno	Kings	Madera	Tulare
White	73.4%	66.4%	68.2%	68.9%	66.5%
African American/Black	61.4%	54.5%	59.1%	64.7%	61.7%
American Indian/Alaska Native	58.6%	42.7%	LNE	LNE	51.1%
Asian American	78.5%	66.5%	67.7%	68.8%	71.0%
Filipino	70.5%	66.1%	64.6%	N/A	59.6%
Hispanic/Latino	57.3%	53.5%	55.4%	54.7%	57.2%
Native Hawaiian/Pacific Islander	51.6%	LNE	N/A	N/A	N/A
Multiracial	68.9%	54.8%	LNE	62.2%	59.9%

[67] Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010. Source geography: Tract
[68] Source: 2003 and 2011-12 California Health Interview Surveys Cited in: Wolstein, J. Babey. S. and A. Diamant Obesity in California 2015 UCLA Center for Health Policy Research.
[69] Ibid
[70] Source: California Dept. of Education, Physical Fitness Testing Research Files. Accessed at http://www.cde.ca.gov/ta/tg/pf/pftresearch.asp (Jan. 2015).

SUMMARY

The region has high rates of adults and children who are obese or overweight. Using California data alone we can extrapolate that American Indian, Black, Pacific Islander and Latino adults are most likely to be obese. Among youth, Native Hawaiian, Latino, American Indian and Black are the least likely to be of a healthy weight or underweight in Grade 9. Factors that contribute to this health outcome are linked to limited consumption of wholesome fruits and vegetables and less opportunity to be physically active.

Substance Abuse

Definition: Substance abuse, also referred to as "substance use disorder"[71], is defined as a dependency on mind and behavior altering substances. It is associated with family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. The health impact of substance abuse can lead to several negative health outcomes such as: cardiovascular conditions, sexually transmitted diseases, and HIV.[72]

Relevant Health Outcome Data

Indicator	CA Average	Fresno	Kings	Madera	Tulare
Estimated Adults Drinking Excessively[73]	17.02%	16.8%	14%	14.7%	18.2%
Percent of Adults Current Smokers[74]	12.8%	13.5%	12.6%	13.6%	14.3%
Youth Who Self Report Any Alcohol/Drug Use in the last 30 Days[75]	1.3%	1.1%	LNE	1.2%	1.3%

Relevant Data —Focus Group and Stakeholder Themes **(Primary Data)**

Participants who completed our community survey did not select alcohol abuse in high frequency as one of the top three health concerns. It also did not get raised in our stakeholder interviews. However when participants were asked what factors most impact the overall health of the community, substance abuse was identified by a high percent of healthcare workers and residents We have summarized the survey outcomes for this question in the table below. Residents in Fresno selected Alcohol abuse the least often while residents in Tulare selected drug abuse more often. Drug abuse was selected the most often by health care workers in Fresno and Tulare Counties.

The extent to which Drug Abuse and Alcohol Abuse is seen as one of the 3 behaviors that most affect health in the community		Healthcare Workers	Residents
Fresno	Drug abuse	46.50%	32.20%
	Alcohol abuse	30.20%	19.50%
Kings	Drug Abuse	35.00%	58.20%
	Alcohol Abuse	35.00%	20.00%
Madera	Drug Abuse	38.10%	41.35%
	Alcohol Abuse	28.60%	50.38%
Tulare	Drug Abuse	52.70%	61.10%
	Alcohol Abuse	33.30%	38.90%

When we asked about why alcohol and drug abuse was an issue, participants raised concerns about the limited number of wholesome activities and life stress that face the communities with high rates of poverty.

The Sub Populations Experiencing Greatest Impact

---

[71] Mental Health and Substance Use Disorders See: http://www.mentalhealth.gov/what-to-look-for/substance-abuse/
[72] Healthy People 2020 Topics. See: http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Substance-Abuse
[73] Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County
[74] Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County
[75] Data Source: Special tabulation by the State of California, Office of Statewide Health Planning and Development (Sept. 2015). Cited at Kidsdata.org

The following tables summarize the number of hospitalizations related to drug and alcohol use in all four counties for all age groups among all ethnic groups[76]:

	Fresno			Kings			Madera			Tulare		
Ethnic Group	N	Pop	Rate	N	Pop	Rate	N	Pop	Rate	N	Pop	Rate
White/Other/ Unknown	508	303,946	167.1	63	52,116	120.9	57	55,397	102.9	212	144,447	146.8
Black	72	47,219	152.5	3	10,034	*	7	5,230	*	5	5,837	*
Hispanic	442	500,527	88.3	55	81,357	67.6	39	86,639	45.0	166	286,323	58.0
American Indian	8	6,471	*							5	3,576	*
Asian/PI	21	93,719	22.	1	5,076	*				1	15,165	*

This data indicates that Whites, Latinos, and Blacks in Fresno County have the highest rates of substance abuse that leads to hospitalization. In Kings, Madera and Tulare County Whites and Latinos have consistently high rates of substance abuse that leads to hospitalization.

Substance abuse data by race and ethnicity for the region's youth is not available at the county level. The 2012 California Health Survey reports that **12.4%** of California's teenagers have tried marijuana, cocaine, sniffing glue, and other drugs. In Fresno, Kings, Madera and Tulare Counties that percentage drops to **8.4%.**

The following table shows the percent of California youth who self-report using any and no alcohol and drugs in the last month.[77] Higher rates of use exist among Latinos, American Indian/Alaskan Native and Blacks compared to Asian and Native Hawaiian/Pacific Islanders and Other ethnic groups.

Race/Ethnicity	**Any**	**None**
African American/Black	28.1%	71.9%
American Indian/Alaska Native	28.8%	71.2%
Asian	13.5%	86.5%
Hispanic/Latino	31.4%	68.6%
Native Hawaiian/Pacific Islander	22.8%	77.2%
White	27.7%	72.3%
Multi-racial	25.7%	74.3%
Other	23.8%	76.2%

In addition to the disparities in substance abuse among California youth, other data suggests disparities exist in health outcomes associated with substance abuse. The National Institute on Alcohol Abuse and Alcoholism suggests that key health outcome disparities exist on alcohol use also among Latinos, African Americans, and Native Americans:

[76] Source: California Office of Statewide Health Planning and Development, Inpatient Discharge Data
Prepared by: California Department of Public Health, Safe and Active Communities Branch.
Report generated from http://epicenter.cdph.ca.gov on: January 21, 2016

[77] Data Source: California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). Definition Percentage of public school students in grades 7, 9, 11, and non-traditional students reporting whether they used alcohol or any illegal drug (excluding tobacco) in the past 30 days, by race/ethnicity.

- Cirrhosis death rates are very high among white Americans of Hispanic origin, lower among non-Hispanic Blacks, and lower still among non-Hispanic whites.[78]
- Hispanics and Blacks have a higher risk for developing alcohol-related liver disease than whites.
- Alcohol-related traffic deaths are many times more frequent among Native Americans or Alaska natives than among other minorities.
- Self-reported rates of DUI are highest among mixed race and Native Americans and Alaska Natives.
- Hispanics are overrepresented among drunk drivers and DUI-related fatalities.
- Between 2001 and 2005, alcohol played a role in 11.7 percent of all Native American deaths, which is more than twice the rates of the general American public.[79]

SUMMARY

While residents in the region did not name substance abuse as a top health concern, they did identify both alcohol and drug abuse as key behaviors that interfere with the health of their community. Statewide data suggest that Latino, American Indian/Alaska Native and African American youth more often report some use of drugs or alcohol. Discussions about why these behaviors persist focused on the limited number of wholesome activities available for youth and the life stressors common among poor working families experience.

[78] National Institute on Alcohol Abuse and Alcoholism 2009-2013 Health Disparities Strategic Plan, p.4

[79] Ethnicity and Health Disparities in Alcohol Research, Chartier and Caetano http://pubs.niaaa.nih.gov/publications/arh40/152-160.htm

APPENDIX D: Primary Data Collection Questions

i. Community Survey Questions

ii. Focus Group Questions

iii. Stakeholder Survey Questions

APPENDIX D.1: Community Survey Questions

1. In which county do you live?
   -Fresno -Kings -Madera - Tulare

2. As a community member, please identify the hospital where you typically receive health care services?
3. Please indicate the place where you and your family receive primary health care services.
   a. Doctor's Office
   b. Urgent Care
   c. Free Community Health clinic/Health Fair
   d. School Based Health Center
   e. Hospital Emergency Department
   f. Other:
4. Are you a staff member of a health care facility? Y or No
5. If so, for which hospital do you work?
6. What community health challenges do you experience most in your department? (Select Top 3)
   ☐ Lack of preventive care
   ☐Lack of health knowledge
   ☐Language barriers
   ☐Access to resources
   ☐Care Compliance
   ☐Understanding of coverage
   ☐Under-insured
   ☐Uninsured

7. What department do you work in?
8. What is your home zip code?
9. Please rate the **overall health** of your community.
   ☐ Excellent ☐ Good ☐ Ok ☐ Poor ☐ Very Poor ☐ Don't Know
10. Please rate how well your county works to help solve community problems?
    ☐ Excellent ☐ Good ☐ Ok ☐ Poor ☐ Very Poor ☐ Don't Know
11. What are the three biggest health problems in your community? (Please choose three)
    - ◻ Age-related health problems (like arthritis, Alzheimer's)
    - ◻ Cancer
    - ◻ Tooth problems
    - ◻ Heart disease
    - ◻ Infectious diseases(e.g., hepatitis or TB)
    - ◻ Mental health issues (e.g., depression)
    - ◻ Motor vehicle injuries (including pedestrian and bicycle accidents)
    - ◻ Poor birth outcomes (e.g., baby underweight)
    - ◻ Breathing problems/asthma, COPD
    - ◻ Age-related health problems (like arthritis, Alzheimer's)
    - ◻ Motor vehicle injuries (including pedestrian and bicycle accidents)
    - ◻ Poor birth outcomes (e.g., baby underweight)
    - ◻ Breathing problems/asthma, COPD
    - ◻ Sexually transmitted diseases
    - ◻ Youth violence (like gang fights, murders)
    - ◻ Domestic violence
    - ◻ Child abuse or neglect
    - ◻ Obesity
    - ◻ Other:

12. What are the three biggest social and economic problems in your community (Choose three)

13. What are the three biggest social and economic problems in your community (Choose three)
    ☐ Not enough local jobs
    ☐ Poverty
    ☐ Overcrowded housing
    ☐ Homelessness
    ☐ Not enough education/high school drop-outs
    ☐ Gangs
    ☐ Racism and discrimination
    ☐ No health insurance
    ☐ Not enough interesting activities for youth
    ☐ Fear of crime
    ☐ Not enough healthy food
    ☐ Inadequate public transportation
    ☐ Not enough police and firefighters
    ☐ Other

14. What are the three biggest obstacles to having a healthy environment in your community? Choose three
    - □ Air pollution (dirty air)
    - □ Pesticide use
    - □ Poor housing conditions
    - □ Home is too far from shops, work, school
    - □ Too many hot days
    - □ Cigarette smoke
    - □ Not enough sidewalks and bike paths
    - □ Trash on streets and sidewalks
    - □ Flooding problems
    - □ Unsafe drinking water
    - □ Not enough safe places to be physically active (i.e. parks)
    - □ Not enough places nearby to buy healthy and affordable foods
    - □ Not enough public transportation
    - □ Speeding/Traffic
    - □ No sidewalks or street lights
    - □ Other

15. What are the three behaviors that most affect health in your community? Choose three
    - ☐ Alcohol abuse (drinking too much)
    - ☐ Driving while drunk/on drugs
    - ☐ Drug abuse
    - ☐ Lack of exercise
    - ☐ Poor eating habits
    - ☐ Not getting "shots" (vaccines) to prevent disease
    - ☐ Smoking/tobacco use
    - ☐ Unsafe sex (e.g., not using condom or birth control)
    - ☐ Using weapons/guns
    - ☐ Not getting regular checkups by the doctor
    - ☐ Life stress/not able to deal with life stresses
    - ☐ Teenage sex
    - ☐ Talk/texting and driving
    - ☐ Other
16. In your opinion, is store window advertising of tobacco, alcohol, and sugary beverages a problem in your community?
    - □Not a problem
    - □ A big problem
    - □ A small problem
    - □ A medium problem
    - □ I don't know
    - □ Other:
17. What three things make it hard to get healthcare in your community? Choose three.
    - □ It is NOT hard to get health care
    - □ No health insurance
    - □ Medi-Cal is too hard to get
    - □ Medi-Cal is too hard to use
    - □ No health care available at night or weekends
    - □ Can't get off work to see a doctor
    - □ The only place to go is the emergency room
    - □ Covered California/Obama Care is too hard to get
    - □ Covered California/Obama Care is too hard to use
    - □ No transportation
    - □ Waiting time to see the doctor is too long
    - □ Doctors and staff don't speak languages found in our community
    - □ High co-pays and deductibles
    - □ Other

18. What are the greatest behavior concerns children and adolescents face in your community?
    a. Mental health issues (e.g. depression)
    b. Domestic violence
    c. Alcoholism
    d. Motor vehicle injuries
    e. Youth violence (gang fights, murders)
    f. Suicide
    g. Other
19. What are the greatest needs of children, and their families in your community?
20. What resources are available to help address these issues identified above?
21. When you think about the resources and services that help members of your community stay health, what three organizations stand out (Example: health and Human Services, YMCA, Boys and Girls Club)
22. Which of your three choices above do you see taking a leadership role at improving the health of your community?
23. What are the five most important parts of a healthy thriving community? Choose three
    - ☐Safe place to raise kids
    - ☐ Community involvement
    - ☐ Affordable housing
    - ☐ Good air quality
    - ☐ Services for elders
    - ☐ Good schools
    - ☐ Access to healthy food
    - ☐ Diversity is respected
    - ☐ People know how to stay healthy
    - ☐Parks and recreation facilities
    - ☐ Jobs
    - ☐ Time for family
    - ☐ Low crime and violence
    - ☐ Access to healthcare
    - ☐ Inexpensive childcare
    - ☐ Green/open spaces
    - ☐ Support agencies (e.g., social workers, churches and temples)
    - ☐ Other:

24. What are **two things** that make you **most proud** of your community?
25. What activities would energize you enough to **become involved** (or more involved) in building a healthier community?
26. What are the **two things** you would like to **improve** in your community?

Please tell us about yourself:

27. What is your age? _____________

28. Please indicate your gender. Choose one:
□ Female □ Male □ Other:

29. What is your highest educational level? **Choose one:**

□ Less than high school
□ High school diploma
□ GED
□ Some college
□ College degree
□ Graduate/professional degree
□ Other:

30. How many people live in your household?
1
2
3
4
5
Other (please explain):

31. How would you rate your health in general? Choose one.
□ Excellent □ Very Good □ Good □ Fair □ Poor □ Don't Know

21. Please rate your family's overall health **Choose one answer**

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Don't Know

32. Please rate how well your neighbors and your county work together to help solve community problems?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Don't Know

33. What is your annual household income? **Choose one:**

□ Less than $10,000
□ $10,000 to $14,999
□ $15,000 to $24,999
□ $25,000 to $34, 999
□ $35,000 to $49,999
□ $50,000 to $74,999
□ $75,000 to $99,999
□ $100,000 to $149,000
□ $150,000 to $199,999
□ $200,000 or more
□ Don't know

34. What language(s) do you speak at home? **Choose one:**

□ English □ Spanish □ Other:

35. How well do you speak English? **Choose one:**

□ Very well □ Well □ Not well □ Not at all

36. What race and ethnic group do you most identify with? **Check all that apply:**

□ Black/African American
□ White/Caucasian

□ Asian(if checked, please select a choice below):

o Cambodian
o Chinese
o Korean
o Hmong
o Vietnamese
o Filipino
o Pakistani
o Japanese
o Thai
o Laotian
o East Indian
o Native Hawaiian or Pacific Islander
o Other: _____

□ Hispanic/Latino (if checked, please select a choice below):

o Mexicano
o Salvadoreño
o Puertorriqueño
o Nicaragüense
o Other: ______

□ Native American/Alaska Native (Indicate your tribal affiliation or Indigenous Community below):

____

□ Other: ________

Thank you very much for your participation!

APPENDIX D.2: Focus Group Questions/Data

i. Focus Group Questions

- In your opinion, what are the three (3) biggest health problems in your community
- In your opinion, what are the three (3) biggest social and economic problems in your community?
- In your opinion, what are the three (3) biggest obstacles to having a healthy environment in your community?
- In your opinion, what are the three (3) behaviors that most affect health in your community?
- In your opinion, what three (3) things make it hard to get healthcare in your community?
- What are some key services you believe would help address these challenges?
- ONE effort that would make the greatest impact on health outcomes in your community/region?
- Are you aware of any NEW programs or services that were created in the last three years that have the potential to address your community's health needs?
- What would you say is currently working well to address health needs in your community?

iii. Focus Group Results

COUNTY	**Survey Question: 11** In your opinion, what are the three (3) biggest health problems in your community?	**Survey Question: Q12** In your opinion, what are the three (3) biggest social and economic problems in your community?	**Survey Question: Q13** In your opinion, what are the three (3) biggest obstacles to having a healthy environment in your community?	**Survey Question: Q14** In your opinion, what are the three (3) behaviors that most affect health in your community?	**Survey Question: Q16** In your opinion, what three (3) things make it hard to get healthcare in your community?	What are some key services you believe would help address these challenges?	ONE effort that would make the greatest impact on health outcomes in your community/region?
FRESNO	• Obesity • Diabetes • Cancer • Respiratory issues • Mental health	• Lack of quality of education • High poverty rates • Lack of vocational programs • Lack of quality housing • No access to higher education • Transportation	• Lack of access to free parks • No access to quality healthy food • Poverty	• Teen pregnancy • Lack of access to health care • Stress	• Not enough medical providers • Lack of quality health insurance • Poverty	• Upstream interventions • Regional initiatives • Advisory Councils • Health Fairs • Parental Engagement	• Upstream health initiatives • Improved economic conditions • Improved community infrastructure for healthy living
KINGS	• Obesity • Diabetes • Mental health • Substance abuse	• Poverty • Lack of jobs • No activities for youth • Lack of education • No grocery stores	• Pollutions • Lack of green spaces	• Substance abuse • Poor eating habits and exercise habits • Stress • Lack of parental engagemen t		• Upstream interventions • More community clinics • Health Education especially in rural areas	• Health education • Upstream health initiatives
MADERA	• Obesity • Breathing problems • Alcoholism • Substance abuse • Dental care • STD's	• Homelessness • Gangs • Poverty	• Not enough spaces for youth • Lack of jobs	• Teen sex • Preventive care • Stress • Poor eating habits • Lack of exercise	• Lack of public transportati on • Lack of quality health insurance • Poverty	• Upstream Interventions • Coordinated care, especially for mental health issues • Community advisory councils	• More education • More upstream health initiatives

TULARE	• Cancer • Mental health • Dental care • Poor outcomes • Teen pregnancy • Domestic violence • Chronic disease	• Segregated communities • Poor quality of education • Poverty • Housing • Gangs	• Air pollution • Lack of green spaces • Gang violence	• STD's • Substance abuse • Stress	• Transportat ion	• Upstream interventions • Collaboration • More access to care	• Economic conditions • Improved community infrastructure • Upstream health initiatives

County	Are you aware of any NEW programs or services that were created in the last three years that have the potential to address your community's health needs?	What would you say is currently working well to address health needs in your community?
Madera County	• Community clinic • Neighborhood stabilization programs • Healthy eating programs	• Community Clinic • Community Outreach
Fresno County	• Fresno school/PD (focus on children overcoming life) • Fresno movement promoting reading • Fresno County Community Health Improvement (Robust public health presence/stepping/inform infrastructure by listening to community) • Barrios Unidos	• Non-profit collaboration • ACA • FHQC - high fee, Clinica Sierra Vista - long delay in getting appointments. • NGO's • Health Fairs • Charitable Care
Kings County	• School-based health centers, • Kings partnership for prevention	• FQHC and rural health network • Public outreach improving with coordinated efforts
Tulare County	• Doctor's Academy (health careers program) • Pharmacy School • Teaching Health Center • Community's (Valley) Coordinate Health Program • Children's Hospital program to address diabetes • School-based clinic by Sierra Vista • San Joaquin Valley PRIME • FBHC (4 wg) TCE - focusing on youth • Off the Front (Obesity Prevention, School-Based) • Pre-term birth initiative (men and women) • UCSF Health Policy Institute (FCHIP) • Farmer's Market	• Public health outreach by public agencies • Faith based, charitable care • Hospital providers

APPENDIX D.3: Stakeholder Survey Questions

- Of the three health needs identified by survey respondents in your county, would you please rank order those and tell us why would you rank them this way?
- What are the three biggest social and economic problems in your community?
- In your opinion, what are the three (3) biggest obstacles to having a healthy environment in your community? (Please choose three)
- In your opinion, what are the three (3) behaviors that most affect health in your community? (Please choose three)
- In your opinion, what three (3) things make it hard to get healthcare in your community? (Please choose three)
- Given the health needs you've identified, what one effort do you believe would make the greatest impact on health outcomes in your region?
- What is currently working well to address health needs in your community?

In addition, those community leaders who were based in a healthcare setting were also asked:

- What are some key activities your organization is using now to address these challenges?

Hospital CEOs who participated in the interviews were also asked:

- What are the key ways your community benefit dollars are used to address these needs

APPENDIX E: Data for Health Need Identification

FRESNO COUNTY

- **25.96% of the total population lives in poverty versus 15.94% of Californians**
- **26.94% of the adult population does not have a high school degree vs 18.76% California adults**
- **29.7% of adults have no insurance versus 24.71% of Californians**
- **7.8% of children have no insurance versus 8.32% of Californians**

Health Needs (health outcomes that are disproportionately impacting a particular population).	**Community Stated as Health Concern?** (2 out of 3 sources: survey, focus group or interview)	**Secondary Data Affirms Health Need Exists?** (**County data differs negatively from state average, rate or percentages at levels >2% diff)	**Are there Health Disparities?** (do ethnic minorities experience higher rates of this indicator?)
Access to care	YES **SURVEY:** 26.5% of HCW and 11.5% of residents indicated the biggest problem in community was no health care The reasons most often cited as what makes it hard to get healthcare were: • No health insurance • Can't afford medicine • Insurance does not cover the care I need • Waiting time to see the doctor is too long • Not enough Doctors **INTERVIEWS:** Several Stakeholders selected "no health insurance" as a primary reason why healthcare is hard to get as well as MediCal and Medicare are too hard to use and that the only place to go for care is the ED in Fresno County **FOCUS GROUPS:** Focus group participants raised "not enough doctors", "lack of quality health insurance" and "poverty" as the three things that make it hard to get health care in the region.	YES Insurance **29.7%** of those age 18 and over have no insurance versus 24.71% of Californians in this age cohort** Health Care Professional Shortage Area Status **81.67%** of Fresno County residents live in a HCPSA versus 25.18%**	YES Statewide ethnic minorities are disproportionately uninsured Whites: 14.67% African American/Black: 20.93% Latino: 38.69% Population without consistent source of primary data by Race/Ethnicity: Non-Hispanic **White: 10.44%** versus CA 9.99% Non-Hispanic **Black: 12.24%** versus CA 11.03% Non-Hispanic **Other race: 13.21%** versus CA13.85% Hispanic or Latino: 18.6% versus 19.27% CA Uninsured population by race alone Non-Hispanic white: **10.98%** versus CA 9.63% Black/African American:**25.95%** versus CA 14.22% Native American: 17.99% versus CA 23.05% Asian:**17.99%** versus CA 13.05% Population patient Discharges for Preventable Conditions, percentage of total discharges White: 10.14% versus 10.32% CA Black: **14.29%** versus 13.79% CA Asian/Pacific Islander: 7.43% versus 8.37% CA
Asthma/ Breathing problems	YES **SURVEY** 46.7% of HCW and 41.4% of residents listed Breathing problems as a concern. This made it the second most frequently chosen concern. **INTERVIEWS** 3 stakeholders listed this as a 1st concern, 4 listed as 2nd and 6 listed this as 3rd. **FOCUS GROUP** Breathing Problems was raised as a concern.	YES The overall prevalence rate for asthma is **19.4%** Fresno County versus 14.1% in CA Fresno County shows ED Visits rates per 10,000 are above State Age 0 – 17: **134.1** vs 79.4 Age 18+: **51.2** vs 39.6 This is also the case for Hospitalizations Age 0 – 17: **22.8** vs 11.7 Age 18+: **10.2** vs 7.5 Source: California Breathing, Fresno County Profile, 2015	YES National data suggests Latinos are 40% more likely to die from Asthma than other demographic groups Patient Discharges for Asthma, Percent of total discharges by race: White: **.99%** versus .73% CA Black:**2.21%** versus 1.8% CA Asian/Pacific Islander: **1%** versus .78% CA Hospitalization Rates for Fresno County Whites: 12.9 African American/Black: 36.3 Latino: 11.2 Asian/PI: 7.1 ED Visits for Fresno County Whites: 63.5 African American/Black: 128.3 Latino: 71.6 Asian/PI: 16.7 Source: California Breathing, Fresno County Profile, 2015

Cancers	NO **Survey** Only 18.3% of HCW rated this as a health concern versus 12.6% of residents **FOCUS GROUP** Cancer was raised as concern **INTERVIEWS** Stakeholders did not select Cancer as a concern	YES Fresno County has an overall Cancer Mortality rate **156.63** deaths per 100,000 versus 157.95 in CA The annual incidence rate of breast cancer is **111.3** per 100,000 versus 122.4 in California The rate of Cervical Cancer is **9** per 100,000 versus 7.8 in California The rate of Colon/Rectal Cancer is **38.7** versus 41.5 in California The rate of Lung Cancer is **52.7** versus 49.5 in California** The rate of Prostate Cancer is **132.9** versus 136.4	YES African Americans have a higher rate of Colorectal, Lung and Prostrate cancers. Breast Cancer Incidence Rates per 100,000 in Fresno: Whites: 118.6 African Americans/Blacks: 104.4 American Indian/Alaskan Native: 36.9 Asian/PI: 71.2 Latino: 88 Colorectal Cancer Incidence Rates per 100,000 in Fresno: Whites: 40.8 African Americans/Blacks: 44.7 American Indian/Alaskan Native: not avail Asian/PI: 33.7 Latino: 38.7 Lung Cancer Incidence Rates per 100,000 in Fresno Whites: 54.3 African Americans/Blacks: 78.1 American Indian/Alaskan Native: 32.9 Asian/PI: 32.4 Latino: 32.8 Prostate Cancer Incidence Rates per 100,000 in Fresno Whites: 134.7 African Americans/Blacks: 189 American Indian/Alaskan Native: not available Asian/PI: 68.5 Latino: 117.8 Source: *Data Source: National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles.* *2007-11. Source geography: County*
Climate Health	YES **SURVEY** 83.5% of HCW and 78.2% of residents listed air pollution as one of the 3 obstacles making it difficult to have a healthy community. This was the most frequently chosen item identified as an obstacle. 40% of HCW and 14.9% of residents also listed too many hot days as an obstacle **FOCUS GROUP** The three most often concerns raised were ☐Lack of access to free parks ☐No access to quality healthy food	YES The Percent of Days Exceeding Ozone Standards is **6.50%** versus the CA average of 2.7%** The Percent of Days Exceeding Standards for Particulate Matter is **7.84%** versus 4.17%**	**N/A**

Economic Security	YES SURVEY 53.1% of HCW and 70.1% of residents listed poverty as a concern FOCUS GROUPS High rates of poverty and lack of good jobs were listed as concerns INTERVIEWS 14 of the stakeholders ranked this as the 1st concern and 3 ranked it as their 2nd concern	YES Poverty **27.4%** of Fresno's residents live below the poverty level versus 16.4 % of Californians** Educational Attainment **36.5%** of Fresno county residents do not have a high school diploma versus 26.1% of Californians**	YES Population in Poverty Race alone, Percent White:**22.25%** versus CA 14.67% Black/African American: 39.61% versus CA 24.77% Native American/Alaska Native: **30.51%** versus CA 24.15% Asian:**25.42%** versus CA 11.95% Native Hawaiian/Pacific Islander: **39.54%** versus CA 16.88% Multi-Race: **28.53%** versus CA 15.98% Population with no High school Diploma by Race alone, Percent: White:**21.24%** versus CA 16.01% Black/African American:**18.22%** versus CA 11.79% Native American/Alaskan Native: 22.85% Versus CA 24.61% Asian: **27.73%** versus CA 13.59% Native Hawaiian/Pacific Islander: **31.09%** versus CA 16.32% Multiple Race: **22.25%** versus CA 14.78% Ethnic minorities have disproportionate rates of poverty in Fresno than across California African American: **39.6%** vs 24.8% Am Ind/Alskn: **30.5%** vs 24.1% Asian: **27.8%** vs 11.9% Latino: **34.9%** vs 23.1% MultiRacial: **28.5%** vs 16.0% Native Hawaiian/Pacific Islander:**50.6%** vs 16.9% White: **22.3%** vs 14.7% Data Source: Factfinder, US Census American Survey 2014
Diabetes	YES **SURVEY:** 39.8% of HCW and 36.8% of residents ranked Diabetes as a health concern. This made Diabetes 4th most frequently chosen health concern **INTERVIEW:** 6 placed it 2nd; 4 placed it 3rd FOCUS GROUPS identified diabetes as a problem	YES **9%** of Fresno adults have diabetes versus 8.05% of CA Diabetes hospitalizations (Age-Adjusted Discharge Rate: **13.33** versus10.4 CA	YES Diabetes Prevalence percent of adults age 20+ Percent Males with Diabetes: **9.6%** versus CA8.41% Percent Females with Diabetes: **8.15%** versus CA 7.13% Population by Race, Patient discharges for diabetes, Percent of Total discharges: White: **.87%** versus .77% CA Asian/Pacific Islander: .5% versus .59% CA Multi-Race:.8% versus .87% CA Population by Ethnicity, Patient discharges, Percentage of Total Discharges Hispanic/Latino:**.93%** versus .91% CA Not Hispanic/Latino:**.89%** versus .79% CA Hispanics and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from their disease. [4] Hispanics, African Americans, and Asian/Pacific Islanders have higher prevalence of type 2 diabetes than non---Hispanic Whites. Hispanics and African Americans have two times higher prevalence: 1 in 20 non---Hispanic Whites have type 2 diabetes, compared with 1 in 10 Hispanics and 1 in 11 African Americans Source: The Burden of Diabetes in California September 2014
CVD/Stoke Heart Disease	NO SURVEY 28% of HCW and 18.4% of residents listed heart disease as a health concern. FOCUS GROUP Not raised as a concern INTERVIEWS None of the stakeholders selected heart disease as a concern	NO **3.70%** of residents have heart disease versus 3.45% in CA **27.8%** of residents have high blood pressure versus 26.2%	NO In California, adult rates of heart disease for ethnic groups fall below national averages except for African Americans but less than 2% difference. Whites: 4.5% African Americans: 4.27% Latinos: 2.38% Other: 2.46%

HIV/AIDS/ STD	NO **SURVEY** 3.2% of HCW and 2.3% of residents ranked sexually transmitted diseases as a top health concerns **INTERVIEWS** No interviewees raised sexually transmitted diseases as a concern **FOCUS GROUPS** Sexually transmitted diseases were not raised as a concern.	YES The prevalence rate for **HIV** is 200.7 per 100,000 versus 363 in California. The rate of Gonorrhea infection is **157.3** per 100,000 versus 89.09 in California** The rate of Chlamydia infection is **639** per 100,00 versus 444.91 in California**	YES Higher rates in HIV and Sexually Transmitted Diseases exist for African Americans **Fresno County HIV Prevalence Rates per 100,000** White: 189.83 Black: 784.6 Latino: 184.95 *Statewide Gonorrhea Rates per 100,000 show ethnic disparities*: Whites: 49.17 African American/Black: **302.31** Asian/PI: 19.66 American Indian/ Alaskan Native: 51.87 Latino: 58.5 Statewide Chlamydia Rates per 100,000 show ethnic disparities Whites: 162.93 African American/Black: **915.08** Asian/PI: 119.76 American Indian/Alaskan Native: 247.44 Latino: 383.7
Maternal/Infant Health	Pre---Term Births **NO** **SURVEY:** only 1.8% HCW chose poor birth outcomes as a health need, 17.2% of Residents chose this **INTERVIEW**: no interviews listed this as a concern **FOCUS GROUPS**: not raised as a concern Child Abuse **NO** **SURVEY:** Only 4.6& of HCW listed child abuse as a concern, 6.9% of residents **INTERVIEW:** no interviewees raised this **FOCUS GROUPS:** Not raised	Pre Term Births **NO** Fresno County **10.2** per 1,000 versus California 8.8** (CDPH Dept of Maternal Infant Health) Immunizations NO **95%** of all Kindergarteners have required immunizations, compared to 90.4% CA Pre Natal Care **NO** Women in all ethnic groups receive prenatal care in the first trimester at higher rates than CA African Am: **87.5%** vs 78.3 Am Ind/Alskn: **77.1%** vs 68.9% Asian/Pac Isl: **87.2%** vs 86.5% Latina: **87.3%** vs 81.3% White: **91.2%** vs 87.5% MultiRacial: **88.6%** vs 82.4% (kidsdata.org) Child Abuse: **NO** Fresno County **8.4** child abuse cases per 1,000 versus 8.7 in California Teen Pregnancy **YES**	Pre---Term Births **YES** California rates of preterm births show ethnic disparities Whites: 7.9 African American 12.8 Latino: 9.0 (CDPH Dept of Maternal Infant Health) Child Abuse: **YES** Fresno Rates of protected service/child placement in foster care per 1,000 African American: 177 Am Indian/Alaska: 80.6 Asian/Pac Islander: 33.5 Hispanic: 71.5 White: 54.1 Fresno County has higher rates of Teen Pregnancies per 1,000 across all ethnic groups African Am: **55.3** vs 28.3 Am Ind/Alskn: not avail Asian/Pac Isl: **24.2** vs 4.8 Latina: **49.9** vs 34.9 White: **14.5** vs 9.2 MultiRacial: **25.4** vs 16.5 Source: kidsdata.org
Mental health	YES **SURVEY:** 40.7% of HCW and 43.7% residents selected mental health as a health concern. <u>This made</u> mental health the third most frequently chosen concern. **INTERVIEW:** 7 placed it 1st, 4 placed it 2nd,5 placed it 3rd **FOCUS GROUPS** mental health was consistently raised as a concern	YES **13.6%** of adults in Fresno County self---report poor mental health versus vs 15.9% in California. The average number of Mentally Unhealthy Days for adults in Fresno County is 3.7 versus 3.6 for Californians as a whole [5] Fresno County's suicide rate is **8.83** per 100,000 versus 10.24 for California as a whole NO Children show lower rates of mental illness per 1,000 than CA 5--- 14 yrs: 1.1 vs 2.7 15---19 yrs 6.6 vs 9.7 Ages 5 – 19 yrs 2.9 vs 5.1 Source : Kidsdata.org Mental Health Care Provider Rate (per 100,000 population) **119.8** vs. 157 CA rate and 134.1 US rate **27.4%** of adults aged 18 and older in Fresno Co. who self-report that they receive insufficient social and emotional support all or most of the time vs. 24.6 % CA percentage and 20.7% US Percentage.	YES Suicide Mortality, Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity Non-Hispanic white:12.24 versus 14.8 CA Black: 4.79 versus 6.36 CA Native American/Alaskan Native:**11.46** versus 5.9 CA Multi Race: 3.47 versus 5.84 CA Hispanic/Latino: 3.99 versus 4.04 CA Percent Adults with Poor Mental Health by Race / Ethnicity Non-Hispanic White: **18.8%** versus CA 17.9% Non-Hispanic Black: **38.5%** versus CA 17.3% Non Hispanic other race: 5.7% versus CA 9.7% Hispanic Latino: 9.1% versus CA 16.4%

Obesity	YES **SURVEY** 59.6% of HCW and 56.3% of residents listed poor eating habits as behaviors that affect the health of the community making this the top 3 behaviors of concern. This was the most frequently chosen health concern. **INTERVIEW:** 9 interviewees raised Obesity as 1st priority concern, 4 raised this as 2nd priority **FOCUS GROUP**: Obesity was raised as a health concern.	YES **28.7%** of Fresno adults are obese versus 22.32% of CA** 34.94% of Fresno adults are overweight versus 35.8% CA The percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category (Obese) for body composition on the Fitnessgram physical fitness test is 23.5% versus 18.99% CA	YES Students overweight (in "Needs Improvement" fitness zone), Percent by Race/Ethnicity Non-Hispanic White: **18.21%** versus CA 15.93% Black/African American: 19.86% versus CA 20.33% Hispanic/Latino: **22.07%** versus CA 21.6% Asian:**18.15%** versus CA 15.13% Multi Race: 18.01% versus 18.3% Adults Obese (BMI>30.0) by gender Males:**29.3%** versus 23.13% Females: **27.7%** versus 21.45% CA Data on overweight adults shows that ethnic disparities exist in California: Whites: 35.64% African Americans: 37.89% Latinos: 39.41% Other: 28.8% Source: *Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.* *Additional data analysis by CARES. 2011-12. Source geography: County*
Oral/ Dental Care	NO **SURVEY:** 5.3% of HCW reported teeth problems as a concern vs 5.7% of residents **INTERVIEW:** Not raised as a concern. **FOCUS GROUP:** Not raised as a concern	YES **12%** of Adults have poor dental health (6 or more permanent teeth removed) versus CA 11.3% **39%** adults with no dental exam (FRESNO) vs 30.5% in CA** Percentage of children age 2-11 who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year **41.23%** versus 18.5% CA Percentage of adults who self-report having no dental insurance for some or all of the past 12 months. 36.5% versus 40.9% CA	YES Percent Children Without Recent Dental Exam by Race / Ethnicity Non-Hispanic white: **49.8%** versus 21.7% CA Hispanic Latino: **20.18%** versus 16.9% CA Adult Population Without Dental Insurance, Percent by Race / Ethnicity Hispanic or Latino **37.4%** versus 41.96% CA
Overall Health, Mortality and Self Reported Health	N/A	YES Premature death measured by total years lost shows Fresno well above CA rate: **7,009** years lost per 100,000 versus 5,229** **23.94%** of adults self report being in poor health versus 18.4% in CA**	N/A
Substance abuse ---or substance use disorder	NO **SURVEY:** HCW 7.8% vs 8.0% of residents saw alcoholism as a problem **INTERVIEWS** 3 stakeholders ranked alcohol abuse as the number one behavior that threatens the health of the community; 4 ranked it second. 5 stakeholders ranked drug abuse as the number one behavior that threatens the health of the community. **FOCUS GROUP** Participants did not raise substance abuse as a health concern or behavior that threatens the community.	YES Percent of persons alcohol dependence and or substance abuse in Fresno region[2] **9.79** versus **7.3%** in **CA****	YES Latinos report a higher rate of use of an illicit drug than other demographic groups. 47% use Marijuana. Source: Partnership Attitude Tracking Study (PATS) 2013
Violence and Unintentional Injury	NO **SURVEY:** Only 8.0% of HCW and 4.6% of residents listed youth violence as a health concern, Only 5.5% of HCW and 10.3% of residents listed domestic violence as a health concern **INTERVIEW:** Not raised **FOCUS GROUPS**: Not raised	YES Homicide rate is **7.36** per 100,000 in Fresno compared to 5.6 in California** Fresno County's mortality rate for pedestrian accidents is **2.54** per 100,000 compared to 2.02 for California Fresno County's mortality rate due to motor vehicle accidents is **10.42** per 100,000 compared to 6.13 for California**	YES Homicide rates in Fresno show substantial ethnic differences African American: **25.73** Asians: 4.11 Latinos: 8.23 Whites: 3.31 California's homicide rate for those age 10 – 24 is 7.87 per 100,000 but for blacks that figure is 38.10 [3]

KINGS COUNTY

- **20.98% of the total population lives in poverty versus 15.94% of Californians**
- **29.05% of the adult population does not have a high school degree vs 18.76% California adults**
- **24.61% of adults have no insurance versus 23.91% of Californians**
- **8.1% of children have no insurance versus 7.89% of Californians**

Health Needs (health outcomes that are disproportionately impacting a particular population).	**Community Stated as Health Concern?** (2 out of 3 sources: survey, focus group or interview)	**Secondary Data Affirms Health Need Exists?** (**County data differs negatively from state average, rate or percentages at levels >2% diff)	**Are there Health Disparities?** (do ethnic minorities experience higher rates of this indicator?)
Access to care	YES Only 22.5% of HCW and 10.9% of residents indicated it was NOT difficult to get healthcare in Fresno County. The biggest reasons cited for making it difficult to get healthcare among residents in Kings were: • Waiting time to see doctors • Cant's afford medicine • High co---pays and deductibles The biggest reasons cited for making it difficult to get healthcare among HCW were: • High copays and deductibles • Waiting time to see doctors Can't afford medicine	YES Insurance **24.61%** of those age 18 and over have no insurance versus 23.91% of Californians in this age cohort Health Care Professional Shortage Area Status **100%** of Kings County residents live in a HCPSA versus 25.18%**	YES Statewide ethnic minorities are disproportionately uninsured Whites: 14.67% African American/Black: 20.93% Latino: 38.69% Population without consistent source of primary data by Race/Ethnicity: Non-Hispanic **White: 19.15%** versus CA 9.99% Non-Hispanic **Other race: 25%** versus CA13.85% Hispanic or Latino: 9.59% versus 19.27% CA Uninsured population by race alone Non-Hispanic white: 8.6% versus CA 9.63% Black/African American:12.45% versus CA 14.22% Native American: **31.42%** versus CA 23.05% Asian:12.21% versus CA 13.05% Population patient Discharges for Preventable Conditions, percentage of total discharges White: 12.14% versus 10.32% CA Black: 10.29% versus 13.79% CA
Asthma/ Breathing problems	YES SURVEY 37.5% of HCW and 36.4% of residents listed Breathing problems as a concern. INTERVIEWS 1 stakeholder listed this as a 1st concern and 2 listed this as 3rd. FOCUS GROUPS Breathing Problems was raised as a concern.	YES The overall prevalence rate for asthma is **17.3%** versus 14.2% CA However, the region shows ED Visits rates per 10,000 are above State ED Visits Age 0 – 17: 140.1 vs 79.4 Age 18+: 79.1 vs 39.6 Hospitalizations Age 0 – 17: 17.2 vs 11.7 Age 18+: 15.2 vs 7.5 Source: California Breathing, Kings County Profile, 2015	YES National data suggests Latinos are 40% more likely to die from Asthma than other demographic groups Patient Discharges for Asthma, Percent of total discharges by race: White: 1.42% versus .73% CA Black:2.14% versus 1.8% CA Hospitalization Rates for Ethnic Minorities Show Whites: 12.9 African American/Black: 36.3 Latino: 11.2 Asian/PI: 7.1 ED Visits for Ethnic Minorities Show Whites: 63.5 African American/Black: 128.3 Latino: 71.6 Asian/PI: 16.7

Cancers	NO SURVEY Only 15.1% of HCW and 9.1% of residents listed Cancer as a health concern. INTERVIEWS No stakeholder listed as concern FOCUS GROUPS Not raised as a concern	YES Fresno County has an overall Cancer Mortality rate **147.1** deaths per 100,000 versus 157.95 in CA The annual incidence rate of breast cancer is **103.8** per 100,000 versus 122.4 in California The rate of Cervical Cancer is **11.1** per 100,000 versus 7.7 in California The rate of Colon/Rectal Cancer is **37.7** versus 40 in California The rate of Lung Cancer is **50.7** versus 48 in California** The rate of Prostate Cancer is **116.6** versus 126.9	YES African Americans have a higher rate of Colorectal, Lung and Prostrate cancers. Breast Cancer Incidence Rates per 100,000 in Kings: Whites: 102.5 African Americans/Blacks: not avail American Indian/Alaskan Native: not avail Asian/PI: 144.6 Latino: 85.5 Colorectal Cancer Incidence Rates per 100,000 in Kings: Whites: 37.9 African Americans/Blacks: not avail American Indian/Alaskan Native: not avail Asian/PI: not avail Latino: 38.2 Lung Cancer Incidence Rates per 100,000 in Kings: Whites: 50.6 African Americans/Blacks: 79.4 American Indian/Alaskan Native: not avail Asian/PI: not avail Latino: 29.5 Prostate Cancer Incidence Rates per 100,000 in
Climate Health	YES **SURVEY** 80 % of HCW and 75.4% of residents listed air pollution as a key obstacle for a healthy community **INTERVIEWS** 2 stakeholders listed this as a 1st obstacle and 1 listed this as 3rd **FOCUS GROUPS** The three most often concerns raised were: • Pollution • Lack of green spaces • Poverty	YES The Percent of Days Exceeding Ozone Standards is **4.26%** versus the CA average of 2.47%** The Percent of Days Exceeding Standards for Particulate Matter is **8.04%** versus 4.17%**	**N/A**
Economic Security	YES **SURVEY** 60.0% of HCW and 60.0% of residents listed poverty as a concern **FOCUS GROUPS** High rates of poverty and lack of good jobs were listed as concerns **INTERVIEWS** 1 stakeholder ranked this as the 1st concern and 1 listed this as 2nd	YES Poverty **20.98%** of Kings County residents live in Poverty versus 15.94% of Californians** Educational Attainment **29.05%** of Kings county residents do not have a high school diploma versus 18.76% of Californians**	YES Population in Poverty Race alone, Percent White:22.54% versus CA 14.67% Black/African American: 27.56% versus CA 24.77% Native American/Alaska Native: 39.13% versus CA 24.15% Asian: 8.83% versus CA 11.95% Native Hawaiian/Pacific Islander: 3.77% versus CA 16.88% Multi-race: 28.53% versus CA15.98% Population with no High school Diploma by Race alone, Percent: White:26.42% versus CA 16.01% Black/African American: 24% versus CA 11.79% Native American/Alaskan Native: 32.28% Versus CA 24.61% Asian: 18.89% versus CA 13.59% Native Hawaiian/Pacific Islander: 15.13% versus CA 16.32% Multiple Race: 25.9% versus CA14.78% Ethnic minorities have disproportionate rates of poverty in Kings than across California African American: **21.13** vs 23.84% Asian/Pac Isl: **39**vs 2.7% Latina: **45.1%** vs 31.4% White: **16.6%** vs 11% MultiRacial: **34.4%** vs 17.1% Am Ind/Alskn: not avail Native Hawaiian/Pacific Islander: not avail

Diabetes	YES **SURVEY** 67.5% of HCW and 54.4% of residents ranked Diabetes as a health concern. **INTERVIEWS** 1 stakeholder listed it as 1st concern **FOCUS GROUPS** Participants identified Diabetes as a concern	NO **8.7%** of Kings' adults have diabetes versus 8.05% of CA Diabetes hospitalizations (Age-Adjusted Discharge Rate: 12.35% versus10.4 % CA	YES Diabetes Prevalence percent of adults age 20+ Percent Males with Diabetes: 9% versus CA 8.41% Percent Females with Diabetes: 7.7% versus CA 7.13% Population by Race, Patient discharges for diabetes, Percent of Total discharges: White: **1%** versus .77% CA Black: .86% versus 1.62% Multi-Race:.34% versus .87% CA Population by Ethnicity, Patient discharges, Percentage of Total Discharges Hispanic/Latino:1.14% versus .91% CA Not Hispanic/Latino:.78% versus .79% CA Hispanics and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from their disease. [4]
Heart Disease	YES **SURVEY** 27.5% of HCW and 10.9% of residents ranked heart disease as a health concern. **INTERVIEWS** 1 stakeholder listed this as 3rd **FOCUS GROUPS** Not raised as a concern	NO Kings County **3.9%** vs. California 3.5%	NO In California, adult rates of heart disease for ethnic groups fall below national averages except for African Americans but less than 2% difference. Whites: 4.5% African Americans: 4.27% Latinos: 2.38% Other: 2.46%
HIV/AIDS/ STD	NO **SURVEY** 2.5% of HCW and 9.1% of residents ranked sexually transmitted diseases as a top health concerns **INTERVIEWS** No interviewees raised sexually transmitted diseases as a concern **FOCUS GROUPS** Sexually transmitted diseases were not raised as a concern.	NO The prevalence rate for HIV is **176.7** per 100,000 versus 363 in California. The rate of Gonorrhea infection is **28.6** per 100,000 versus 89.09 in California** The rate of Chlamydia infection is **362.9** per 100,00 versus 444.91 in California**	YES Statewide Gonorrhea Rates per 100,000 show ethnic disparities: Whites: 49.17 African American/Black: **302.31** Asian/PI: 19.66 American Indian/ Alaskan Native: 51.87 Latino: 58.5 Statewide Chlamydia Rates per 100,000 show ethnic disparities: Whites: 162.93 African American/Black: **915.08** Asian/PI: 119.76 American Indian/Alaskan Native: 247.44 Latino: **383.7**
Maternal/Infant Health	Pre---Term Births **NO** **SURVEY** None **INTERVIEWS** No stakeholder listed this as a concern **FOCUS GROUPS** Not raised as concern Child Abuse **NO** **SURVEY** 0% of HCW listed child abuse as a concern while 7.3% of residents listed it as concern **INTERVIEWS** No stakeholders raised this	Pre Term Births **YES** Fresno County **8.0** per 1,000 versus California 8.8** (CDPH Dept of Maternal Infant Health) Immunizations **NO** **96.7%** of all Kindergarteners have required immunizations, compared to 90.4% CA Pre Natal Care **NO** Women in all ethnic groups receive prenatal care in the first trimester at higher rates than CA African Am: **67.5%** vs 78.3 Am Ind/Alskn: LNE vs 68.9% Asian/Pac Isl: **82.7%** vs 86.5% Latina: **63.8%** vs 81.3% White: **80.4%** vs 87.5% MultiRacial: **69.7%** vs 82.4% (kidsdata.org)	Pre---Term Births **YES** California rates of preterm births show ethnic disparities Whites: 7.9 African American 12.8 Latino: 9.0 (CDPH Dept of Maternal Infant Health) Teen pregnancy or unwanted pregnancy YES Teen births in Kings County is 48% among Latinas compared to 34.9% in California

Mental health	YES **SURVEY** 37.5% of HCW and 32.7% of community members said mental health issues important **INTERVIEWS** 1 stakeholder ranked mental health as 3rd **FOCUS GROUPS** Substance abuse and life stress were identified and listed as very important root cause of mental health in the community.	YES Mental Health Care Provider Rate (per 100,000 population) **56.8** vs. 157 CA rate and 134.1 US rate 21.4% of adults aged 18 and older in Kings Co. who self-report that they receive insufficient social and emotional support all or most of the time vs. 24.6 % CA percentage and 20.7% US Percentage.	YES Suicide Mortality, Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity Non-Hispanic white:11.4 versus 14.8 CA Black: 5.74 versus 6.36 CA Asian:16.63 versus 6.82 Native American/Alaskan Native: 4.41 versus 5.9 CA Multi Race: 11.74 versus 5.84 CA Hispanic/Latino: 4.73 versus 4.04 CA Percent Adults with Poor Mental Health by Race / Ethnicity Non-Hispanic White: 15% versus CA 17.9% Non Hispanic other race: 10.7% versus CA 9.7% Hispanic Latino: 9.5% versus CA 16.4%
Obesity	YES **SURVEY** 57.5%% of HCW and 50.9% of residents listed obesity as a health concern. **INTERVIEWS** All stakeholders s ranked obesity as 1st **FOCUS GROUPS** The community members ranked obesity as one of the top four concerns.	YES **24.8%** of Kings adults are obese versus 22.3% in CA** **52%** of Kings adults are overweight versus 35.8% in CA The percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category (Obese) for body composition on the Fitnessgram physical fitness test is 23.33% versus 18.99% CA	YES Students overweight (in "Needs Improvement" fitness zone), Percent by Race/Ethnicity Non-Hispanic White: 16.29% versus CA 15.93% Black/African American: 21.84% versus CA 20.33% Hispanic/Latino: 20.9% versus CA 21.6% Asian:17.81% versus CA 15.13% Multi Race: 16.11% versus 18.3% Adults Obese (BMI>30.0) by gender Males:25.8% versus 23.13% Females: 23.3% versus 21.45% CA Data on overweight adults shows that ethnic disparities exist in California: Whites: 35.64% African Americans: 37.89% Latinos: 39.41% Other: 28.8% Source: *Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County*
Oral/ Dental Care	NO **SURVEY** Only 2.5% of HCW and 7.3% of residents indicated teeth problems were a concern. **INTERVIEWS** This was not raised as a concern. **FOCUS GROUPS** This concern was not raised.	YES 8.8% of Adults have poor dental health (6 or more permanent teeth removed) versus CA 11.3% The percentage of adults age 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year 36% versus 30.5 % CA Percentage of children age 2-11 who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year 22.1% versus 18.5% CA Percentage of adults who self-report having no dental insurance for some or all of the past 12 months. 45.4% versus 40.9% CA	YES Percent Children Without Recent Dental Exam by Race / Ethnicity Non-Hispanic white: 64.2% versus 21.7% CA Hispanic Latino: 10.9% versus 16.9% CA Adult Population Without Dental Insurance, Percent by Race / Ethnicity Hispanic or Latino 47.73% versus 41.96% CA
Overall Health, Mortality and Self Reported Health	N/A	YES Premature death measured by total years lost shows Kings well above CA rate: **6,372** years lost per 100,000 versus 5,594** **26.9%** of adults self report being in poor health versus 18.4% in CA**	N/A

Substance abuse ---or substance use disorder	YES **SURVEY** 35% of HCW and 58.2.5 of residents identified drug abuse as a major concern **INTERVIEWS** 3 stakeholders ranked drug abuse as 1st **FOCUS GROUPS** Community members identified this as a major priority	YES Percent of persons with alcohol dependence and or substance abuse in Kings region 9.49 * Rate of substance abuse/alcohol dependence in **CA 2013: 7.3%** SAMHSA publication percentage of adults age 18 and older who self-report currently smoking cigarettes some days or every day 13.5 % versus 12.8% CA	N/A
Violence and Unintentional Injury	NO **SURVEY** 30.0% of HCW and 41.8% of residents identified violence as a concern, this was not in the top 3 **INTERVIEWS** None **FOCUS GROUPS** No	NO Homicide rate is 5.7% per 100,000 in Kings compared to 5.6 in California	YES California's homicide rate for those age 10 – 24 is 7.87 per 100,000 but for blacks that figure is 38.10 [2]

MADERA COUNTY

23.2% of the total population lives in poverty versus 16.4% of Californians

- **26.2% of the adult population does not have a high school degree versus 26.1% of California adults**
- **29.2% of adults have no insurance versus 24.71% of Californians**
- **10.1% of children have no health insurance versus 8.32% of Californians**

Health Needs (health outcomes that are disproportionately impacting a particular population).	**Community Stated as Health Concern?** (2 out of 3 sources: survey, focus group or interview)	**Secondary Data Affirms Health Need Exists?** (**County data differs negatively from state average, rate or percentages at levels >2% diff)	**Are there Health Disparities?** (do ethnic minorities experience higher rates of this indicator?)
Access to care	YES **SURVEY:** 23.8% of HCW and 7.52% of residents indicated it was NOT difficult to get healthcare in Madera County. The reasons most often cited as what makes it hard to get healthcare among residents were: • No health insurance • Can't afford medicine • Waiting time to see the doctor is too long The reasons most often cited as what makes it hard to get healthcare among HCWs were: • High co---pays and deductibles • Can't afford medicine **INTERVIEWS:** Stakeholders ranked three reasons as the top reasons why healthcare is hard to get in Madera County: not enough healthcare is available at night or on weekends, insurance does not cover the care needed and that there are not enough physicians here **FOCUS GROUPS**: Focus group participants raised a lack of public transportation, lack of quality health insurance and poverty as key reasons why healthcare is hard to get	YES Insurance: 29.2% of those age 18 and over have no health insurance versus 24.71% of Californians Health Care Professional Shortage Area **100% of** Madera County vs. 25.18% of Californians live in an HCPSA	YES Statewide ethnic minorities are disproportionately uninsured Whites: 14.67% African American/Black: 20.93% Latino: 38.69% Population without consistent source of primary data by Race/Ethnicity: Non-Hispanic **White: 11.32%** versus CA 9.99% Non-Hispanic **Black: 20%** versus CA 11.03% Hispanic or **Latino: 22.5%** versus 19.27% CA Uninsured population by race alone Non-Hispanic **white: 11.37%** versus CA 9.63% Black/African American:11.94% versus CA 14.22% Native American: 17.87% versus CA 23.05% Asian:**17.07%** versus CA 13.05% Population patient Discharges for Preventable Conditions, percentage of total discharges White: 10.31% versus 10.32% CA Black: 14.03% versus 13.79% CA

Asthma/ Breathing problems	YES **SURVEY:** 38.1% of HCW and 28.57% community members selected breathing problems as a health concern making it the second most common item **INTERVIEWS:** All interviewees ranked breathing problems as third most important concern in the region **FOCUS GROUPS:** Community members raised breathing problems as a major health concern in their community.	YES The overall prevalence rate for asthma is **15.5%** Madera County versus 14.1% in CA for all ages Madera County shows ED Visits rates per 10,000 are above State for adults: Age 0 -- 17: 155.5 vs 79.4 Age 18+: 44.0 vs 39.6 This is also the case for Hospitalizations Age 0 – 17: 15.3 vs 11.7 Age 18+: 3.5 vs 7.5 Source: California Breathing, Madera County Profile, 2015	YES National data suggests Latinos are 40% more likely to die from Asthma than other demographic groups Patient Discharges for Asthma, Percent of total discharges by race: White: .87% versus .73% CA Black:2.31% versus 1.8% CA Hospitalization Rates per 10,000 for Madera County: Whites: 11.4 African American/Black: **49.9** Latino: 5.5 Asian/PI: NA ED Visits Whites: 63.5 African American/Black: **337.3** Latino: **78.6** Asian/PI: NA Source California Breathing, County
Cancers	**NO** **SURVEY** Only 9.5% of HCW and 24.06% of residents selected cancer as a top 3 health concern. **INTERVIEWS** Stakeholders did not raise cancer as a key concern **FOCUS GROUPS** Participants did not raise cancer as a key concern	**YES** Madera County has an overall Cancer Mortality rate is **103.5** per 100,000 versus 122.4 in California The rate of Cervical Cancer is **13.5** per 100,000 versus 7.8 in California** The rate of Colon/Rectal Cancer is **38.7** versus 41.5 in California The rate of Lung Cancer is **40.9** versus 49.5 in California	**YES** Available data shows that Latinos have equal or lower incidence of all cancers to whites: Breast Cancer Incidence Rates per 100,000 in Madera: Whites: 110.5 African Americans/Blacks: NA American Indian/Alaskan Native: NA Asian/PI: NA Latino: **70.1** Colorectal Cancer Incidence Rates per 100,000 in Madera: Whites: 43.3 African Americans/Blacks: NA American Indian/Alaskan Native: NA Asian/PI: NA Latino: 43.6 Lung Cancer Incidence Rates per 100,000 in Madera Whites: 54.6 African Americans/Blacks: 84.8 American Indian/Alaskan Native: NA Asian/PI: NA Latino: 40.3 Cervical Cancer Incidence Rates per 100,000 in Madera Whites: 13.4 Latino: 13.8 African American: NA Asian: NA
Climate Health	YES **SURVEY** 57.1% of HCW and 52.63% of residents listed air pollution as one of the 3 obstacles making it difficult to have a healthy community. This was the most frequently chosen item identified as an obstacle. 38.1% of HCW and 15.79%% of residents also listed too many hot days as an obstacle **FOCUS GROUP** The most frequent concerns raised were • Pollution • Lack of green spaces **INTERVIEWS** Air pollution was listed as the 1st concern among 13 stakeholders. Too Many Hot Days was ranked the 3rd by the stakeholders	NO The Percent of Days Exceeding Ozone Standards is **3.36%** versus the CA average of 2.7% The Percent of Days Exceeding Standards for Particulate Matter is **5.31%** versus 4.17%	**NA**

Economic Security	YES **SURVEY** 28.6% of HCW and 30.08% of residents selected poverty as a concern **FOCUS GROUPS** Participants identified three major concerns: • Homelessness • Gangs • Poverty **INTERVIEWS** Stakeholders identified the following as social and economic concerns: • Poverty • Not enough local jobs • Not enough education • Gangs	YES Poverty **23.2%** of Madera's residents live in Poverty versus 16.4 % of Californians Source: American Fact Finder Educational Attainment **26.2%** of Madera county residents have less than a high school diploma versus 26.1% in California	YES Population in Poverty Race alone, Percent White:23.23% versus CA 14.67% Black/African American: 39.91% versus CA 24.77% Native American/Alaska Native: 21.98% versus CA 24.15% Asian:13.51% versus CA 11.95% Native Hawaiian/Pacific Islander: 2.75% versus CA 16.88% Multi-Race: 18.69% versus CA 15.98% Population with no High school Diploma by Race alone, Percent: White:29.31% versus CA 16.01% Black/African American: 23.74% versus CA 11.79% Native American/Alaskan Native: 41.33% Versus CA 24.61% Asian: 14.25% versus CA 13.59% Native Hawaiian/Pacific Islander: 22.13% versus CA 16.32% Multiple Race: 30.68% versus CA14.78% Ethnic minorities have disproportionate rates of poverty in Madera County than across California African American: **39.9%** vs 24.8% Asian: **13.5%** vs 11.9% Latino: **29.1%** vs 23.1% White: **23.2%** vs 14.7% MultiRacial: **18.7%** vs 16% Am Ind/Alskn: 22.0% vs 24.1 Native Hawaiian/Pacific Islander: 2.8% vs 16.9% FactFinder US CENSUS 2010 – 2014 Poverty Status American Community Survey 5 year Estimates
Diabetes	YES **SURVEY:** 28.6% of HCW and 32.33% or residents listed diabetes as concern (5th and 3rd ranking concerns, respectively) **INTERVIEWS:** Stakeholders ranked diabetes as either the first or third most important concern **FOCUS GROUPS:** Participants did not raise diabetes as a concern.	YES Diabetes hospitalizations (Age-Adjusted Discharge Rate: 10.79% versus10.4 % CA 8% of Adults in Madera County have been told they have diabetes vs. 8.05% of Californians *Data Source: Centers for Medicare and Medicaid Services. 2012. Source geography: County* More recent data suggests a higher prevalence rate of **10.2%** of Madera's adults have diabetes compared to 8.4% of California adults Data Source: The Burden of Diabetes in California September 2014	YES Diabetes Prevalence percent of adults age 20+ Percent Males with Diabetes: 9.4% versus CA8.41% Percent Females with Diabetes: 8.3% versus CA 7.13% Population by Race, Patient discharges for diabetes, Percent of Total discharges: White: **.79%** versus .77% CA Black:1.49 % versus 1.62% Multi-Race: .66% versus .87% CA Population by Ethnicity, Patient discharges, Percentage of Total Discharges Hispanic/Latino:.92% versus .91% CA Not Hispanic/Latino:.81% versus .79% CA Hispanics and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from their disease. Hispanics, African Americans, and Asian/Pacific Islanders have higher prevalence of type 2 diabetes than non--- Hispanic Whites. Hispanics and African Americans have two times higher prevalence: 1 in 20 non--- Hispanic Whites have type 2 diabetes, compared with 1 in 10 Hispanics and 1 in 11 African Americans Data Source: The Burden of Diabetes in California September 2014

Heart Disease	NO **SURVEY:** HCW 38.1% and 8.27% of community members selected heart disease as a major health concern **INTERVIEWS:** Stakeholders did not raise heart disease as a health concern **FOCUS GROUPS:** Heart disease was not identified as health priority by community members.	YES 3.6% of adults aged 18 and older have ever been told by a doctor that they have coronary heart disease or angina in Madera County vs. 3.5% in California. This indicator is relevant because coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks. Percentage of the Medicare fee---for---service population with ischaemic heart disease in Kings County is **29.49%** vs. 26.1% in California. Within the report area the rate of death due to coronary heart disease per 100,000 population is **135.6** in Madera County vs. 106.5 in California. **33.6%** of adults aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension in Madera County vs. 26.2% in California.	NO In California, adult rates of heart disease for ethnic groups fall below national averages except for African Americans but less than 2% difference. Whites: 4.5% African Americans: 4.27% Latinos: 2.38% Other: 2.46% It should be noted that racial and ethnic minority populations confront more barriers to CVD diagnosis and care, receive lower quality treatment, and experience worse health outcomes than their white counterparts. Such disparities are linked to a number of complex factors such as income and education, genetic and physiological factors, access to care, and communication barriers.
HIV/AIDS/ STD	NO **SURVEY** None of the HCW selected sexually transmitted diseases as the top health concern. Only 6.77% of residents selected this as a concern. **INTERVIEW** None of those interviewed raised sexually transmitted disease as an problem **FOCUS GROUPS** Sexually transmitted diseases were raised as a concern	NO The rate of HIV Prevalence in Madera County is **150.7** per 100,000 versus a rate of 363 in California	YES *Statewide Gonorrhea Rates per 100,000 show ethnic disparities*: Whites: 49.17 African American/Black: **302.31** Asian/PI: 19.66 American Indian/ Alaskan Native: 51.87 Latino: 58.5 Statewide Chlamydia Rates per 100,000 show ethnic disparities: Whites: 162.93 African American/Black: **915.08** Asian/PI: 119.76 American Indian/Alaskan Native: 247.44 Latino: **383.7**
Maternal/Infant Health	Child Abuse: NO **SURVEY:** None **INTERVIEWS**: All interviewees ranked child abuse as the second most important concern **FOCUS GROUPS:** None	NO Child Abuse: Rate of child abuse in Madera County is 9 per 1,000 which is the same as rate for CA (Kidscount.org)	Child Abuse: NO
Mental health	YES **SURVEY:** 38.1% HCW and 9.77% community members ranked this as a concern **INTERVIEWS:** All interviewees identified this as a major concern **FOCUS GROUPS:** Community members did not say mental health issues were the most important health issue in their community, instead they said substance abuse and stress. Substance abuse and poverty were identified and listed as very important root cause of mental health concerns in the community.	YES **18.6%** of adults in Madera County self---report poor mental health versus vs 15.9% in California. The average number of Mentally Unhealthy Days for adults in Madera County is 4.6 versus 3.6 for Californians as a whole [5] Madera County's suicide rate is **14.8** per 100,000 versus **10.2** in California. Mental Health Care Provider Rate (per 100,000 population) **70.2** vs. 157 CA rate and 134.1 US rate **24.9%** of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time compared to24.6 % CA percentage and 20.7% US percentage The rate of death due to intentional self-harm (suicide) per 100,000 population, age-adjusted to the year 2000 standard. 17.37 versus 9.8 CA	YES In California, the rate of mental illness for children was 7.6% but higher rates are found among Latinos (8.0%), African American (8.0%). Suicide Mortality, Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity Non-Hispanic white:30.26 versus 14.8 CA Black: 4.61 versus 6.36 CA Native Hawaiian/Pacific Islander: versus 9.68 CA Multi Race: 14.42 versus 5.84 CA Hispanic/Latino: 3.31 versus 4.04 CA Percent Adults with Poor Mental Health by Race / Ethnicity Non-Hispanic White: 23.8% versus CA 17.9% Non Hispanic other race:20.6% versus CA 9.7% Hispanic Latino: 14.6% versus CA 16.4%

Obesity	YES **SURVEY:** HCW 42.9% and community members 36.84% ranged obesity as a concern **INTERVIEWS**: All interviewees ranked obesity as third **FOCUS GROUPS:** Obesity was ranked very highly by community members. Community members were concerned with obesity and also related poor eating habits and lack of exercise.	YES 26.6% of adults aged 20 and older self---report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in Madera County vs. 22.3% in California. 37% of adults aged 18 and older self---report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight) in Madera County vs. 35.8% in California. The percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category (Obese) for body composition on the Fitness gram physical fitness test is 23.22% versus 18.99% CA	YES Students overweight (in "Needs Improvement" fitness zone), Percent by Race/Ethnicity Non-Hispanic White: 18.46% versus CA 15.93% Black/African American: 18.95% versus CA 20.33% Hispanic/Latino: 21.23% versus CA 21.6% Asian:15 % versus CA 15.13% Multi Race: 21.16% versus 18.3% Adults Obese (BMI>30.0) by gender Males:27.3% versus 23.13% Females: 25.9% versus 21.45% CA Obesity disproportionately affects California's poorest individuals. Adults living below 200% FPL had a higher prevalence of obesity (31 percent) than their higher income counterparts (20 percent).
Oral/ Dental Care	NO **SURVEY:** 9.5% of HCW and 23.31% of residents indicated teeth problems are a concern **INTERVIEWS**: None **FOCUS GROUPS**: Community members listed this a concern	YES This indicator reports the number of dentists per 100,000 population. Madera County 43.3 vs. California 77.5 The percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection is 19.4% versus 11.3% The percentage of adults age 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year 28.9% versus 30.5 % CA Percentage of children age 2-11 who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year 25.2% versus 18.5% CA Percentage of adults who self-report having no dental insurance for some or all of the past 12 months. 52.5% versus 40.9% CA	YES Percent Children Without Recent Dental Exam by Race / Ethnicity Non-Hispanic white: 25.2% versus 21.7% CA Hispanic Latino: 21.5% versus 16.9% CA Adult Population Without Dental Insurance, Percent by Race / Ethnicity Hispanic or Latino 52.38% versus 41.96% CA
Overall Health, Mortality and Self Reported Health			
Substance abuse ---or substance use disorder	YES **SURVEY:** HCW 28.6% and community members 50.38% ranged alcohol abuse as a top behavior **INTERVIEWS:** All interviewees ranked drug abuse as the number one most important concern **FOCUS GROUPS:** Community members mentioned this a primary concern	YES Rate of substance abuse/alcohol dependence in **CA 2013: 7.3%** SAMHSA publication Percent of persons alcohol dependence and or substance abuse in Fresno region **9.64 *** percentage of adults age 18 and older who self-report currently smoking cigarettes some days or every day 13.6% versus 12.8% CA	
Violence and Unintentional Injury	NO **SURVEY** Only 19.0% of HCW listed youth violence as a health need, while 15.04% of residents did so and only 4.8%% listed domestic violence as a health need, while 10.53% of residents did so **INTERVIEW:** Stakeholders did not raise youth violence or domestic abuse as concerns. **FOCUS GROUPS:** Participants raised gangs as a concern.	YES The Homicide rate is **6.13** per 100,000 in Madera County compared to 5.6 in California Madera County's mortality rate for pedestrian accidents is **2.65** per 100,000 compared to 2.02 for California Madera County's mortality rate due to motor vehicle accidents is **9.31** per 100,000 compared to **6.13** for California**	YES Homicides in Madera by race and ethnicity is only available for Latinos who show a higher rate 6.39 per 100,000 versus 4.72 for whites. Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide---Ranging Online Data for Epidemiologic Research. 2007---11. Source geography: County California's homicide rate for those age 10 – 24 is 7.87 per 100,000 but for blacks that figure is 38.10 [3]

TULARE COUNTY

- **26.18% of the total population lives in poverty versus 15.94% of Californians**
- **31.99% of the adult population does not have a high school degree vs 18.76% California adults**
- **28.95% of adults have no insurance versus 23.91% of Californians**
- **7.39% of children have no insurance versus 7.89% of Californians**

Health Needs (health outcomes that are disproportionately impacting a particular population).	**Community Stated as Health Concern?** (2 out of 3 sources: survey, focus group or interview)	**Secondary Data Affirms Health Need Exists?** (**County data differs negatively from state average, rate or percentages at levels >2% diff)	**Are there Health Disparities?** (do ethnic minorities experience higher rates of this indicator?)
Access to care	YES Only 18.3% of HCW and 16.7% of residents indicated it was NOT difficult to get healthcare in Tulare County. The biggest reasons cited for making it difficult to get healthcare among residents in Tulare were: • Insurance doesn't cover services needed • Cant's afford medicine The biggest reasons cited for making it difficult to get healthcare among HCW were: • Insurance doesn't cover services needed Can't afford medicine	YES Insurance **28.95%** of those age 18 and over have no insurance versus 23.91% of Californians in this age cohort ** Health Care Professional Shortage Area Status **100%** of Tulare County residents live in a HCPSA versus 25.18%**	YES Statewide ethnic minorities are disproportionately uninsured Whites: 14.67% African American/Black: 20.93% Latino: 38.69% Population without consistent source of primary data by Race/Ethnicity: Non-Hispanic **White: 14.38%** versus CA 9.99% Non-Hispanic **Black: 25%** versus CA 11.03% Non-Hispanic **Other race: 15.79%** versus CA13.85% Hispanic or Latino: 13.97% versus 19.27% CA Uninsured population by race alone Non-Hispanic white: 11.43% versus 9.63% CA Black/African American:12.69% versus 14.22% CA Native American: 16.19% versus 23.05% CA Asian:17.31% versus 13.05% CA Population patient Discharges for Preventable Conditions, percentage of total discharges White: 12.47% versus 10.32% CA Black: 14.68% versus 13.79% CA Asian/Pacific Islander: 9.69% versus 8.37% CA
Asthma/ Breathing problems	YES **SURVEY** 35.5% of HCW and 44.4% of residents listed Breathing problems as a concern. **INTERVIEWS** 10 stakeholders listed this as a 1st concern, 1 listed it as 2nd, and 1 listed this as 3rd. **FOCUS GROUPS** Breathing Problems was raised as a concern.	YES The overall prevalence rate for asthma is 14.2% versus 14.2% CA However, the region shows ED Visits rates per 10,000 are above State ED Visits Age 0 – 17: 73.4 vs 79.4 Age 18+: 41.1 vs 39.6 Hospitalizations Age 0 – 17: 10.3 vs 11.7 Age 18+: 9.2 vs 7.5 Source: California Breathing, Tulare County Profile, 2015	YES National data suggests Latinos are 40% more likely to die from Asthma than other demographic groups Patient Discharges for Asthma, Percent of total discharges by race: White: 1% versus .73% CA Black:2.13% versus 1.8% CA Asian/Pacific Islander: 1.19% versus .78% CA Hospitalization Rates for Ethnic Minorities Show Whites: 12.9 African American/Black: 36.3 Latino: 11.2 Asian/PI: 7.1 ED Visits for Ethnic Minorities Show Whites: 63.5 African American/Black: 128.3 Latino: 71.6 Asian/PI: 16.7

Cancers	NO **SURVEY** Only 16.1% of HCW and 11.1% of residents listed Cancer as a health concern. **INTERVIEWS** No stakeholder listed as concern **FOCUS GROUPS** Cancer was raised as a concern	YES Tulare County has an overall Cancer Mortality rate **155.4** deaths per 100,000 versus 157.95 in CA The annual incidence rate of breast cancer is **104.5** per 100,000 versus 122.4 in California The rate of Cervical Cancer is **10.7** per 100,000 versus 7.7 in California The rate of Colon/Rectal Cancer is **37** versus 40 in California The rate of Lung Cancer is **49.3** versus 48 in California** The rate of Prostate Cancer is **108.5** versus 126.9	YES African Americans have a higher rate of Colorectal, Lung and Prostrate cancers. Breast Cancer Incidence Rates per 100,000 in Kings: Whites: 102.5 African Americans/Blacks: not avail American Indian/Alaskan Native: not avail Asian/PI: 144.6 Latino: 85.5 Colorectal Cancer Incidence Rates per 100,000 in Kings: Whites: 37.9 African Americans/Blacks: not avail American Indian/Alaskan Native: not avail Asian/PI: not avail Latino: 38.2 Lung Cancer Incidence Rates per 100,000 in Kings: Whites: 50.6 African Americans/Blacks: 79.4 American Indian/Alaskan Native: not avail Asian/PI: not avail Latino: 29.5 Prostate Cancer Incidence Rates per 100,000 in Kings: Whites: 107.4 African Americans/Blacks: 160.6 American Indian/Alaskan Native: not available Asian/PI: not avail Latino: 114.4 Source: *Data Source: National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles. 2007-11. Source geography: County*
Climate Health	YES **SURVEY** 80.6 % of HCW and 76.4% of residents listed air pollution as a key obstacle for a healthy community **INTERVIEWS** 10 stakeholders listed this as a 1st concern, 1 listed it as 2nd, and 1 listed this as 3rd. **FOCUS GROUPS** The three most often concerns raised were: • Pollution • Lack of green spaces • Poverty	YES The Percent of Days Exceeding Ozone Standards is **6.70%** versus the CA average of 2.47%** The Percent of Days Exceeding Standards for Particulate Matter is **8.19%** versus 4.17%**	N/A

Economic Security	YES **SURVEY:** 74.2% of HCW and 69.4% of residents listed poverty as a concern **INTERVIEWS:** 5 stakeholders ranked this as the 1st concern and 3 listed this as 2nd **FOCUS GROUPS** Poverty was raised as concern as well as poor quality of education and poor housing conditions.	YES Poverty **26.18%** of Tulare County residents live in Poverty versus 15.94% of Californians** Educational Attainment **31.99%** of Tulare county residents do not have a high school diploma versus 18.76% of Californians**	YES Population in Poverty Race alone, Percent White:27.02% versus CA 14.67% Black/African American: 39.87% versus CA 24.77% Native American/Alaska Native: 35.73% versus CA 24.15% Asian: 19.18% versus CA 11.95% Native Hawaiian/Pacific Islander: 38.56% versus CA 16.88% Multi-Race: 28.15% versus CA 15.98% Population with no High school Diploma by Race alone, Percent: White:31.13% versus CA 16.01% Black/African American: 22.12% versus CA 11.79% Native American/Alaskan Native: 28.49% Versus CA 24.61% Asian: 26.03% versus CA 13.59% Native Hawaiian/Pacific Islander: 11.42% versus CA 16.32% Multiple Race: 26.54% versus CA14.78% Ethnic minorities have disproportionate rates of poverty in Kings than across California African American: **21.13** vs 23.84% Asian/Pac Isl: **39**vs 12.7% Latina: **45.1%** vs 31.4% White: **16.6%** vs 11% MultiRacial: **34.4%** vs 17.1% Am Ind/Alskn: not avail Native Hawaiian/Pacific Islander: not avail
Diabetes	YES **SURVEY** 72% of HCW and 37.5% of residents ranked diabetes as a health concern **INTERVIEWS** 3 stakeholders listed it as 1st concern , 6 stakeholders listed it as 2nd, and 2 listed as 3rd. **FOCUS GROUPS** Not identified as a concern	NO 7.4% of Tulare's adults have diabetes versus 8.05% of CA Diabetes hospitalizations (Age-Adjusted Discharge Rate: 12.66 versus10.4 % CA	YES Diabetes Prevalence percent of adults age 20+ Percent Males with Diabetes: 8.3% versus CA8.41% Percent Females with Diabetes: 7% versus CA 7.13% Population by Race, Patient discharges for diabetes, Percent of Total discharges: White: **.92%** versus .77% CA Black:1.6 % versus 1.62% American Indian/Alaskan Native: versus .85% CA Asian/Pacific Islander: .51% versus .59% CA Multi-Race:.88% versus .87% CA Population by Ethnicity, Patient discharges, Percentage of Total Discharges Hispanic/Latino:.93% versus .91% CA Not Hispanic/Latino:.85% versus .79% CA Hispanics and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from their disease. [4]
Heart Disease	NO **SURVEY** 20.4% of HCW and 22.2% of residents ranked heart disease as a health concern. **INTERVIEWS** Not raised as a concern **FOCUS GROUPS** Not raised as a concern	NO Tulare County 2.7% vs. California 3.5%	NO In California, adult rates of heart disease for ethnic groups fall below national averages except for African Americans but less than 2% difference. Whites: 4.5% African Americans: 4.27% Latinos: 2.38% Other: 2.46%
HIV/AIDS/ STD	NO **SURVEY** 1.1% of HCW and 1.4% of residents ranked sexually transmitted diseases as a top health concerns **INTERVIEWS** Not raised **FOCUS GROUPS** Sexually transmitted diseases were not raised as a concern.	YES The prevalence rate for HIV is 67.4 per 100,000 versus 363 in California. The rate of Gonorrhea infection is 37 per 100,000 versus 89.09 in California** The rate of Chlamydia infection is 449.6 per 100,00 versus 444.91 in California**	YES Statewide Gonorrhea Rates per 100,000 show ethnic disparities: Whites: 49.17 African American/Black: 302.31 Asian/PI: 19.66 American Indian/ Alaskan Native: 51.87 Latino: 58.5

<table>
<tr>
<td>Maternal/Infant Health</td>
<td>Pre---Term Births NO

SURVEY
None

INTERVIEWS
No stakeholder listed this as a concern

FOCUS GROUPS
Not raised as concern

Child Abuse NO

SURVEY
1.1% of HCW listed child abuse as a concern while 5.6% of residents listed it as concern

INTERVIEWS
No stakeholders raised this

FOCUS GROUPS
Not raised

Teen pregnancy or unwanted pregnancy
NO
SURVEY: HCW 17.5% and community members 27.3% identified this a major concern
INTERVIEWS: None FOCUS GROUPS: None</td>
<td>Pre Term Births YES

Fresno County 9.9 per 1,000 versus California 8.8**
(CDPH Dept of Maternal Infant Health)

Immunizations NO
96.5% of all Kindergarteners have required immunizations, compared to 90.4% CA

Pre Natal Care NO
Women in all ethnic groups receive prenatal care in the first trimester at higher rates than CA

African Am: 86.8% vs 78.3 Am Ind/Alskn: 57.7% vs 68.9%
Asian/Pac Isl: 80.3% vs 86.5%
Latina: 81.4% vs 81.3% White: 85.6% vs 87.5% MultiRacial: 80.2% vs 82.4%
(kidsdata.org)

Teen pregnancy or unwanted pregnancy
YES
Teen births in Kings County 41.2% compared to 23.2% in California</td>
<td>Pre---Term Births YES

California rates of preterm births show ethnic disparities
Whites: 7.9

African American 12.8 Latino
California rates of preterm births show ethnic disparities
Whites: 7.9
: 9.0
(CDPH Dept of Maternal Infant Health)

Teen pregnancy or unwanted pregnancy YES

Teen births in Tulare County is 71.9 among Latinas compared to 53.1 in California</td>
</tr>
<tr>
<td>Mental health</td>
<td>YES
SURVEY
39.8% of HCW and 50.0% of community members said mental health issues important

INTERVIEWS
4 stakeholders ranked mental health as 1st and 1 raised it as 2nd

FOCUS GROUPS
Mental health was raised as a concern</td>
<td>YES

Mental Health Care Provider Rate (per 100,000 population) 123.9 vs. 157 CA rate and 134.1 US rate

Suicide is10.4 per 100,000 in Tulare county compared to 10.2 CA rate

29.5% of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time compared to24.6 % CA percentage and 20.7% US percentage

The rate of death due to intentional self-harm (suicide) per 100,000 population, age-adjusted to the year 2000 standard. 10.53 versus 9.8 CA</td>
<td>YES
Suicide Mortality, Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity
Non-Hispanic white:17.58 versus 14.8 CA
Native American/Alaskan Native: 9.3 versus 5.9 CA
Multi Race: 3.41 versus 5.84 CA
Hispanic/Latino: 5.81 versus 4.04 CA

Percent Adults with Poor Mental Health by Race / Ethnicity
Non-Hispanic White: 6.3% versus CA 17.9%
Hispanic Latino: 24.9% versus CA 16.4%</td>
</tr>
<tr>
<td>Obesity</td>
<td>YES

SURVEY
57.0%% of HCW and 44.4% of residents listed obesity as a health concern.

INTERVIEWS: 1 stakeholders ranked obesity as 2nd and 1 ranked it as 3rd

FOCUS GROUPS: Not raised</td>
<td>YES
29.4% of Tulare adults are obese versus 22.3% in CA**

36.5 of Tulare adults are overweight versus 35.8% in CA

The percentage of children in grades 5, 7, and 9 ranking within the "High Risk" category (Obese) for body composition on the Fitnessgram physical fitness test is 23.18% versus 18.99% CA</td>
<td>YES
Students overweight (in “Needs Improvement” fitness zone), Percent by Race/Ethnicity
Non-Hispanic White: 17.97% versus CA 15.93%
Black/African American: 19.24% versus CA 20.33%
Hispanic/Latino: 20.74% versus CA 21.6%
Asian:15.05 % versus CA 15.13%
Multi Race: 18.31% versus 18.3%

Adults Obese (BMI>30.0) by gender
Males:30.8% versus 23.13%
Females: 27.8% versus 21.45% CA

Data on overweight adults shows that ethnic disparities exist in California:
Whites: 35.64%
African Americans: 37.89% Latinos: 39.41%
Other: 28.8%

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-</td>
</tr>
</table>

Oral/ Dental Care	YES	YES The percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection is 12.2% versus 11.3% The percentage of adults age 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year 37.2% versus 30.5 % CA Percentage of children age 2-11 who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year 27.9% versus 18.5% CA Percentage of adults who self-report having no dental insurance for some or all of the past 12 months. 343.2% versus 40.9% CA	YES Percent Children Without Recent Dental Exam by Race / Ethnicity Non-Hispanic white: 23.8% versus 21.7% CA Non-Hispanic Black:100% versus 11.6% CA Non-Hispanic other race: versus 21.1% CA Hispanic Latino: 22.5% versus 16.9% CA Adult Population Without Dental Insurance, Percent by Race / Ethnicity Hispanic or Latino 44.22% versus 41.96% CA
Overall Health, Mortality and Self Reported Health	NO **SURVEY** Only 3.2% of HCW and 4.2% of residents chose this as a health concern. **INTERVIEWS** Not raised **FOCUS GROUPS** Dental health was raised in the focus groups	YES 12.2% of Adults have poor dental health (6 or more permanent teeth removed) versus CA 11.3%	YES See "Racial and ethnic Disparities in Dental Care for Publicly Insured Children, Health Affairs July 2010
Substance abuse ---or substance use disorder	**N/A**	YES Premature death measured by total years lost shows Tulare well above CA rate: 7,367 years lost per 100,000 versus 5,594** 24.8% of adults self report being in poor health versus 18.4% in CA** percentage of adults age 18 and older who self-report currently smoking cigarettes some days or every day 14.3 % versus 12.8% CA percentage of adults age 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women) 18.2% versus 17.2%	
Violence and Unintentional Injury	YES **SURVEY** 33.3% of HCW and 38.9% of residents identified drug abuse as a major concern **INTERVIEWS** 5 stakeholders ranked drug abuse as 1st and 2 ranked it as 2nd **FOCUS GROUPS** Substance abuse was raised as a concern	YES Rate of substance abuse/alcohol dependence in **CA 2013: 7.3%** SAMHSA publication Percent of persons alcohol dependence and or substance abuse in Tulare region ??*	YES

APPENDIX F: KP Fresno Service Area Prioritization Exercise Matrix

KP Fresno Service Area Prioritization Exercise

Name: ____________________ **Role:** __________ **Organization:** __________________

INSTRUCTIONS:

1. Rate each health need listed below against the following criteria:
   - **Severity of Health Need** - This need greatly impacts individual quality of life.
   - **Magnitude/Scale of Need** - This need impacts large numbers of residents.
   - **Clear disparities or inequities** - This need impacts unique populations
2. Fill in cells of the matrix by rating each health issue against each criteria on a scale of 1-3.

   3 = criterion met well   **2** = criterion met   **1** = criterion not met
3. *Email completed form to: Teri@leapsolutions.com*

Health Need	*Severity of Health Need*	*Magnitude/Scale of Need*	*Clear Disparities or Inequities*	Priority Score	*YOUR RANKING 1 - 7*
Access to Healthcare					
Asthma					
Diabetes					
Economic Security					
Mental Health					
Obesity					
Substance Abuse					

1. As you think about how you ranked these health needs, what if any other criteria entered into your decision?
2. What community resources do you feel are now available to address these needs? (please list as many community sources as you wish)

Email completed form to: Teri@leapsolutions.com