MORE
COMMUNITY VOICES

Adventist Health Hanford

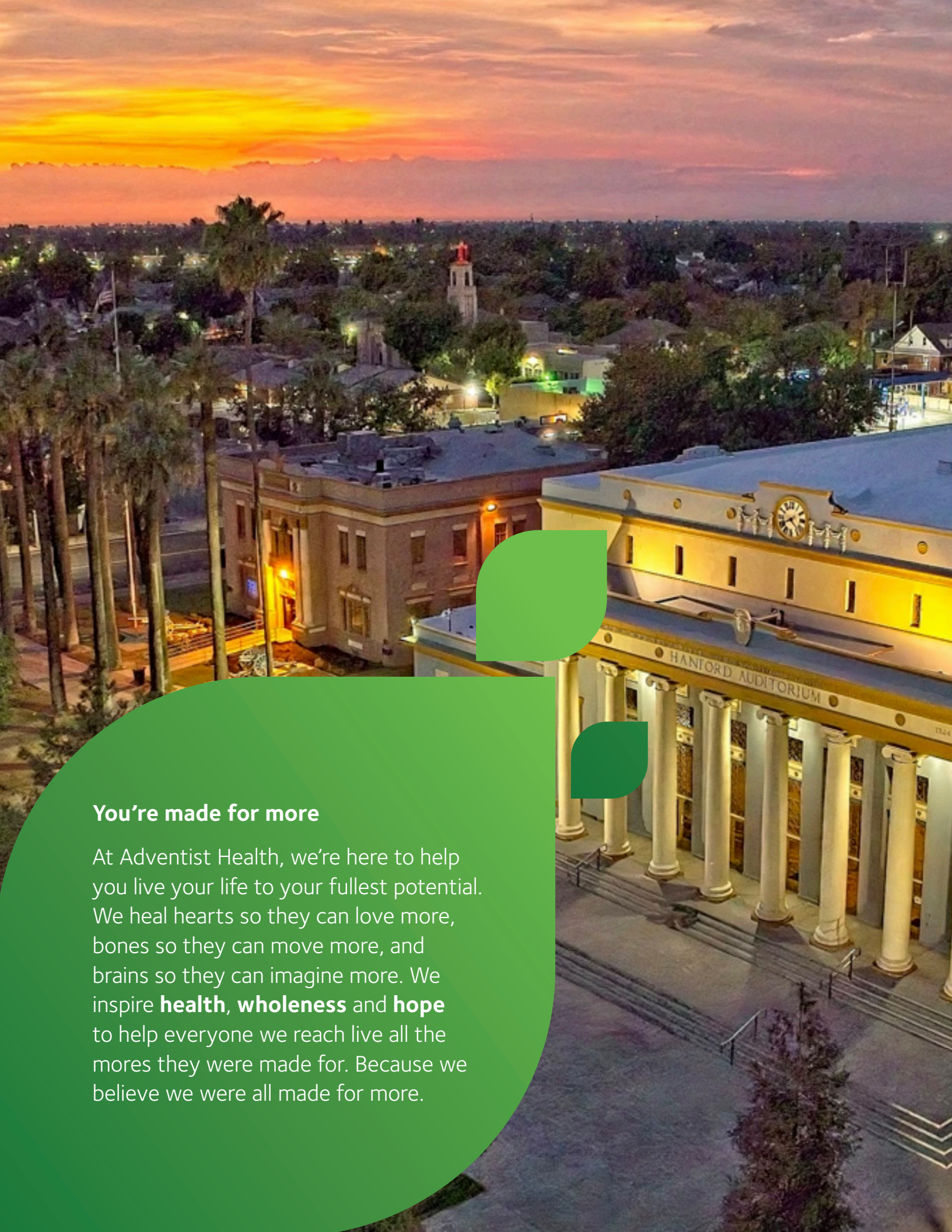
Adventist Health Selma

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

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

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

Table of Contents



You're made for more

At Adventist Health, we're here to help you live your life to your fullest potential. We heal hearts so they can love more, bones so they can move more, and brains so they can imagine more. We inspire **health**, **wholeness** and **hope** to help everyone we reach live all the mores they were made for. Because we believe we were all made for more.

Executive Summary

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

For 2025, the following Adventist Health hospitals in Central California: Delano, Hanford, Tulare, Reedley and Selma, collaborated with community partners to create a concise report the entire community could contribute to and access, regardless of public health context or reading ability. Input was gathered from focus groups and key informants representing the broad interests of the community served by our hospital, and collaborative organizations. We intentionally prioritized gathering insights from local health officials with knowledge and expertise about community health needs, community-based organizations, medical providers, and members of medically underserved, low-income and minority populations.

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

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

Access to Care

Financial Stability

Mental Health

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

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

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

Identity of Steering Committee Hospital & Partner Organizations

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

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

Joe Alvarez
Community Pastor, Pastor

Miriam Cardenas-Aleman
Kings Canyon Unified School District,
School Health Liaison

Rosemary Caso
United Way of Tulare County, Executive Director

Andrew Cromwell
Koinonia Church, Pastor

Jeff Garner
KCAO, Executive Director

Pawan Gill
Kern Health, Systems, Health Equity Manager

Brian Johnson
City of Hanford, City Communication Manager

Mark Mondell
City of Tulare, City Manager

Julie Mooney
Champions Recovery, Program Director

Rose Mary Rahn
Kings County Public Health, Director

Jasmine Ochoa
Kern County Public Health, Health Equity Officer

Gabriela Rodriguez
KPFP, Executive Director

Raman Singh
Adventist Health, Director of Nursing

Jan Smith
Adventist Health, Director, Community Integration

Amy Travis
First 5 Kern County, Executive Director

Nicole Zieba
City of Reedley, City Manager

A. CHNA Community Defined

Getting to Know Our Community

The Central California CHNA encompasses five hospitals: Delano, Hanford/Selma, Reedley and Tulare. One of Central California's most prized assets is our geography, a region known for its agricultural productivity that feeds the world and a short road trip away from natural wonders like the Sierra Nevada and the Central Coast. Sitting in the heart of the most productive farmland in the world, agriculture remains a major contributor to the economy and our community. According to the California Department of Food and Agriculture, more than 250 different crops, worth $30 billion per year, are grown within the Central Valley.

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

- High school graduation rate of 89.7%.
- 23.55% of the population holds an Associate's level degree or higher, compared to 44.42% in California.
- The unemployment rate is 9.38%.
- Based on the Area Median Income, residents spend 59.27% of their income on housing and transportation alone.

We recognize the challenges we face and are optimistic about exploring opportunities to improve our health and well-being. In the following pages, we'll review lessons learned and accomplishments from the past three years. We'll dive deeper into the high priority needs, community voices and data that guided the Community Health Needs Assessment process.

Adventist Health Selma is licensed under Adventist Health Hanford and is considered a separate location.

Hanford and Selma

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

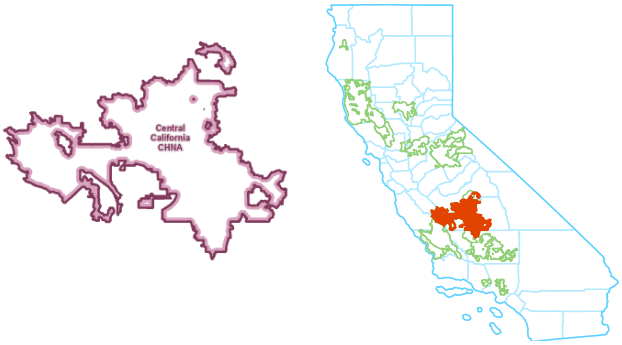
- **Central California CHNA** as the full area encompassed in this report, as defined by zip codes listed in Section I. A. Defining the Community We Serve, and is referenced in indicator graphic dials, tables and charts throughout this report.
- **Adventist Health Hanford** as the hospital facility conducting this CHNA report.
- **Adventist Health Selma** as the hospital facility conducting this CHNA report.

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

Defining the Community We Serve

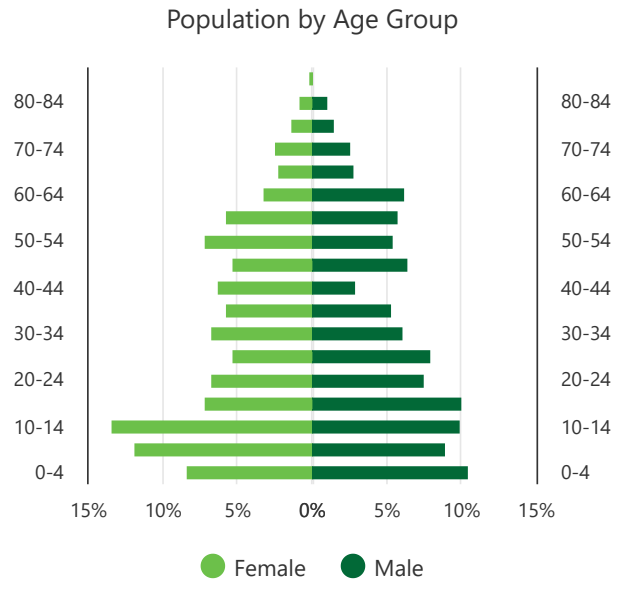
To define our community, we used the hospital's primary service area and vetted the zip codes with Steering Committee members. We also invited our Steering Committee members to expand the CHNA service area to include zip codes based on the constituents they serve.

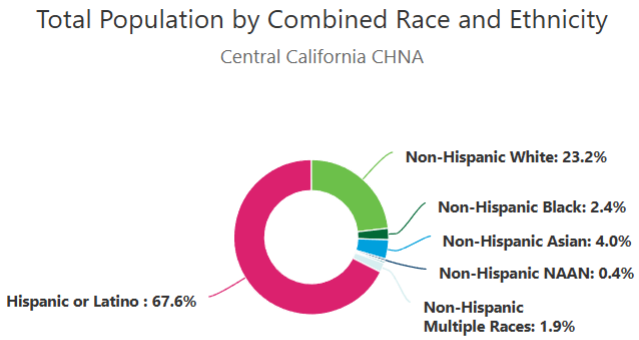
The report area is located in the state of California and includes a total population of 795,814 (based on the 2020 Decennial Census). The largest city in the report area is Visalia city, with a population of 141,384. The report area is comprised of the following ZIP codes: 93201, 93202, 93204, 93210, 93212, 93215, 93218, 93219, 93227, 93230, 93234, 93239, 93242, 93245, 93247, 93250, 93256, 93257, 93258, 93261, 93266, 93267, 93270, 93272, 93274, 93277, 93291, 93292, 93609, 93615, 93616, 93618, 93621, 93625, 93631, 93646, 93647, 93648, 93654, 93656, 93662, 93673.



Total Population
795,814

Demographic Profile





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

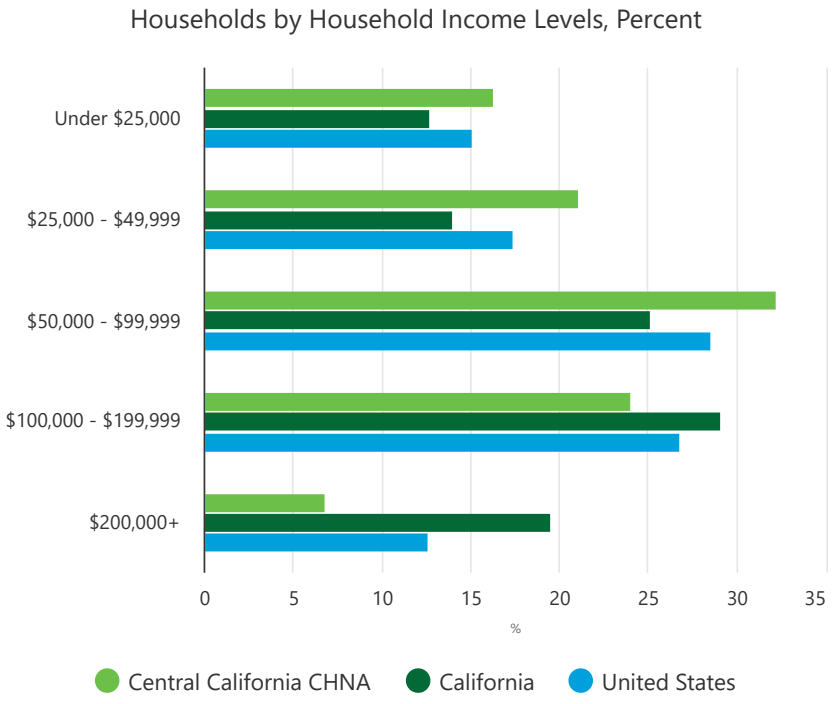
Students Experiencing Homelessness, Percent
2.59%
California: 3.96%

Associate's Degree or Higher
23.55%
California: 44.42%

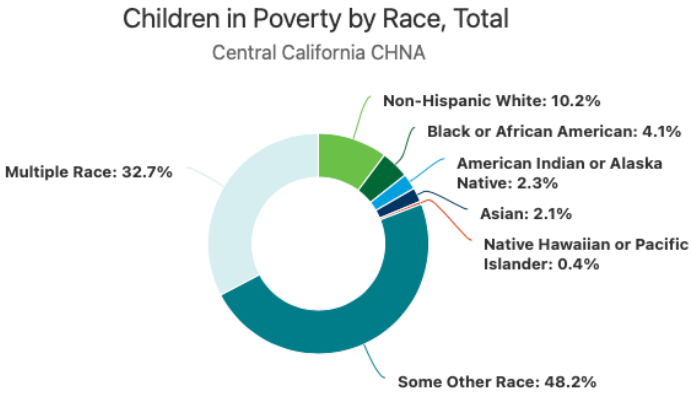
Labor Force Participation Rate
59.09%
California: 63.86%

56.83%
California: 55.79%
of the population **owns** their home

43.17%
California: 44.21%
of the population **rents** their home



Data Source: US Census Bureau, American Community Survey. 2019-23.



Childhood Poverty Rate
25.37%
California: 15.15%

II. About Us

Adventist Health

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

Adventist Health Hanford & Selma

Adventist Health Hanford is a 153-bed acute-care hospital that has been providing comprehensive healthcare services in the heart of Central California since 1965. Our hospital is committed to delivering the highest level of clinical quality and safety, medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Our continuum of care network of healthcare resources and expertise allow us to provide patients with seamless coordination and access to specialized services.

Specialties Brought to our Community

- Bariatrics
- Breast Care
- Cancer Center
- Diagnostics, Imaging & Radiology
- Digestive Care
- Emergency Care
- Heart Care
- Intensive Care
- Joint Replacement Center
- Laboratory Services
- Maternity Care
- Rehabilitation Services
- Stroke Care
- Surgical Services

Adventist Health Selma, also located in Central California, is a 57-bed acute-care hospital offering vital access to the community in the heart of the San Joaquin Valley. Our hospital is committed to delivering the highest level of clinical quality and safety, medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Our continuum of care network of healthcare resources and expertise allow us to provide patients with seamless coordination and access to specialized services.

Specialties Brought to our Community

- Emergency Care
- Imaging Services
- Intensive Care Unit
- Laboratory Services
- Surgical Services

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the last three years, Adventist Health Hanford and Adventist Health Selma focused on financial stability, food security and mental health. To document our impact, we have been monitoring and evaluating progress through annual updates and the Community Health Implementation Strategy (CHIS). In collaboration with the community, we implemented goals, actions, solutions and programs to address each high priority need.

In partnership with the Selma Healthcare District, Adventist Health Hanford & Selma addressed mental health through a $222,000 pilot project to better care for mental health in the community. Adventist Health Hanford and Selma dedicated a two-person clinical team to assess and treat patients and direct them to local behavioral and mental health resources more quickly.

In partnership with Vituity and other community organizations, Adventist Health Hanford provided free dental and medical exams along with food distribution and financial literacy resources to over 400 community members. Adventist Health Hanford Chaplain provides a weekly suicide prevention support group for community members suffering from depression or families that have been affected by suicide.

Adventist Health Selma associates provided over 300 backpacks for families who couldn't afford school supplies. Mobile Care Clinic served over 1,300 patients in 2024 focusing their efforts to serve in rural communities with no access to a healthcare facility in their community as well as the unhoused population.

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

A Look Forward: After the CHNA Report

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

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


CINEMA
California
DRY CLEANER

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

III. High Priority Health Needs

Access to Care

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

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

One of the many challenges in accessing health care is ensuring that people can engage with a service provider. Key informants described the diverse agricultural communities, voicing that "[we have] more low-income migrant, maybe undocumented populations that have trouble arranging transportation and work is important to them. So, to take a day off of work means a lot." When asked about getting all the medical care needed to live a healthy life, a community survey indicated 24% of respondents did not receive the care they needed. Of the respondents, 28% attributed their lack of care to barriers like location of medical care, inconvenient hours and transportation challenges. In the Central California service area, 88.79% of the population lives in a primary care Health Professional Shortage Area (HPSA), compared to 22.59% in California. This HPSA designation identifies geographic areas and populations that lack sufficient health care professionals to meet the community's health needs.

Given that many Central California residents live in underserved areas, increasing access and reducing barriers to healthcare in our community can improve health outcomes and reduce disparities. For additional data, see the secondary data summary.

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

Data Highlights

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

"...our population is growing here in Hanford and we have one large hospital...if you're going into their emergency room or you're trying to access some type of routine medical care, there's just a longer wait and it's harder to get those services."

"...that middle range sometimes suffers because it's like you make enough that you don't qualify for programs, [but you] don't make enough so the cost of the insurance is... going to be prohibitive, a burden on your family."

"...a lot of family or people here are traveling to Mexico for treatments more affordable..."

"We see a lot of our population that unfortunately, because of their work, there is no offer of, especially in a lot of [agricultural] sectors, there's no offer of health insurance."

"Access to affordable healthcare. Even though we've got systems in place, federal, state and other, a lot of people just don't get a[n] affordable plan that's effective...for the conditions they have."

"...if you have a physician that doesn't understand that patient's culture, what could be normal in regards to a value or belief to that physician could be offensive to that patient."

"You are vulnerable and this person [medical provider] is educated and knows better, so you're taking what they're saying as truth. So there's a sense of I can't speak up for myself because they know better."

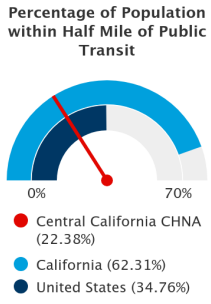
"It just compiles with people's...distrust and frustration with medical providers...there's not this sense of...empathy and really wanting to engage in you as an individual...I think that's contributing to a larger conception of I can't go there and have my problem actually solved."

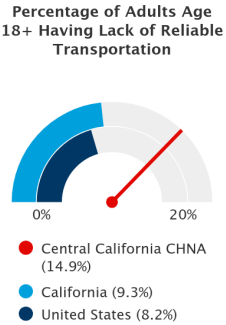
"...I know in our county we really don't have a lot of specialty services..."

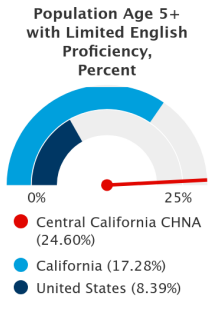
"...[we have] more low-income migrant, maybe undocumented populations that have trouble arranging transportation and work is important to them. So to take a day off of work means a lot..."

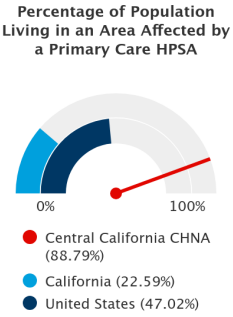
"There's not as much labor and delivery options for women and pregnant women in the county."

"We have a lot of families that have to work out there. They might be farm laborers, and they have to take a day off of work to then get transportation to get to where they need to be. And that's the day of work...and if everything doesn't work out with the specialist or gets cancelled [it] like derails the whole [day]. I just feel like transportation has been an issue for a while."









Community Resources

Administration for Community Living
acl.gov/programs/aging-and-disability-networks
800-677-1116

Central California Alliance for Health
thealliance.health
800-700-3874

Healthcare Enrollment Services
coveredca.com
800-300-1506

Community Health Needs Assessment Full Report

Location

Central California CHNA

Health Needs: Access to Care

Availability - Primary Care - Primary Care Shortage Areas

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

Types of HPSA

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

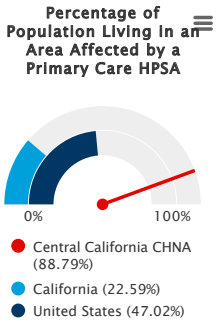
This indicator reports the total population in the report area that is living in a primary care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

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

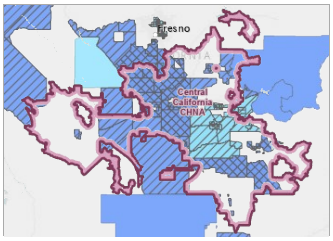
The population figures used in this calculation are from the 2019 American Community Survey 5-year Estimates.

Within the report area, there are 698,673 people living in a primary care Health Professional Shortage Area. This represents 88.79% of the total population.

Report Area	Total Population (ACS 2019 5-Year Estimates)	Population Living in an Area Affected by a Primary Care HPSA	Percentage of Population Living in an Area Affected by a Primary Care HPSA
Central California CHNA	786,914	698,673	**88.79%**
Fresno County, CA	984,521	376,423	38.23%
Kern County, CA	887,641	546,648	61.58%
Kings County, CA	150,691	150,691	100.00%
Monterey County, CA	433,410	233,240	53.82%
San Benito County, CA	60,376	60,376	100.00%
Tulare County, CA	461,898	435,256	94.23%
California	39,283,497	8,874,701	22.59%
United States	324,697,795	152,777,506	47.02%



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



View larger map

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

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

Primary Care HPSA Population Underserved

This indicator reports the designated primary care HPSA population in the report area that are underserved, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [Underserved HPSA Population] / [Designated HPSA Population] * 100

Report Area	Designated Primary Care HPSA Population	Primary Care HPSA Population Underserved	Percentage of Primary Care HPSA Population Underserved
Central California CHNA	580,119	255,707	43.78%
Fresno County, CA	303,010	160,540	52.98%
Kern County, CA	476,065	281,156	59.06%
Kings County, CA	145,895	43,477	29.80%
Monterey County, CA	137,145	94,366	68.81%
San Benito County, CA	59,219	17,392	29.37%
Tulare County, CA	317,504	164,280	51.74%
California	5,988,716	2,710,171	45.23%
United States	72,823,197	37,666,041	51.65%

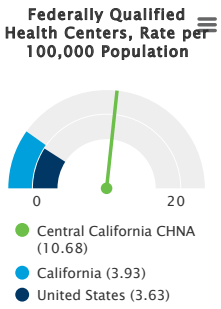
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024.

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

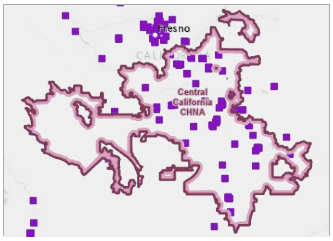
This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care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

Within the report area, there are 85 Federally Qualified Heath Centers. This means there is a rate of 10.68 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Central California CHNA	795,651	85	10.68
Fresno County, CA	1,008,654	70	6.94
Kern County, CA	909,235	46	5.06
Kings County, CA	152,486	16	10.49
Monterey County, CA	439,035	21	4.78
San Benito County, CA	64,209	1	1.56
Tulare County, CA	473,117	55	11.63
California	39,538,223	1,554	3.93
United States	334,735,155	12,138	3.63



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. 2024.



View larger map

Federally Qualified Health Centers, POS December 2024

Federally Qualified Health Centers, POS December 2024
Central California CHNA

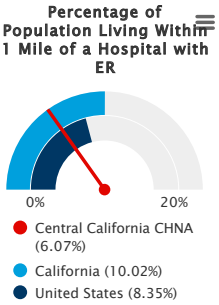
Availability - Hospitals & Clinics - Proximity to Hospitals with ER

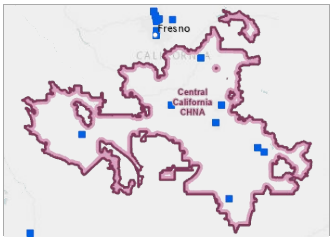
This indicator reports the percentage of the total population living within 1 mile of a hospital with an emergency room. Having good access to hospitals with an emergency room is important for community health because these hospitals play an important role in rapid and serious medical conditions.

As of 2023, of the report area's 795,651 total population, 48,260 or 6.07% live within 1 mile of a hospital with an emergency room. This is less than the state's reported rate of 10.02%.

Report Area	Total Population	Population Within 1 Mile of a Hospital with ER	Percent Within 1 Mile of a Hospital with ER
Central California CHNA	795,651	48,260	**6.07%**
Fresno County, CA	1,008,654	36,998	3.67%
Kern County, CA	909,235	64,515	7.1%
Kings County, CA	152,486	5,799	3.8%
Monterey County, CA	439,035	37,878	8.63%
San Benito County, CA	64,209	11,998	18.69%
Tulare County, CA	473,117	31,316	6.62%
California	39,538,223	3,961,644	10.02%
United States	334,735,155	27,942,571	8.35%

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





View larger map

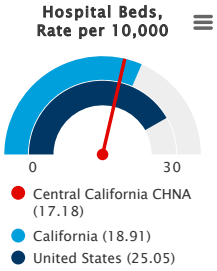
All Hospitals, POS December 2024

All Hospitals, POS December 2024
Central California CHNA

Availability - Hospitals & Clinics - Hospital Beds Per Capita

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

Report Area	Hospital Beds, Total	Total Population (2020)	Hospital Beds, Rate per 10,000
Central California CHNA	1,367	795,651	**17.18**
Fresno County, CA	1,563	1,008,654	15.50
Kern County, CA	1,675	909,235	18.42
Kings County, CA	235	152,486	15.41
Monterey County, CA	756	439,035	17.22
San Benito County, CA	88	64,209	13.71
Tulare County, CA	715	473,117	15.11
California	74,762	39,538,223	18.91
United States	830,171	331,449,281	25.05

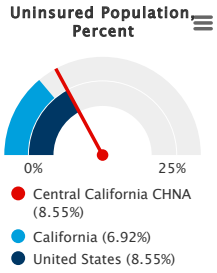


Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Hospital Service Area. 2023.

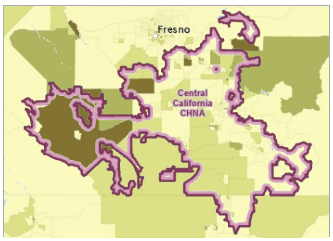
Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.
In the report area 8.55% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.92%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Central California CHNA	767,518	65,604	**8.55%**
Fresno County, CA	1,000,249	70,433	7.04%
Kern County, CA	888,229	69,712	7.85%
Kings County, CA	135,709	10,715	7.90%
Monterey County, CA	420,702	41,838	9.94%
San Benito County, CA	65,903	4,154	6.30%
Tulare County, CA	471,506	37,746	8.01%
California	38,761,738	2,682,732	6.92%
United States	327,425,278	28,000,876	8.55%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

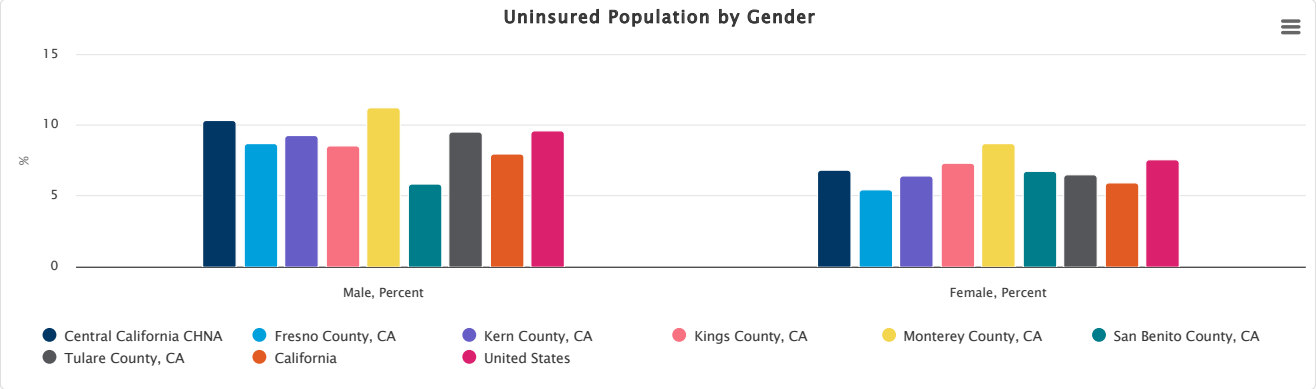
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Central California CHNA

Uninsured Population by Gender

This indicator reports the uninsured population by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	39,558	26,046	10.28%	6.81%
Fresno County, CA	43,242	27,191	8.69%	5.41%
Kern County, CA	41,040	28,672	9.26%	6.44%
Kings County, CA	5,786	4,929	8.48%	7.31%
Monterey County, CA	23,421	18,417	11.24%	8.68%
San Benito County, CA	1,942	2,212	5.85%	6.76%
Tulare County, CA	22,395	15,351	9.52%	6.50%
California	1,526,004	1,156,728	7.93%	5.92%
United States	15,443,840	12,557,036	9.59%	7.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.

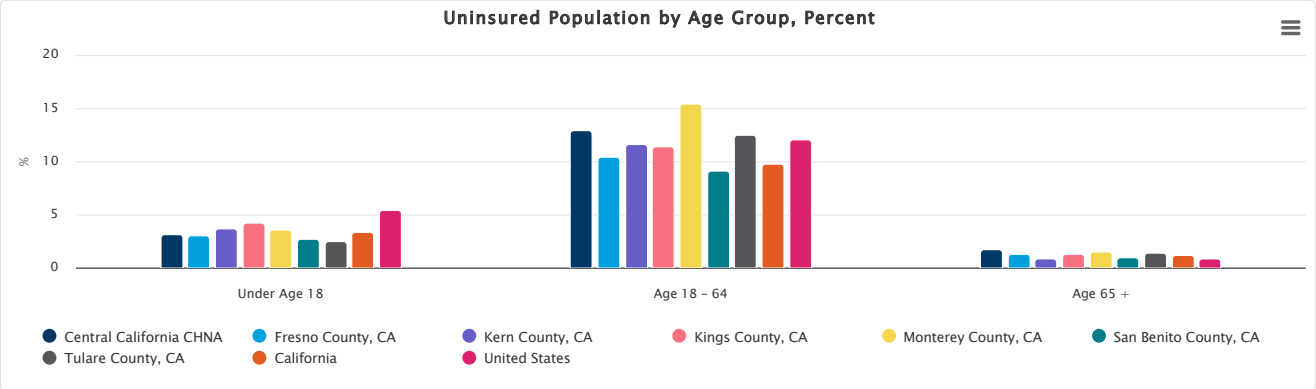


Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.
The percentage values could be interpreted as, for example, *"Of all the population under age 18 within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Under Age 18	Age 18 - 64	Age 65 +
Central California CHNA	3.12%	12.92%	1.70%
Fresno County, CA	2.97%	10.43%	1.21%
Kern County, CA	3.68%	11.55%	0.85%
Kings County, CA	4.23%	11.31%	1.29%
Monterey County, CA	3.50%	15.34%	1.52%
San Benito County, CA	2.71%	9.11%	0.88%
Tulare County, CA	2.48%	12.48%	1.41%
California	3.35%	9.77%	1.09%
United States	5.39%	11.98%	0.83%

Data Source: US Census Bureau, American Community Survey. 2019-23.

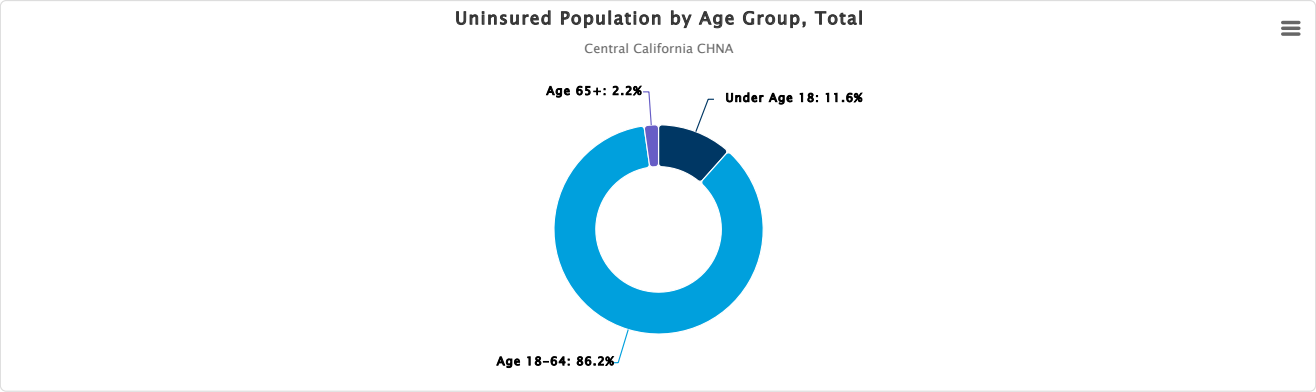


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Central California CHNA	7,607	56,534	1,463
Fresno County, CA	8,891	60,015	1,527
Kern County, CA	10,179	58,653	880
Kings County, CA	1,828	8,684	203
Monterey County, CA	4,176	36,718	944
San Benito County, CA	478	3,598	78
Tulare County, CA	3,724	33,251	771
California	310,351	2,307,944	64,437
United States	4,208,983	23,338,717	453,176

Data Source: US Census Bureau, American Community Survey. 2019-23.

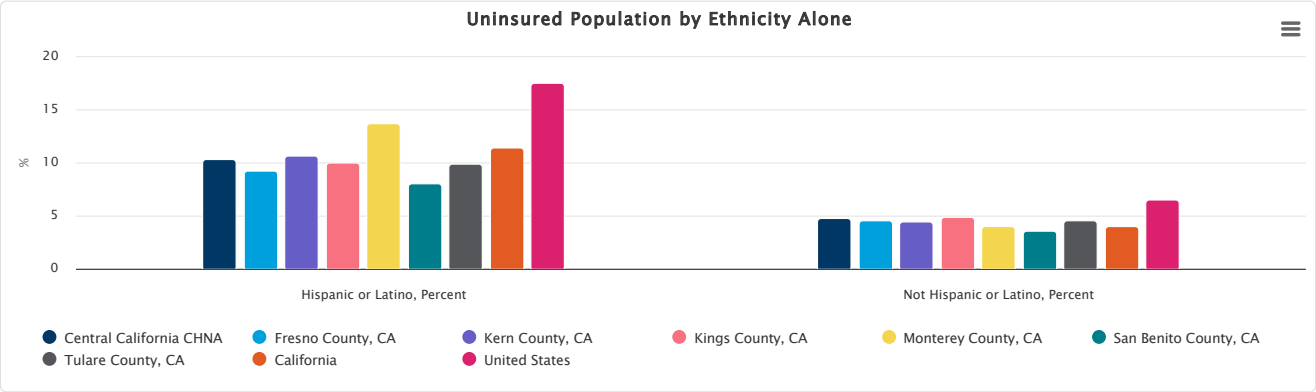


Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	54,236	11,368	10.32%	4.69%
Fresno County, CA	49,545	20,888	9.14%	4.56%
Kern County, CA	52,544	17,168	10.57%	4.39%
Kings County, CA	8,095	2,620	9.99%	4.79%
Monterey County, CA	35,505	6,333	13.59%	3.97%
San Benito County, CA	3,260	894	8.00%	3.55%
Tulare County, CA	30,617	7,129	9.81%	4.47%
California	1,760,029	922,703	11.37%	3.96%
United States	10,900,185	17,100,691	17.47%	6.45%

Data Source: US Census Bureau, American Community Survey. 2019-23.

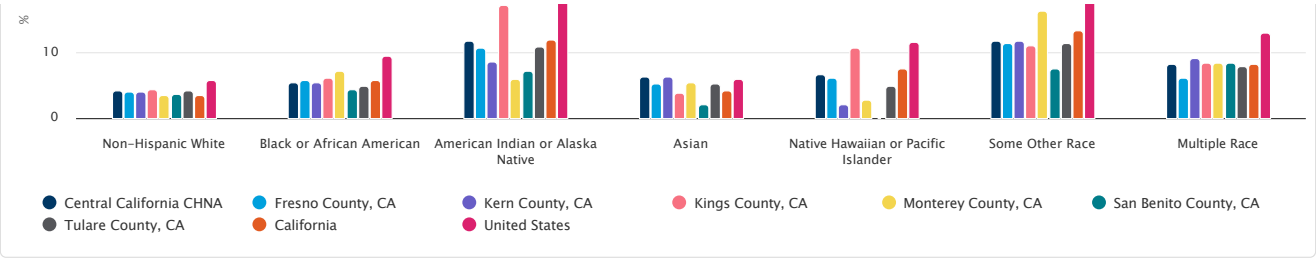


Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.
The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	4.20%	5.47%	11.79%	6.23%	6.60%	11.70%	8.23%
Fresno County, CA	3.99%	5.75%	10.73%	5.29%	6.13%	11.33%	6.08%
Kern County, CA	3.92%	5.42%	8.54%	6.18%	2.08%	11.73%	9.03%
Kings County, CA	4.36%	6.07%	17.15%	3.76%	10.66%	11.01%	8.33%
Monterey County, CA	3.37%	7.17%	5.90%	5.39%	2.74%	16.26%	8.44%
San Benito County, CA	3.57%	4.29%	7.16%	1.97%	0.00%	7.42%	8.45%
Tulare County, CA	4.19%	4.79%	10.82%	5.25%	4.79%	11.33%	7.78%
California	3.52%	5.65%	11.90%	4.06%	7.56%	13.37%	8.27%
United States	5.71%	9.46%	19.22%	5.89%	11.59%	19.70%	12.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.

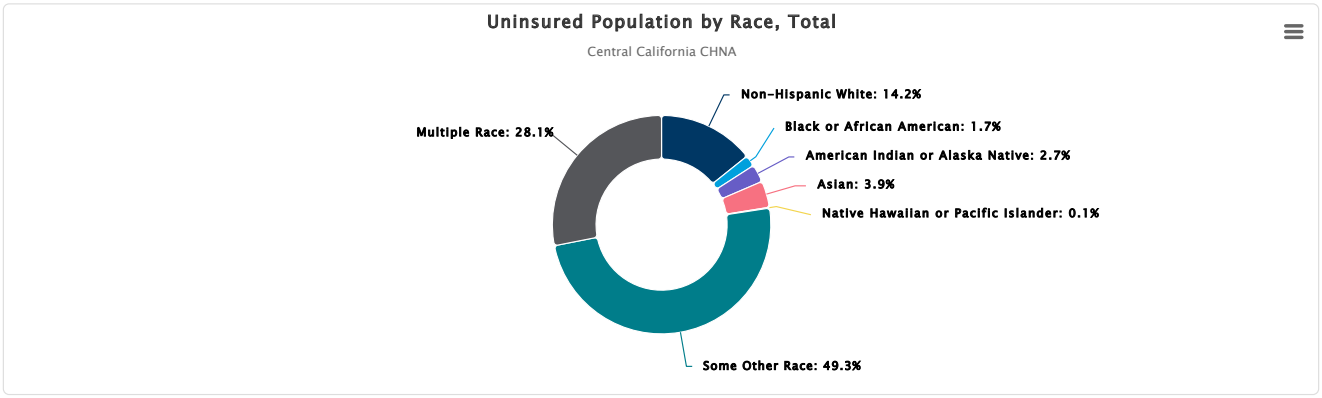


Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	7,266	843	1,353	1,995	63	25,170	14,339
Fresno County, CA	10,751	2,485	1,477	5,852	100	22,981	12,770
Kern County, CA	10,734	2,280	915	2,832	29	18,699	17,075
Kings County, CA	1,672	407	456	176	29	3,314	2,280
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Benito County, CA	710	29	88	45	0	763	1,821
Tulare County, CA	5,165	333	759	877	33	15,713	7,824
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

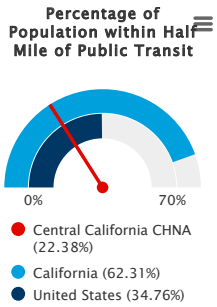
Data Source: US Census Bureau, American Community Survey. 2019-23.



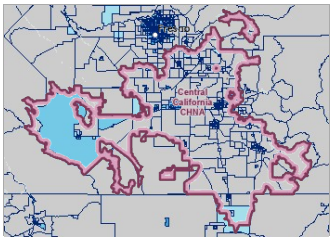
Barriers - Transportation - Distance to Public Transit

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

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Central California CHNA	454,467	101,711	**22.38%**
Fresno County, CA	978,130	523,423	53.51%
Kern County, CA	883,053	390,904	44.27%
Kings County, CA	150,075	83,601	55.71%
Monterey County, CA	433,212	302,737	69.88%
San Benito County, CA	59,416	31,320	52.71%
Tulare County, CA	460,477	6,724	1.46%
California	39,148,760	24,391,714	62.31%
United States	322,903,030	112,239,342	34.76%



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



View larger map

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

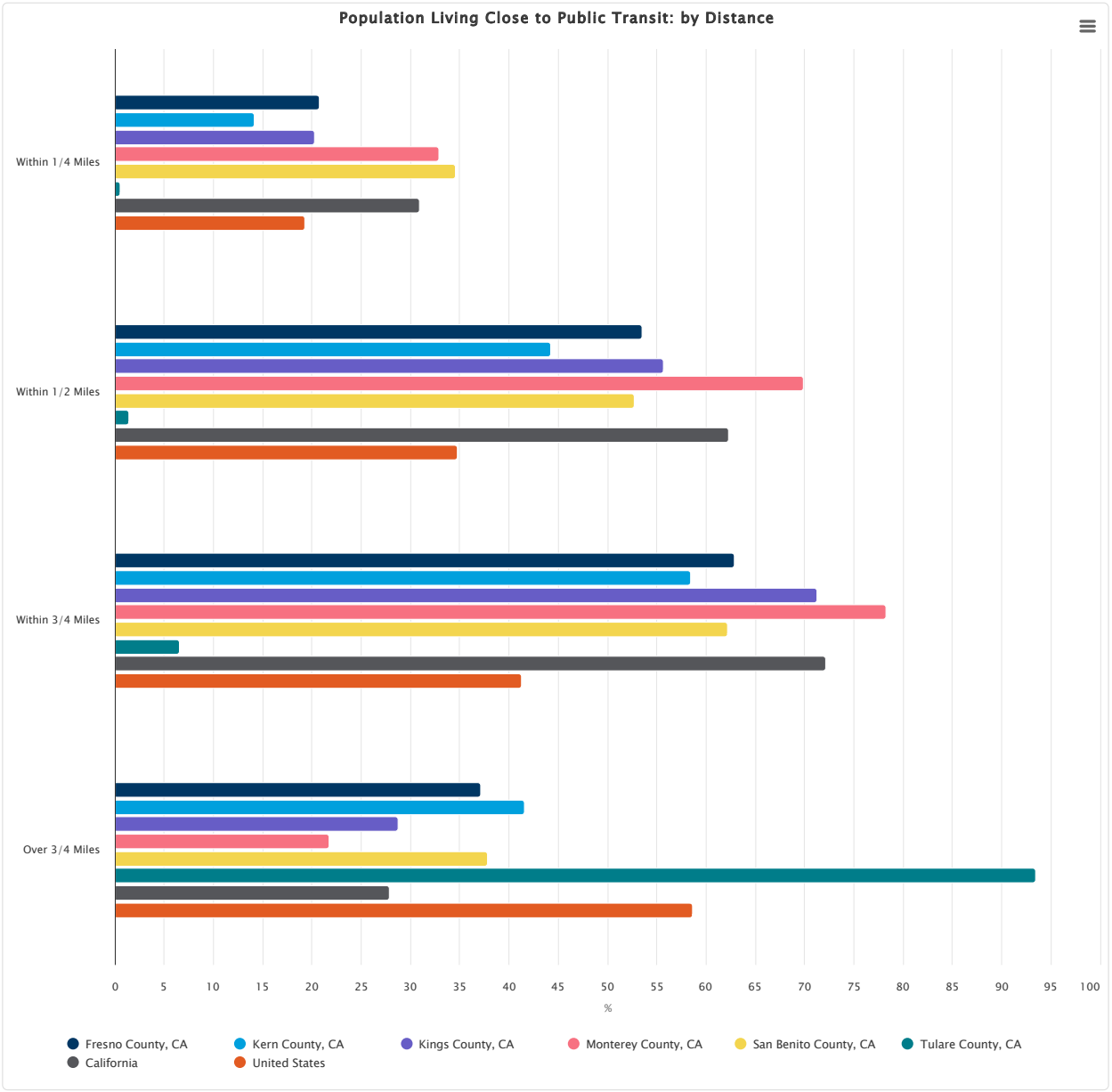
- 800 - 1200 Meters (0.5 - 0.75 Miles)
- 400 - 800 Meters (0.25 - 0.5 Miles)
- 200 - 400 Meters (0.125 - 0.25 Miles)
- Closer than 200 Meters (< 0.125 Miles)
- Further than 1200 Meters (> 0.75 Miles)
- Central California CHNA

Population Living Close to Public Transit: by Distance

This indicator reports the percentages of population living within 1/4, 1/2, 3/4, and over 3/4 miles from the nearest transit stop.

Report Area	Within 1/4 Miles	Within 1/2 Miles	Within 3/4 Miles	Over 3/4 Miles
Fresno County, CA	20.77%	53.51%	62.91%	37.09%
Kern County, CA	14.13%	44.27%	58.39%	41.61%
Kings County, CA	20.3%	55.71%	71.25%	28.75%
Monterey County, CA	32.86%	69.88%	78.27%	21.73%
San Benito County, CA	34.58%	52.71%	62.22%	37.78%
Tulare County, CA	0.56%	1.46%	6.54%	93.46%
California	30.95%	62.31%	72.11%	27.83%
United States	19.25%	34.76%	41.26%	58.64%

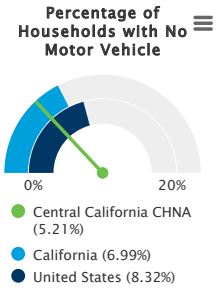
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



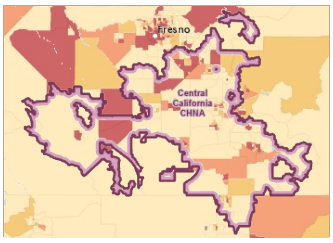
Barriers - Transportation - Households with No Vehicle

This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates. Of the 234,087 total households in the report area, 12,196 or 5.21% are without a motor vehicle.

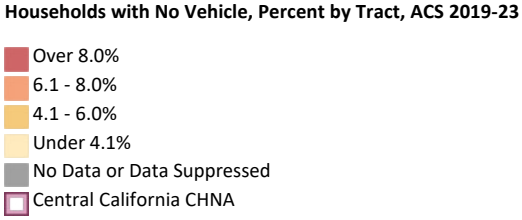
Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Central California CHNA	234,087	12,196	**5.21%**
Fresno County, CA	322,163	23,037	7.15%
Kern County, CA	281,416	18,305	6.50%
Kings County, CA	43,736	2,556	5.84%
Monterey County, CA	132,046	6,041	4.57%
San Benito County, CA	20,188	530	2.63%
Tulare County, CA	142,026	6,617	4.66%
California	13,434,847	939,021	6.99%
United States	127,482,865	10,602,826	8.32%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

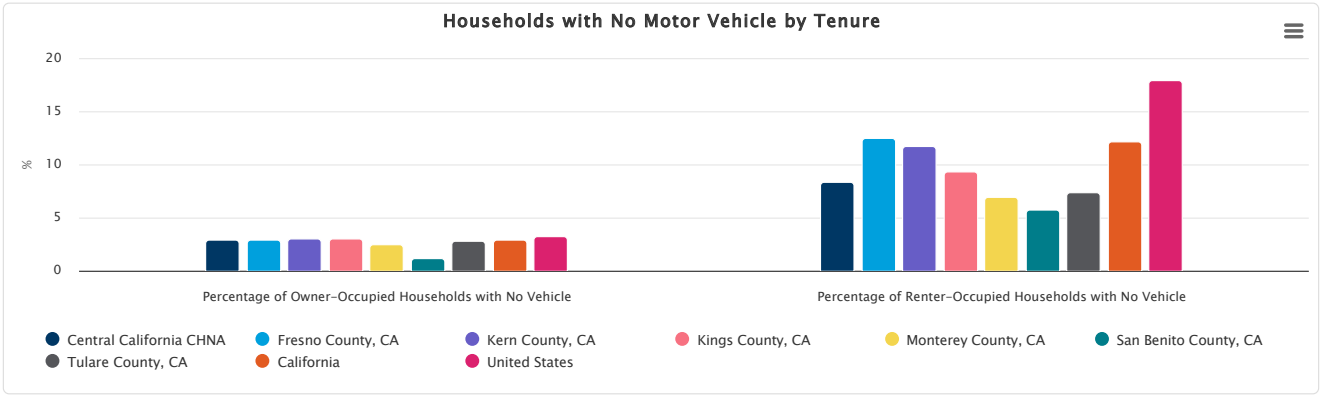


Households with No Motor Vehicle by Tenure

This indicator reports the total and percentage of households with no vehicle by tenure.
These numbers in the following table could be interpreted as (take the first two columns as an example), *"Within the report area, there are a total of (value) owner-occupied households with no vehicle. This accounts for (value) of all the owner-occupied households."*

Report Area	Owner-Occupied Households	Owner-Occupied Households, Percent	Renter-Occupied Households	Renter-Occupied Households, Percent
Central California CHNA	3,769	2.88%	8,241	8.30%
Fresno County, CA	5,218	2.92%	17,819	12.41%
Kern County, CA	5,115	3.04%	13,190	11.66%
Kings County, CA	721	3.01%	1,835	9.29%
Monterey County, CA	1,690	2.45%	4,351	6.90%
San Benito County, CA	154	1.13%	376	5.72%
Tulare County, CA	2,271	2.73%	4,346	7.39%
California	216,828	2.89%	722,193	12.16%
United States	2,636,344	3.18%	7,966,482	17.87%

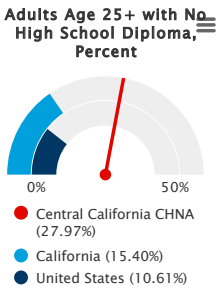
Data Source: US Census Bureau, American Community Survey. 2019-23.



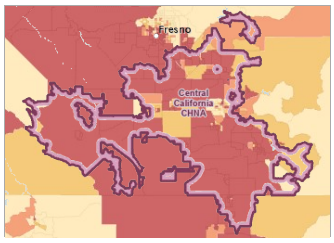
Barriers - Health Literacy - Educational Attainment

Within the report area there are 135,293 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 27.97% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
Central California CHNA	483,664	135,293	**27.97%**
Fresno County, CA	631,185	135,093	21.40%
Kern County, CA	558,810	127,772	22.87%
Kings County, CA	95,545	24,617	25.76%
Monterey County, CA	279,274	74,469	26.67%
San Benito County, CA	43,450	7,283	16.76%
Tulare County, CA	284,744	72,985	25.63%
California	26,941,198	4,149,146	15.40%
United States	228,434,661	24,230,217	10.61%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Population with No High School Diploma (Age 25+), Percent by Tract, ACS 2019-23

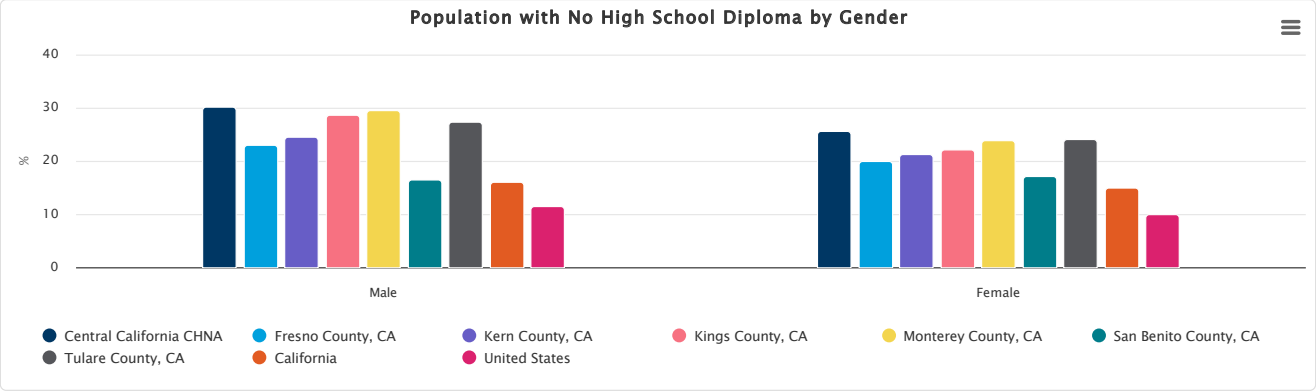
- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed
- Central California CHNA

Population with No High School Diploma by Gender

This indicator reports the population age 25+ with no high school diploma by gender.
The percentage values could be interpreted as, of all the males age 25+ within the report area, the percentage without a high school diploma is 30.14%; of all the females age 25+ within the report area, the percentage without a high school diploma is 25.64%.

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	75,613	59,680	30.14%	25.64%
Fresno County, CA	71,511	63,582	22.87%	19.96%
Kern County, CA	69,486	58,286	24.53%	21.15%
Kings County, CA	15,506	9,111	28.57%	22.07%
Monterey County, CA	41,591	32,878	29.35%	23.90%
San Benito County, CA	3,591	3,692	16.38%	17.15%
Tulare County, CA	38,430	34,555	27.27%	24.02%
California	2,111,415	2,037,731	15.87%	14.94%
United States	12,672,705	11,557,512	11.38%	9.87%

Data Source: US Census Bureau, American Community Survey. 2019-23.

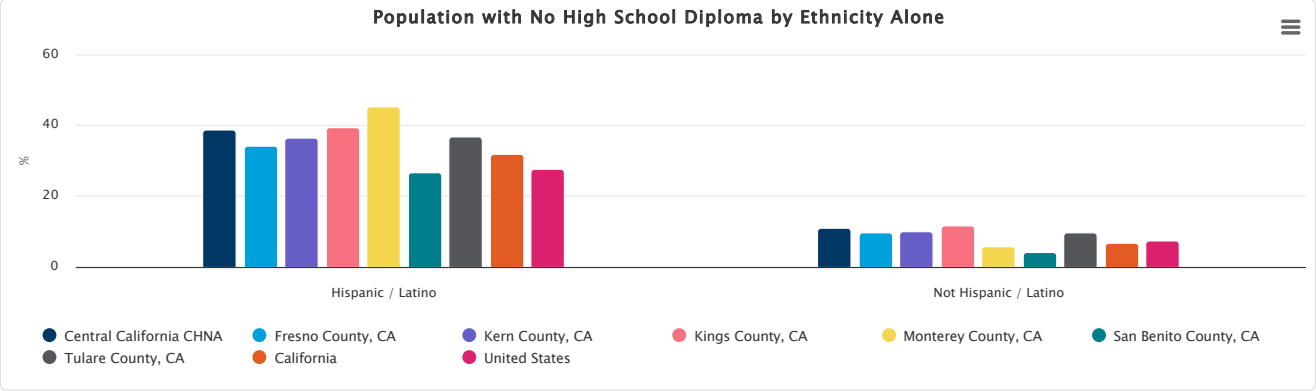


Population with No High School Diploma by Ethnicity Alone

This indicator reports the population age 25+ with no high school diploma by ethnicity alone.
The percentage values could be interpreted as, of all the Hispanic population age 25+ within the report area, the percentage without a high school diploma is 38.72%; of all the non-Hispanic population age 25+ within the report area, the percentage without a high school diploma is 10.96%.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	114,774	20,519	38.72%	10.96%
Fresno County, CA	103,605	31,488	34.13%	9.61%
Kern County, CA	99,890	27,882	36.22%	9.85%
Kings County, CA	19,299	5,318	39.20%	11.48%
Monterey County, CA	66,924	7,545	45.19%	5.75%
San Benito County, CA	6,483	800	26.65%	4.18%
Tulare County, CA	61,772	11,213	36.61%	9.67%
California	2,963,752	1,185,394	31.69%	6.74%
United States	10,132,918	14,097,299	27.46%	7.36%

Data Source: US Census Bureau, American Community Survey. 2019-23.

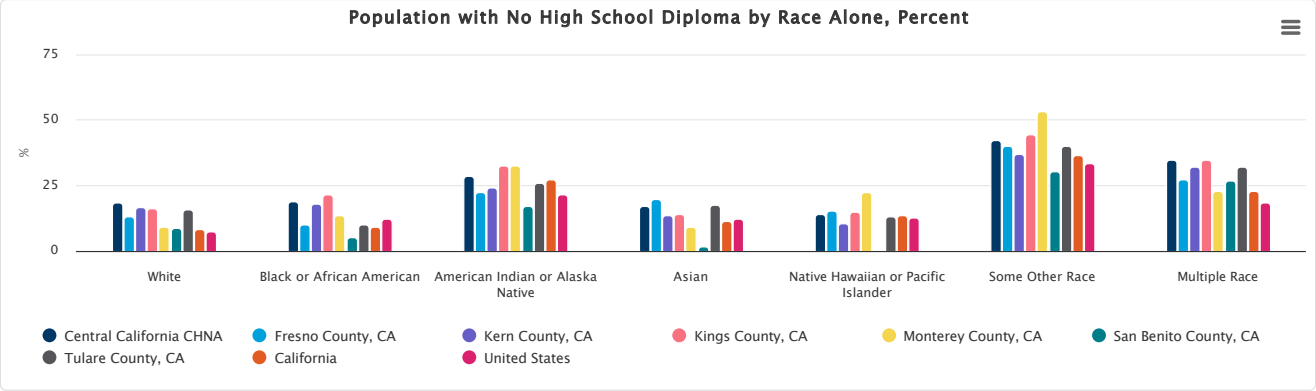


Population with No High School Diploma by Race Alone, Percent

This indicator reports the percentage of population age 25+ with no high school diploma by race alone in the report area. The percentage values could be interpreted as, for example, *"Of all the white population age 25+ in the report area, the percentage with no high school diploma is (value)."*

Report Area	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	18.18%	18.61%	28.66%	16.88%	14.01%	42.03%	34.82%
Fresno County, CA	12.88%	9.88%	22.25%	19.45%	15.09%	40.13%	27.05%
Kern County, CA	16.69%	17.84%	24.09%	13.42%	10.48%	36.88%	31.82%
Kings County, CA	15.93%	21.54%	32.34%	14.04%	14.70%	44.15%	34.76%
Monterey County, CA	8.90%	13.48%	32.42%	8.89%	22.08%	53.15%	22.86%
San Benito County, CA	8.39%	5.21%	16.83%	1.34%	0.00%	30.21%	26.60%
Tulare County, CA	15.81%	9.71%	25.64%	17.51%	12.95%	39.99%	31.77%
California	8.28%	9.18%	26.94%	11.14%	13.33%	36.28%	22.77%
United States	7.12%	11.94%	21.51%	11.97%	12.73%	33.21%	18.36%

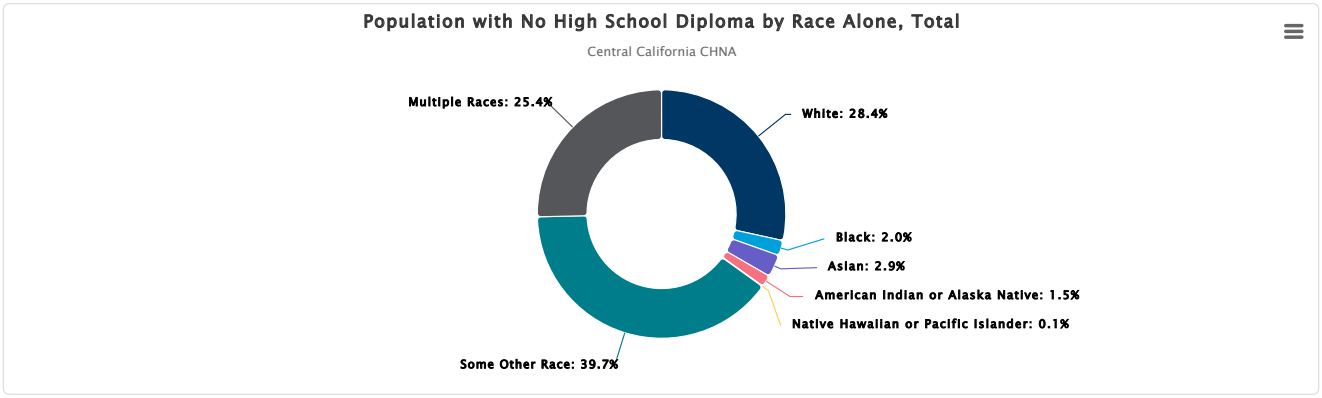
Data Source: US Census Bureau, American Community Survey. 2019-23.



Population with No High School Diploma by Race Alone, Total

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Central California CHNA	38,475	2,675	3,929	2,075	102	53,718	34,319
Fresno County, CA	37,024	2,763	13,883	1,894	159	48,626	30,744
Kern County, CA	48,615	4,979	4,323	1,803	104	33,904	34,044
Kings County, CA	7,272	1,516	578	584	41	8,869	5,757
Monterey County, CA	10,296	965	1,712	813	340	52,459	7,884
San Benito County, CA	1,776	33	22	140	0	2,032	3,280
Tulare County, CA	20,821	403	1,958	1,168	50	31,156	17,429
California	1,050,186	139,805	495,148	79,473	13,685	1,538,790	832,059
United States	10,836,488	3,217,325	1,664,267	393,606	51,272	4,453,551	3,613,708

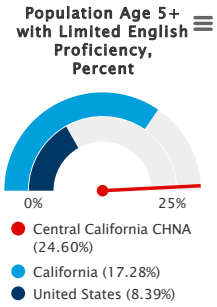
Data Source: US Census Bureau, American Community Survey. 2019-23.



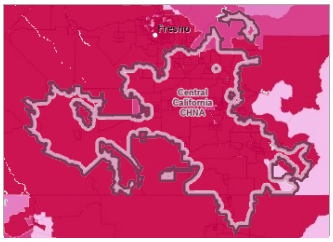
Barriers - Health Literacy - Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 740,941 total population aged 5 and older in the report area, 182,242 or 24.60% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
Central California CHNA	740,941	182,242	**24.60%**
Fresno County, CA	940,103	162,647	17.30%
Kern County, CA	844,742	146,893	17.39%
Kings County, CA	141,762	28,465	20.08%
Monterey County, CA	406,954	100,871	24.79%
San Benito County, CA	61,827	10,046	16.25%
Tulare County, CA	440,766	102,332	23.22%
California	37,028,644	6,400,397	17.28%
United States	313,447,641	26,299,012	8.39%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Population with Limited English Proficiency, Percent by Tract, ACS 2019-23

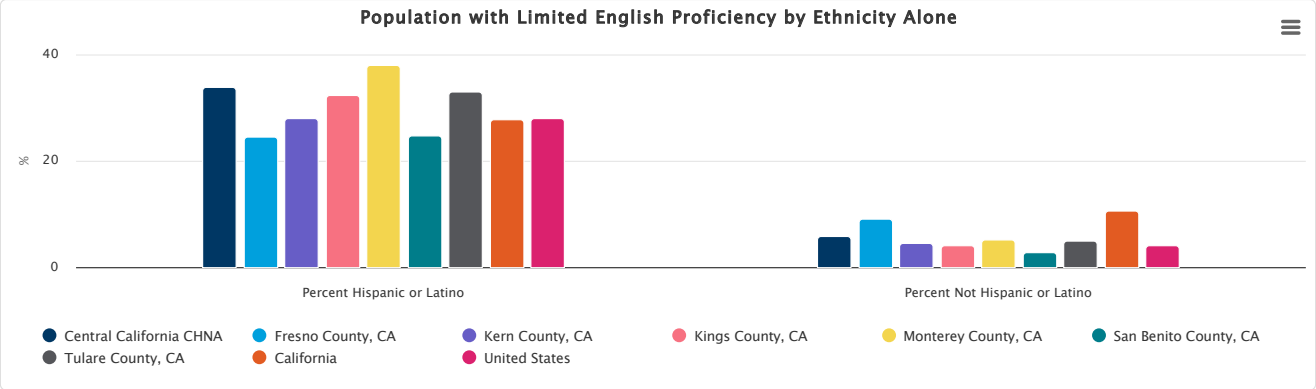
- Over 4.0%
- 2.1 - 4.0%
- 1.1 - 2.0%
- Under 1.1%
- No Data or Data Suppressed
- Central California CHNA

Population with Limited English Proficiency by Ethnicity Alone

This indicator reports the total and percentage of population aged 5 and older who speak a language other than English at home and speak English less than "very well" by ethnicity alone in the report area. The percentage values could be interpreted as, for example, *"Among the Hispanic population in the report area, the percentage of the population with limited English proficiency is (value)."*

Report Area	Total Hispanic or Latino	Total Not Hispanic or Latino	Percent Hispanic or Latino	Percent Not Hispanic or Latino
Central California CHNA	168,052	14,190	33.88%	5.79%
Fresno County, CA	122,746	39,901	24.49%	9.09%
Kern County, CA	129,776	17,117	27.85%	4.52%
Kings County, CA	26,026	2,439	32.36%	3.98%
Monterey County, CA	92,413	8,458	38.04%	5.16%
San Benito County, CA	9,395	651	24.77%	2.72%
Tulare County, CA	94,903	7,429	32.90%	4.88%
California	4,008,878	2,391,519	27.61%	10.62%
United States	16,290,980	10,008,032	28.02%	3.92%

Data Source: US Census Bureau, American Community Survey. 2019-23.

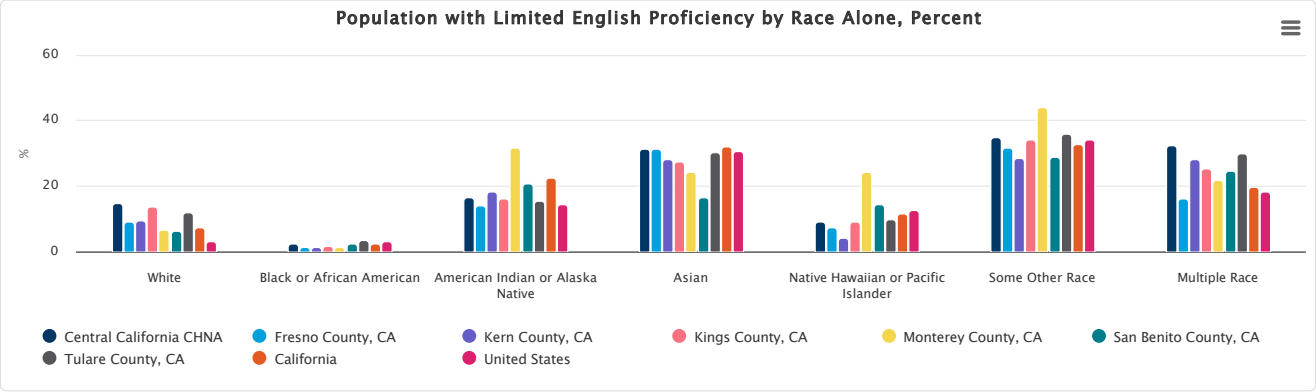


Population with Limited English Proficiency by Race Alone, Percent

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.
The percentage values could be interpreted as, for example, *"Of all the white population in the report area, the percentage of population with limited English proficiency is (value)."*

Report Area	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	14.65%	2.22%	16.39%	31.41%	9.01%	34.94%	32.15%
Fresno County, CA	9.12%	1.16%	14.08%	31.31%	7.10%	31.67%	16.16%
Kern County, CA	9.50%	1.25%	18.17%	28.07%	3.91%	28.31%	27.96%
Kings County, CA	13.51%	1.56%	15.94%	27.20%	8.84%	34.08%	25.36%
Monterey County, CA	6.46%	1.17%	31.49%	24.12%	24.10%	44.10%	21.88%
San Benito County, CA	6.13%	2.36%	20.48%	16.44%	14.17%	28.66%	24.61%
Tulare County, CA	11.75%	3.35%	15.18%	30.28%	9.79%	35.74%	29.94%
California	7.13%	2.23%	22.24%	32.04%	11.45%	32.77%	19.53%
United States	3.13%	3.11%	14.39%	30.47%	12.50%	33.93%	18.06%

Data Source: US Census Bureau, American Community Survey. 2019-23.

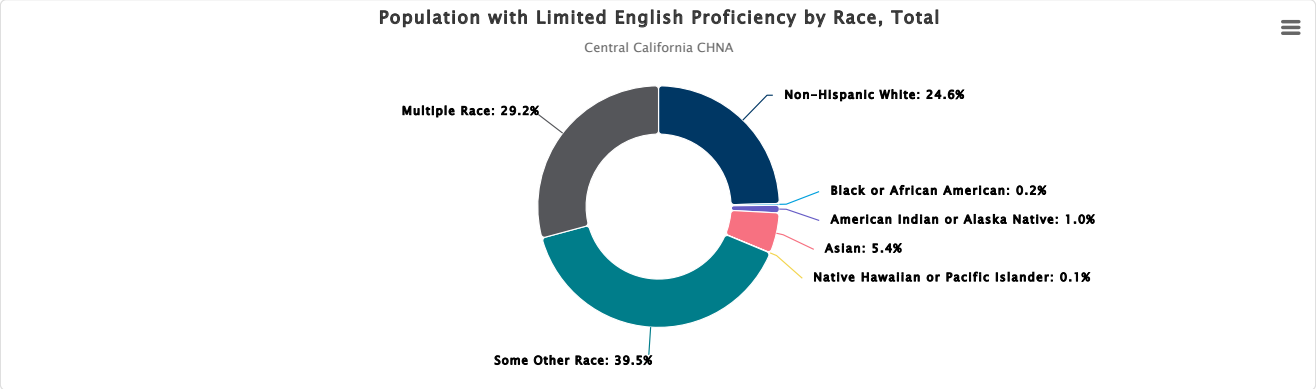


Population with Limited English Proficiency by Race, Total

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by race alone in the report area.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	44,792	444	1,853	9,833	96	72,020	53,204
Fresno County, CA	36,236	480	1,862	32,301	110	60,590	31,068
Kern County, CA	39,604	539	1,890	12,277	55	42,841	49,687
Kings County, CA	8,810	145	441	1,388	29	10,410	7,242
Monterey County, CA	9,768	108	1,084	5,842	534	71,746	11,789
San Benito County, CA	1,717	16	238	357	18	2,833	4,867
Tulare County, CA	22,130	226	1,036	4,805	66	46,260	27,809
California	1,171,612	46,021	93,958	1,831,952	16,068	2,097,665	1,143,121
United States	6,268,072	1,198,675	395,358	5,604,715	73,488	6,939,133	5,819,571

Data Source: US Census Bureau, American Community Survey. 2019-23.

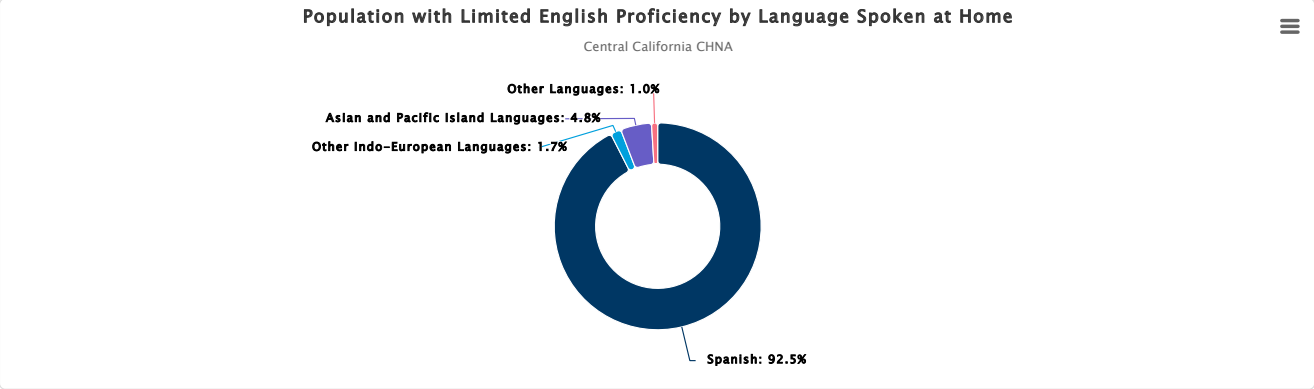


Population with Limited English Proficiency by Language Spoken at Home

This indicator reports the total population aged 5 and older who speak a language other than English at home and speak English less than "very well" by language spoken at home in the report area.

Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
Central California CHNA	168,610	3,035	8,837	1,760
Fresno County, CA	123,244	11,972	24,160	3,271
Kern County, CA	130,855	4,404	9,189	2,445
Kings County, CA	26,331	499	1,498	137
Monterey County, CA	92,597	1,947	5,439	888
San Benito County, CA	9,480	76	411	79
Tulare County, CA	95,244	1,684	4,390	1,014
California	4,043,207	518,139	1,705,745	133,306
United States	16,642,933	3,637,966	4,890,240	1,127,873

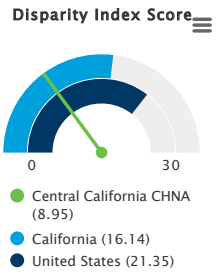
Data Source: US Census Bureau, American Community Survey. 2019-23.



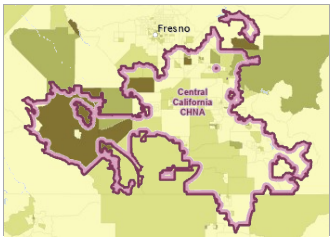
Barriers - Medical Insurance - Health Insurance Disparities

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

Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Central California CHNA	4.13%	10.32%	5.39%	9.91%	**8.95**
Fresno County, CA	3.99%	9.14%	5.76%	8.01%	9.95
Kern County, CA	3.92%	10.57%	5.42%	9.73%	13.52
Kings County, CA	4.36%	9.99%	6.08%	9.61%	10.90
Monterey County, CA	3.37%	13.59%	7.17%	13.29%	12.94
San Benito County, CA	3.57%	8.00%	4.29%	7.65%	10.25
Tulare County, CA	4.19%	9.81%	4.79%	9.56%	9.49
California	3.52%	11.37%	5.65%	8.82%	16.14
United States	5.71%	17.47%	9.47%	13.32%	21.35



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Central California CHNA

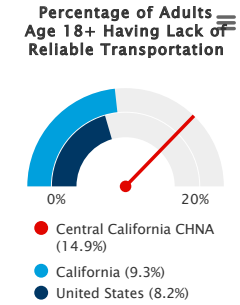
Barriers - Transportation - Lack of Reliable Transportation

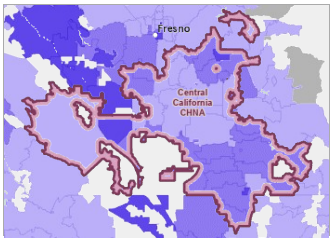
This indicator reports the percentage of adults age 18 and older who report having a lack of reliable transportation in the past 12 months.

Within the report area, there were 14.9% of adults 18 and older who rreport having a lack of reliable transportation in the past 12 months of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ Having Lack of Reliable Transportation (Crude)	Adults Age 18+ Having Lack of Reliable Transportation (Age-Adjusted)
Central California CHNA	795,651	14.9%	No data
Fresno County, CA	1,015,190	12.8%	13.0%
Kern County, CA	916,108	12.9%	12.9%
Kings County, CA	152,981	12.5%	12.3%
Monterey County, CA	432,858	11.2%	11.4%
San Benito County, CA	67,579	10.6%	10.7%
Tulare County, CA	477,544	15.1%	14.9%
California	39,029,342	9.3%	9.5%
United States	333,287,557	8.2%	8.7%

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





View larger map

Lack of Reliable Transportation, Prevalence Among Adults Age 18+ by ZCTA, CDC BRFSS PLACES Project 2022

- Over 29.1%
- 22.1% - 29.0%
- 15.1% - 22.0%
- Under 15.1%
- No Data or Data Suppressed
- Central California CHNA

Finacial Stability

Financial stability refers to having a reliable and sufficient income to meet basic needs such as housing, food, healthcare and transportation, while being able to handle unexpected expenses. Financial stability is a critical social determinant of health, as individuals with steady income are more likely to access preventive care, afford nutritious food, maintain safe living conditions and plan for the future.

However, many people face persistent financial instability which impacts their health and well-being. In the United States, 36.8 million Americans were living in poverty in 2023 (US Census Bureau), and 28% of adults went without medical care in 2022 because they could not afford it (Federal Reserve). Financial instability is linked to higher rates of chronic disease, mental health issues and shorter life expectancy due to limited access to health resources and higher exposure to stressors. In the Central California service area, the primary and secondary data confirm that financial stability is a high priority need.

With a median household income of $67,109 compared to California's $96,334, achieving financial stability in the Central California service area can be a challenge. Additionally, one in four children (25.37%) ages 0-17 live in households with income below the Federal Poverty Level. A high unemployment rate of 9.38% indicates that job conditions may be unstable.

People with steady jobs, or positions that continue for a long time with regular pay, are more likely to be healthy and less likely to have an income below the poverty level (Healthy People 2030). A key informant noted, "when people have access to great career opportunities and they're able to find permanent stable jobs, that helps provide for their stability [...] in their household, in their finances, with education, with healthcare, with transportation, with daycare."

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

Scan QR Code to explore the full live data report on Financial Stability or visit: cares.page.link/ud2R

Data Highlights

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

"I do feel...when folks do have a job and a career...the mental and the physical well being of an individual does increase...it adds...this further purpose to one's life and contribution to their community."

"Agriculture doesn't pay much...maybe 60% of the maybe 70% of the population have agriculture as their background...they're not making that much money to be able to live comfortably in a home."

"...when you compare working at minimum wage full time or not being employed and getting CalWorks and Medi-Cal...so why work?"

"...minimum wage is really not enough to live [on] in this state. And even in the smaller communities like Delano, it's really not enough."

"...it's just choices that as the rent skyrockets, health insurance goes up...people are making choices not to go to the doctor, not to take their medication...and they're making choices to adversely affect their health because they're paying other bills."

"...we don't have enough agencies local around here that has funding to help them pay their bills. And for [Kern County]...we will help pay energy and utilities...but only if we have the funding, if the grant is still there. But when we run out, we don't have it."

"And when people have access to great career opportunities and they're able to find permanent stable jobs, that helps provide for their stability...in their household, in their finances, with education, with healthcare, with transportation, with daycare...I think great jobs provide many people purpose and meaning..."

"We've got to bring in better employers to...get people better paying jobs, so that with those jobs they're in a safer work environment and they have higher incomes. And then they could have private insurance and then they could take care of themselves."

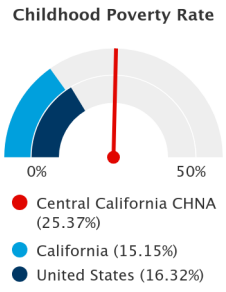
"...our responsibility is to bring in those larger employers and those industry sectors so they can create that economic diversity and then that will help fuel more of those [college] programs in our school systems."

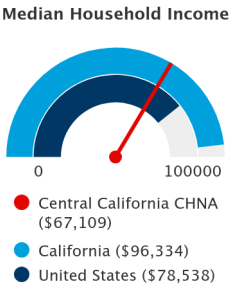
"...we're building a business incubator right next door to City Hall. I've reserved 25% of that business incubator for immigrant businesses, so if you help, if you have a business idea and you want to start a business and you don't want to work for someone else, bring your idea to the incubator. We'll put you in the incubator and we'll wrap around you all the services you need."

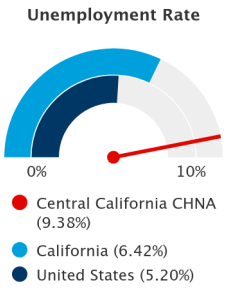
Community Resources

BenefitsCal
benefitscal.com

The California Wellness Foundation
calwellness.org/money/what-we-fund/economic-security-and-dignity
818-702-1900







Community Health Needs Assessment Full Report

Location

Central California CHNA

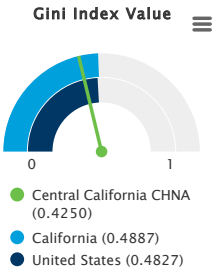
Basic Needs: Financial Stability

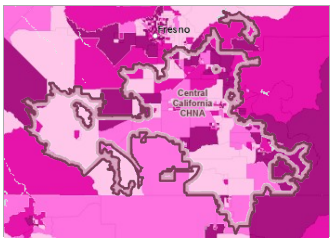
Income - Income Inequality

This indicator reports income inequality using the Gini coefficient. Gini index values range between zero and one. A value of one indicates perfect inequality where only one household has any income. A value of zero indicates perfect equality, where all households have equal income.
Note: Index values are acquired from the 2019-23 American Community Survey and are not available for custom report areas or multi-county areas.

Report Area	Total Households	Gini Index Value
Central California CHNA	234,087	0.4250
Fresno County, CA	322,163	0.4735
Kern County, CA	281,416	0.4645
Kings County, CA	43,736	0.4211
Monterey County, CA	132,046	0.4627
San Benito County, CA	20,188	0.4193
Tulare County, CA	142,026	0.4401
California	13,434,847	0.4887
United States	127,482,865	0.4827

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





View larger map

Income Inequality (GINI), Index Value by Tract, ACS 2019-23

- Over 0.460
- 0.431 - 0.460
- 0.401 - 0.430
- Under 0.401
- No Data or Data Suppressed
- Central California CHNA

Income Inequality (GINI Index) by Year

This indicator reports the GINI index from 2012-16 to 2019-23.

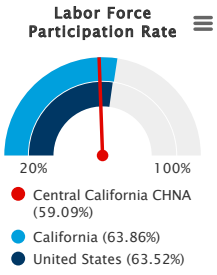
Report Area	2012-16	2013-17	2014-18	2015-19	2016-20	2017-21	2018-22	2019-23
Fresno County, CA	0.48	0.48	0.48	0.47	0.48	0.47	0.47	0.47
Fresno County, CA	0.45	0.45	0.45	0.44	0.44	0.44	0.45	0.45
Kern County, CA	0.42	0.41	0.45	0.43	0.42	0.42	0.43	0.41
Kern County, CA	0.46	0.46	0.46	0.47	0.47	0.46	0.47	0.46
Kings County, CA	0.45	0.44	0.43	0.43	0.41	0.41	0.41	0.42
Kings County, CA	0.51	0.54	0.53	0.54	0.57	0.55	0.49	0.47
Monterey County, CA	0.44	0.44	0.44	0.43	0.43	0.44	0.45	0.44
Monterey County, CA	0.46	0.46	0.46	0.46	0.46	0.45	0.46	0.46
San Benito County, CA	0.41	0.40	0.40	0.41	0.41	0.41	0.41	0.42
San Benito County, CA	0.58	0.60	0.61	0.61	0.55	0.57	0.56	0.55
Tulare County, CA	0.44	0.43	0.43	0.42	0.43	0.41	0.42	0.43
Tulare County, CA	0.47	0.47	0.48	0.47	0.46	0.46	0.45	0.44
California	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49
United States	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48

Data Source: US Census Bureau, American Community Survey. 2019-23.

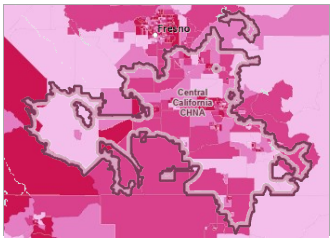
Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2019 – 2023 American Community Survey, of the 602,688 working age population, 356,134 are included in the labor force. The labor force participation rate is 59.09%.

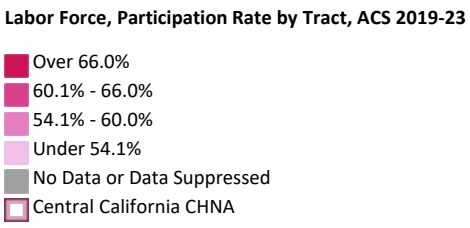
Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Central California CHNA	602,688	356,134	**59.09%**
Fresno County, CA	761,285	466,586	61.29%
Kern County, CA	677,057	398,143	58.80%
Kings County, CA	115,997	64,752	55.82%
Monterey County, CA	335,220	202,644	60.45%
San Benito County, CA	51,266	34,250	66.81%
Tulare County, CA	349,036	211,707	60.65%
California	31,545,603	20,144,078	63.86%
United States	267,393,519	169,855,626	63.52%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



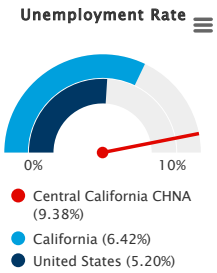
View larger map



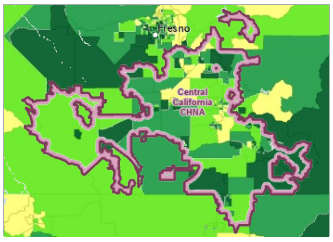
Employment - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 33,391, or 9.38% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Central California CHNA	356,134	33,391	**9.38%**
Fresno County, CA	466,586	39,771	8.55%
Kern County, CA	398,143	33,049	8.35%
Kings County, CA	64,752	5,787	9.82%
Monterey County, CA	202,644	10,068	5.13%
San Benito County, CA	34,250	2,038	5.96%
Tulare County, CA	211,707	18,688	8.85%
California	20,144,078	1,282,259	6.42%
United States	169,855,626	8,759,317	5.20%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Unemployed Workers, Percent by Tract, ACS 2019-23

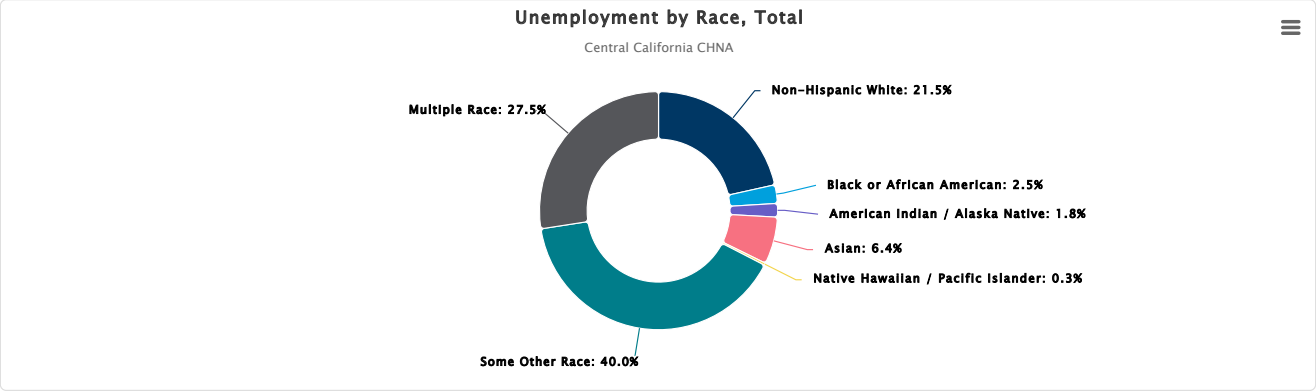
- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Central California CHNA

Unemployment by Race, Total

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

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	5,700	669	489	1,695	77	10,594	7,274
Fresno County, CA	7,593	2,408	785	3,603	24	9,627	9,213
Kern County, CA	9,265	2,781	562	1,220	76	6,236	7,187
Kings County, CA	1,438	340	124	164	31	1,530	1,134
Monterey County, CA	3,091	251	129	796	164	2,733	1,622
San Benito County, CA	465	2	27	17	2	381	499
Tulare County, CA	3,834	272	357	676	31	6,417	3,890
California	413,831	106,059	18,806	158,934	6,166	236,196	227,927
United States	4,184,342	1,757,752	108,909	456,672	22,627	698,102	1,076,447

Data Source: US Census Bureau, American Community Survey. 2019-23.

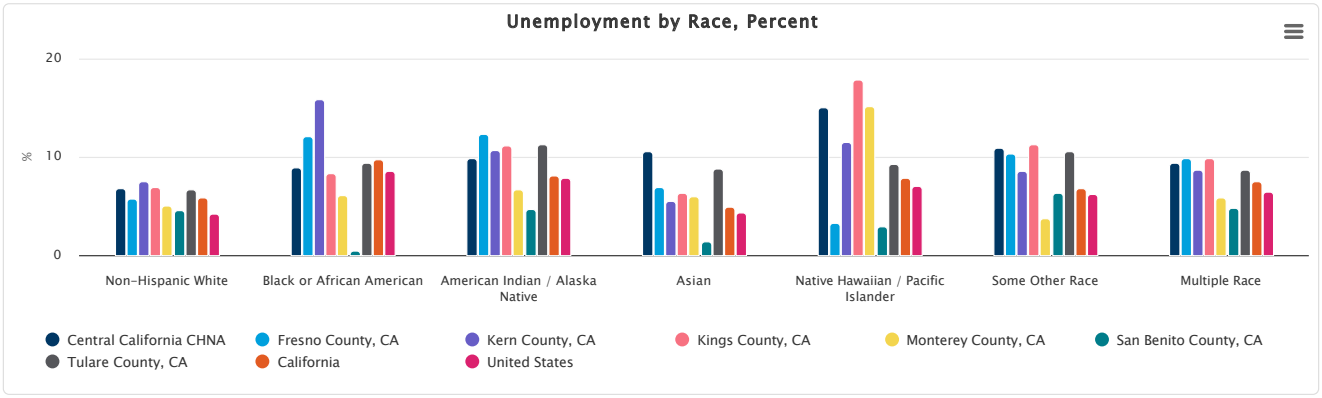


Unemployment by Race, Percent

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

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	6.72%	8.84%	9.82%	10.54%	15.01%	10.92%	9.38%
Fresno County, CA	5.70%	12.06%	12.30%	6.85%	3.27%	10.28%	9.81%
Kern County, CA	7.49%	15.78%	10.67%	5.45%	11.45%	8.54%	8.60%
Kings County, CA	6.92%	8.30%	11.16%	6.28%	17.82%	11.19%	9.78%
Monterey County, CA	5.03%	6.11%	6.69%	5.94%	15.12%	3.68%	5.81%
San Benito County, CA	4.50%	0.43%	4.65%	1.30%	2.90%	6.27%	4.71%
Tulare County, CA	6.64%	9.39%	11.22%	8.72%	9.28%	10.49%	8.61%
California	5.81%	9.76%	8.07%	4.88%	7.88%	6.77%	7.44%
United States	4.17%	8.58%	7.87%	4.28%	7.05%	6.21%	6.40%

Data Source: US Census Bureau, American Community Survey. 2019-23.

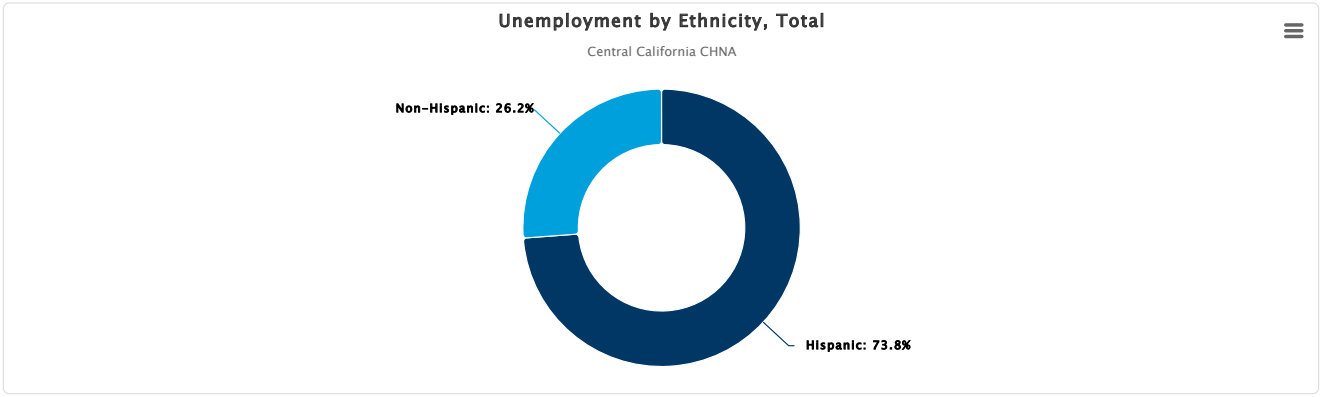


Unemployment by Ethnicity, Total

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

Report Area	Hispanic	Non-Hispanic
Central California CHNA	24,319	8,627
Fresno County, CA	24,644	15,127
Kern County, CA	18,208	14,841
Kings County, CA	3,643	2,144
Monterey County, CA	5,342	4,726
San Benito County, CA	1,509	529
Tulare County, CA	13,663	5,025
California	537,311	744,948
United States	1,889,916	6,869,401

Data Source: US Census Bureau, American Community Survey. 2019-23.

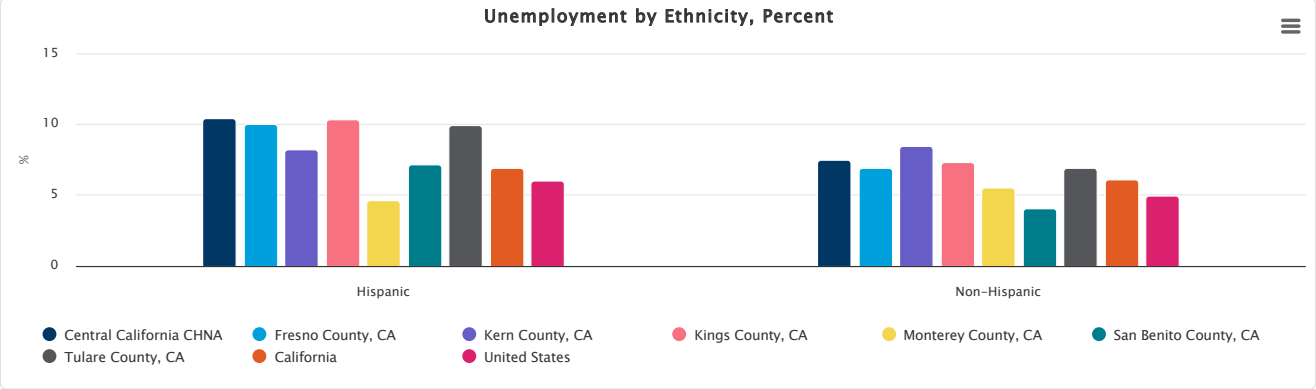


Unemployment by Ethnicity, Percent

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

Report Area	Hispanic	Non-Hispanic
Central California CHNA	10.40%	7.43%
Fresno County, CA	10.01%	6.86%
Kern County, CA	8.20%	8.42%
Kings County, CA	10.33%	7.27%
Monterey County, CA	4.58%	5.49%
San Benito County, CA	7.14%	4.04%
Tulare County, CA	9.88%	6.85%
California	6.87%	6.04%
United States	6.00%	4.97%

Data Source: US Census Bureau, American Community Survey. 2019-23.

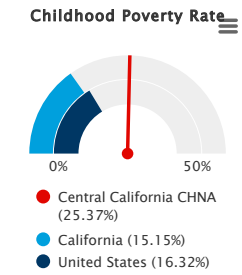


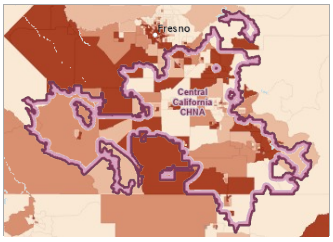
Income - Childhood Poverty Rate

In the report area 25.37% or 58,194 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population < Age 18	Population < Age 18 in Poverty	Childhood Poverty Rate
Central California CHNA	769,408	229,349	58,194	**25.37%**
Fresno County, CA	994,567	278,756	70,989	25.47%
Kern County, CA	886,335	258,663	66,762	25.81%
Kings County, CA	139,672	41,112	9,702	23.60%
Monterey County, CA	419,124	111,276	20,085	18.05%
San Benito County, CA	65,660	16,528	1,772	10.72%
Tulare County, CA	470,078	141,134	33,980	24.08%
California	38,529,452	8,590,409	1,301,440	15.15%
United States	324,567,147	72,472,636	11,829,878	16.32%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





View larger map

Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2019-23

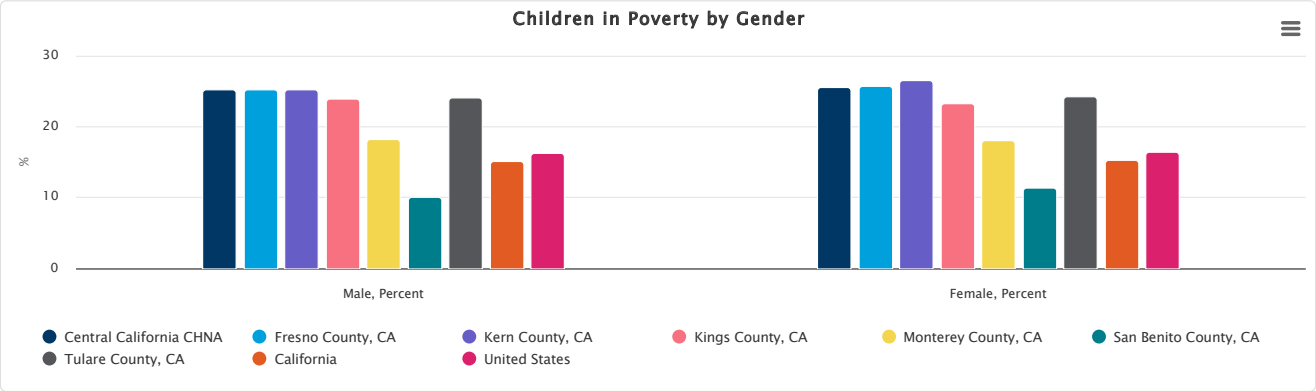
- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Central California CHNA

Children in Poverty by Gender

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

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	29,586	28,608	25.25%	25.51%
Fresno County, CA	35,804	35,185	25.20%	25.75%
Kern County, CA	33,206	33,556	25.18%	26.47%
Kings County, CA	4,983	4,719	23.96%	23.23%
Monterey County, CA	10,234	9,851	18.11%	17.99%
San Benito County, CA	833	939	10.06%	11.39%
Tulare County, CA	17,269	16,711	24.01%	24.15%
California	662,455	638,985	15.07%	15.24%
United States	6,037,616	5,792,262	16.28%	16.37%

Data Source: US Census Bureau, American Community Survey. 2019-23.

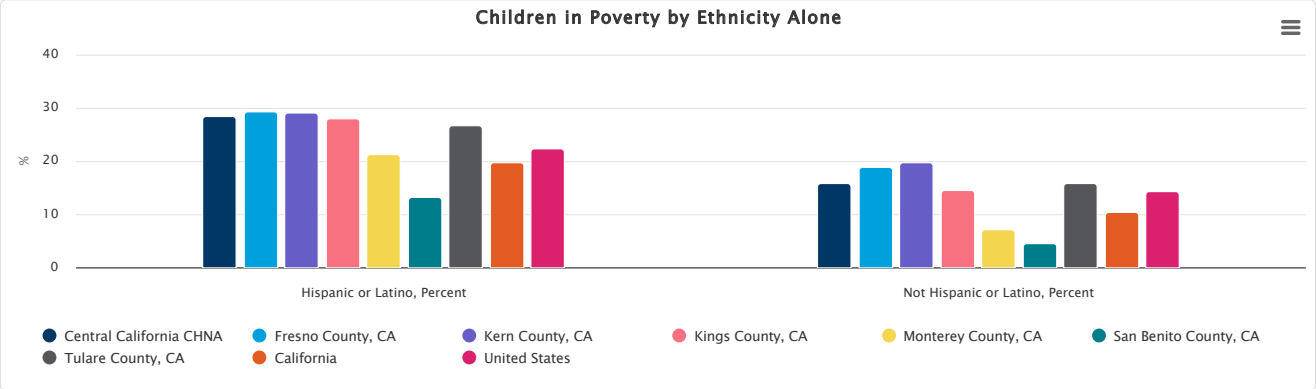


Children in Poverty by Ethnicity Alone

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

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	50,229	7,965	28.31%	15.75%
Fresno County, CA	52,342	18,647	29.16%	18.78%
Kern County, CA	49,330	17,432	29.03%	19.64%
Kings County, CA	7,831	1,871	27.83%	14.42%
Monterey County, CA	18,370	1,715	21.16%	7.01%
San Benito County, CA	1,563	209	13.16%	4.49%
Tulare County, CA	28,640	5,340	26.68%	15.81%
California	872,964	428,476	19.71%	10.30%
United States	4,180,720	7,649,158	22.26%	14.25%

Data Source: US Census Bureau, American Community Survey. 2019-23.

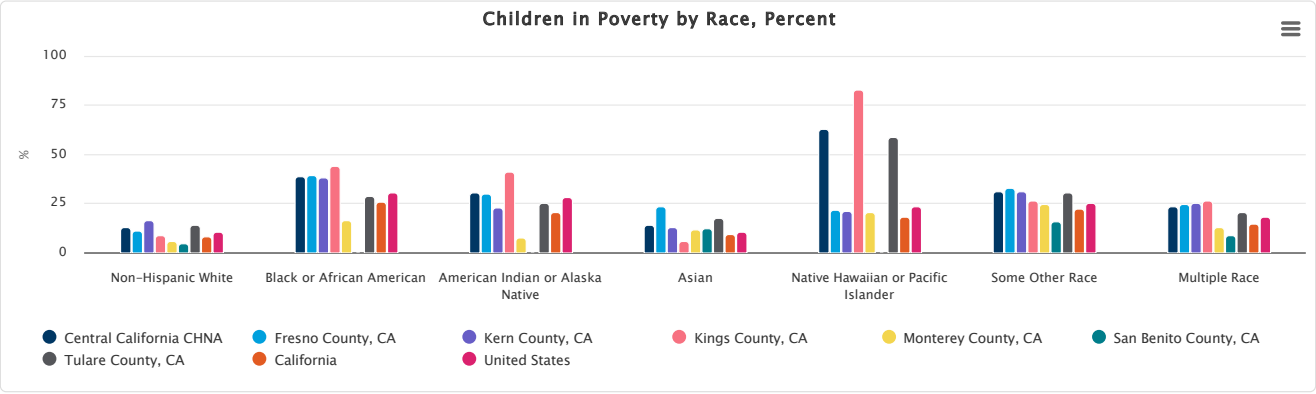


Children in Poverty by Race, Percent

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

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	12.68%	38.74%	30.56%	13.64%	62.50%	30.61%	23.25%
Fresno County, CA	10.67%	39.04%	29.90%	22.97%	21.59%	32.45%	24.26%
Kern County, CA	16.13%	38.16%	22.87%	12.66%	21.16%	30.87%	24.94%
Kings County, CA	8.68%	43.90%	40.59%	5.46%	82.72%	25.95%	25.96%
Monterey County, CA	5.34%	15.98%	7.51%	11.64%	20.05%	24.58%	12.61%
San Benito County, CA	4.51%	0.00%	0.00%	12.14%	0.00%	15.87%	8.38%
Tulare County, CA	14.10%	28.34%	25.08%	17.19%	58.45%	30.46%	20.52%
California	7.82%	25.58%	20.38%	9.39%	17.71%	22.10%	14.39%
United States	10.03%	30.17%	27.96%	10.09%	23.01%	24.72%	17.65%

Data Source: US Census Bureau, American Community Survey. 2019-23.

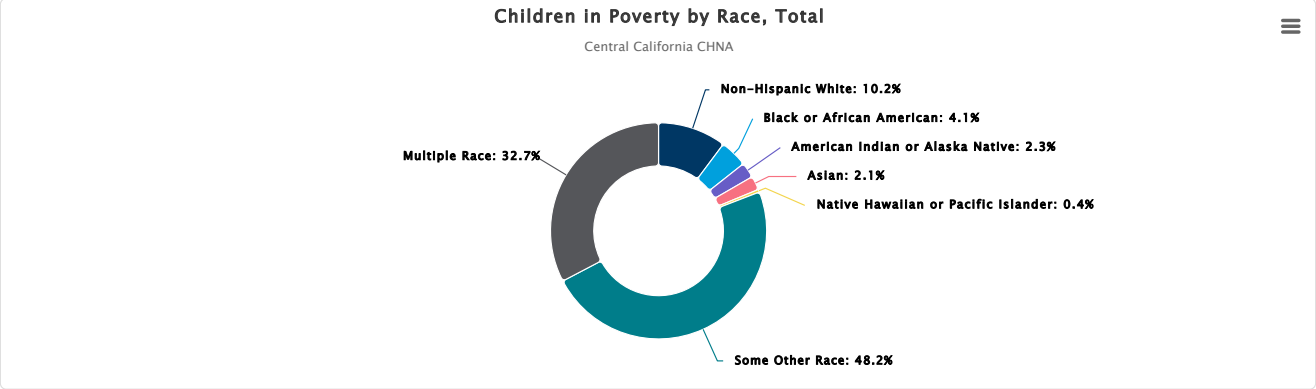


Children in Poverty by Race, Total

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

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	4,378	1,770	993	895	175	20,637	14,004
Fresno County, CA	4,881	4,414	1,145	6,943	114	19,330	18,180
Kern County, CA	8,940	5,105	551	1,329	73	15,491	16,191
Kings County, CA	713	821	291	44	67	2,462	2,706
Monterey County, CA	816	214	42	447	86	14,258	2,345
San Benito County, CA	150	0	0	59	0	354	583
Tulare County, CA	3,332	608	486	717	128	13,692	7,078
California	159,032	110,186	20,317	100,971	5,448	389,279	294,258
United States	3,485,516	2,945,781	207,029	375,774	35,256	1,470,871	2,097,833

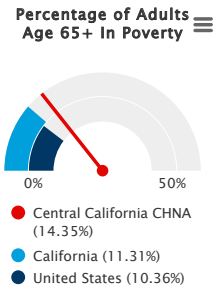
Data Source: US Census Bureau, American Community Survey. 2019-23.



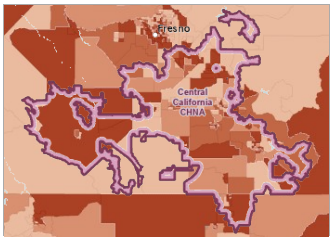
Income - Senior Poverty Rate

In the report area 14.35% or 12,336 older adults aged 65 or older are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Age 65+	Population Age 65+ in Poverty	Population Age 65+ in Poverty, Percent
Central California CHNA	769,408	85,940	12,336	**14.35%**
Fresno County, CA	994,567	126,060	18,415	14.61%
Kern County, CA	886,335	104,013	15,549	14.95%
Kings County, CA	139,672	15,728	1,657	10.54%
Monterey County, CA	419,124	62,143	6,715	10.81%
San Benito County, CA	65,660	8,815	725	8.22%
Tulare County, CA	470,078	54,607	7,240	13.26%
California	38,529,452	5,889,841	666,273	11.31%
United States	324,567,147	54,579,391	5,654,531	10.36%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

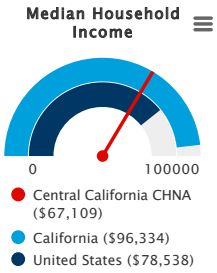
Population Below the Poverty Level, Senior (Age 65+), Percent by Tract, ACS 2019-23

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

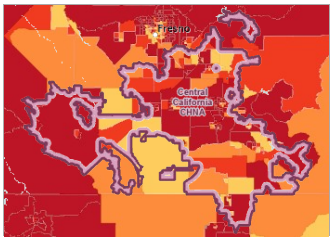
Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 230,069 households in the report area, with an average income of $86,115 and a median income of $67,109.

Report Area	Total Households	Average Household Income	Median Household Income
Central California CHNA	230,069	$86,115	**$67,109**
Fresno County, CA	322,163	$97,005.29	$71,434
Kern County, CA	281,416	$91,401.00	$67,660
Kings County, CA	43,736	$86,267.72	$68,750
Monterey County, CA	132,046	$128,334.16	$94,486
San Benito County, CA	20,188	$138,188.77	$108,289
Tulare County, CA	142,026	$90,157.44	$69,489
California	13,434,847	$136,729.66	$96,334
United States	127,482,865	$110,490.58	$78,538



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Median Household Income by Tract, ACS 2019-23

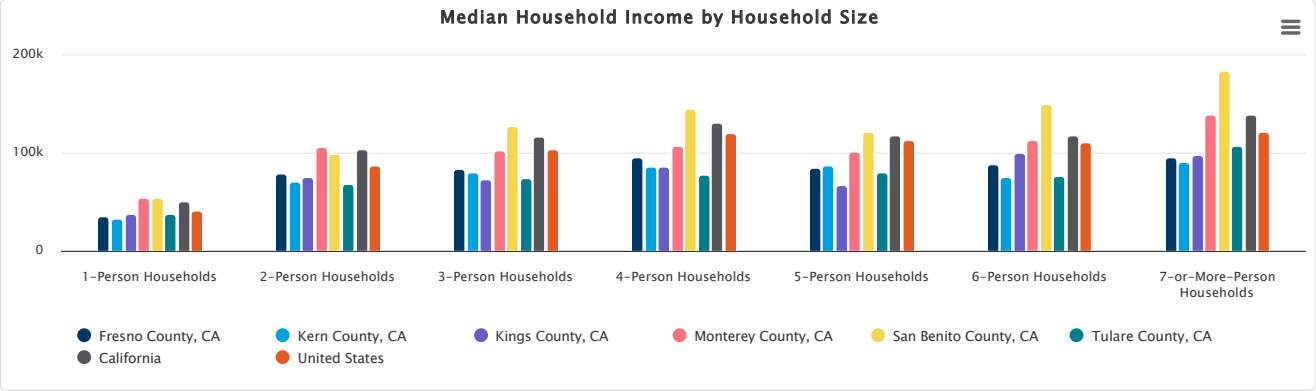
- Over $70,000
- $60,000 - $70,000
- $50,000 - $59,999
- Under $50,000
- No Data or Data Suppressed
- Central California CHNA

Median Household Income by Household Size

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

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Fresno County, CA	$34,448	$78,376	$83,448	$94,830	$83,873	$87,492	$94,288
Kern County, CA	$31,986	$69,492	$79,955	$85,083	$86,540	$74,976	$89,457
Kings County, CA	$37,180	$74,521	$72,511	$85,043	$66,882	$99,688	$97,109
Monterey County, CA	$53,400	$104,987	$101,318	$106,438	$100,963	$112,523	$137,696
San Benito County, CA	$53,186	$98,404	$126,250	$143,750	$120,739	$149,016	$182,917
Tulare County, CA	$36,482	$67,787	$73,101	$77,037	$79,045	$75,746	$105,966
California	$49,595	$102,789	$115,509	$129,753	$117,386	$116,568	$138,755
United States	$40,456	$86,971	$102,372	$118,913	$111,952	$109,893	$120,082

Data Source: US Census Bureau, American Community Survey. 2019-23.

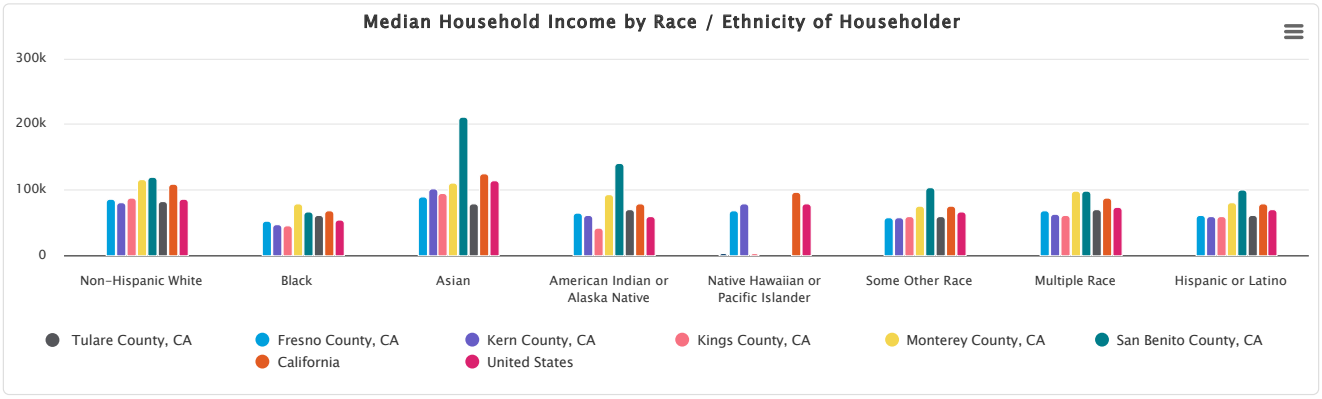


Median Household Income by Race / Ethnicity of Householder

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

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Fresno County, CA	$85,064	$51,280	$88,247	$63,992	$67,868	$57,945	$67,479	$60,754
Kern County, CA	$80,401	$46,541	$101,199	$60,375	$78,125	$57,787	$62,942	$59,498
Kings County, CA	$86,480	$44,240	$95,217	$40,917	$2,499	$58,469	$61,081	$59,072
Monterey County, CA	$116,317	$78,750	$109,731	$92,361	No data	$74,717	$98,204	$79,579
San Benito County, CA	$118,801	$65,385	$210,673	$140,972	No data	$103,662	$98,696	$100,204
Tulare County, CA	$82,643	$61,105	$78,750	$69,375	No data	$58,634	$69,290	$61,418
California	$109,049	$67,365	$125,149	$78,909	$96,758	$74,377	$87,968	$78,763
United States	$84,745	$53,444	$113,106	$59,393	$78,640	$65,558	$73,412	$68,890

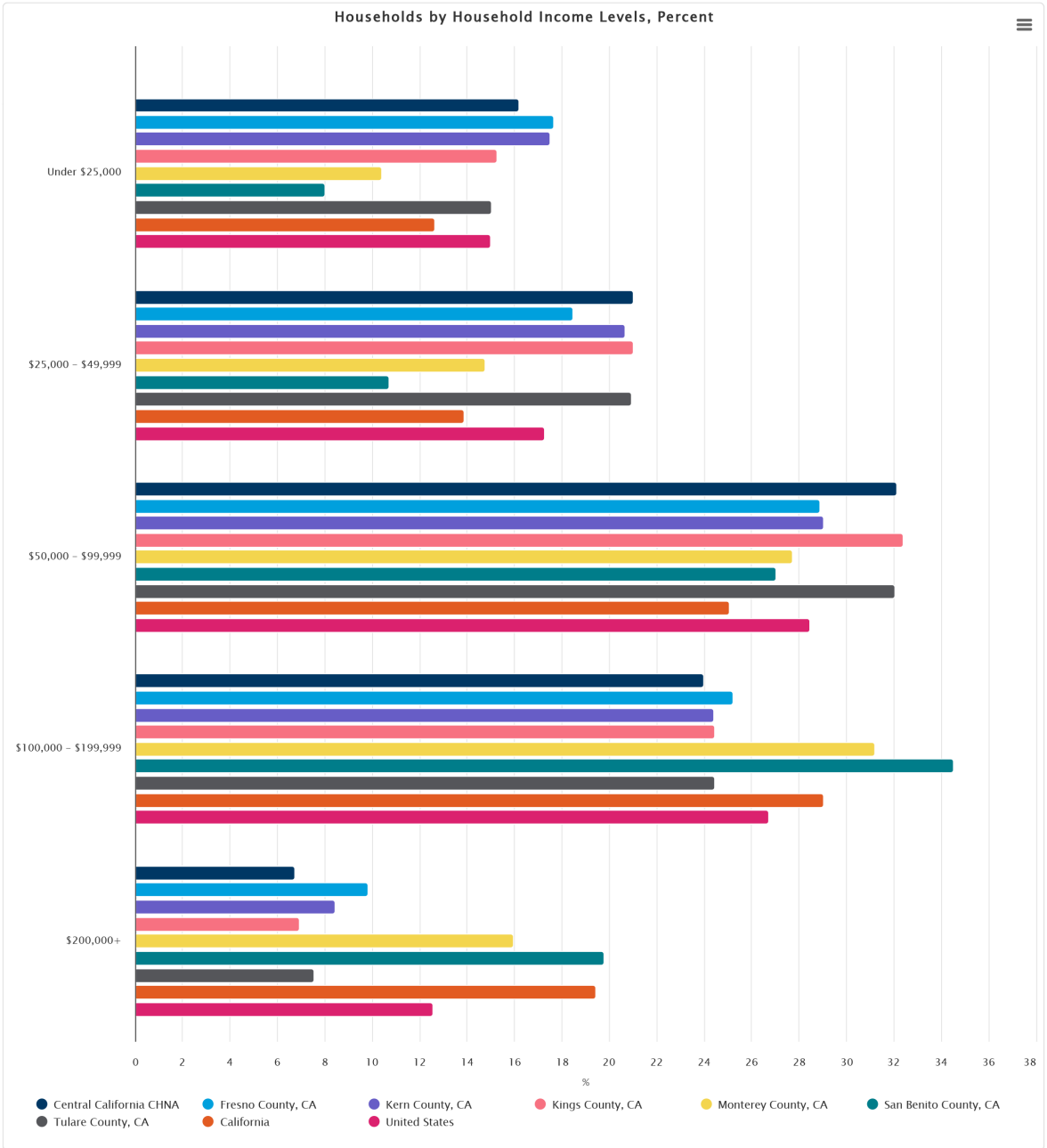
Data Source: US Census Bureau, American Community Survey. 2019-23.



Households by Household Income Levels, Percent

Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Central California CHNA	16.17%	21.01%	32.10%	23.97%	6.75%
Fresno County, CA	17.65%	18.46%	28.87%	25.20%	9.81%
Kern County, CA	17.51%	20.64%	29.02%	24.39%	8.44%
Kings County, CA	15.25%	20.99%	32.39%	24.45%	6.93%
Monterey County, CA	10.38%	14.74%	27.72%	31.19%	15.97%
San Benito County, CA	8.02%	10.70%	27.01%	34.51%	19.76%
Tulare County, CA	15.04%	20.94%	32.03%	24.43%	7.56%
California	12.62%	13.87%	25.05%	29.03%	19.43%
United States	15.00%	17.28%	28.46%	26.70%	12.56%

Data Source: US Census Bureau, American Community Survey. 2019-23.



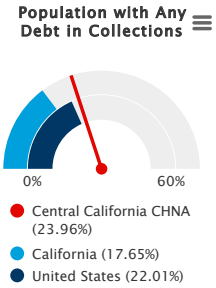
Security - Population with Debt

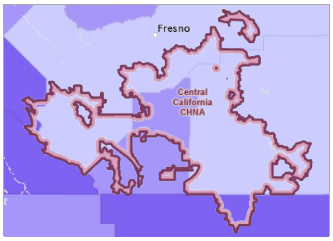
This indicator reports data from a 2 percent nationally representative panel of deidentified, consumer-level records from a major credit bureau at the national, state, and county levels for the 50 states and Washington, DC, as of 2023, compiled by the Urban Institute. The share with any debt in collections and the median debt in collections within the report area are shown as below. The Share with Any Debt in Collections is defined as the share of people with a credit bureau record who have any debt in collections. This includes past-due credit lines that have been closed and charged-off on the creditor's books as well as unpaid bills reported to the credit bureaus that the creditor is attempting to collect. The Median Debt in Collections is the median amount of all debt in collections among those with any debt in collections.

Note: Credit bureau metrics are not reported when they are based on fewer than 50 people.

Report Area	Share with Any Debt in Collections	Median Debt in Collections
Central California CHNA	**23.96%**	No data
Fresno County, CA	23.65%	$2,090
Kern County, CA	26.78%	$2,224
Kings County, CA	24.72%	$2,026
Monterey County, CA	18.25%	$2,756
San Benito County, CA	19.70%	$2,418.5
Tulare County, CA	23.34%	$1,950
California	17.65%	$2,276
United States	22.01%	$2,123

Note: This indicator is compared to the state average.
Data Source: Debt in America, The Urban Institute. 2019-24.





View larger map

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

- Over $2,000
- $1,701 - $2,000
- $1,401 - $1,700
- Under $1,401
- No Data or Data Suppressed
- Central California CHNA

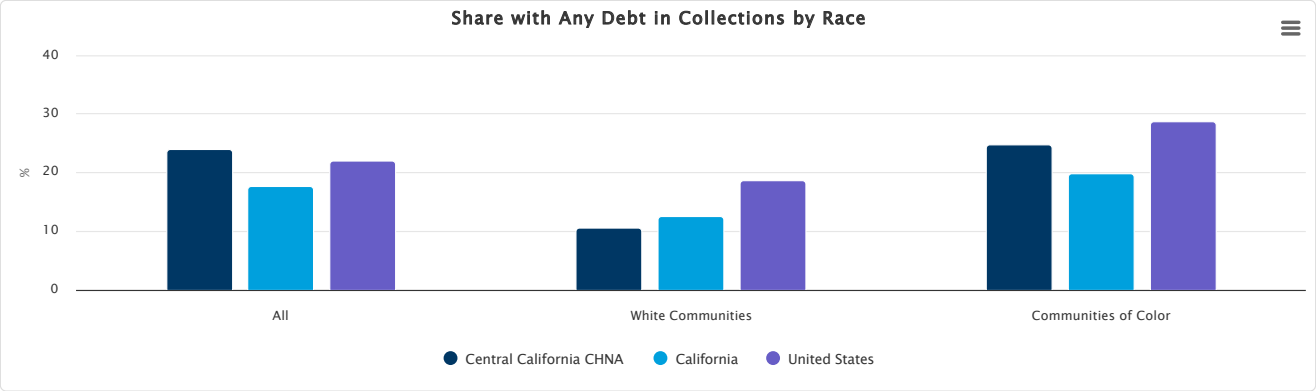
Share with Any Debt in Collections by Race

The table below reports how debt affects communities across the US in terms of race. White communities and communities of color are based on zip codes where most residents are white (at least 60 percent of the population are white) or most residents are people of color (at least 60 percent of the population are of color). As of December 2023, of all the people who have a credit bureau record in the report area, there were 23.95% that have any debt in collections. In white communites, there were 10.59% people with any debt in collections while in communities of color, this ratio is 24.65%.

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

Report Area	Share with Any Debt in Collections, All	Share with Any Debt in Collections, White Communities	Share with Any Debt in Collections, Communities of Color
Central California CHNA	23.95%	10.59%	24.65%
California	17.65%	12.55%	19.74%
United States	22.01%	18.63%	28.60%

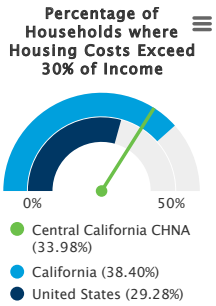
Data Source: Debt in America, The Urban Institute. 2019-24.



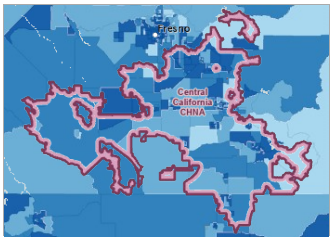
Security - Housing Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. Of the 230,069 total households in the report area, 78,172 or 33.98% of the population live in cost burdened households.

Report Area	Total Households	Cost-Burdened Households	Cost-Burdened Households, Percent
Central California CHNA	230,069	78,172	**33.98%**
Fresno County, CA	322,163	115,913	35.98%
Kern County, CA	281,416	102,854	36.55%
Kings County, CA	43,736	14,989	34.27%
Monterey County, CA	132,046	51,113	38.71%
San Benito County, CA	20,188	7,469	37.00%
Tulare County, CA	142,026	47,374	33.36%
California	13,434,847	5,158,482	38.40%
United States	127,482,865	37,330,839	29.28%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Cost Burdened Households (Housing Costs Exceed 30% of Household Income), Percent by Tract, ACS 2019-23

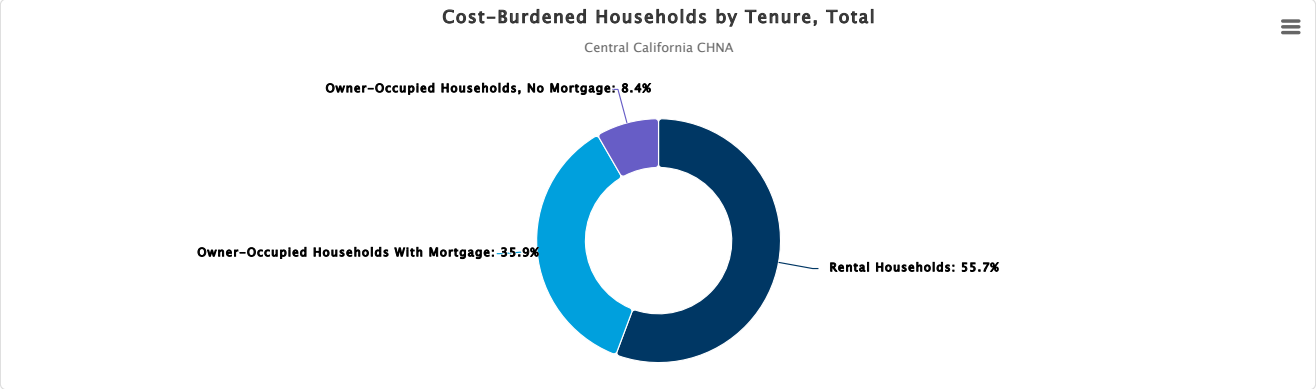
- Over 35.1%
- 28.1 - 35.0%
- 21.1 - 28.0%
- Under 21.1%
- No Data or Data Suppressed
- Central California CHNA

Cost-Burdened Households by Tenure, Total

These data show the number of households that spend more than 30% of the household income on housing costs. In the report area, there were 79,421 cost burdened households according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where household housing costs and income earned was identified in the American Community Survey.

Report Area	Cost-Burdened Households	Cost-Burdened Rental Households	Cost-Burdened Owner-Occupied Households w/ Mortgage	Cost-Burdened Owner-Occupied Households w/o Mortgage
Central California CHNA	79,421	46,325	29,894	6,946
Fresno County, CA	115,913	74,013	38,892	8,509
Kern County, CA	102,854	58,836	39,334	9,297
Kings County, CA	14,989	9,159	5,347	1,180
Monterey County, CA	51,113	33,690	16,165	3,758
San Benito County, CA	7,469	3,084	4,237	537
Tulare County, CA	47,374	27,096	18,696	3,910
California	5,158,482	3,087,543	1,911,566	387,697
United States	37,330,839	20,909,407	13,886,916	4,391,728

Data Source: US Census Bureau, American Community Survey. 2019-23.

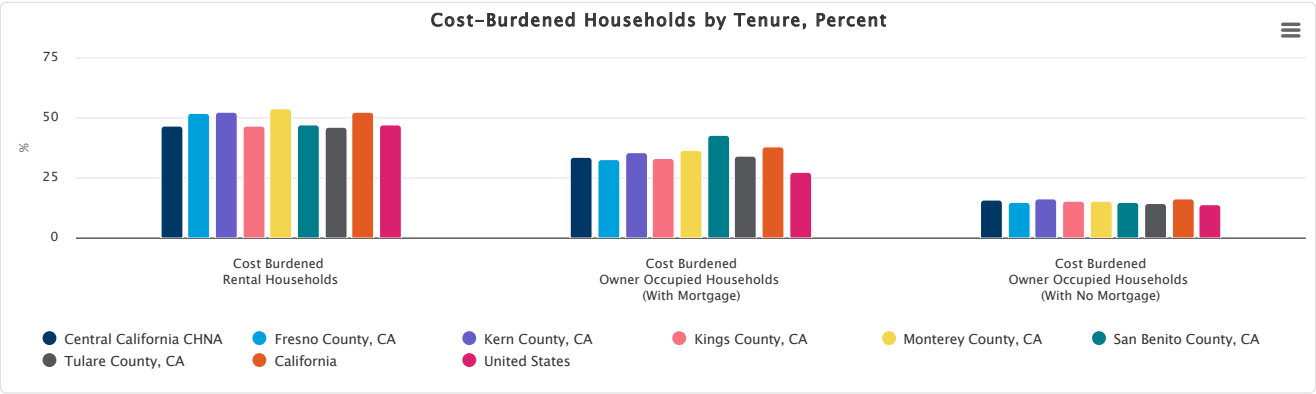


Cost-Burdened Households by Tenure, Percent

These data show the percentage of households by tenure that are cost burdened. Cost burdened rental households (those that spent more than 30% of the household income on rental costs) represented 46.29% of all of the rental households in the report area, according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 5-year estimates. The data for this indicator is only reported for households where tenure, household housing costs, and income earned was identified in the American Community Survey.

Report Area	Rental Households	Rental Households Cost-Burdened, Percent	Owner-Occupied Households w/ Mortgage	Owner-Occupied Households w/ Mortgage Cost-Burdened, Percent	Owner-Occupied Households w/o Mortgage	Owner-Occupied Households w/o Mortgage Cost-Burdened, Percent
Central California CHNA	100,076	46.29%	89,062	33.57%	44,949	15.45%
Fresno County, CA	143,630	51.53%	119,869	32.45%	58,664	14.50%
Kern County, CA	113,095	52.02%	111,333	35.33%	56,988	16.31%
Kings County, CA	19,760	46.35%	16,277	32.85%	7,699	15.33%
Monterey County, CA	63,013	53.47%	44,509	36.32%	24,524	15.32%
San Benito County, CA	6,575	46.90%	9,985	42.43%	3,628	14.80%
Tulare County, CA	58,773	46.10%	55,376	33.76%	27,877	14.03%
California	5,940,036	51.98%	5,095,484	37.51%	2,399,327	16.16%
United States	44,590,828	46.89%	50,718,449	27.38%	32,173,588	13.65%

Data Source: US Census Bureau, American Community Survey. 2019-23.

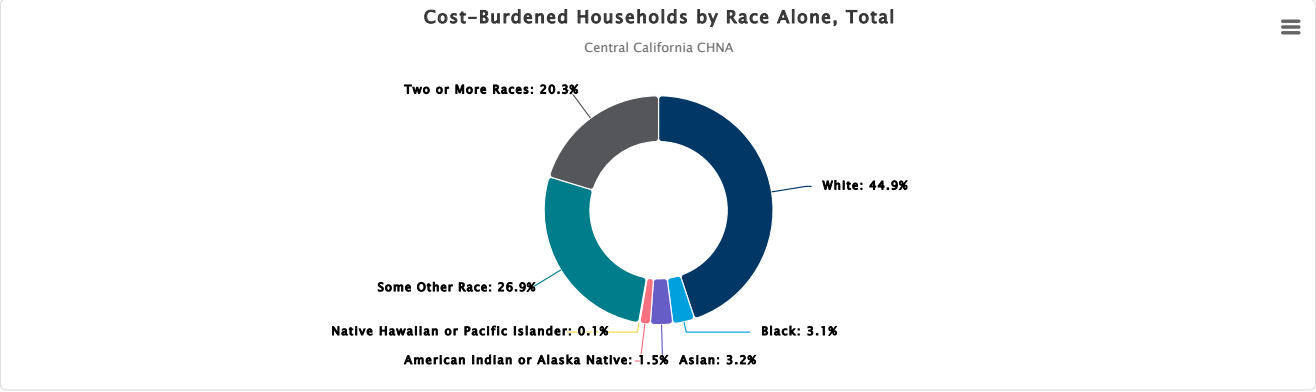


Cost-Burdened Households by Race Alone, Total

This indicator reports the number of cost-burdened households (i.e., those that spend more than 30% of their household income on housing costs) by the householder's race alone, without considering respondents' ethnicity. The data for this indicator is only reported for households where household housing costs, income earned, and race was identified in the 2019-23 American Community Survey.

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Two or More Races
Central California CHNA	35,095	2,428	2,475	1,170	113	21,044	15,847
Fresno County, CA	52,600	7,507	10,314	1,885	297	22,065	21,245
Kern County, CA	52,858	7,603	3,721	1,548	181	16,620	20,323
Kings County, CA	7,225	1,431	472	288	17	3,040	2,516
Monterey County, CA	21,760	1,329	3,035	397	304	18,801	5,487
San Benito County, CA	4,029	203	167	60	24	997	1,989
Tulare County, CA	22,111	852	1,297	555	73	13,447	9,039
California	2,489,148	417,444	688,466	55,030	16,993	792,452	698,949
United States	22,465,807	6,393,544	1,974,714	286,541	67,283	2,530,433	3,612,517

Data Source: US Census Bureau, American Community Survey. 2019-23.

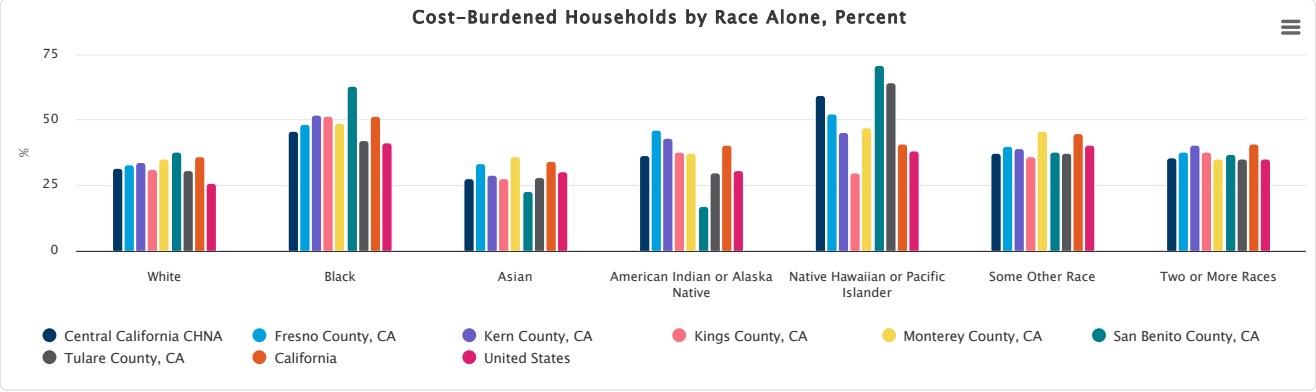


Cost-Burdened Households by Race Alone, Percent

This indicator reports the percentage of cost-burdened households (i.e., those that spend more than 30% of their household income on housing costs) by the householder's race alone, without considering respondents' ethnicity.
The percentage values could be interpreted as, for example, *"Of all occupied housing units with a white alone householder within the report area, the proportion whose housing costs exceed 30% of their household income in the past 12 months is (value)."* Note that data are only reported for households where household housing costs, income earned, and race was identified in the 2019-23 American Community Survey.

Report Area	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Two or More Races
Central California CHNA	31.52%	45.53%	27.55%	36.44%	59.47%	37.17%	35.70%
Fresno County, CA	32.92%	48.52%	33.42%	46.22%	52.11%	40.11%	37.68%
Kern County, CA	33.66%	51.99%	28.88%	42.98%	45.14%	39.20%	40.27%
Kings County, CA	31.01%	51.42%	27.73%	37.94%	29.82%	36.04%	37.55%
Monterey County, CA	34.94%	48.65%	35.93%	37.31%	46.84%	45.69%	34.90%
San Benito County, CA	37.64%	63.04%	22.54%	16.81%	70.59%	37.67%	36.96%
Tulare County, CA	30.78%	42.05%	28.23%	29.87%	64.04%	37.46%	35.16%
California	35.81%	51.44%	34.15%	40.37%	40.64%	44.89%	40.82%
United States	25.61%	41.10%	30.02%	30.74%	37.97%	40.56%	35.13%

Data Source: US Census Bureau, American Community Survey. 2019-23.



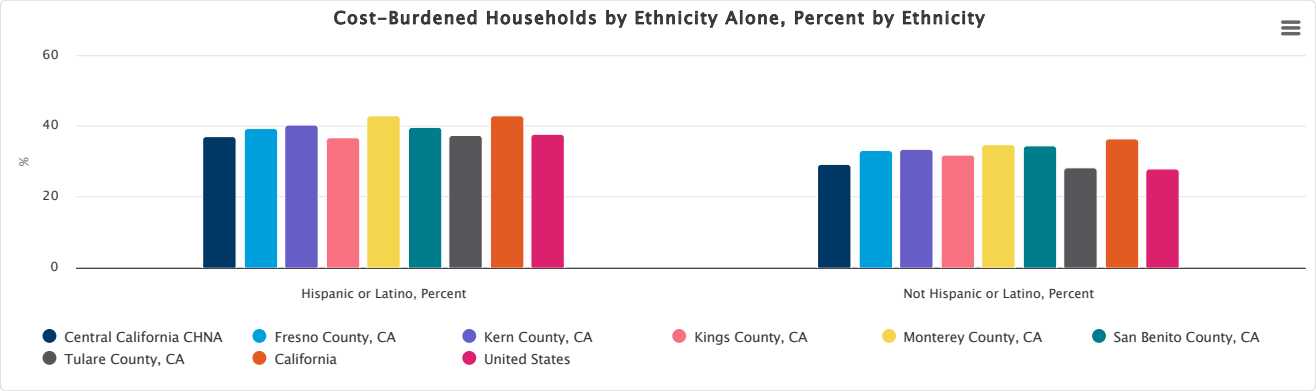
Cost-Burdened Households by Ethnicity Alone, Percent by Ethnicity

This indicator reports the percentage of households that spend more than 30% of their household income on housing costs by ethnicity alone during 2019-2023, according to the American Community Survey (ACS). Note that the data for this indicator are only reported for households where housing costs, income earned, and ethnicity were identified in the American Community Survey.

Within the report area, there were 51,097 cost-burdened households of Hispanic or Latino origin, representing 37.10% of the Hispanic or Latino households. There were 27,075 cost-burdened households of non-Hispanic or Latino origin in the report area, representing 29.32% of the total non-Hispanic households.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	51,097	27,075	37.10%	29.32%
Fresno County, CA	58,302	57,611	39.24%	33.19%
Kern County, CA	52,239	50,615	40.17%	33.44%
Kings County, CA	7,987	7,002	36.61%	31.95%
Monterey County, CA	27,135	23,978	42.92%	34.84%
San Benito County, CA	4,075	3,394	39.64%	34.26%
Tulare County, CA	29,836	17,538	37.22%	28.35%
California	1,771,076	3,387,406	43.00%	36.36%
United States	6,921,852	30,408,987	37.78%	27.86%

Data Source: US Census Bureau, American Community Survey. 2019-23.



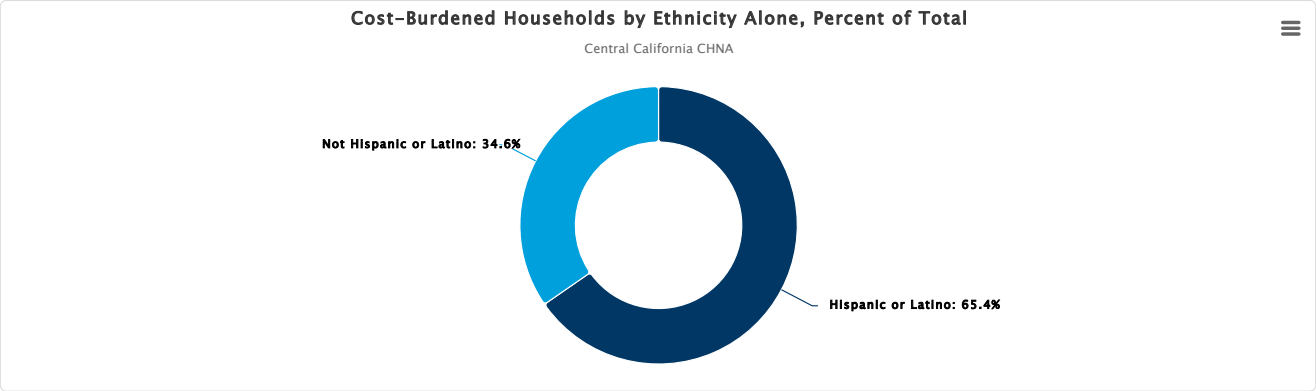
Cost-Burdened Households by Ethnicity Alone, Percent of Total

This indicator reports the percentage of households that spend more than 30% of their household income on housing costs by ethnicity alone during 2019-2023, according to the American Community Survey (ACS). Note that the data for this indicator are only reported for households where housing costs, income earned, and ethnicity were identified in the American Community Survey.

Within the report area, there were 51,097 cost-burdened households of Hispanic or Latino origin, representing 65.36% of the total cost-burdened households. There were 27,075 cost-burdened households of non-Hispanic or Latino origin in the report area, representing 34.64% of the total cost-burdened households.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	51,097	27,075	65.36%	34.64%
Fresno County, CA	58,302	57,611	50.30%	49.70%
Kern County, CA	52,239	50,615	50.79%	49.21%
Kings County, CA	7,987	7,002	53.29%	46.71%
Monterey County, CA	27,135	23,978	53.09%	46.91%
San Benito County, CA	4,075	3,394	54.56%	45.44%
Tulare County, CA	29,836	17,538	62.98%	37.02%
California	1,771,076	3,387,406	34.33%	65.67%
United States	6,921,852	30,408,987	18.54%	81.46%

Data Source: US Census Bureau, American Community Survey. 2019-23.



Mental Health

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

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

The growing prevalence of mental health as an issue is affecting many community residents. People note a wide variety of factors that contribute to poor mental health, such as adverse childhood experiences and poverty. One focus group participant noted that the unhoused population with serious mental health disorders "don't have access to adequate mental health services or if they need to be on medication, they can't afford the medication because they don't have insurance." In the Central California service area, nearly one in five adults (19.6%) self-reported as having poor mental health, which can negatively impact overall health outcomes. Moreover, three out of every ten people on Medicare have been diagnosed with mental health and substance use prevalence. Focus group participants note that there is often "a waitlist for mental health providers, which if you [are] in crisis, you're going to have to call 9-1-1."

Community health and wellness can be difficult to achieve when indicators of poor mental health and the factors undermining them are prevalent. Opportunities to address mental health and improve outcomes do exist, despite increased risk factors. Securing more resources and programming, along with sharing existing opportunities, can improve overall health outcomes and reduce disparities. For additional data, see the following pages.

Scan QR Code to explore the full live data report on Mental Health or visit: cares.page.link/x1Jt

Data Highlights

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

"...we have a wait list for mental health providers, which if you have or [are] in crisis, you're going to have to call 911...instead of actually going to your counselor."

"...that's something I've seen with youth, their depression, their anxieties...it hits them more when they're hitting eighth grade because they can't read. They're behind in math, they're not reading...because they're very distracted with social media."

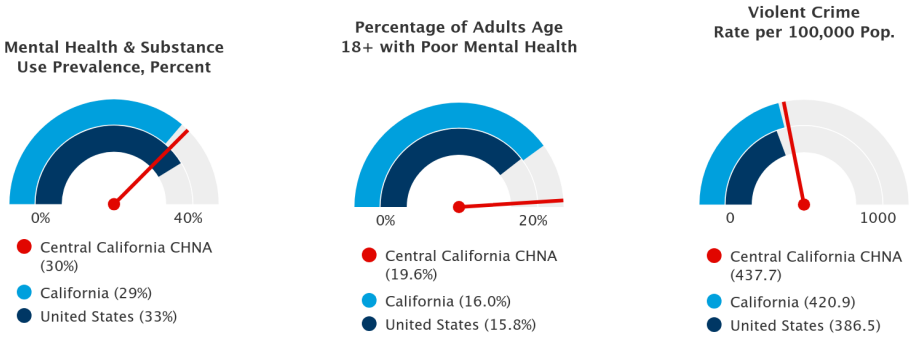
"...we know right now that a lot of kids [are] dealing with anxiety, trauma or they already tell themselves, I'm stressed."

"...serious mental health disorders really play a big part in the homeless population. And it can be really hard because...a lot of the time they don't have access to adequate mental health services or if they need to be on medication, they can't afford the medication because they don't have insurance..."

"...when you talk about the needs of mental health, you've got people who are cutters, you've got people who are bulimic...and I don't know anybody in this community that can help those specific needs."

"I think a positive trend is a focus on mental health. We do have social workers in all of our schools, so it's easier to assess somebody if a kid is having some kind of issues."

"...I do feel like the homeless population is really a symptom of a lot of other factors that we have in our community, drug use, the lack of of access and mental health early on..."



Community Resources

California Youth Crisis Hotline
800-843-5200

Central California Alliance for Health
thealliance.health/for-members/get-care/behavioral-health-care
800-700-3874

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

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

Community Health Needs Assessment Full Report

Location

Central California CHNA

Health Needs: Mental Health

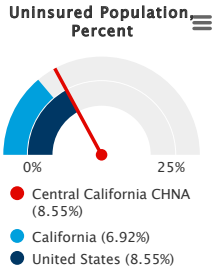
Risk Factors - Access to Care - Medical Insurance

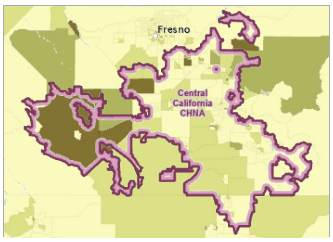
The lack of health insurance is considered a *key driver* of health status.

In the report area 8.55% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.92%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Central California CHNA	767,518	65,604	**8.55%**
Fresno County, CA	1,000,249	70,433	7.04%
Kern County, CA	888,229	69,712	7.85%
Kings County, CA	135,709	10,715	7.90%
Monterey County, CA	420,702	41,838	9.94%
San Benito County, CA	65,903	4,154	6.30%
Tulare County, CA	471,506	37,746	8.01%
California	38,761,738	2,682,732	6.92%
United States	327,425,278	28,000,876	8.55%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.





View larger map

Uninsured Population, Percent by Tract, ACS 2019-23

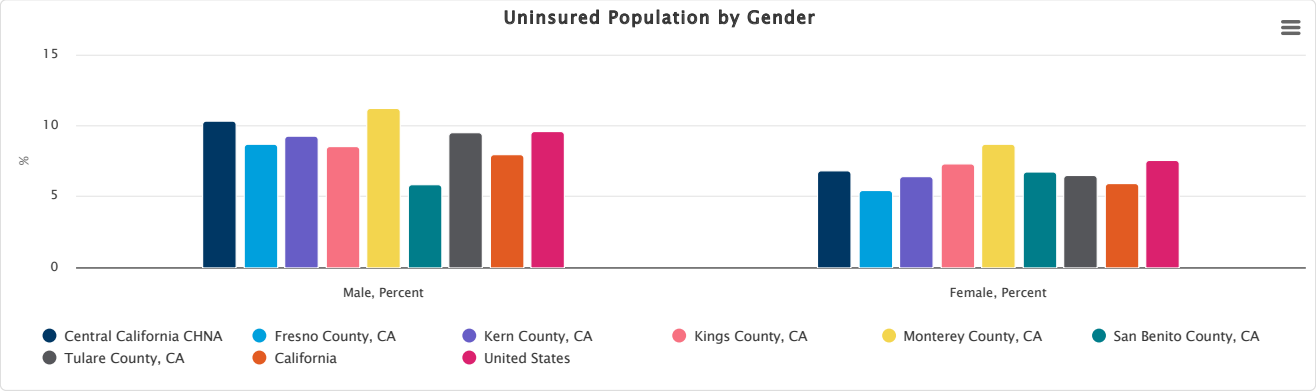
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Central California CHNA

Uninsured Population by Gender

This indicator reports the uninsured population by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
Central California CHNA	39,558	26,046	10.28%	6.81%
Fresno County, CA	43,242	27,191	8.69%	5.41%
Kern County, CA	41,040	28,672	9.26%	6.44%
Kings County, CA	5,786	4,929	8.48%	7.31%
Monterey County, CA	23,421	18,417	11.24%	8.68%
San Benito County, CA	1,942	2,212	5.85%	6.76%
Tulare County, CA	22,395	15,351	9.52%	6.50%
California	1,526,004	1,156,728	7.93%	5.92%
United States	15,443,840	12,557,036	9.59%	7.55%

Data Source: US Census Bureau, American Community Survey. 2019-23.

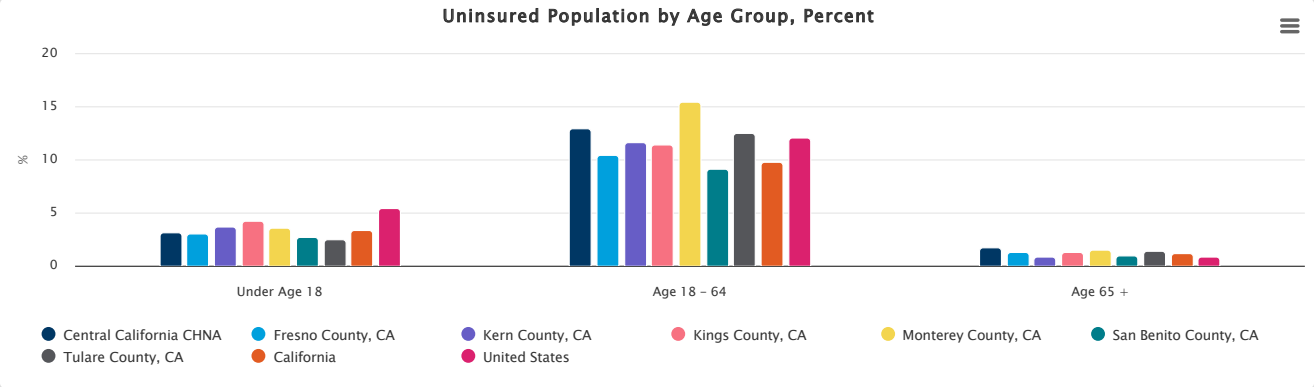


Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.
The percentage values could be interpreted as, for example, *"Of all the population under age 18 within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Under Age 18	Age 18 - 64	Age 65 +
Central California CHNA	3.12%	12.92%	1.70%
Fresno County, CA	2.97%	10.43%	1.21%
Kern County, CA	3.68%	11.55%	0.85%
Kings County, CA	4.23%	11.31%	1.29%
Monterey County, CA	3.50%	15.34%	1.52%
San Benito County, CA	2.71%	9.11%	0.88%
Tulare County, CA	2.48%	12.48%	1.41%
California	3.35%	9.77%	1.09%
United States	5.39%	11.98%	0.83%

Data Source: US Census Bureau, American Community Survey. 2019-23.

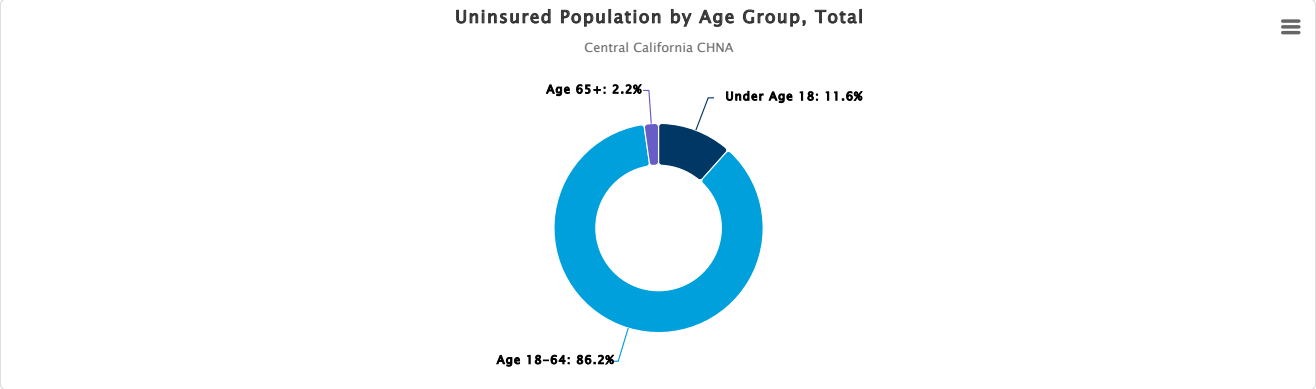


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
Central California CHNA	7,607	56,534	1,463
Fresno County, CA	8,891	60,015	1,527
Kern County, CA	10,179	58,653	880
Kings County, CA	1,828	8,684	203
Monterey County, CA	4,176	36,718	944
San Benito County, CA	478	3,598	78
Tulare County, CA	3,724	33,251	771
California	310,351	2,307,944	64,437
United States	4,208,983	23,338,717	453,176

Data Source: US Census Bureau, American Community Survey. 2019-23.

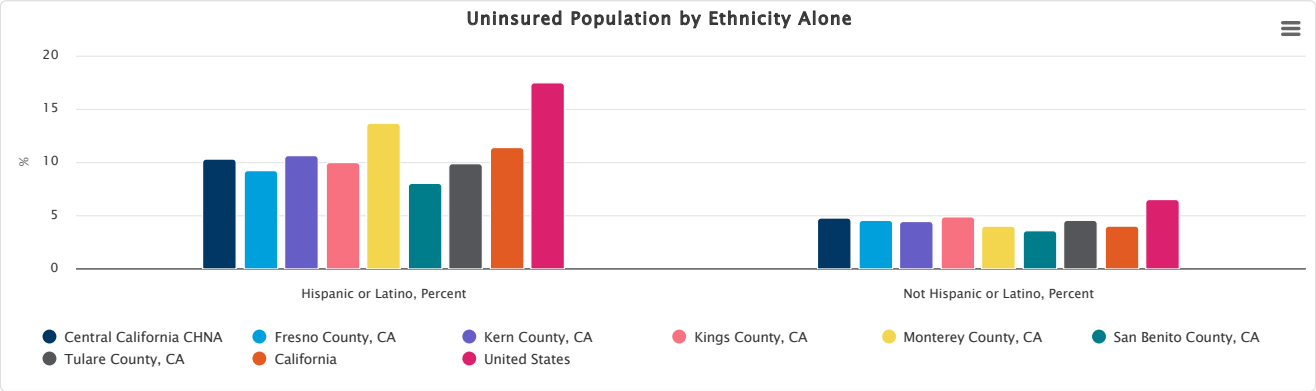


Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Central California CHNA	54,236	11,368	10.32%	4.69%
Fresno County, CA	49,545	20,888	9.14%	4.56%
Kern County, CA	52,544	17,168	10.57%	4.39%
Kings County, CA	8,095	2,620	9.99%	4.79%
Monterey County, CA	35,505	6,333	13.59%	3.97%
San Benito County, CA	3,260	894	8.00%	3.55%
Tulare County, CA	30,617	7,129	9.81%	4.47%
California	1,760,029	922,703	11.37%	3.96%
United States	10,900,185	17,100,691	17.47%	6.45%

Data Source: US Census Bureau, American Community Survey. 2019-23.

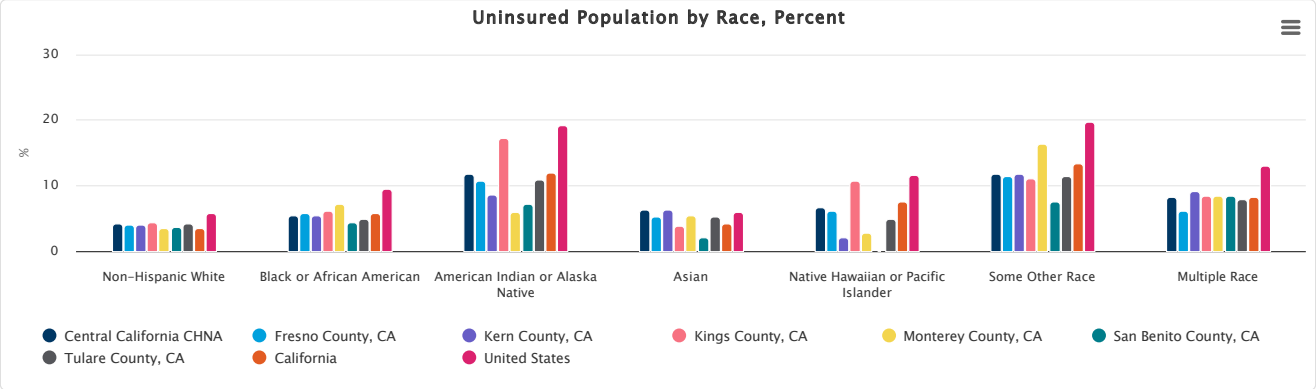


Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.
The percentage values could be interpreted as, for example, *"Of all the non-Hispanic white population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	4.20%	5.47%	11.79%	6.23%	6.60%	11.70%	8.23%
Fresno County, CA	3.99%	5.75%	10.73%	5.29%	6.13%	11.33%	6.08%
Kern County, CA	3.92%	5.42%	8.54%	6.18%	2.08%	11.73%	9.03%
Kings County, CA	4.36%	6.07%	17.15%	3.76%	10.66%	11.01%	8.33%
Monterey County, CA	3.37%	7.17%	5.90%	5.39%	2.74%	16.26%	8.44%
San Benito County, CA	3.57%	4.29%	7.16%	1.97%	0.00%	7.42%	8.45%
Tulare County, CA	4.19%	4.79%	10.82%	5.25%	4.79%	11.33%	7.78%
California	3.52%	5.65%	11.90%	4.06%	7.56%	13.37%	8.27%
United States	5.71%	9.46%	19.22%	5.89%	11.59%	19.70%	12.98%

Data Source: US Census Bureau, American Community Survey. 2019-23.

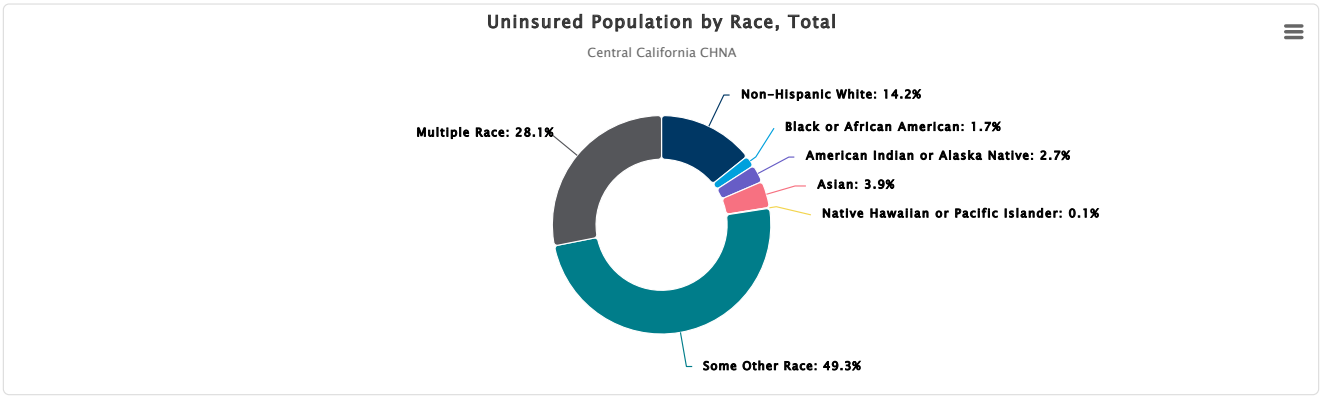


Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

Report Area	Non-Hispanic White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	7,266	843	1,353	1,995	63	25,170	14,339
Fresno County, CA	10,751	2,485	1,477	5,852	100	22,981	12,770
Kern County, CA	10,734	2,280	915	2,832	29	18,699	17,075
Kings County, CA	1,672	407	456	176	29	3,314	2,280
Monterey County, CA	3,820	521	195	1,321	58	28,387	4,847
San Benito County, CA	710	29	88	45	0	763	1,821
Tulare County, CA	5,165	333	759	877	33	15,713	7,824
California	471,187	118,238	52,186	242,128	10,982	903,127	524,941
United States	10,876,176	3,775,959	549,575	1,134,010	71,131	4,280,782	4,567,337

Data Source: US Census Bureau, American Community Survey. 2019-23.



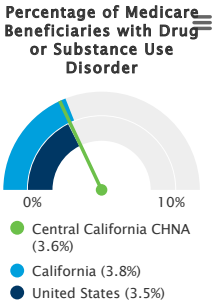
Risk Factors - Drugs & Alcohol - Substance Use Disorder

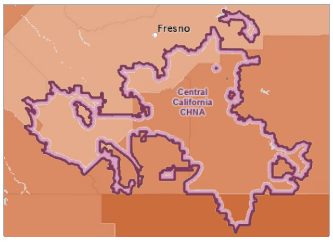
This indicator reports the percentage of the Medicare Fee-for-Service population with substance use disorder. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program.

Within the report area, there are a total of 2,500 beneficiaries with substance use disorder. This represents a 3.6% of the Medicare Fee-for-Service beneficiaries.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Drug/Substance Use Disorder	Percentage with Drug/Substance Use Disorder
Central California CHNA	69,913	2,500	3.6%
Fresno County, CA	77,958	2,247	2.9%
Kern County, CA	61,717	3,120	5.1%
Kings County, CA	12,512	403	3.2%
Monterey County, CA	53,963	1,622	3.0%
San Benito County, CA	6,717	139	2.1%
Tulare County, CA	45,846	1,703	3.7%
California	2,859,642	107,557	3.8%
United States	33,499,472	1,172,214	3.5%

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





View larger map

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

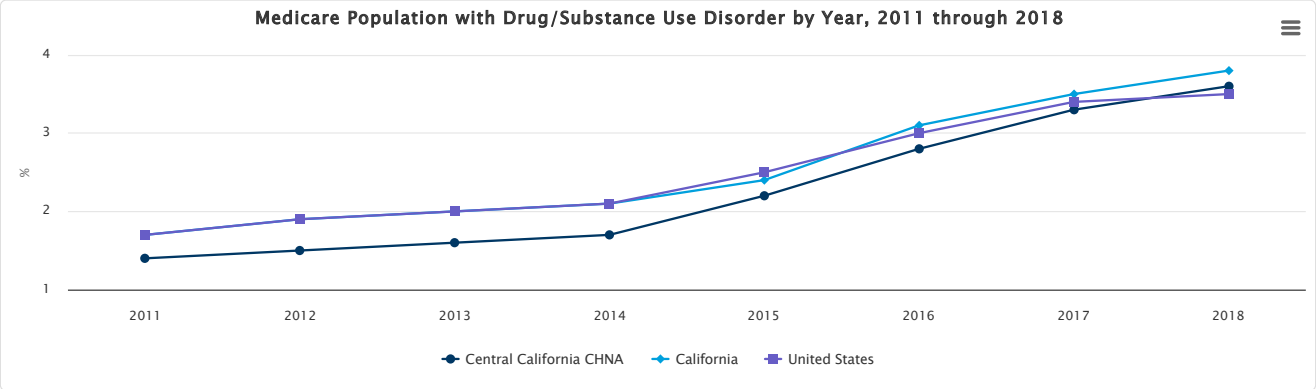
- Over 5.0%
- 3.1 - 5.0%
- 2.1 - 3.0%
- Under 2.1%
- No Data or Data Suppressed
- Central California CHNA

Medicare Population with Drug/Substance Use Disorder by Year, 2011 through 2018

This indicator reports the percentage of the Medicare Fee-for-Service population with drug or substance use disorders over time.

Report Area	2011	2012	2013	2014	2015	2016	2017	2018
Central California CHNA	1.4%	1.5%	1.6%	1.7%	2.2%	2.8%	3.3%	3.6%
California	1.7%	1.9%	2.0%	2.1%	2.4%	3.1%	3.5%	3.8%
United States	1.7%	1.9%	2.0%	2.1%	2.5%	3.0%	3.4%	3.5%

Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

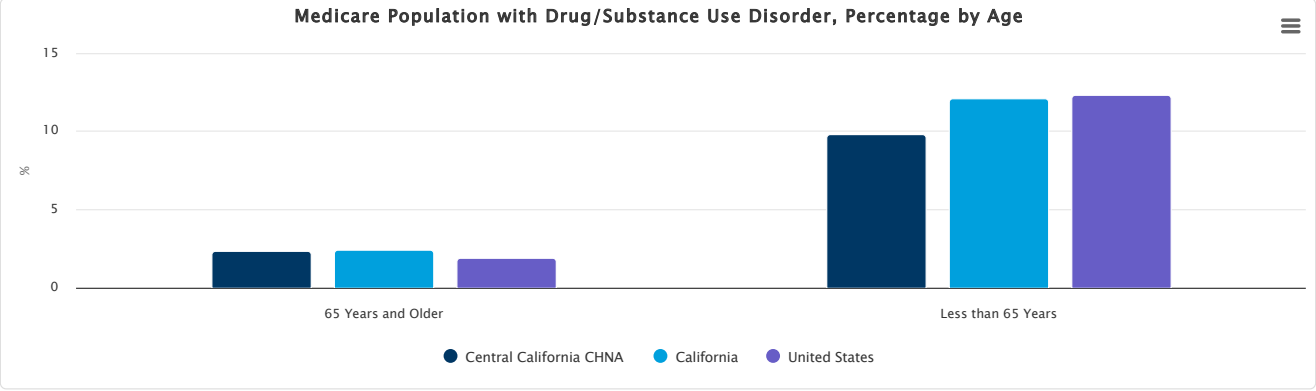


Medicare Population with Drug/Substance Use Disorder, Percentage by Age

This indicator reports the prevalence of drug or substance use disorders among Medicare beneficiaries by age.
The percentage values could be interpreted as, for example, *"Of all the Medicare beneficiaries age 65 and older within the report area, the proportion with drug or substance use disorders is (value)."*

Report Area	65 Years and Older	Less than 65 Years
Central California CHNA	2.3%	9.8%
California	2.4%	12.1%
United States	1.9%	12.3%

Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.



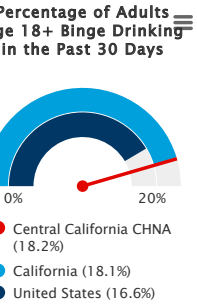
Risk Factors - Drugs & Alcohol - Binge Drinking

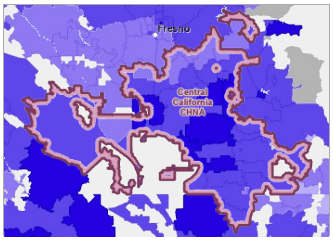
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Within the report area there are 18.2% adults age 18+ who reported having four or more drinks in the last month of the total population age 18+.

Report Area	Total Population	Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)
Central California CHNA	795,651	**18.2%**	No data
Fresno County, CA	1,015,190	16.3%	16.2%
Kern County, CA	916,108	18.1%	17.7%
Kings County, CA	152,981	19.7%	18.8%
Monterey County, CA	432,858	17.0%	17.6%
San Benito County, CA	67,579	19.6%	19.9%
Tulare County, CA	477,544	18.9%	18.6%
California	39,029,342	18.1%	18.8%
United States	333,287,557	16.6%	18.0%

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





View larger map

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

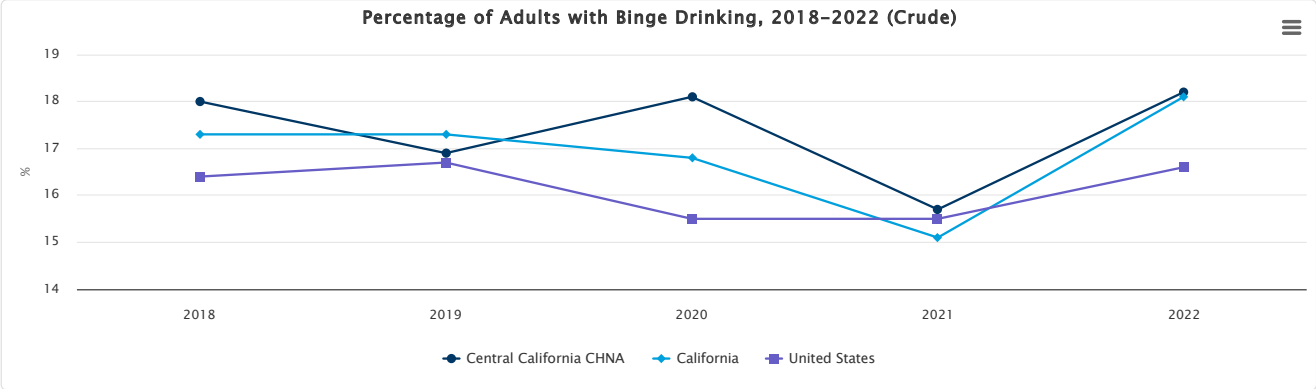
- Over 19.0%
- 16.1 - 19.0%
- 13.1 - 16.0%
- Under 13.1%
- No Data or Data Suppressed
- Central California CHNA

Percentage of Adults with Binge Drinking, 2018-2022 (Crude)

The table and chart below display annual trends in the percentage of adults age 18+ who report binge drinking.

Report Area	2018	2019	2020	2021	2022
Central California CHNA	18.0%	16.9%	18.1%	15.7%	18.2%
California	17.3%	17.3%	16.8%	15.1%	18.1%
United States	16.4%	16.7%	15.5%	15.5%	16.6%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

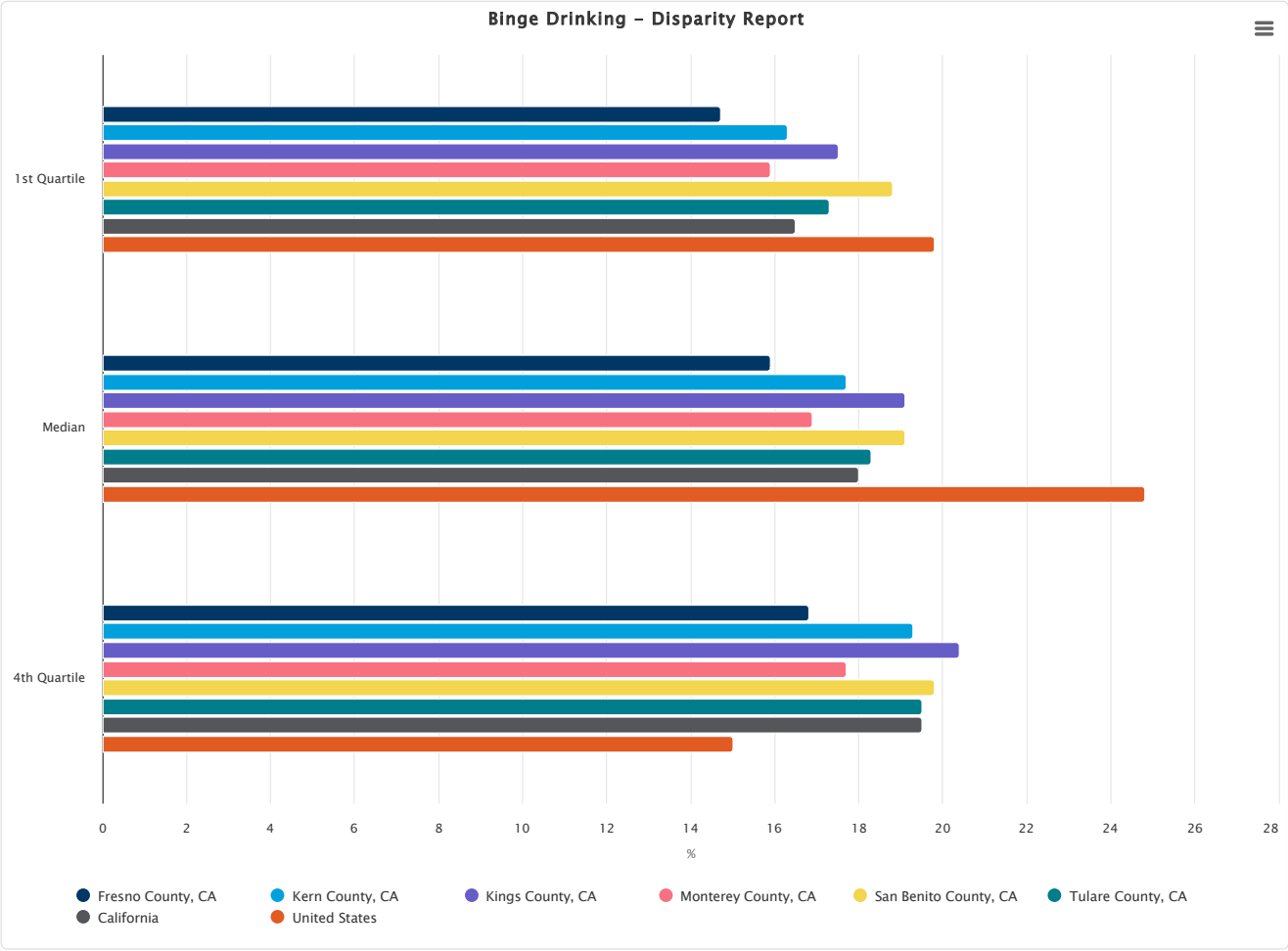


Binge Drinking - Disparity Report

The table and chart below display the median and interquartile ranges for census tract values related to the indicator.

Report Area	1st Quartile	Median	4th Quartile
Fresno County, CA	14.70%	15.90%	16.80%
Kern County, CA	16.30%	17.70%	19.30%
Kings County, CA	17.50%	19.10%	20.40%
Monterey County, CA	15.90%	16.90%	17.70%
San Benito County, CA	18.80%	19.10%	19.80%
Tulare County, CA	17.30%	18.30%	19.50%
California	16.50%	18.00%	19.50%
United States	19.80%	24.80%	15.00%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

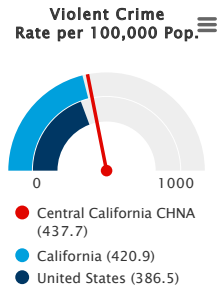


Risk Factors - Stress & Trauma - Violent Crime Rate

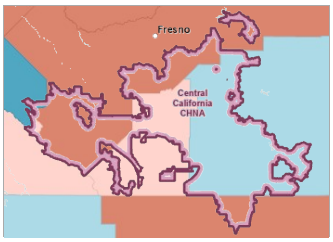
This indicator reports the rate of violent crime offenses reported by law enforcement per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. The data for this indicator are obtained from the 2022 County Health Rankings, which utilizes figures from the 2014 and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

In the report area, 3,388 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 437.7 per 100,000 residents is higher than the statewide rate of 420.9 per 100,000.
Note: Data are suppressed for counties if, for both years of available data, the population reported by agencies is less than 50% of the population reported in Census or less than 80% of agencies measuring crimes reported data.

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Central California CHNA	3,388	**437.7**
Fresno County, CA	5,264	541.8
Kern County, CA	4,797	545.3
Kings County, CA	668	443.4
Monterey County, CA	1,828	420.6
San Benito County, CA	176	298.7
Tulare County, CA	1,756	381.8
California	164,253	420.9
United States	1,240,534	386.5



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



View larger map

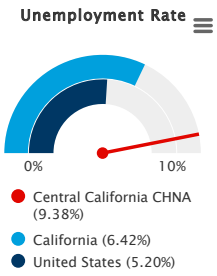
Violent Crime, Rank by County, County Health Rankings 2022

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

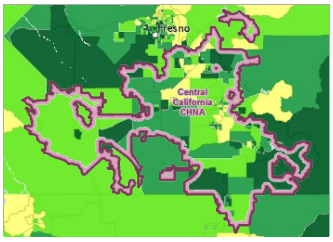
Risk Factors - Stress & Trauma - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 33,391, or 9.38% of the civilian labor force. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Central California CHNA	356,134	33,391	**9.38%**
Fresno County, CA	466,586	39,771	8.55%
Kern County, CA	398,143	33,049	8.35%
Kings County, CA	64,752	5,787	9.82%
Monterey County, CA	202,644	10,068	5.13%
San Benito County, CA	34,250	2,038	5.96%
Tulare County, CA	211,707	18,688	8.85%
California	20,144,078	1,282,259	6.42%
United States	169,855,626	8,759,317	5.20%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2019-23.



View larger map

Unemployed Workers, Percent by Tract, ACS 2019-23

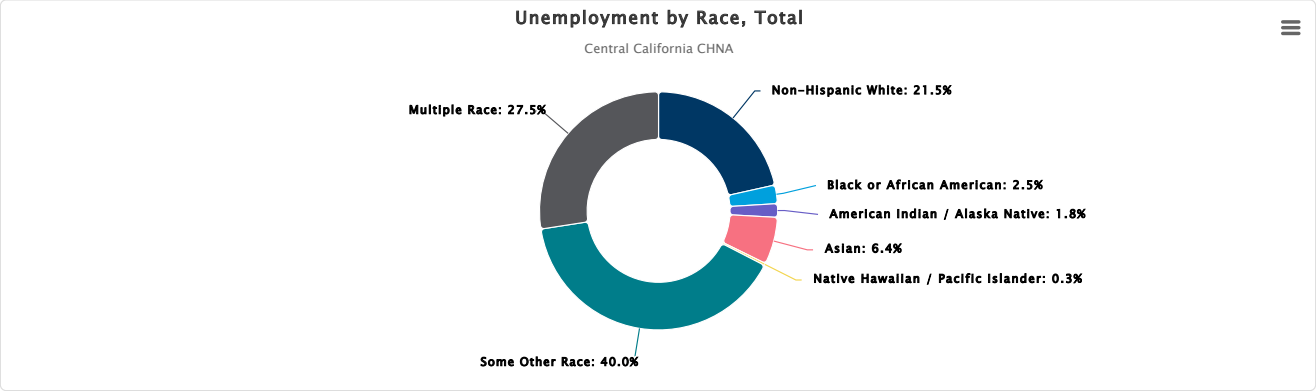
- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- Central California CHNA

Unemployment by Race, Total

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

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	5,700	669	489	1,695	77	10,594	7,274
Fresno County, CA	7,593	2,408	785	3,603	24	9,627	9,213
Kern County, CA	9,265	2,781	562	1,220	76	6,236	7,187
Kings County, CA	1,438	340	124	164	31	1,530	1,134
Monterey County, CA	3,091	251	129	796	164	2,733	1,622
San Benito County, CA	465	2	27	17	2	381	499
Tulare County, CA	3,834	272	357	676	31	6,417	3,890
California	413,831	106,059	18,806	158,934	6,166	236,196	227,927
United States	4,184,342	1,757,752	108,909	456,672	22,627	698,102	1,076,447

Data Source: US Census Bureau, American Community Survey. 2019-23.

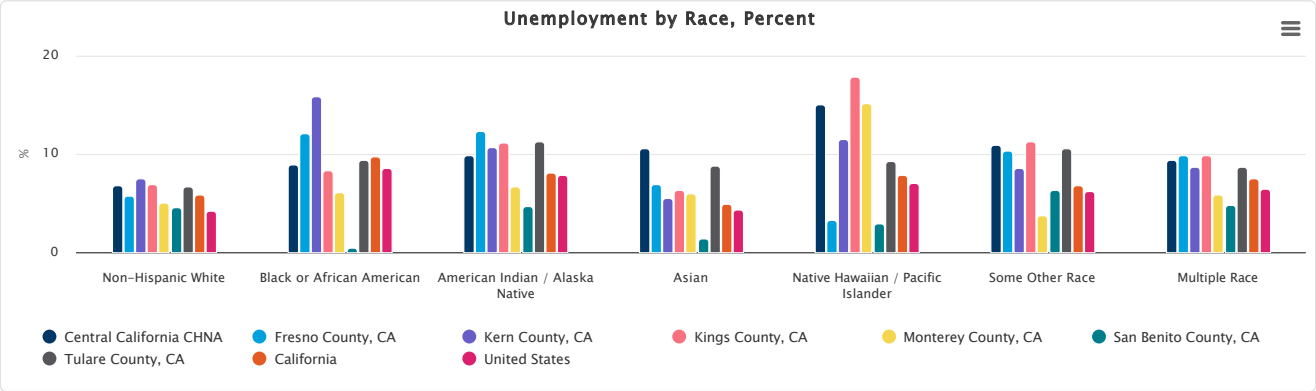


Unemployment by Race, Percent

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

Report Area	Non-Hispanic White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Central California CHNA	6.72%	8.84%	9.82%	10.54%	15.01%	10.92%	9.38%
Fresno County, CA	5.70%	12.06%	12.30%	6.85%	3.27%	10.28%	9.81%
Kern County, CA	7.49%	15.78%	10.67%	5.45%	11.45%	8.54%	8.60%
Kings County, CA	6.92%	8.30%	11.16%	6.28%	17.82%	11.19%	9.78%
Monterey County, CA	5.03%	6.11%	6.69%	5.94%	15.12%	3.68%	5.81%
San Benito County, CA	4.50%	0.43%	4.65%	1.30%	2.90%	6.27%	4.71%
Tulare County, CA	6.64%	9.39%	11.22%	8.72%	9.28%	10.49%	8.61%
California	5.81%	9.76%	8.07%	4.88%	7.88%	6.77%	7.44%
United States	4.17%	8.58%	7.87%	4.28%	7.05%	6.21%	6.40%

Data Source: US Census Bureau, American Community Survey. 2019-23.

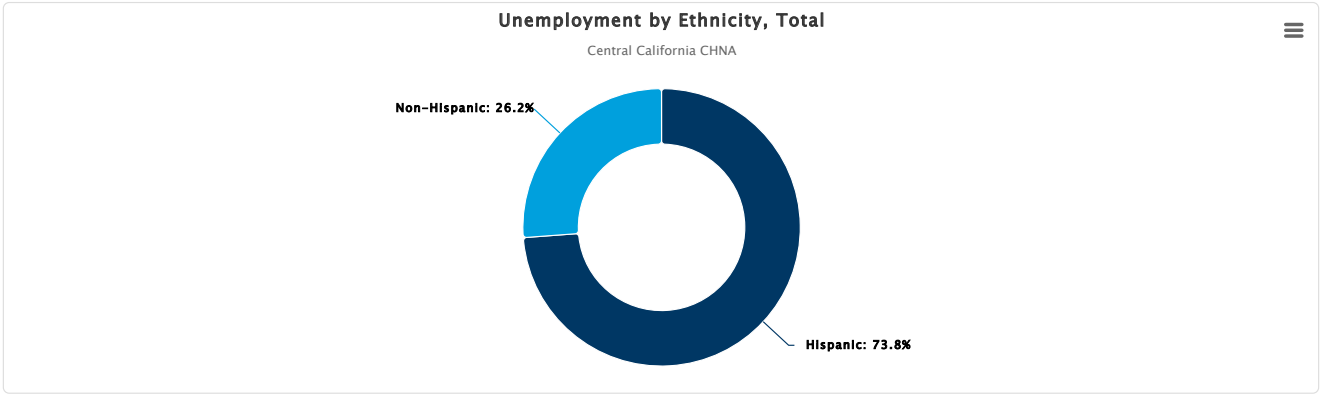


Unemployment by Ethnicity, Total

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

Report Area	Hispanic	Non-Hispanic
Central California CHNA	24,319	8,627
Fresno County, CA	24,644	15,127
Kern County, CA	18,208	14,841
Kings County, CA	3,643	2,144
Monterey County, CA	5,342	4,726
San Benito County, CA	1,509	529
Tulare County, CA	13,663	5,025
California	537,311	744,948
United States	1,889,916	6,869,401

Data Source: US Census Bureau, American Community Survey. 2019-23.

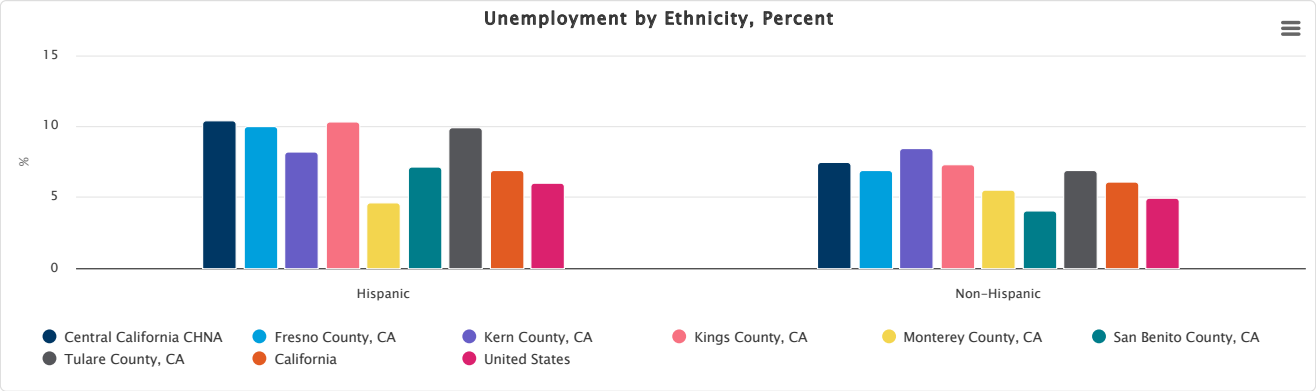


Unemployment by Ethnicity, Percent

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

Report Area	Hispanic	Non-Hispanic
Central California CHNA	10.40%	7.43%
Fresno County, CA	10.01%	6.86%
Kern County, CA	8.20%	8.42%
Kings County, CA	10.33%	7.27%
Monterey County, CA	4.58%	5.49%
San Benito County, CA	7.14%	4.04%
Tulare County, CA	9.88%	6.85%
California	6.87%	6.04%
United States	6.00%	4.97%

Data Source: US Census Bureau, American Community Survey. 2019-23.

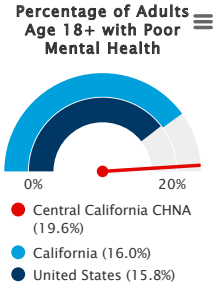


Health Outcomes - Anxiety & Depression - Poor Mental Health

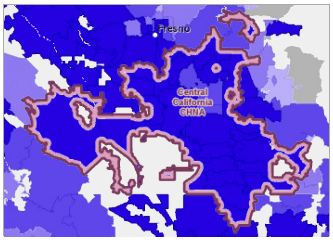
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Within the report area, there were 19.6% of adults 18 and older who reported poor mental health in the past month of the total population age 18 and older.

Report Area	Total Population	Adults Age 18+ with Poor Mental Health (Crude)	Adults Age 18+ with Poor Mental Health (Age-Adjusted)
Central California CHNA	795,651	19.6%	No data
Fresno County, CA	1,015,190	18.7%	18.6%
Kern County, CA	916,108	18.8%	18.5%
Kings County, CA	152,981	19.5%	19.0%
Monterey County, CA	432,858	17.9%	18.1%
San Benito County, CA	67,579	16.2%	16.5%
Tulare County, CA	477,544	19.5%	19.3%
California	39,029,342	16.0%	16.4%
United States	333,287,557	15.8%	16.4%



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



View larger map

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

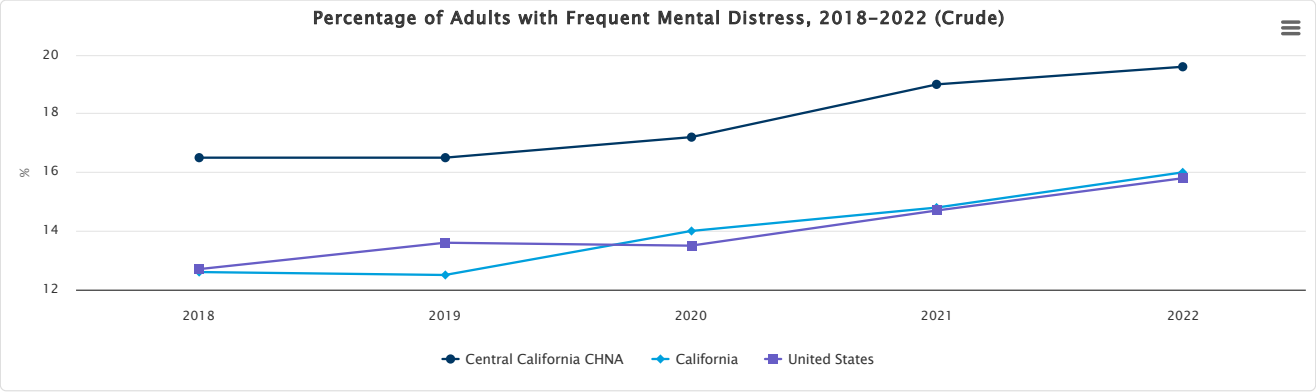
- Over 18.0%
- 16.1 - 18.0%
- 14.1 - 16.0%
- Under 14.1%
- No Data or Data Suppressed
- Central California CHNA

Percentage of Adults with Frequent Mental Distress, 2018-2022 (Crude)

The table and chart below display annual trends in the percentage of adults age 18+ whose report frequent mental distress.

Report Area	2018	2019	2020	2021	2022
Central California CHNA	16.5%	16.5%	17.2%	19.0%	19.6%
California	12.6%	12.5%	14.0%	14.8%	16.0%
United States	12.7%	13.6%	13.5%	14.7%	15.8%

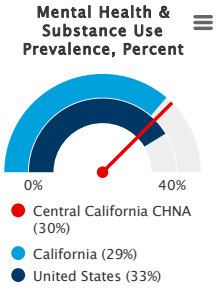
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .



Health Outcomes - Anxiety & Depression - Mental Health Diagnoses

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence for Medicare FFS population in 2022. Data were obtained from the CMS Mapping Medicare Disparities tool.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 (rate displayed as zero for such counties.)

Report Area	FFS Beneficiaries	Mental Health & Substance Use Prevalence, Total	Mental Health & Substance Use Prevalence, Percent
Central California CHNA	65,296	19,791	**30%**
Fresno County, CA	74,538	20,871	28%
Kern County, CA	59,305	18,385	31%
Kings County, CA	11,551	3,465	30%
Monterey County, CA	54,612	14,199	26%
San Benito County, CA	6,902	1,795	26%
Tulare County, CA	42,539	13,187	31%
California	2,778,184	805,673	29%
United States	30,900,366	10,197,121	33%



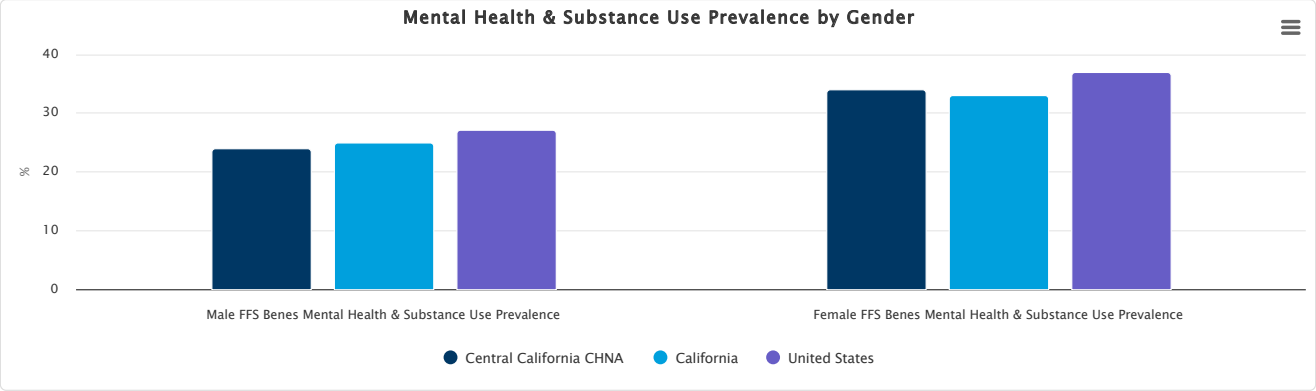
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

Mental Health & Substance Use Prevalence by Gender

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by gender for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	Male FFS Benes	Female FFS Benes	Male FFS Benes Mental Health & Substance Use Prevalence, Percent	Female FFS Benes Mental Health & Substance Use Prevalence, Percent
Central California CHNA	30,681	34,614	24%	34%
California	1,273,797	1,504,387	25%	33%
United States	14,047,306	16,853,060	27%	37%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

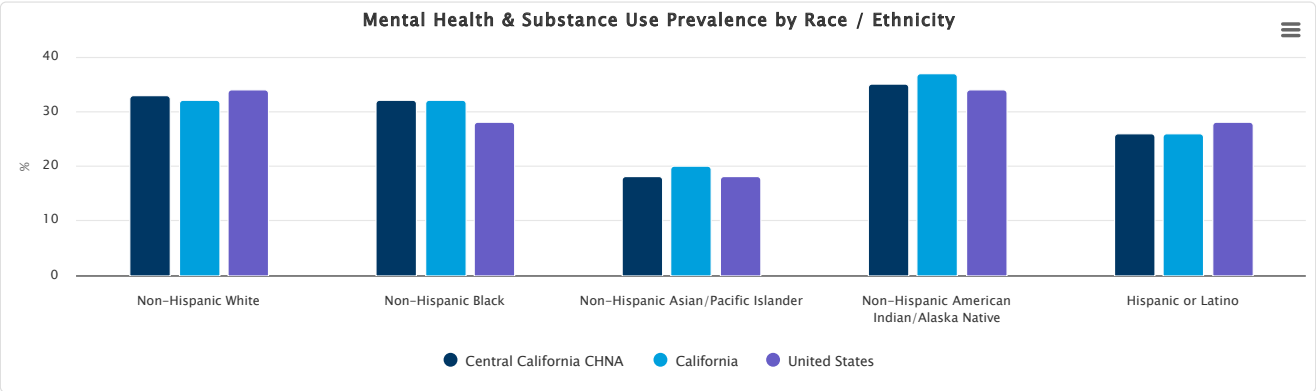


Mental Health & Substance Use Prevalence by Race / Ethnicity

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by race and ethnicity for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian/Pacific Islander	Non-Hispanic American Indian/Alaska Native	Hispanic or Latino
Central California CHNA	33%	32%	18%	35%	26%
California	32%	32%	20%	37%	26%
United States	34%	28%	18%	34%	28%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.

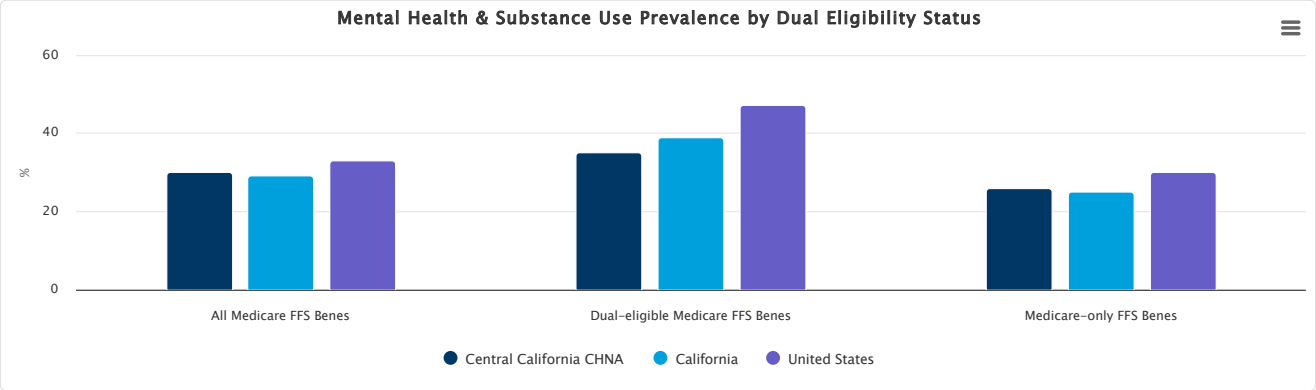


Mental Health & Substance Use Prevalence by Dual Eligibility Status

This indicator reports the unsmoothed age-adjusted rate of mental health & substance use prevalence by dual eligibility status for Medicare FFS population in 2022.
Note: Data are suppressed 1) where total population is less than 11 or 2) when the count of a measure is less than 3 or greater than 0 (rate displayed as zero.)

Report Area	All Medicare FFS Benes	Dual-eligible Medicare FFS Benes	Medicare-only FFS Benes
Central California CHNA	30%	35%	26%
California	29%	39%	25%
United States	33%	47%	30%

Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022.



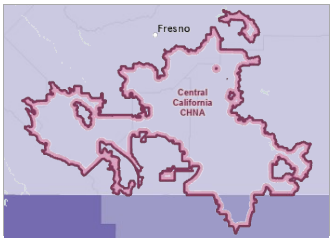
Health Outcomes - Deaths of Despair - Suicide Mortality

This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Within the report area, there are a total of 389 deaths due to suicide. This represents a crude death rate of 9.8 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Central California CHNA	796,838	389	9.8
Fresno County, CA	1,009,190	511	10.1
Kern County, CA	909,833	588	12.9
Kings County, CA	152,948	85	11.1
Monterey County, CA	433,175	233	10.8
San Benito County, CA	65,859	21	6.4
Tulare County, CA	473,788	205	8.7
California	39,222,534	21,240	10.8
United States	331,563,969	240,465	14.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



View larger map

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2019-23

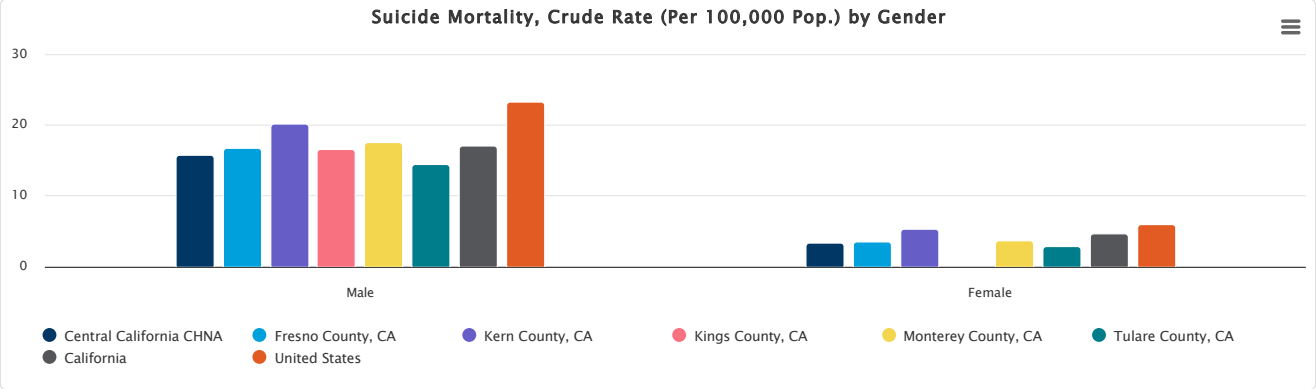
- Over 20.0
- 16.1 - 20.0
- 12.1 - 16.0
- Under 12.1
- Data Suppressed (<10 Deaths)
- Central California CHNA

Suicide Mortality, Crude Rate (Per 100,000 Pop.) by Gender

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide) for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by gender.

Report Area	Male	Female
Central California CHNA	15.8	3.3
Fresno County, CA	16.7	3.5
Kern County, CA	20.2	5.3
Kings County, CA	16.6	No data
Monterey County, CA	17.6	3.7
Tulare County, CA	14.4	2.9
California	17.0	4.7
United States	23.3	6.0

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



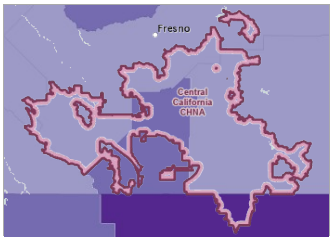
Health Outcomes - Deaths of Despair - Deaths of Despair

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.

Within the report area, there were 2,093 deaths of despair. This represents a crude death rate of 52.5 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
Central California CHNA	796,838	2,093	52.5
Fresno County, CA	1,009,190	2,515	49.8
Kern County, CA	909,833	3,620	79.6
Kings County, CA	152,948	386	50.5
Monterey County, CA	433,175	1,034	47.7
San Benito County, CA	65,859	139	42.2
Tulare County, CA	473,788	1,182	49.9
California	39,222,534	100,758	51.4
United States	331,563,969	970,307	58.5

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



View larger map

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by County, CDC NVSS 2019-23

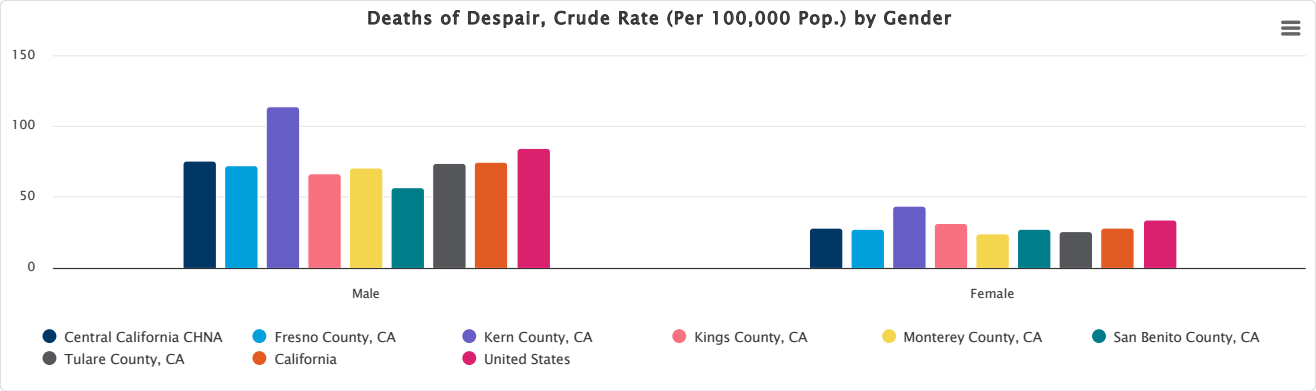
- Over 70.0
- 50.1 - 70.0
- 40.1 - 50.0
- Under 40.1
- Data Suppressed (<10 Deaths)
- Central California CHNA

Deaths of Despair, Crude Rate (Per 100,000 Pop.) by Gender

The table and chart below display crude mortality rates from deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair" for the 5-year period 2019-2023. Rates are calculated per 100,000 population and grouped by gender.

Report Area	Male	Female
Central California CHNA	75.5	28.5
Fresno County, CA	72.3	27.3
Kern County, CA	113.8	43.8
Kings County, CA	66.1	31.2
Monterey County, CA	70.8	23.8
San Benito County, CA	56.7	27.5
Tulare County, CA	74.1	25.7
California	75.0	27.9
United States	84.0	33.7

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.



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

A. Identified Significant Health Needs

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

High Priority Needs

Access to Care

Thealliance.health

Nearly nine out of ten people (88.79%) live in a primary care Health Professional Shortage Area (HPSA), compared to 22.59% in California (U.S. Department of Health and Human Services, 2024). Both focus group participants and key informants noted that access to affordable, specialty care is a community need.

Financial Stability

calwellness.org/money/what-we-fund/economic-security-and-dignity/

One in four children (25.37%) live in households below the Federal Poverty Level (U.S. Census Bureau, 2023). When asked about what makes it hard to live and be well, a community survey showed that 45.3% of respondents selected financial stability related factors.

Mental Health

thealliance.health/for-members/get-care/behavioral-health-care/

Nearly one in five adults (19.6%) self-reported as having poor mental health (Centers for Disease Control and Prevention, 2022). Focus group participants noticed that issues with anxiety and depression are more prevalent with youth and serious mental health disorders are hurting our homeless population.

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

Food Security

ccfoodbank.org

More than three out of four students (77.9%) are eligible for free or reduced-price lunch (National Center for Education Statistics, 2023). Key informants described that a lack of access to healthy foods disproportionately affects certain populations and areas like the central valley despite being in an agricultural region.

Housing

cdss.ca.gov/inforesources/cdss-programs/housing-programs

More than 20% of adults (22.2%) reported experiencing housing insecurity, which is associated with limited access to health care and poor outcomes (Centers for Disease Control and Prevention, 2024). Key informants described the stigma associated with homelessness and its increasing trend that points to a significant health need to address.

Health Conditions

thealliance.health/for-members/health-and-wellness/

The Central California service area performs worse than the State average for obesity, diabetes, heart disease, lung disease, kidney disease, as well as hearing and mobility disabilities. Focus group participants and key informants described many of these health conditions as especially burdensome in underserved communities.

Health Risk Behaviors

recovery.org

The Central California service area performs worse than the State average for smoking, binge drinking, chlamydia infection and teen birth rate. Focus group participants highlighted the social normalization around vaping as well as the community need for providing fentanyl test kits and Narcan.

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

B. Description of Focus Groups & Key Informant Interviews

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

Logistics

Six (6) focus groups with twenty-six (26) people participating. Focus groups were in-person, typically running 90 minutes.

Four (4) key informant interviews. Interviews were conducted virtually, running 60 minutes.

Participating Organizations

- Champions Recovery Alternative Programs Visalia
- City of Tulare
- Community Action Partnership of Kern
- Delano Chamber of Commerce
- Delano Community Leaders
- Kings Community Action Organization
- Kings County Public Health

Represented Race/Ethnicity

- African American
- Asian
- LatinX
- White

Represented Populations

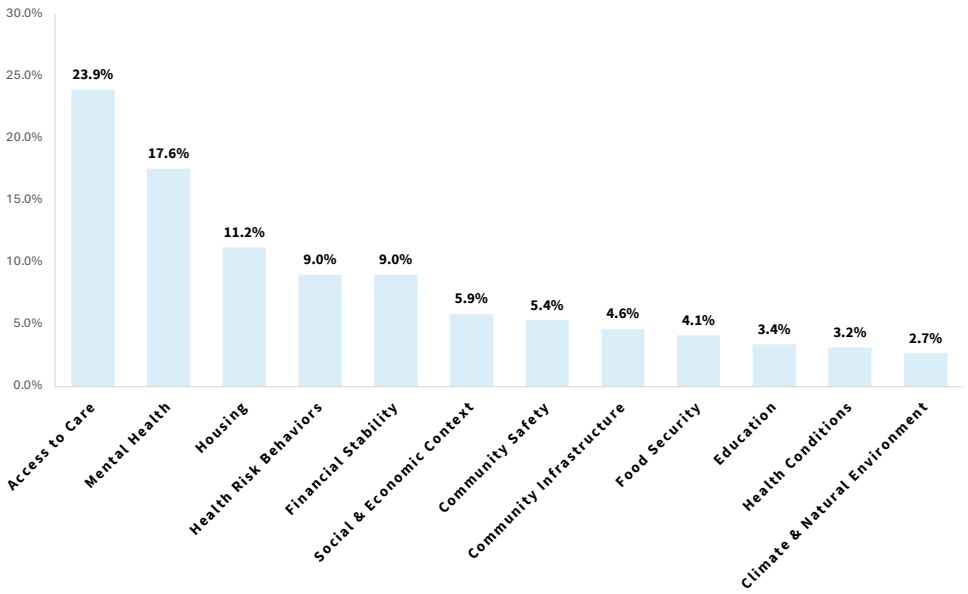
- Agricultural workers
- Civic Government
- Labor or Workforce reps
- Low-income
- LGBTQ Community
- Medically Underserved
- Minority Population
- Older Adults
- Persons with Disability
- Substance Use Disorder
- Unhoused population

C. Focus Groups & Key Informant Interviews Results

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

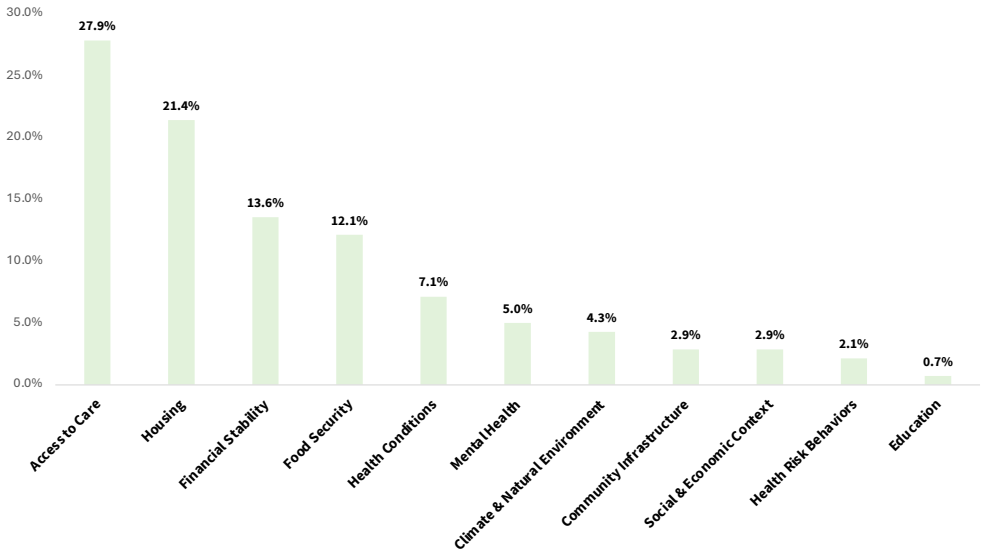
Focus Groups

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



Key Informant Interviews

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



D. Secondary Data Results

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

Priority Health Needs

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

Adults Age 18+ with Poor or Fair General Health (Crude)

27.2%

California: 18.8%

Life Expectancy at Birth (2010-2015)

78.66

California: 80.32

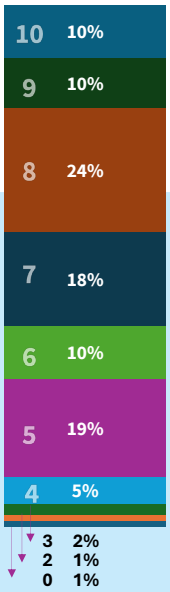
Housing	Health Risk Behaviors	Access to Care	Financial Stability	Mental Health	Social & Economic Context
76	73	73	70	64	64

Food Security	Education	Climate & Natural Environment	Health Conditions	Community Safety	Community Infrastructure
63	57	55	45	41	41

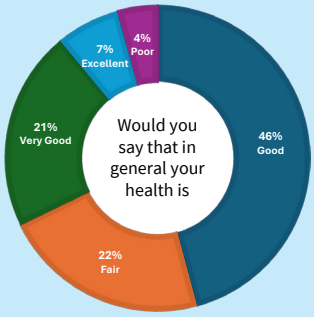
Legend: Excellent | Very Good | Good | Fair | Poor

E. Survey Results

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



Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?

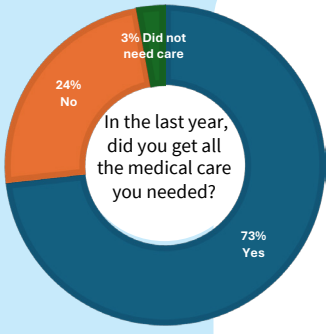


Select 3-5 things that you believe make it hard to live and be well in this community.

High cost of living	20.1%
Lack of affordable housing	14.5%
Bad air and/or water quality	13.7%
Not enough good jobs	10.7%
Access to affordable healthy food	10.1%
Can't get medical care	5.8%
Lack of safe roads, sidewalks, bike lanes	4.1%
Unsafe community	4.0%
Lack of transportation	3.8%
Limited childcare options	3.4%
Limited access to social services or me or my family members	2.4%
No friends or connections to community	2.1%
Lack of good schools	2.0%
Racism	1.9%
High risk for natural disasters (fire, floods, earthquakes)	1.4%
Grand Total	**100.0%**

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

Being overweight	13.6%
Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	13.3%
High blood pressure	11.8%
Diabetes/Kidney Disease	8.7%
Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)	8.1%
Poor eating habits	7.8%
Vision/hearing problems	7.0%
Teeth problems	6.8%
Asthma/COPD	4.9%
No health problems	3.9%
Problems with mobility	3.3%
Heart disease/Stroke	3.0%
Cancer	2.3%
Illness that spreads (like flu, COVID, TB)	1.2%
Respiratory/Lung Disease	1.1%
Mother-Baby care	1.0%
Alcohol and/or drug misuse	1.0%
Learning problems	0.8%
Sexually Transmitted Diseases (STDs)	0.2%
Child/Partner Abuse	0.1%
Grand Total	**100.0%**



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

Poor quality of doctors/nurses	17.9%
Inconvenient hours of operation	12.1%
Specialists not covered by insurance	10.7%
Getting to the clinic was too hard	9.3%
It costs too much	7.9%
I do not have health insurance	7.9%
I do not have a primary care doctor	6.4%
Location of medical care	6.4%
I did not know where to get care	5.7%
I'm uncomfortable speaking with a doctor	5.7%
Doctor or clinic (healthcare provider) did not understand my language, culture or identity	3.6%
Holistic treatments not available	3.6%
There was no doctor that accepted my insurance	2.9%
Grand Total	**100.0%**

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

Housing Options	14.2%
Healthcare & Prescription Costs	13.9%
Utilities/Internet	11.0%
Parks, Recreation and Outdoor Activities	10.6%
Managing Stress and Depression	9.8%
Childcare or Senior Care	9.4%
Neighborhood Safety	7.7%
Social/Community Events	7.6%
Local Food Banks	6.3%
Personal Safety	4.8%
Legal Services	4.6%
Grand Total	**100.0%**

Central California Survey Responses
310

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

V. Process & Methods to Conduct the CHNA

A. Introduction

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

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

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

B. Community Impact Framework

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

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

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

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

C. Data Overview: Description, Benefits & Limitations

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

Description

Key Informant Interviews

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

Focus Group

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

Survey

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

Secondary Public Data

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

Benefits

Key Informant Interviews

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

Focus Group

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

Survey

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

Secondary Public Data

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

Limitations

Key Informant Interviews

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

Focus Group

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

Survey

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

Secondary Public Data

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

References

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

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

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

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

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

D. Focus Group & Key Informant Interview Methodology

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

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

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

E. Survey Methodology

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

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

F. Secondary Data Methodology

Basic Approach

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

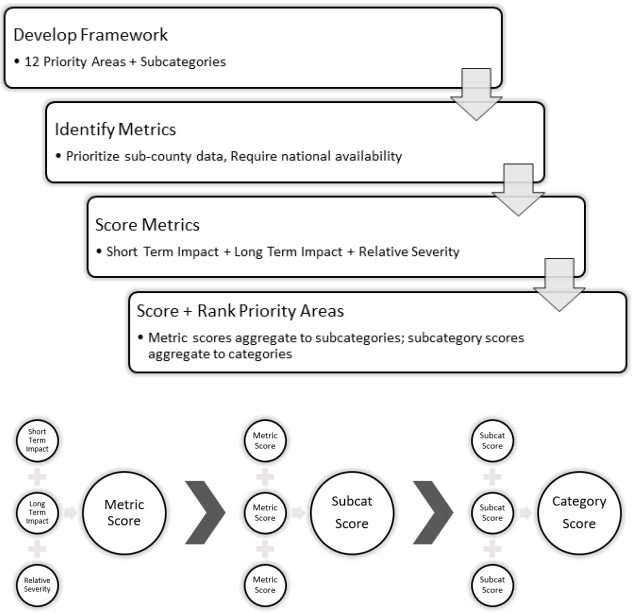


Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Metric Scoring

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

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

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

Transformation of Correlation Scores

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

Category Scores

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

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

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

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

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

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

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

Presentation of Results

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

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

Limitations

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

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

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

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

References

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

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

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

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

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

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

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

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

G. Data Analysis & Identification of Significant Health Needs

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

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

STEP 1: FRAMEWORK & CODEBOOK CREATION

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

STEP 2: DATA COLLECTION

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

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

STEP 3: AGGREGATION

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

STEP 4: SYNTHESIS

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

EVALUATION & HEALTH NEEDS PRIORITIZATION: CHNA Steering Committee

STEP 5: EVALUATION

- Evaluate Significant Health Needs data.

STEP 6: PRIORITIZATION

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

Data Collection to Aggregation

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

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

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

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

For each input text, your goal is:

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

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

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

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

Data Synthesis and Identification of Significant Health Needs

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

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

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

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

Prioritized Criteria

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

Prioritization Process and Selection of High Priority Needs

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

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

I. Written Comments for 2025 CHNA

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

J. CHNA Team Used to Conduct the Assessment

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

Amanjit 'Amy' Lasher
Administrative Director, Community Integration

Sarah Clair, MPA
Manager, Public Affairs

Mitchell Iwahiro, MS
Project Manager, Community Integration

Susan Passalacqua
Manager, Community Benefit Compliance

Lisa Wegley
Program Manager, Community Benefits Operations

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

Matt Gonzales
Salesforce Administrator

Alex McFadyen, PMP
Manager, Consumer Digital Products

Philip Stanley
Digital Marketing Manager

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

Cambria Wheeler
Director, Brand Engagement

CARES

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

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

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

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

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


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

VI. APPROVAL PAGE

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

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

Jason Wells
President, Adventist Health Central California Network

Adventist Health Hanford
115 Mall Drive,
Hanford, CA 93230

Adventist Health Selma
1141 Rose Avenue,
Selma, CA 93662

Appendix:

A. Glossary of Terms & Definitions of Health Needs

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

Access to Care

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

Context/Source

Healthy People 2030. "Health Care Access and Quality"

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

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

Climate & Natural Environment

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

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

Context/Source

World Health Organization. "Climate"

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

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

Community Infrastructure

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

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

Context/Source

Robert Wood Johnson Foundation. "Infrastructure is Public Health"

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

Community Safety

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

Context/Source

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

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

Education

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

Context/Source

American Public Health Association. "Education Health"

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

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

Financial Stability

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

Context/Source

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

Food Security

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

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

Context/Source

World Health Organization. "Food Safety"

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

American Public Health Association. "Food and Nutrition"

Health Conditions

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

Context/Source

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

World Health Organization (WHO). "Noncommunicable Diseases"

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

Health Risk Behaviors

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

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

Context/Source

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

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

Centers for Disease Control and Prevention (CDC). "Sexual Risk Behaviors"

Housing

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

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

Context/Source

Robert Wood Johnson Foundation. "Housing and Health"

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

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

Mental Health

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

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

Context/Source

World Health Organization (WHO). "Mental Health"

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

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

Social & Economic Context

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

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

Context/Source

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

World Health Organization. "Social Determinants of Health"

B. Activity Explanation: Focus Groups & Key Informant Interviews

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

Tallying, Engaging & Asking Questions:

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

ACTIVITY EXPLANATION – Key Informant Interviews

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

Engaging & Asking Questions:

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

B. Focus Group & Key Informant Interview: Question prompter

One of the topics that you identified is _____

Questions:

1. Why do you see ___as a problem that's related to your family/community's health?
2. What do you think creates this issue?
3. How do you see the problem affecting your local friends, family or neighbors?

   Who is most affected by this?
4. What have people tried to do to address this problem? What has worked?

   What are the biggest barriers for _____ (policy/program)?

   What makes it hard to fix this problem in your community?
5. What has changed around this concern in the last 2 - 3 years?

   Are there any new emerging trends or areas of concern in the last few years?
6. If this problem got better, how would your community look different?

Closing question:

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

Conclusion:

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

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

C. Survey Questions:

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

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

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

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

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

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

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

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

D. Prioritization Tools:

1. Health Need – Evaluation Worksheet

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

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

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

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

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

2. Questions to Consider

Do we have any unifying objectives/goals?

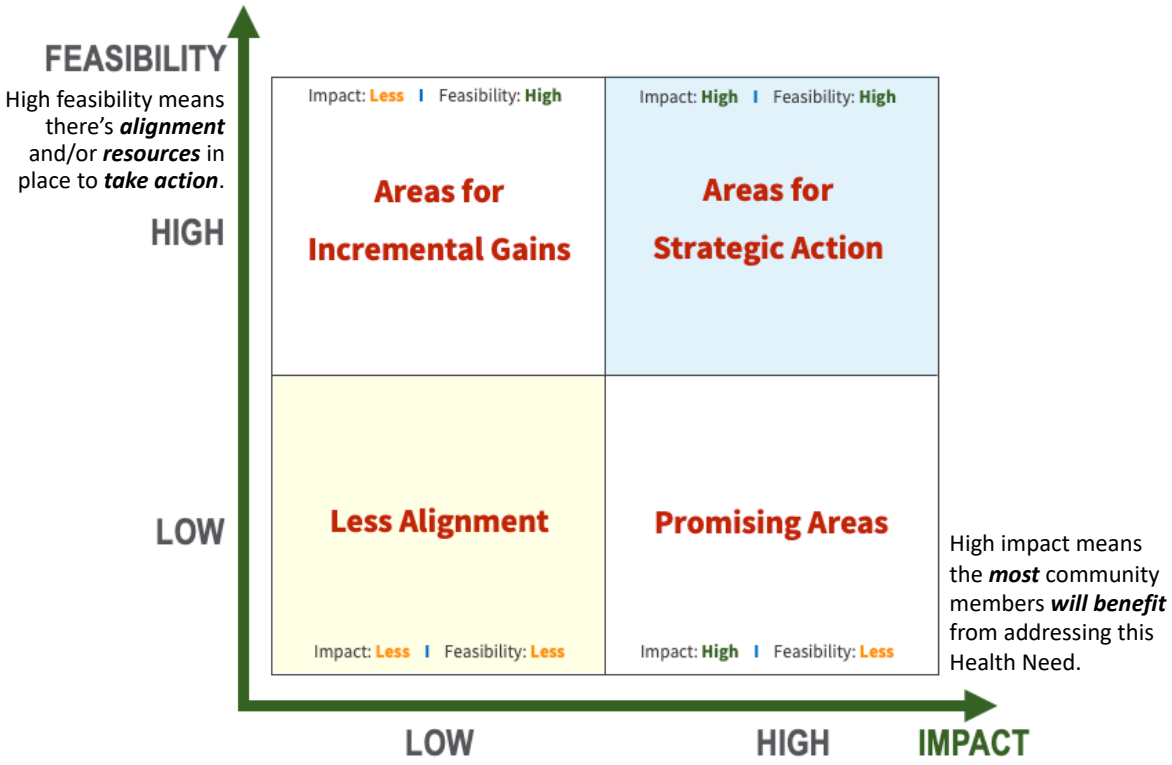
What does immediate success look like (1 - 3yrs)?

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

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

Is this a community-wide or vulnerable population need?

3. Priority Needs Comparison



Adventist Health Hanford

Adventist Health Selma

AdventistHealth.org

241577-M 0725