MORE
COMMUNITY VOICES

Adventist Health
St. Helena

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

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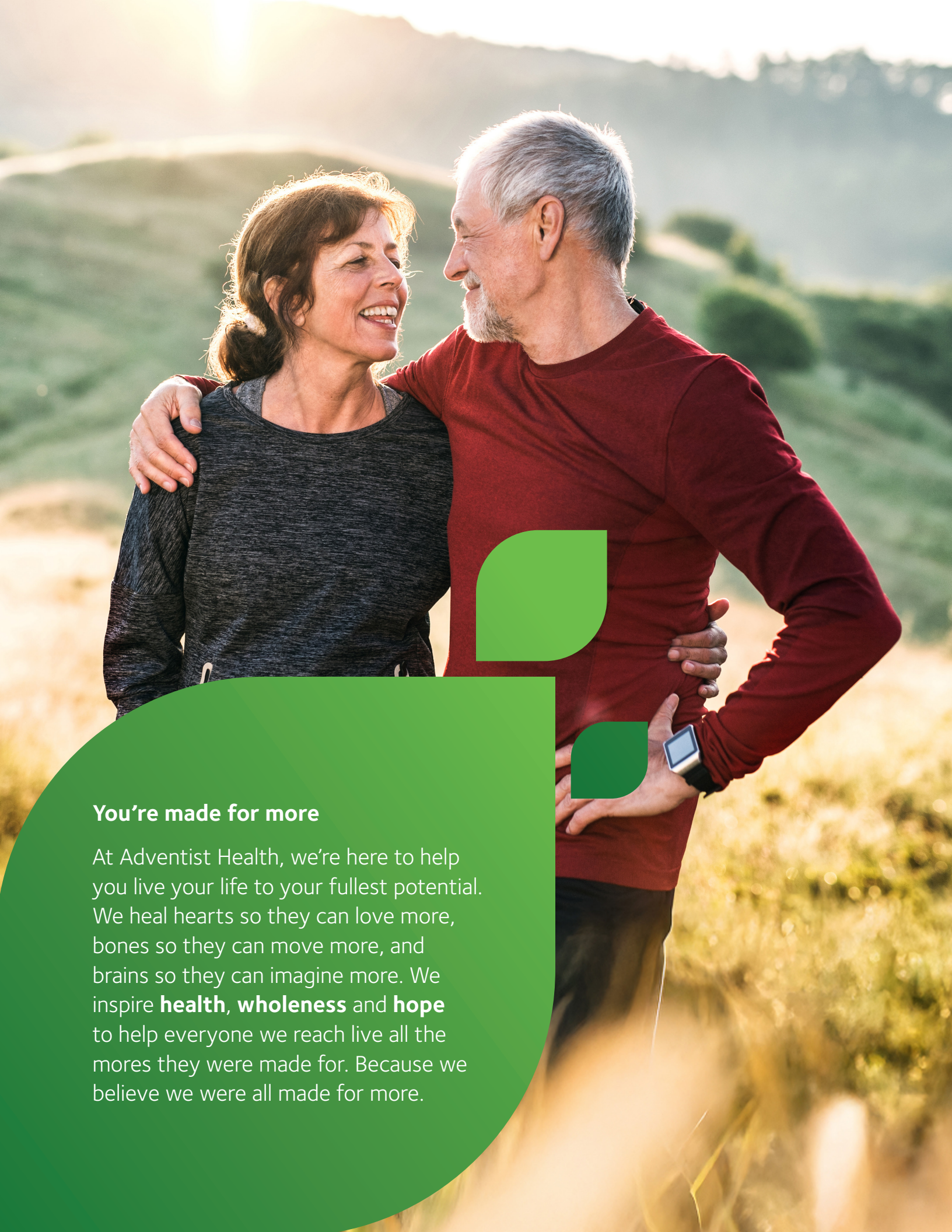


You’re made for more

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, Adventist Health St. Helena 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. Eight 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

Food Security

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/KnpD

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 St. Helena 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.

Kim Baldwin
Adventist Health St. Helena,
Director, Community Benefit/Risk Management

Paul Dohring
City of St. Helena, Mayor

Steve Herber, MD
Adventist Health St. Helena, President

Ericka Iten
Adventist Health St. Helena, Director, Strategy

Noemi Mauricio Jimenez
Adventist Health St. Helena, Mobile Care Supervisor

Jenny Ocon
Up Valley Family Centers, Executive Director

Oscar Ortiz
Napa County Sheriff Department, Sheriff

Dr. Audra Pittman
Calistoga Joint Unified School District, Superintendent

Brad Raulston
Yountville, Town Manager

Donald Williams
City of Calistoga, Mayor

Rob Weiss
Mentis, Executive Director

Jennifer Yasumoto
Napa County Health and Human Services, Agency Director

A. CHNA Community Defined

Getting to Know Our Community

The City of St. Helena is at the epicenter of world-renowned food and wine in the Napa Valley. St. Helena attracts local and international visitors with its historic small-town charm, boutique shopping, and numerous wineries. St. Helena is proud of its heritage and continues to reflect its history as one of the great wine-growing capitals of the world. We are also home to the prestigious Culinary Institute of America and support the extensive agricultural operations of surrounding vineyards. Our community's unique geography contributes to the diversity we celebrate.

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:

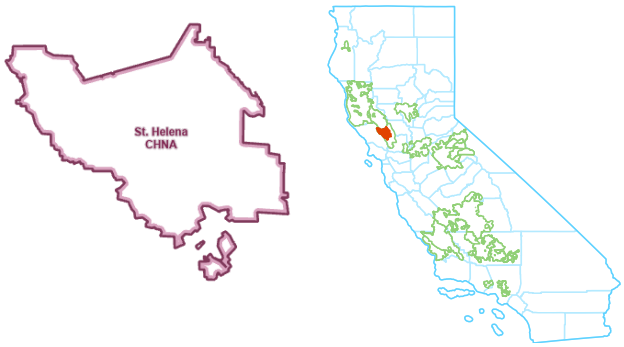
- High school graduation rate of 89.8%.
- Labor force participation rate of 59.74% compared to California's 63.86%.
- 19.41% of households are considered severely burdened, spending 50% or more of their income on housing.
- Based on the Area Median Income, residents spend 47.39% of their income on housing and transportation alone.

We recognize the challenges and are optimistic about finding opportunities to improve our community's environment so we can live the best possible life. In the following pages, we'll review lessons learned and accomplishments over the last three years. We'll dive deeper into the high priority needs, community voices, and data that guided the Community Health Needs Assessment process.

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 22,795 (based on the 2020 Decennial Census). The largest city in the report area is St. Helena city, with a population of 5,430. The report area is comprised of the following ZIP codes: 94508, 94515, 94562, 94567, 94573, 94574, 94576, 94599.

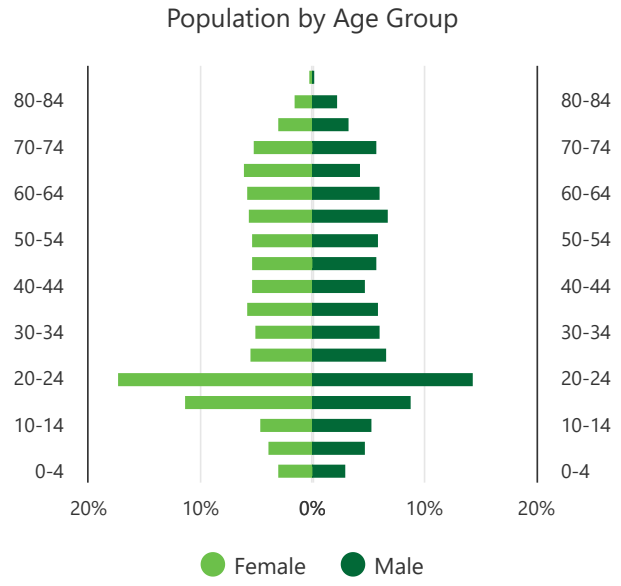


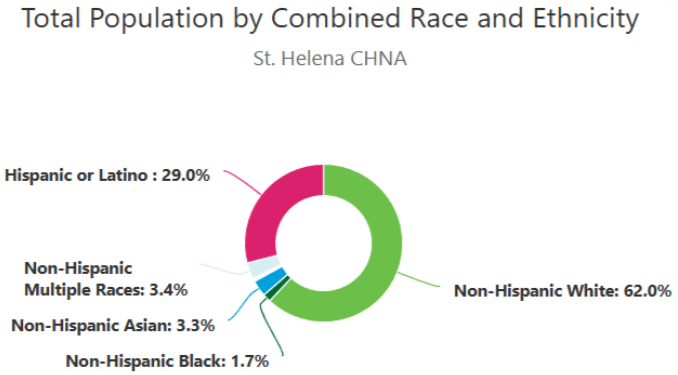
Total Population
22,795

The largest city in the service area is
St. Helena city
with a population of

5,430

Demographic Profile





Students Experiencing Homelessness, Percent
1.56%
California: 3.96%

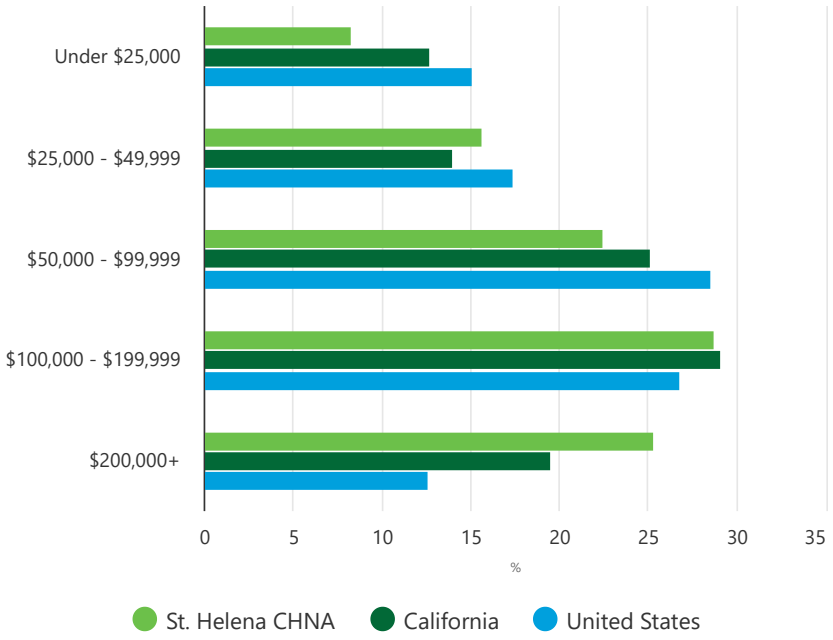
Associate's Degree or Higher
53.73%
California: 44.42%

Labor Force Participation Rate
59.74%
California: 63.86%

65.17%
California: 55.79%
of the population **owns** their home

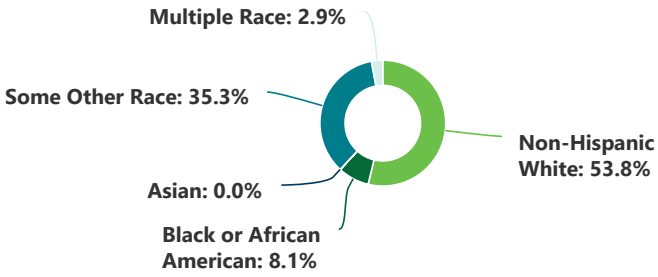
34.83%
California: 44.21%
of the population **rents** their home

Households by Household Income Levels, Percent



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

Children in Poverty by Race, Total
St. Helena CHNA



Childhood Poverty Rate
5.28%
California: 15.15%

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

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 Vallejo

Adventist Health Vallejo is a 61-bed psychiatric hospital that has been serving the Vallejo community and surrounding areas for over 30 years. Our hospital is committed to delivering medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Adventist Health Vallejo offers complete inpatient and outpatient behavioral health programs and services including short-term psychiatric care services for children, adolescents, and adults or those who are dependent on alcohol, drugs or prescription medications.

Adventist Health St. Helena

Adventist Health St. Helena is a 150-bed hospital that has been providing comprehensive healthcare services in St. Helena and the surrounding area since 1878. Our hospital is committed to delivering medical excellence, emergency care, outpatient services and wellness programs to all individuals regardless of insurance or ability to pay. Our continuum-of-care network of healthcare resources and expertise allows us to provide patients with seamless coordination and access to specialized services.

We offer a full continuum of inpatient and outpatient services, including:

- Behavioral Health
- Breast Center
- Cardiac Rehab
- Coon Joint Replacement Institute
- Heart and Vascular Institute
- Hereditary Cancer Syndrome Testing
- Lifestyle Medicine
- Martin-O'Neal Cancer Center
- Palliative Care

A Look Back: Activities Since 2022 CHNA

CHNA Successes

Over the last three years, Adventist Health St. Helena has focused on access to care, health conditions and mental health through community projects and partnerships. To document our impact, we have been monitoring and evaluating progress through annual updates and the Community Health Implementation Strategy (CHIS). Collaborating with the community, we implemented goals, actions, solutions and programs to address each high priority need.

One program that uniquely addressed access to care was the Adventist Health St. Helena Mobile Health services. The Mobile Health team serves the community's adults, families, and vulnerable residents, including older adults and students. Services include preventative screenings such as height, weight, A1C, total cholesterol panels, as well as help with medications, education on chronic disease management and sports physicals for students. The Mobile Health team is bilingual and eliminates cost, transportation, language and technology barriers. In addition, the team provides food distribution to families in the area. In 2023, the mobile health van provided 45,000 pounds of fresh produce.

We encourage future collaboration with other community organizations to build and scale the work addressing community health needs. For a full and complete report of program and activities since the 2022 Community Health Needs Assessment, please visit this link: https://www.adventisthealth.org/clear-lake/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 St. Helena, 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.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stryker

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. St. Helena 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 reach a service provider. Lack of access to a vehicle or reliable public transportation is a primary barrier to accessing health care services in St. Helena, where just 8.8% of residents live within a half mile of public transit compared to 62.31% in California. A community survey showed 21% of individuals did not receive all the medical care they needed and over 22% of respondents attributed their lack of care to transportation related barriers. As one key informant mentioned, there may be only "one car for the whole family, and so transportation getting to St. Helena... may be difficult." Transportation is a social need that disproportionately affects underserved communities, forcing people to forgo or delay health care visits, which can be detrimental to long-term health outcomes.

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

Scan QR Code to explore the full live data report on Access to Care or visit: cares.page.link/82w2

Data Highlights

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

"...transportation can be a real barrier in accessing health care services."

"Let's say their provider left...so now they don't have a provider. So they have medicines and their medicines run out and they don't have anyone else to prescribe."

"...where the emergency department services are utilized way more than any conventional treatment options...it's overwhelming that system that's in place. And ultimately it's short-term care and they're not getting what they really need out of it."

"We don't have enough mental health providers to meet the needs of our community."

"Because of higher demand, hospitals and clinics are very overcrowded."

"...we are inadequately positioned to be able to accommodate the Spanish speaking community..."

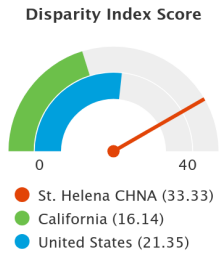
"So there's 30,000 people that are really underserved by resources that they ought to be able to count on."

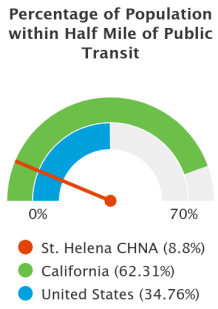
"I think we heard just more generally in the community that there's lack of, there's not enough mental health services to meet the current needs, particularly bilingual and bicultural mental health services."

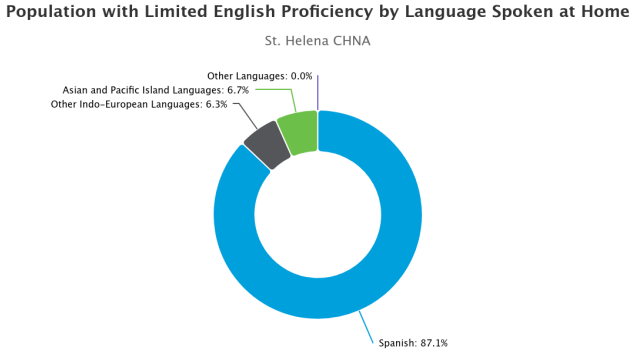
"They might have one car for the whole family, and so transportation getting to Saint Helena or to Santa Rosa may be difficult..."

"If the document is not in their natural language right then and there, they're not understanding the question."

"There's a gap and a need for more opportunities around preventative care as well as access to care providers."







Data Source: US Census Bureau, American Community Survey. 2019-23.
Downloaded from adventisthealth.engagementnetwork.org

Community Resources

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

Healthcare Enrollment Services
coveredca.com
800-300-1506

Health Insurance Access: Community Health Initiative
calchi.org

Napa County Child and Family Services
countyofnapa.org/3256/Child-and-Family-Services
707-253-4391

Community Health Needs Assessment Full Report

Location

St. Helena CHNA

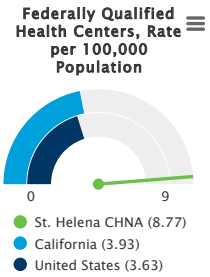
Health Needs: Access to Care

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

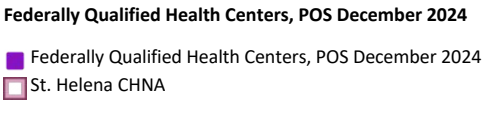
This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care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

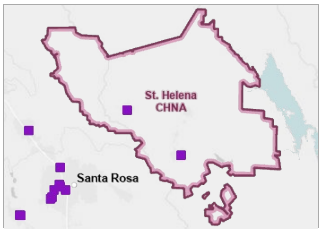
Within the report area, there are 2 Federally Qualified Heath Centers. This means there is a rate of 8.77 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
St. Helena CHNA	22,795	2	**8.77**
Napa County, CA	138,019	7	5.07
Sonoma County, CA	488,863	26	5.32
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.





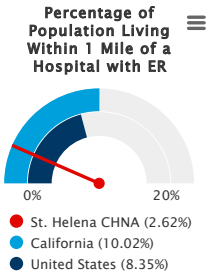
Availability - Hospitals & Clinics - Proximity to Hospitals with ER

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 22,795 total population, 598 or 2.62% 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
St. Helena CHNA	22,795	598	**2.62%**
Napa County, CA	138,019	13,055	9.46%
Sonoma County, CA	488,863	53,987	11.04%
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.

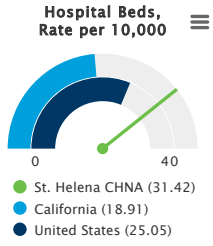


Availability - Hospitals & Clinics - Hospital Beds Per Capita

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
St. Helena CHNA	71	22,795	**31.42**
Napa County, CA	340	138,019	24.63
Sonoma County, CA	938	488,863	19.19
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.



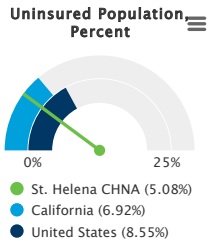
Barriers - Medical Insurance - Population without Medical Insurance

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

In the report area 5.08% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less 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
St. Helena CHNA	21,566	1,096	**5.08%**
Napa County, CA	134,594	7,679	5.71%
Sonoma County, CA	482,063	26,060	5.41%
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.



Uninsured Population, Percent by Tract, ACS 2019-23

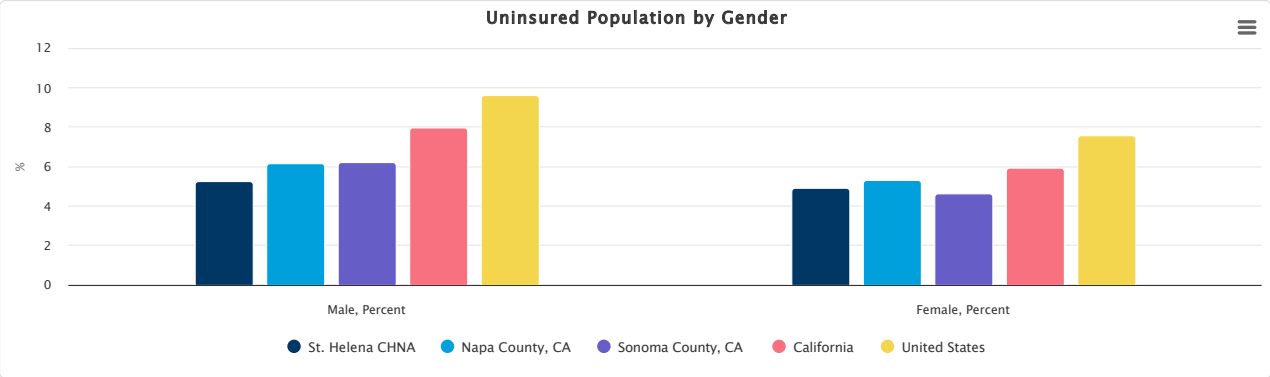
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- St. Helena CHNA

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
St. Helena CHNA	588	508	5.24%	4.91%
Napa County, CA	4,123	3,556	6.13%	5.28%
Sonoma County, CA	14,683	11,377	6.21%	4.63%
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.

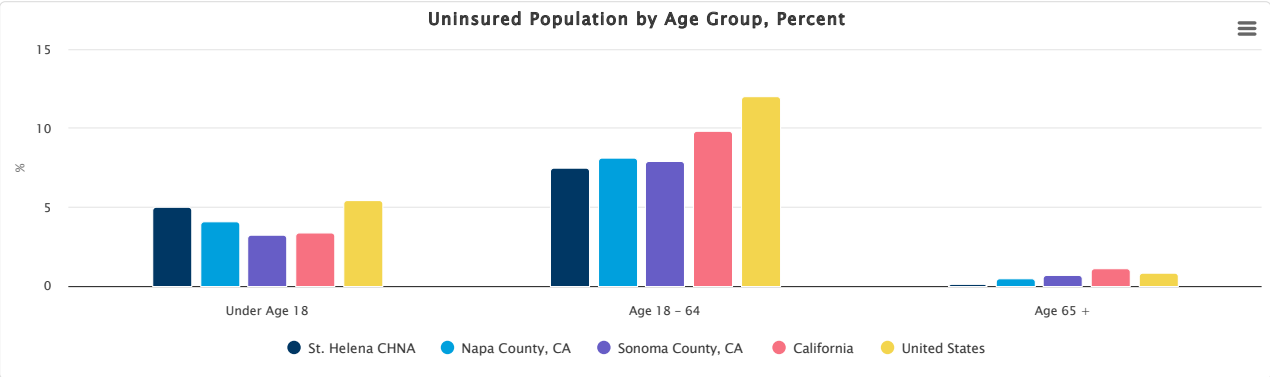


Uninsured Population by Age Group, Percent

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 +
St. Helena CHNA	4.96%	7.49%	0.10%
Napa County, CA	4.09%	8.08%	0.48%
Sonoma County, CA	3.22%	7.89%	0.66%
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.

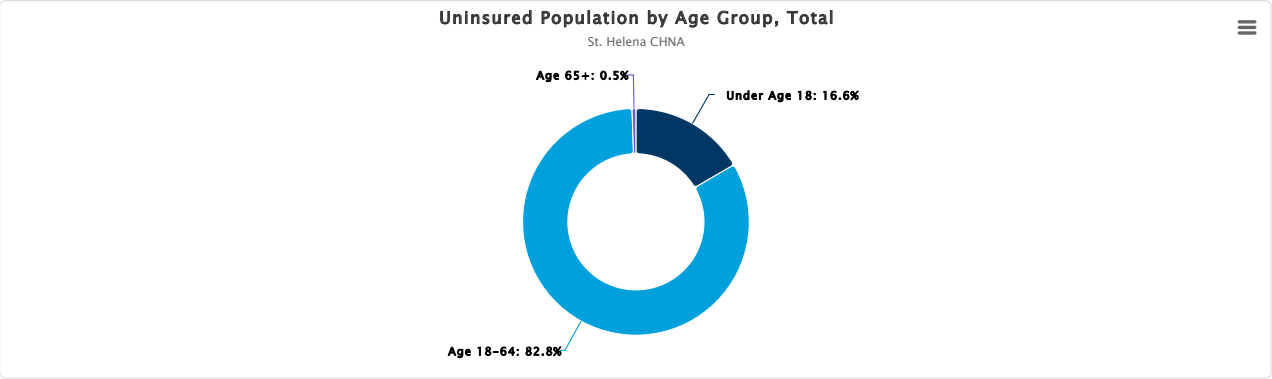


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
St. Helena CHNA	182	908	6
Napa County, CA	1,174	6,374	131
Sonoma County, CA	3,231	22,168	661
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.

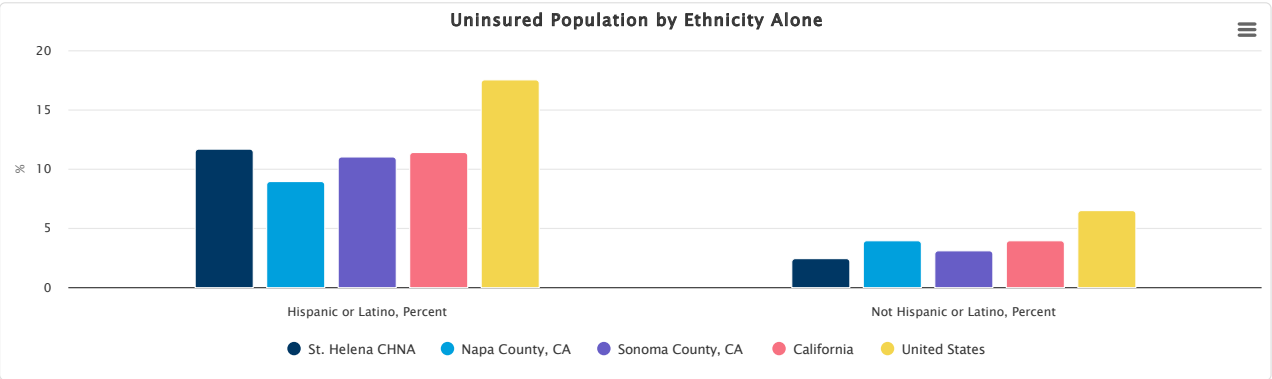


Uninsured Population by Ethnicity Alone

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
St. Helena CHNA	733	363	11.61%	2.38%
Napa County, CA	4,344	3,335	8.96%	3.87%
Sonoma County, CA	15,627	10,433	10.99%	3.07%
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.

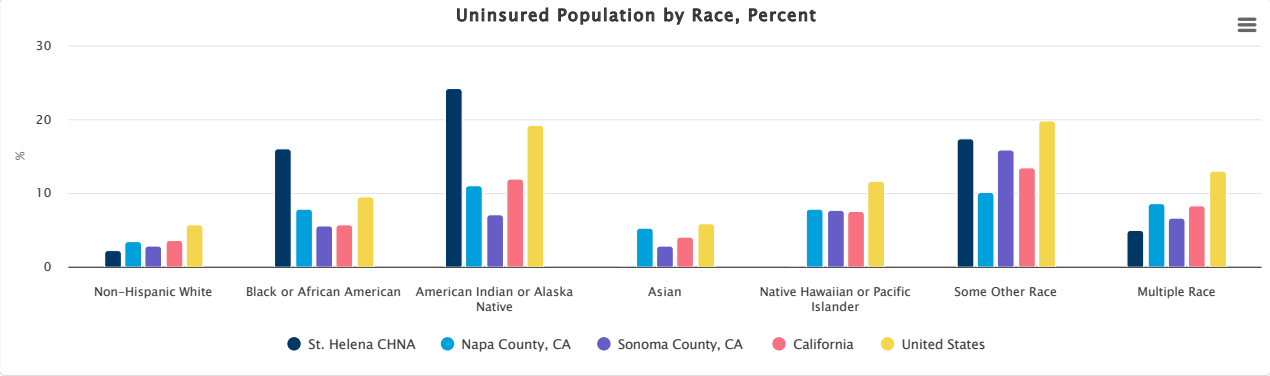


Uninsured Population by Race, Percent

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
St. Helena CHNA	2.25%	15.97%	24.24%	0.00%	0.00%	17.38%	4.88%
Napa County, CA	3.44%	7.80%	11.02%	5.29%	7.73%	10.02%	8.56%
Sonoma County, CA	2.79%	5.49%	7.10%	2.80%	7.64%	15.76%	6.61%
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.

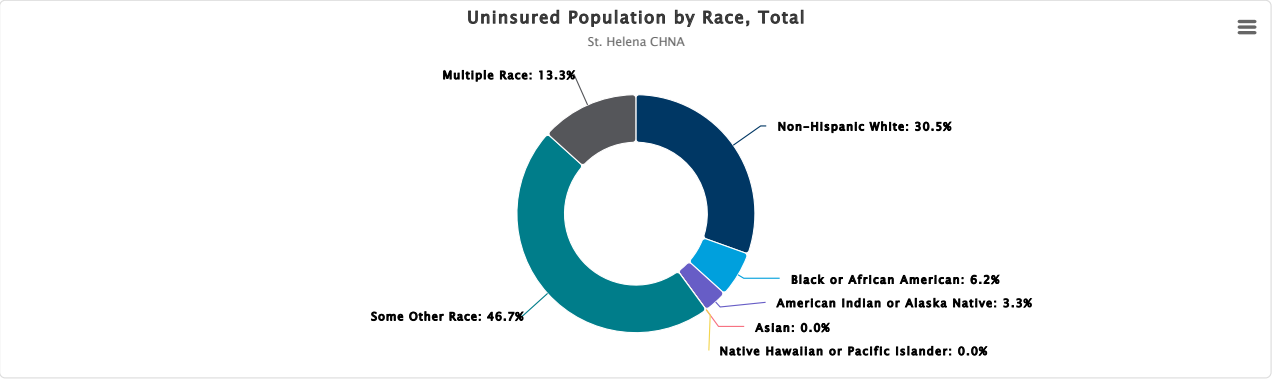


Uninsured Population by Race, Total

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
St. Helena CHNA	300	61	32	0	0	460	131
Napa County, CA	2,286	194	136	572	30	2,003	1,623
Sonoma County, CA	7,942	395	438	598	134	10,725	4,380
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

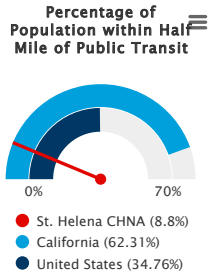
Data Source: US Census Bureau, American Community Survey. 2019-23.



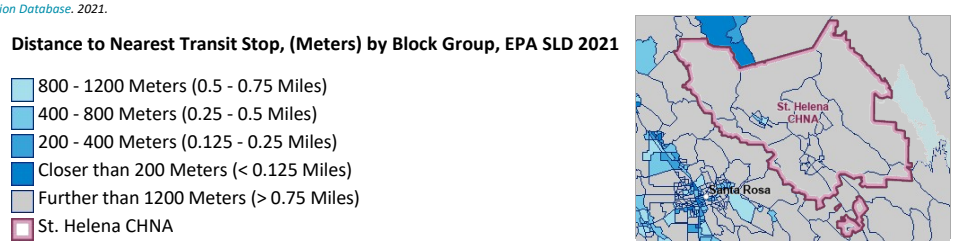
Barriers - Transportation - Distance to Public Transit

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
St. Helena CHNA	23,903	2,104	8.8%
Napa County, CA	140,530	4,670	3.32%
Sonoma County, CA	501,317	246,864	49.24%
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.

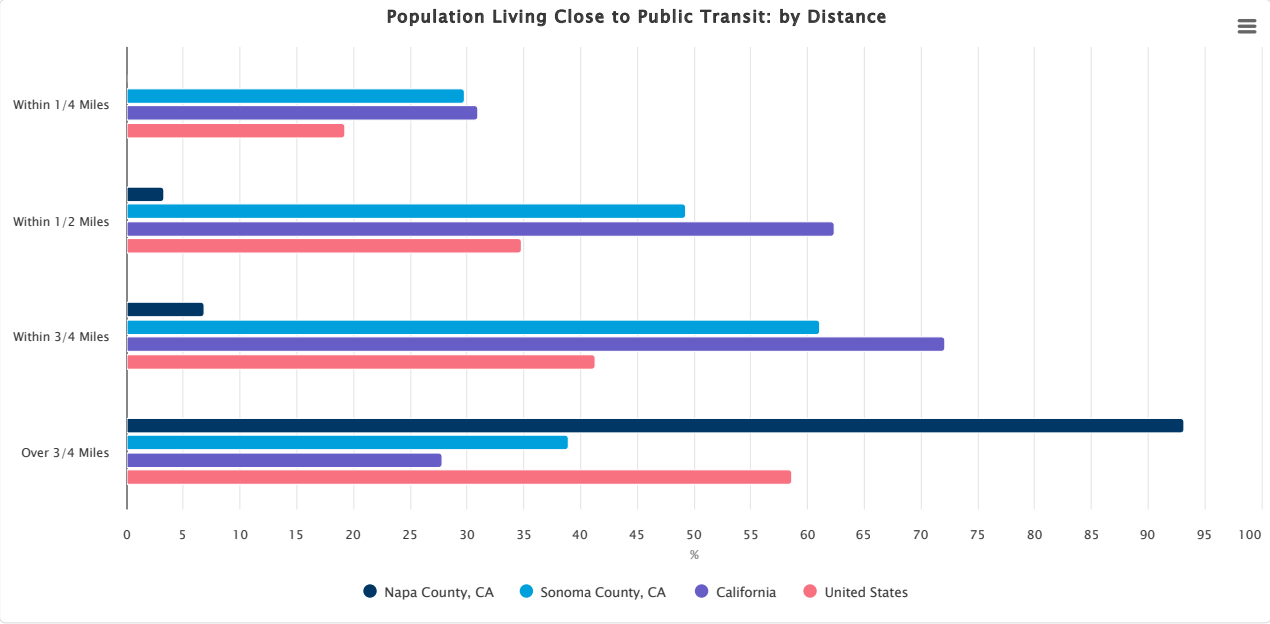


Population Living Close to Public Transit: by Distance

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
Napa County, CA	0%	3.32%	6.83%	93.17%
Sonoma County, CA	29.81%	49.24%	61.06%	38.94%
California	30.95%	62.31%	72.11%	27.83%
United States	19.25%	34.76%	41.26%	58.64%

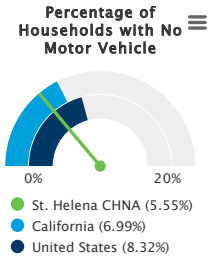
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2021.



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 8,776 total households in the report area, 487 or 5.55% are without a motor vehicle.

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
St. Helena CHNA	8,776	487	5.55%
Napa County, CA	49,663	2,361	4.75%
Sonoma County, CA	190,498	8,847	4.64%
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.

Households with No Vehicle, Percent by Tract, ACS 2019-23

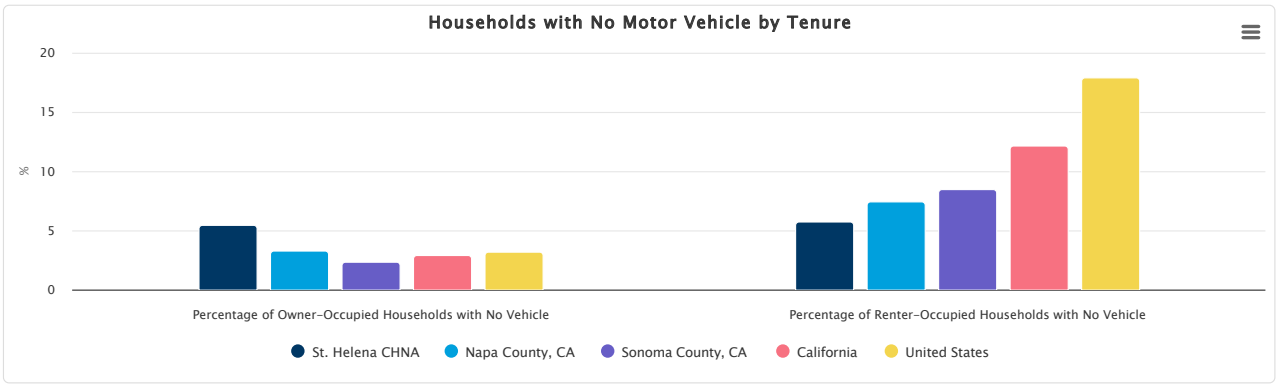
- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed
- St. Helena CHNA

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
St. Helena CHNA	312	5.46%	175	5.72%
Napa County, CA	1,046	3.27%	1,315	7.44%
Sonoma County, CA	2,752	2.32%	6,095	8.46%
California	216,828	2.89%	722,193	12.16%
United States	2,636,344	3.18%	7,966,482	17.87%

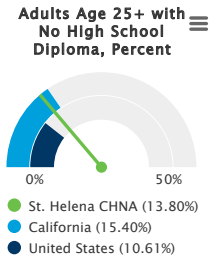
Data Source: US Census Bureau, American Community Survey. 2019-23.



Barriers - Health Literacy - Educational Attainment

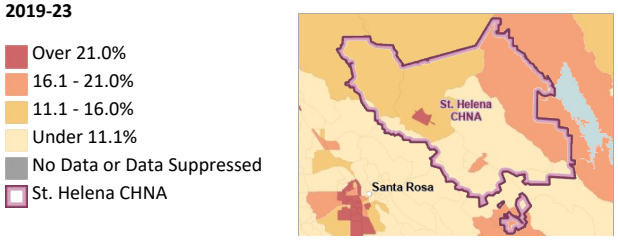
Within the report area there are 2,335 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 13.80% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

Report Area	Total Population Age 25+	Adults Age 25+ with No High School Diploma	Adults Age 25+ with No High School Diploma, Percent
St. Helena CHNA	16,926	2,335	13.80%
Napa County, CA	97,837	14,962	15.29%
Sonoma County, CA	353,701	39,389	11.14%
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.

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

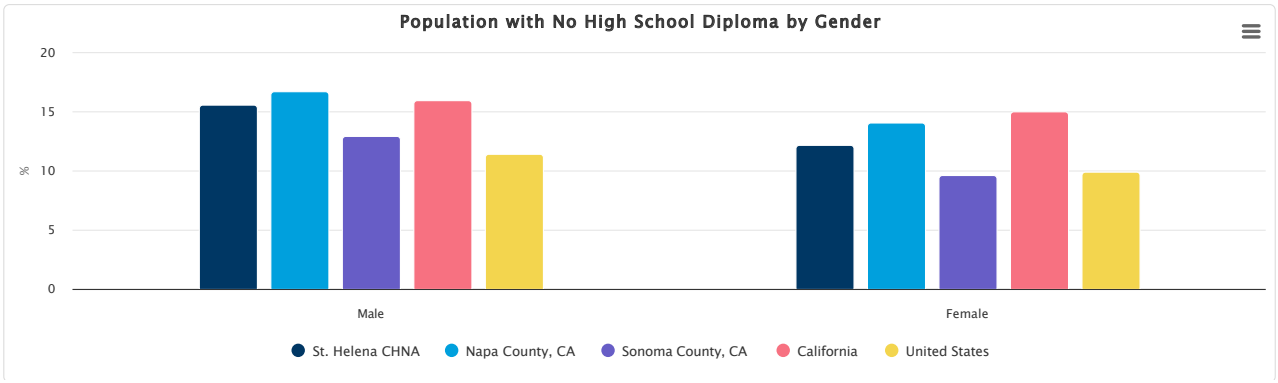


Population with No High School Diploma by Gender

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 15.51%; of all the females age 25+ within the report area, the percentage without a high school diploma is 12.10%.

Report Area	Male	Female	Male, Percent	Female, Percent
St. Helena CHNA	1,305	1,030	15.51%	12.10%
Napa County, CA	8,052	6,910	16.61%	14.00%
Sonoma County, CA	22,044	17,345	12.84%	9.53%
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.

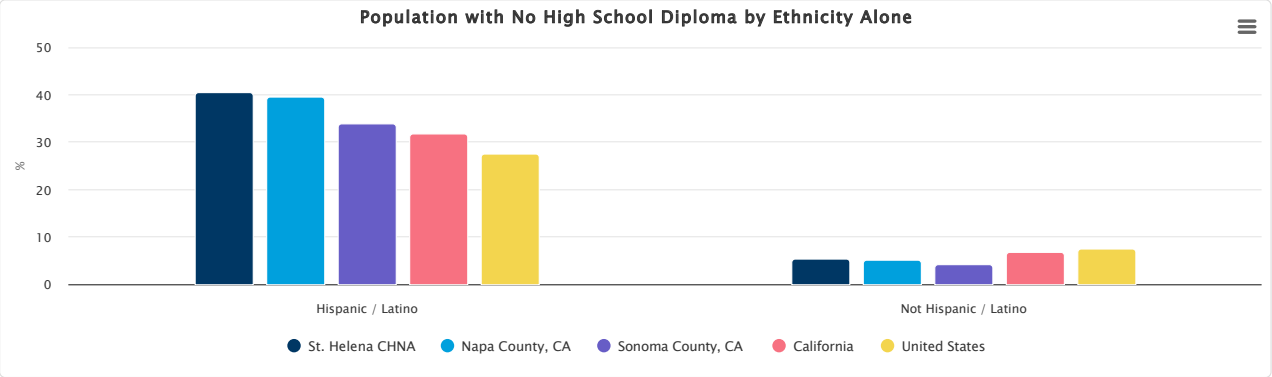


Population with No High School Diploma by Ethnicity Alone

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 40.56%; of all the non-Hispanic population age 25+ within the report area, the percentage without a high school diploma is 5.33%.

Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
St. Helena CHNA	1,649	686	40.56%	5.33%
Napa County, CA	11,411	3,551	39.47%	5.15%
Sonoma County, CA	28,190	11,199	33.79%	4.14%
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.

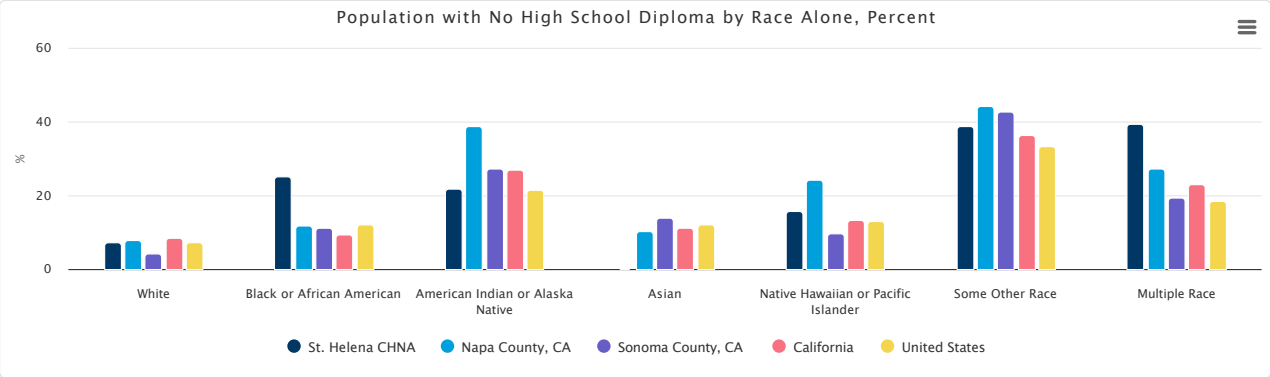


Population with No High School Diploma by Race Alone, Percent

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
St. Helena CHNA	7.00%	25.15%	21.57%	0.00%	15.63%	38.61%	39.32%
Napa County, CA	7.80%	11.71%	38.59%	10.01%	24.21%	44.24%	27.14%
Sonoma County, CA	4.24%	11.16%	26.98%	13.81%	9.60%	42.52%	19.15%
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%

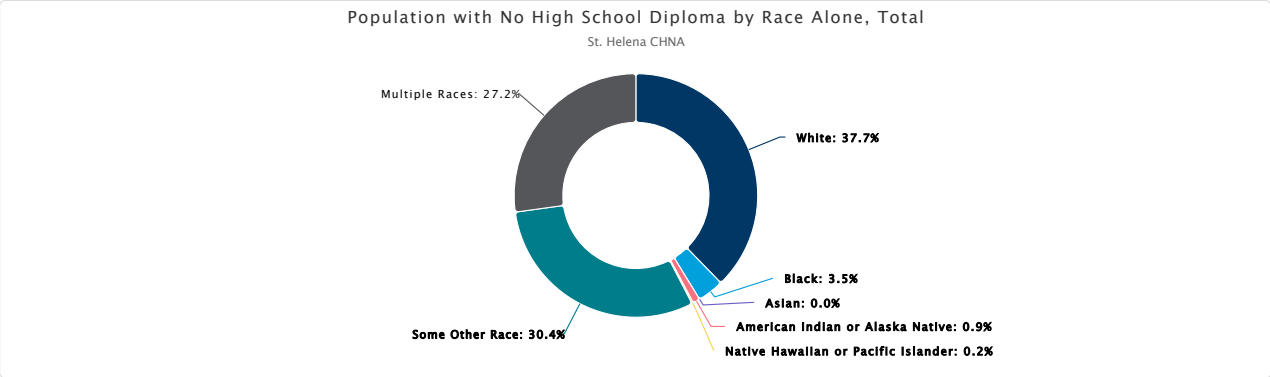
Data Source: US Census Bureau, American Community Survey. 2019-23.



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
St. Helena CHNA	881	82	0	22	5	710	635
Napa County, CA	4,932	210	788	350	61	5,606	3,015
Sonoma County, CA	10,507	587	2,263	1,117	106	17,526	7,283
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.

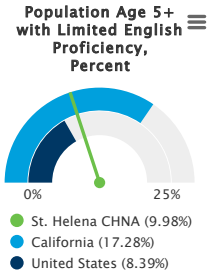


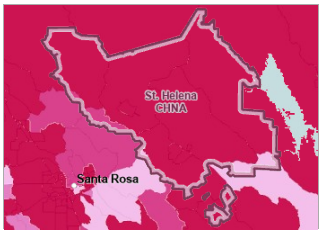
Barriers - Health Literacy - Limited English Proficiency

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 21,444 total population aged 5 and older in the report area, 2,140 or 9.98% have limited English proficiency.

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Population Age 5+ with Limited English Proficiency, Percent
St. Helena CHNA	21,444	2,140	**9.98%**
Napa County, CA	129,849	19,385	14.93%
Sonoma County, CA	462,805	51,616	11.15%
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

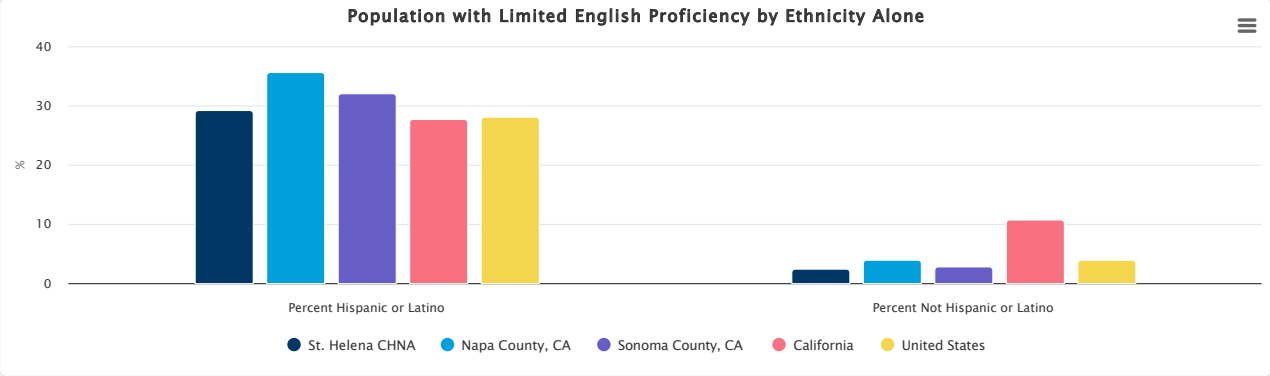
- Over 4.0%
- 2.1 - 4.0%
- 1.1 - 2.0%
- Under 1.1%
- No Data or Data Suppressed
- St. Helena CHNA

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
St. Helena CHNA	1,766	374	29.19%	2.43%
Napa County, CA	16,181	3,204	35.59%	3.80%
Sonoma County, CA	42,360	9,256	31.93%	2.80%
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.

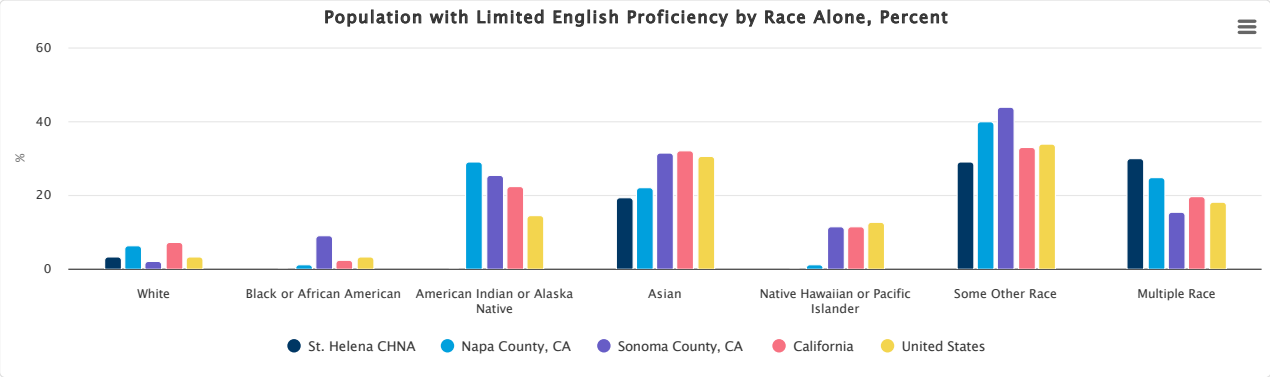


Population with Limited English Proficiency by Race Alone, Percent

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
St. Helena CHNA	3.24%	0.00%	0.00%	19.17%	0.00%	28.91%	29.81%
Napa County, CA	6.10%	1.04%	28.83%	21.90%	1.01%	39.82%	24.68%
Sonoma County, CA	1.82%	8.89%	25.34%	31.44%	11.41%	43.79%	15.24%
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.

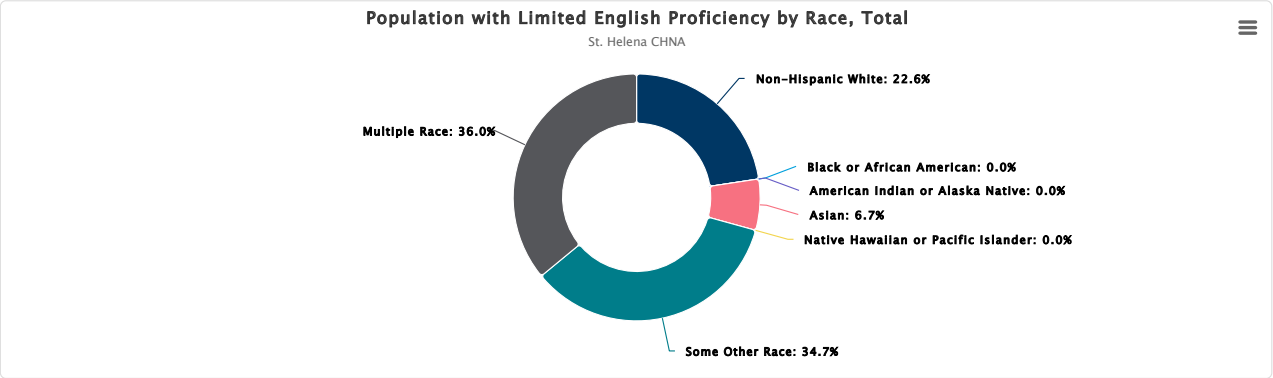


Population with Limited English Proficiency by Race, Total

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
St. Helena CHNA	484	0	0	143	0	743	770
Napa County, CA	4,789	26	335	2,291	4	7,514	4,426
Sonoma County, CA	5,511	651	1,501	6,498	189	28,040	9,226
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.

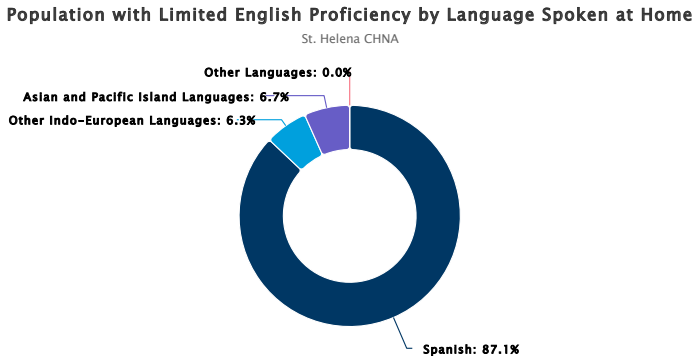


Population with Limited English Proficiency by Language Spoken at Home

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
St. Helena CHNA	1,863	134	143	0
Napa County, CA	16,504	902	1,928	51
Sonoma County, CA	42,587	2,593	5,755	681
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.

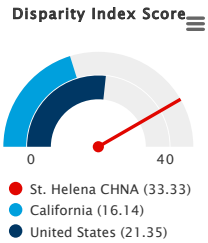


Barriers - Medical Insurance - Health Insurance Disparities

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
St. Helena CHNA	2.25%	11.61%	15.97%	10.01%	**33.33**
Napa County, CA	3.44%	8.96%	7.80%	8.49%	18.92
Sonoma County, CA	2.79%	10.99%	5.49%	9.95%	28.15
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.



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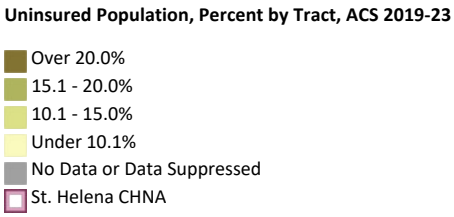


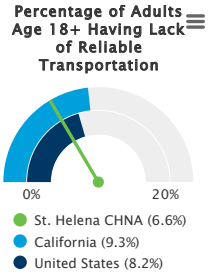
Barriers - Transportation - Lack of Reliable Transportation

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 6.6% 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)
St. Helena CHNA	22,794	**6.6%**	No data
Napa County, CA	134,300	8.0%	8.7%
Sonoma County, CA	482,650	7.0%	7.5%
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.



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 affects low-income communities and contributes to overall health disparities. Public health efforts to improve food security often involve increasing access to grocery stores, farmers markets and community gardens, as well as supporting programs like the Supplemental Nutrition Assistance Program (SNAP). In the St. Helena service area, there are nine SNAP-authorized retailers, a rate of 4.95 per 10,000 people compared to 7.84 per 10,000 people in California. Additionally, 22.35% of the population has low food access, which is defined as living more than ten miles from the nearest supermarket. People noted that there are not affordable grocery stores in Calistoga, sharing further that relying on the food bank means inconsistent access to healthy food options. Access to healthy food is an essential aspect of basic nutrition and is crucial for supporting long-term health outcomes, establishing food security as a priority need.

Addressing food security can improve community health outcomes, increase participation in food assistance programs and reduce disparities. For additional details, see the secondary data summary.

Scan QR Code to explore the full live data report on Food Security or visit: cares.page.link/8o3c

Data Highlights

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

"...recently we got into [helping address] food insecurity. So we set up food, fresh produce distributions for the community. Three times a month. That's not enough."

"There is a problem with [food banks] because you can't eat healthy from the food bank because they have canned food, they don't have fresh fruit."

"So right now, if you want to go buy a lot of food, you have to travel an hour away."

"...sometimes...it's cheaper to buy the thing that's less healthy..."

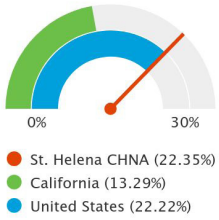
"...we see a lot of cross-pollination. People from St. Helena come to Calistoga and vice versa...some people from Fairfield for instance, they're living here and they pass by on Friday, they stop by to pick up food or they live in Clear Lake. They stop by to pick up food..."

"...in Calistoga there's not an affordable grocery store for the community."

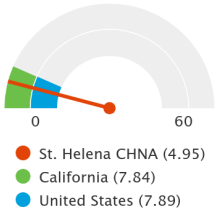
"They [the community] have a higher percentage of need, just plain and simple access to the fundamentals of shelter, food [and] safety."

"In fact, we developed an inventory of resources to address food insecurity, and we keep that updated and we make that available to our patients and they know where the locations are, what the resource is [and] when it's available."

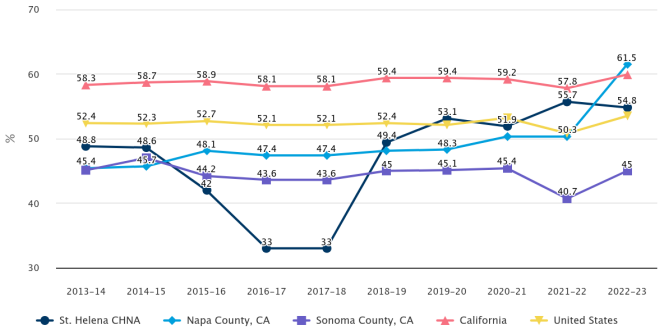
Percent Population with Low Food Access



SNAP-Authorized Retailers, Rate (Per 10,000 Population)



Children Eligible for Free or Reduced Price Lunch by School Year, 2013-14 through 2022-23



Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2022-2023.
Downloaded from adventisthealth.engagementnetwork.org

Community Resources

Community Action of Napa Valley
canv.org/food-bank/
707-253-6100

Napa County Food Assistance
countyofnapa.org/382/Food-Assistance
707-253-4511

Community Health Needs Assessment Full Report

Location

St. Helena CHNA

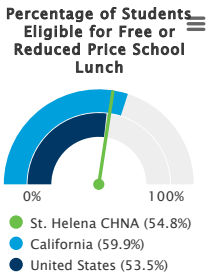
Basic Needs: Food Security

Economic Security - Free/Reduced Price Lunch

Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130 percent (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Out of 2,077 total public school students in the report area, 1,138 were eligible for the free or reduced price lunch program in the latest report year. This represents 54.8% of public school students, which is lower than the state average of 59.9%.
Note: States with more than 80% records "not reported" are suppressed for all geographic areas, including hospital service area, census tract, zip code, school district, county, state, etc.

Report Area	Total Students	Students Eligible for Free or Reduced Price Lunch	Students Eligible for Free or Reduced Price Lunch, Percent
St. Helena CHNA	2,077	1,138	54.8%
Napa County, CA	18,604	11,443	61.5%
Sonoma County, CA	63,218	28,449	45.0%
California	5,838,242	3,497,699	59.9%
United States	46,791,755	24,677,523	53.5%



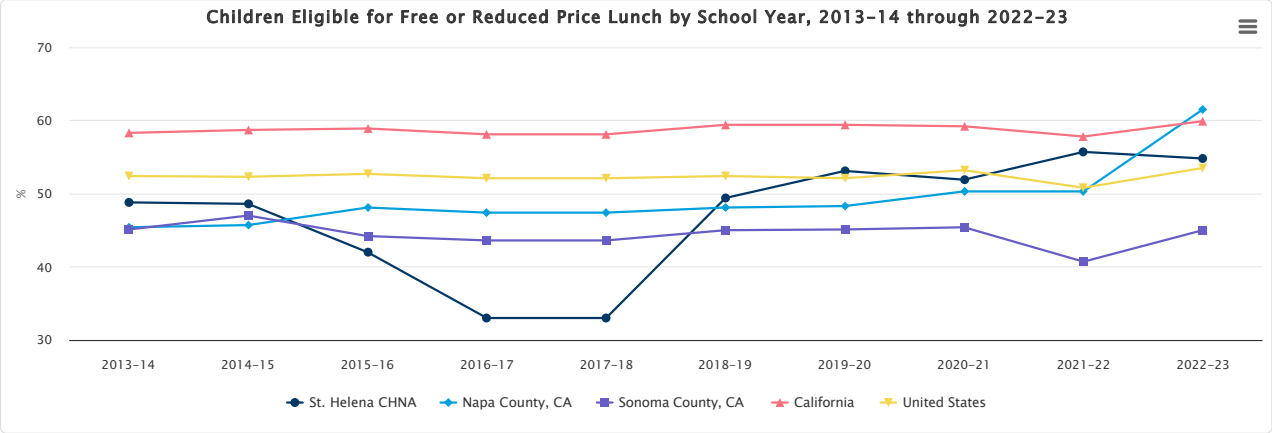
Note: This indicator is compared to the state average.
Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2022-2023.

Children Eligible for Free or Reduced Price Lunch by School Year, 2013-14 through 2022-23

The table below shows local, state, and national trends in student free and reduced lunch eligibility by percent.
Note: The states below have more than 80% public schools labeled as "not reported" in 2022-2023. For consistency, these states still have their values calculated with the limited records on all geographic levels (unless there is not a single record reported in the selected area). Use with caution when comparing to other years. This issue might occur in other states/years as well.
For 2022-2023, watch out for Delaware, District of Columbia, Massachusetts, Montana, Tennessee, West Virginia, American Samoa, and Guam.

Report Area	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St. Helena CHNA	48.8%	48.6%	42.0%	33.0%	33.0%	49.4%	53.1%	51.9%	55.7%	54.8%
Napa County, CA	45.4%	45.7%	48.1%	47.4%	47.4%	48.1%	48.3%	50.3%	50.3%	61.5%
Sonoma County, CA	45.1%	47.0%	44.2%	43.6%	43.6%	45.0%	45.1%	45.4%	40.7%	45.0%
California	58.3%	58.7%	58.9%	58.1%	58.1%	59.4%	59.4%	59.2%	57.8%	59.9%
United States	52.4%	52.3%	52.7%	52.1%	52.1%	52.4%	52.1%	53.2%	50.8%	53.5%

Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2022-2023.



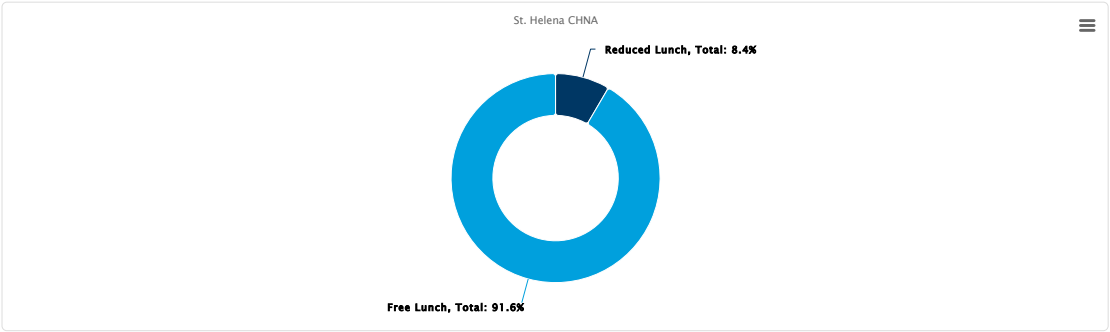
Children Eligible for Free or Reduced Price Lunch by Eligibility

The table below displays the number and percentage of students eligible for free or reduced price lunch by income eligibility category. Percentages in the table below are out of the total student population.
Note: States with more than 80% records labeled as "not reported" are suppressed for all geographic areas.

Report Area	Free Lunch, Total	Free Lunch, Percent	Reduced Lunch, Total	Reduced Lunch, Percent
St. Helena CHNA	1,042	50.2%	96	4.6%
Napa County, CA	9,135	49.1%	2,308	12.4%
Sonoma County, CA	24,203	38.3%	4,246	6.7%
California	3,069,703	52.6%	427,996	7.3%
United States	21,117,358	42.8%	2,275,791	4.6%

Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2022-2023.

The chart below displays the percentage of the students in each eligibility category out of the total number of students eligible for free or reduced price lunch. Of all the 1,138 students eligible for free or reduced price lunch, 91.6% are eligible for free lunch and 8.4% are eligible for reduced lunch.



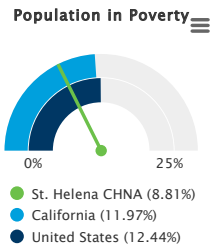
Economic Security - Poverty (100% FPL)

Poverty is considered a *key driver* of health status.

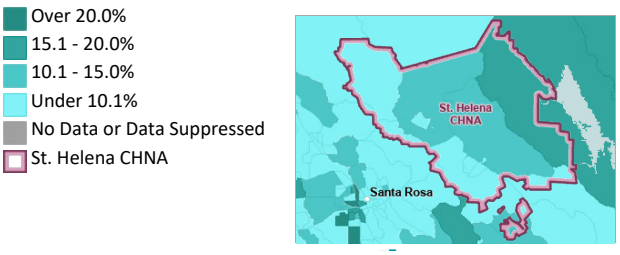
Within the report area 8.81% or 1,801 individuals for whom poverty status is determined are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.
Note: The total population measurements for poverty reports are lower than population totals for some other indicators, as poverty data collection does not include people in group quarters. See "Show more details" for more information.

Report Area	Total Population	Population in Poverty	Population in Poverty
St. Helena CHNA	20,646	1,801	8.81%
Napa County, CA	133,332	11,238	8.43%
Sonoma County, CA	478,869	41,044	8.57%
California	38,529,452	4,610,600	11.97%
United States	324,567,147	40,390,045	12.44%

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



Population Below the Poverty Level, Percent by Tract, ACS 2019-23

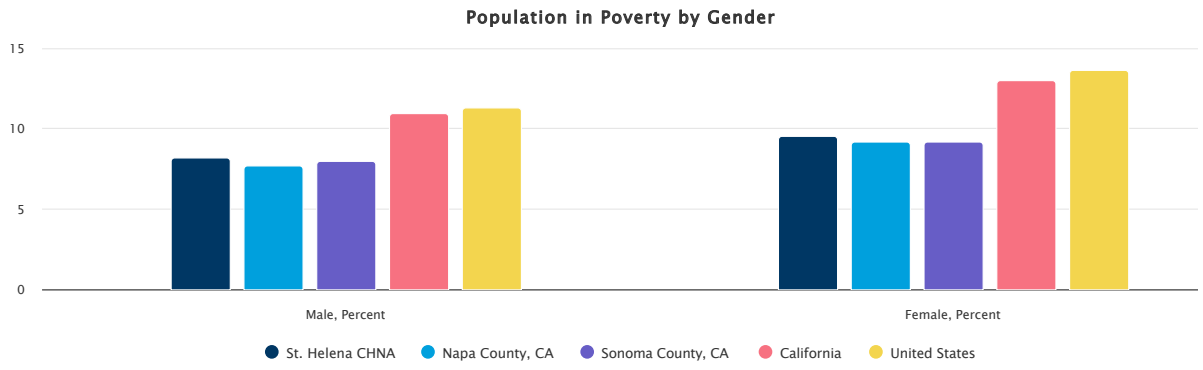


Population in Poverty by Gender

This indicator reports the population in poverty in the report area by gender.
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion living in households with income below the federal poverty level is (value)."*

Report Area	Male	Female	Male, Percent	Female, Percent
St. Helena CHNA	875	926	8.19%	9.50%
Napa County, CA	5,142	6,096	7.70%	9.16%
Sonoma County, CA	18,732	22,312	7.97%	9.15%
California	2,099,885	2,510,715	10.95%	12.97%
United States	18,016,757	22,373,288	11.26%	13.60%

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

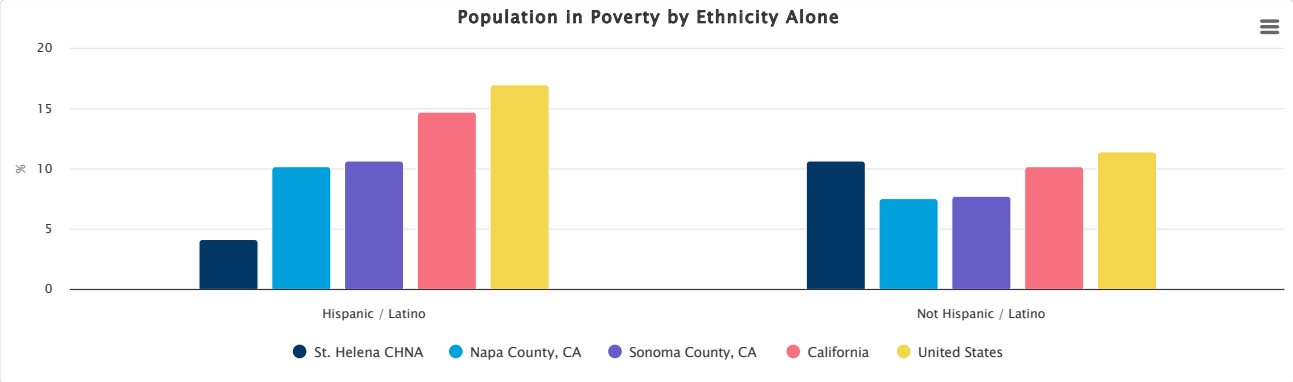


Population in Poverty by Ethnicity Alone

This indicator reports the population in poverty in the report area by ethnicity alone.
The percentage values could be interpreted as, for example, *"Of all the Hispanic population 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
St. Helena CHNA	250	1,551	4.15%	10.60%
Napa County, CA	4,862	6,376	10.10%	7.48%
Sonoma County, CA	14,910	26,134	10.60%	7.73%
California	2,261,589	2,349,011	14.71%	10.14%
United States	10,467,411	29,922,634	16.89%	11.39%

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

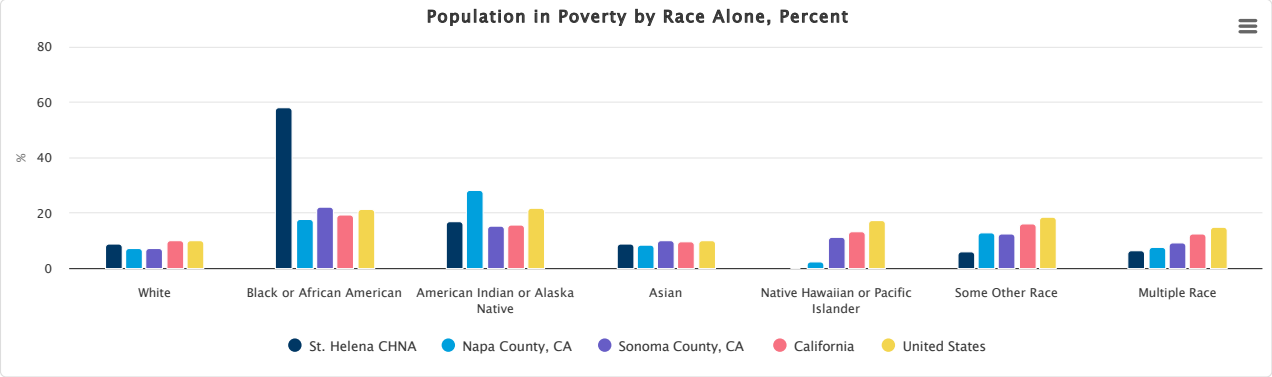


Population in Poverty by Race Alone, Percent

This indicator reports the percentage of population in poverty in the report area by race alone.
The percentage values could be interpreted as, for example, *"Of all the white population within the report area, the proportion living in households with income below the federal poverty level 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
St. Helena CHNA	8.62%	58.12%	16.85%	8.81%	0.00%	5.71%	6.25%
Napa County, CA	7.12%	17.69%	27.90%	8.16%	2.06%	12.67%	7.38%
Sonoma County, CA	7.10%	21.84%	15.27%	10.10%	11.18%	12.35%	9.05%
California	10.08%	19.14%	15.70%	9.69%	13.16%	15.89%	12.34%
United States	9.85%	21.28%	21.81%	9.93%	17.18%	18.24%	14.70%

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

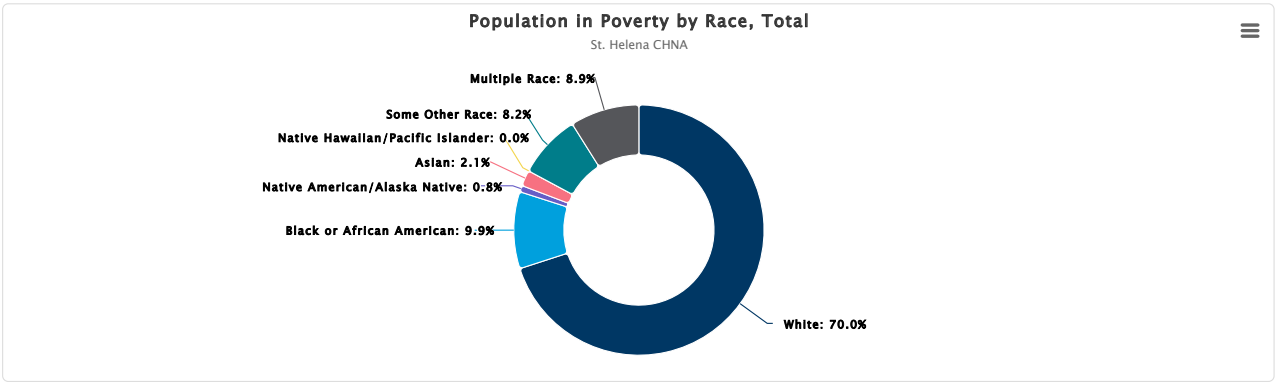


Population in Poverty by Race, Total

This indicator reports the total population in poverty in the report area 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
St. Helena CHNA	1,261	179	15	37	0	148	161
Napa County, CA	5,714	421	332	851	8	2,524	1,388
Sonoma County, CA	22,001	1,518	924	2,128	185	8,326	5,962
California	1,707,897	398,485	68,453	572,153	19,064	1,065,588	778,960
United States	20,312,310	8,404,656	617,308	1,884,376	104,976	3,933,913	5,132,506

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

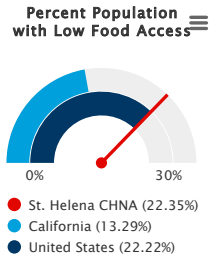


Food Access - Access to Healthy Food

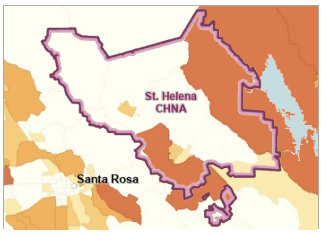
This indicator reports the percentage of the population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the 2019 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.

22.35% of the total population in the report area have low food access. The total population in the report area with low food access is 5,215.

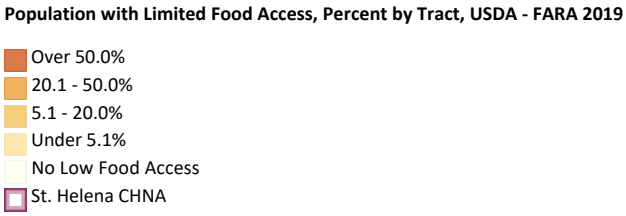
Report Area	Total Population (2010)	Population with Low Food Access	Percent Population with Low Food Access
St. Helena CHNA	23,339	5,215	**22.35%**
Napa County, CA	136,484	16,494	12.08%
Sonoma County, CA	483,878	64,341	13.30%
California	37,253,956	4,951,436	13.29%
United States	308,745,538	68,611,398	22.22%



Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.



View larger map

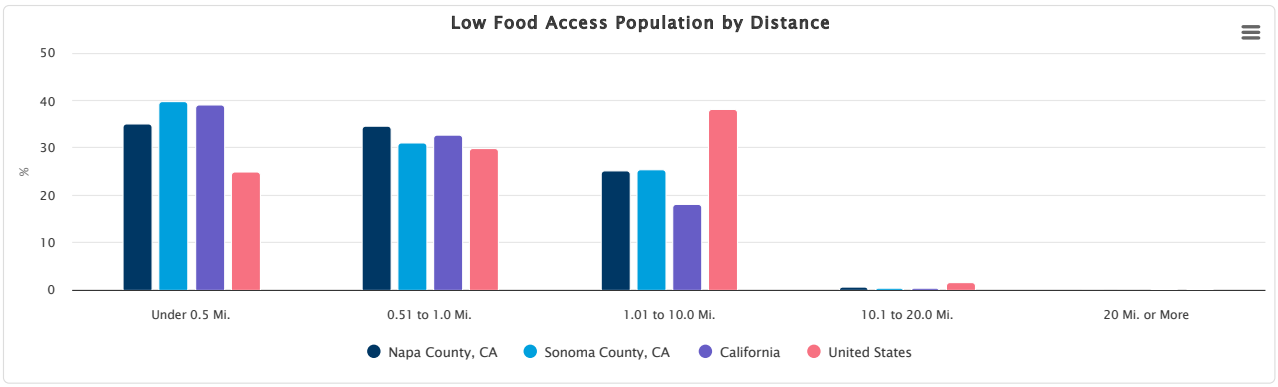


Low Food Access Population by Distance

The table below displays the percentage of the total population in groupings based on distance to large grocery stores.

Report Area	Under 0.5 Mi.	0.51 to 1.0 Mi.	1.01 to 10.0 Mi.	10.1 to 20.0 Mi.	20 Mi. or More
Napa County, CA	34.97%	34.54%	25.08%	0.70%	0.00%
Sonoma County, CA	39.78%	31.07%	25.43%	0.43%	0.00%
California	39.14%	32.55%	17.94%	0.44%	0.09%
United States	24.80%	29.91%	38.12%	1.49%	0.18%

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

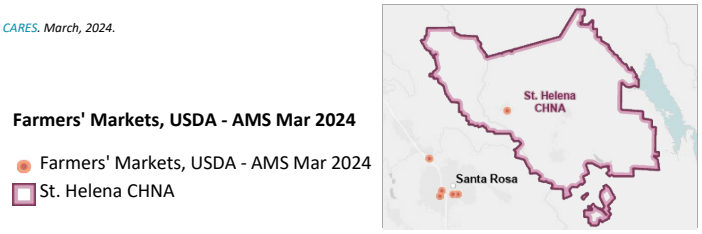


Food Access - Local Food Outlets

This indicator reports the total number of farmers markets and the rate of farmers markets accepting SNAP per 100,000 SNAP recipients. Data come from U.S. Department of Agriculture, 2023.

Report Area	Total Population	Population Below 185% FPL	Number of Farmers Markets	Farmers Markets Accepting SNAP Benefits	Farmers Markets, Rate per 100,000 Pop.	Farmers Markets Accepting SNAP, Rate per 100,000 Low Income Pop.
St. Helena CHNA	20,646	3,505	1	0	4.84	0.00
Napa County, CA	138,795	24,681	5	1	3.60	4.05
Sonoma County, CA	492,498	88,494	15	10	3.05	11.30
California	39,455,353	10,075,419	581	88	1.47	0.87
United States	333,036,755	87,874,715	7,007	686	2.10	0.78

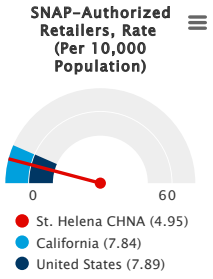
Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, USDA - Agriculture Marketing Service. Additional data analysis by CARES. March, 2024.



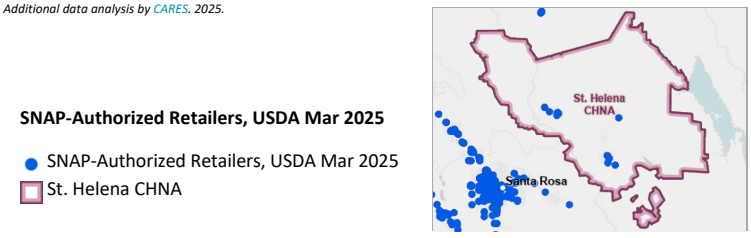
Food Access - SNAP-Authorized Retailers

This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits. The report area contains a total of 10 SNAP-authorized retailers with a rate of 4.95.

Report Area	Total Population (2020)	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers, Rate per 10,000 Population
St. Helena CHNA	22,069	10	4.95
Napa County, CA	136,070	74	5.44
Sonoma County, CA	485,642	375	7.72
California	39,242,785	30,751	7.84
United States	335,409,240	264,826	7.89



Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2025.



Food Access - Healthy Food Access Disparities

This indicator reports the percentage of the report area population living in a food desert by population race and ethnicity. A food desert is defined as a low-income neighborhood (census tract) where a large proportion of the population does not have access to a large grocery store. The disparity index score is a relative measure which expresses the magnitude of disparity in food access 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
Napa County, CA	10.48%	18.30%	12.55%	5.25%	15.48
Sonoma County, CA	10.75%	29.23%	26.48%	19.44%	22.45
California	17.54%	38.70%	37.55%	19.40%	18.50
United States	18.73%	36.99%	45.91%	22.59%	17.62

Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

Food Desert Census Tracts, 1 Mi. / 10 Mi. by Tract, USDA - FARA 2019

- Food Desert
- Not a Food Desert
- No Data
- St. Helena CHNA

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 chronic illness often experience higher levels of stress and anxiety, which can trigger mental health issues. According to the Substance Abuse and Mental Health Services Administration, 23.1% of U.S. adults (59.3 million) experienced a mental health condition in 2022. Living with a mental health condition can vary in severity, causing distress and negatively affecting personal, social and work life. For some, it can significantly impact their ability to carry out daily obligations.

The growing prevalence of mental health as an issue is affecting many community residents. People note a wide variety of factors that contribute to poor mental health, like adverse childhood experiences or poverty. Increased risk factors like stress and trauma due to higher violent crime rates and unemployment, are also linked to mental health outcomes. In the St. Helena CHNA service area, 14.1% of the population reported poor mental health. A key informant noted it's "no surprise that we are in a mental health crisis today with declining mental health and increasing homelessness." A community survey showed 29.1% of respondents are seeking mental health related resources to live better.

Opportunities to address indicators of mental health 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 secondary data summary.

Community Resources

Aldea
aldeainc.org

California Youth Crisis Hotline
800-843-5200

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

Mentis
mentisnapa.org

Napa County Behavioral Health Services
countyofnapa.org/3730/Behavioral-Health-Services-BHS
Crisis Hotline: 707-253-4711

Scan QR Code to explore the full live data report on Mental Health or visit: cares.page.link/pyq5

Data Highlights

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

"I think mental health issues can span all races, gender, socioeconomic factors."

"All the providers that I work with...everyone is seeing a higher mental health acuity in substance abuse clients."

"...but from my research...the most underserved psychiatric population is the elderly."

"But I think the collaborative care, in my opinion in the future would be huge. Just having collaborative care with everyone [including] boys and girls club, with the police, with the hospital, with the psychiatrist, psychologists, counselors. Having people have a team instead of everyone being so isolated..."

"...if I had to refer somebody to a psychiatrist today, I wouldn't even have a name of a psychiatrist."

"...we recognize that we're having a lot of anxiety and depression in younger people."

"...I think there's no surprise that we are in a mental health crisis today with a declining mental health and increasing homelessness."

"But I think from the hospital standpoint or from the healthcare standpoint, we don't have enough mental health staff..."

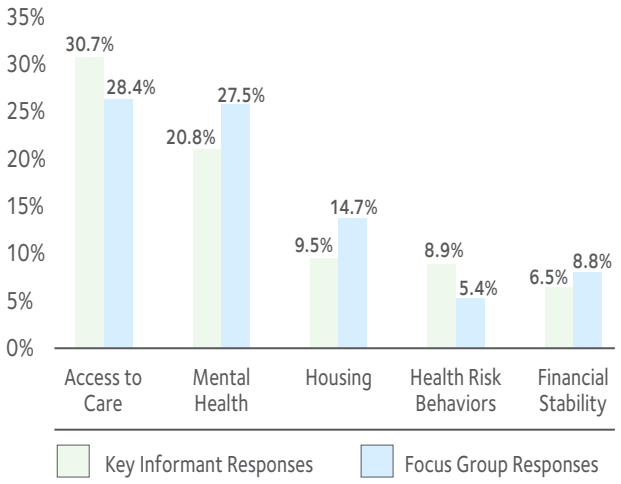
"...there does seem to be a pretty direct relationship between the pandemic and what we're seeing now in terms of youth mental health..."

St. Helena Community Health Needs Survey

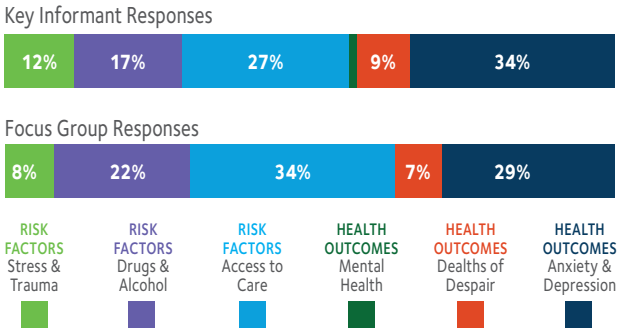
When asked about the resources the community needs more of to live better,

29.1%

selected mental health related resources.



The above chart demonstrates the percentage of total references during key informant interviews and focus groups that centered around the five health need topics listed. The topics are listed in order of most referenced to least referenced community health need during conversations with community members. Please see methodology V. D Focus Group & Key Informant Interview Methodology for more information.



The above chart depicts the reasons why key informant interviewees and focus groups selected Mental Health as a community health need.

Community Health Needs Assessment Full Report

Location

St. Helena CHNA

Health Needs: Mental Health

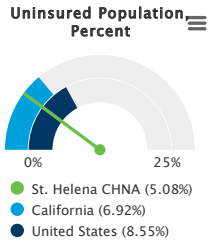
Risk Factors - Access to Care - Medical Insurance

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

In the report area 5.08% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less 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
St. Helena CHNA	21,566	1,096	5.08%
Napa County, CA	134,594	7,679	5.71%
Sonoma County, CA	482,063	26,060	5.41%
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.

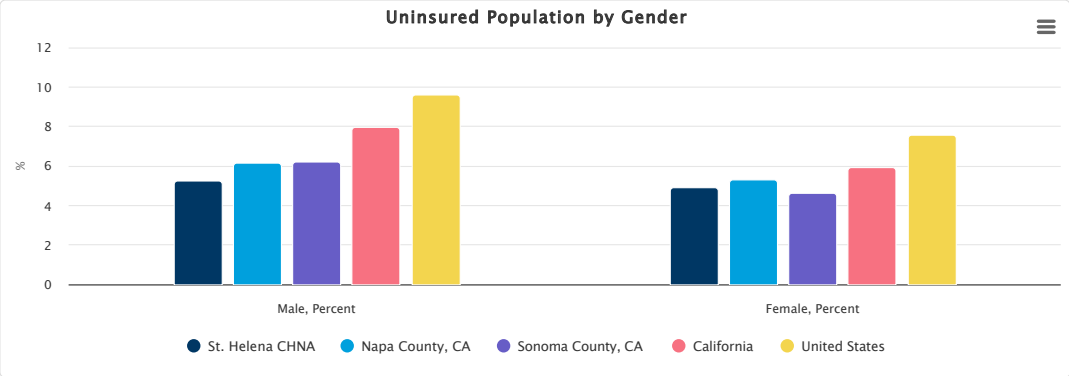


Uninsured Population by Gender

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
St. Helena CHNA	588	508	5.24%	4.91%
Napa County, CA	4,123	3,556	6.13%	5.28%
Sonoma County, CA	14,683	11,377	6.21%	4.63%
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.

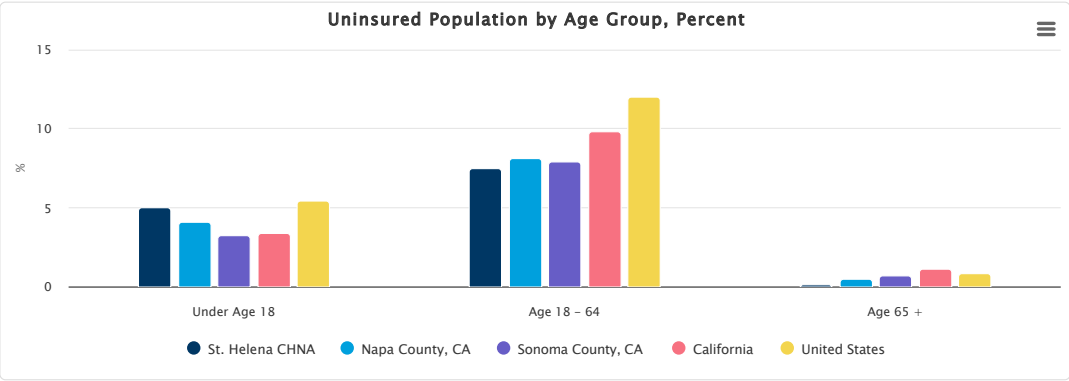


Uninsured Population by Age Group, Percent

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 +
St. Helena CHNA	4.96%	7.49%	0.10%
Napa County, CA	4.09%	8.08%	0.48%
Sonoma County, CA	3.22%	7.89%	0.66%
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.

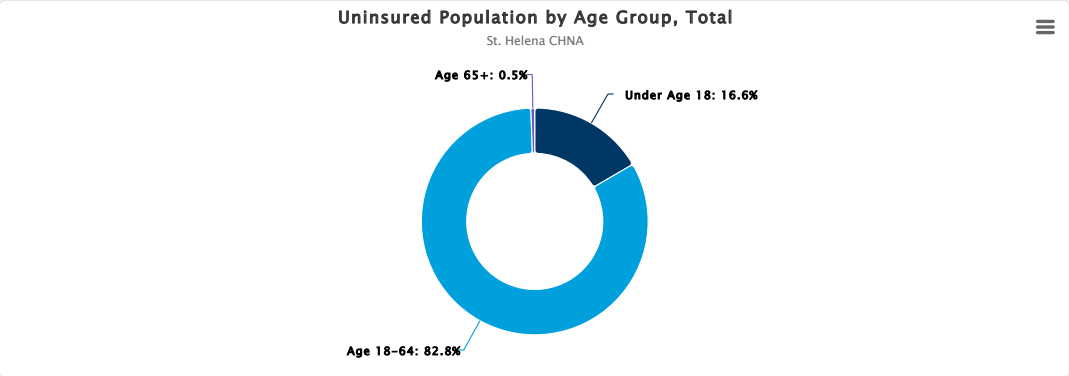


Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

Report Area	Under Age 18	Age 18-64	Age 65+
St. Helena CHNA	182	908	6
Napa County, CA	1,174	6,374	131
Sonoma County, CA	3,231	22,168	661
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.

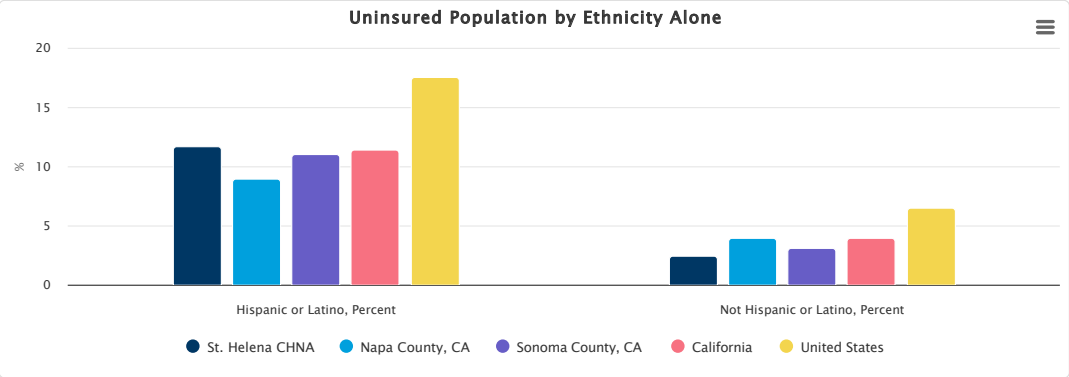


Uninsured Population by Ethnicity Alone

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
St. Helena CHNA	733	363	11.61%	2.38%
Napa County, CA	4,344	3,335	8.96%	3.87%
Sonoma County, CA	15,627	10,433	10.99%	3.07%
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.

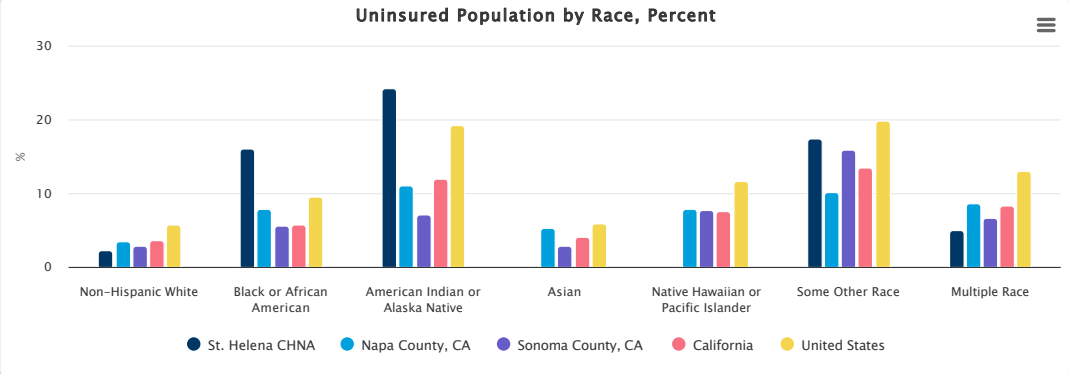


Uninsured Population by Race, Percent

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
St. Helena CHNA	2.25%	15.97%	24.24%	0.00%	0.00%	17.38%	4.88%
Napa County, CA	3.44%	7.80%	11.02%	5.29%	7.73%	10.02%	8.56%
Sonoma County, CA	2.79%	5.49%	7.10%	2.80%	7.64%	15.76%	6.61%
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.

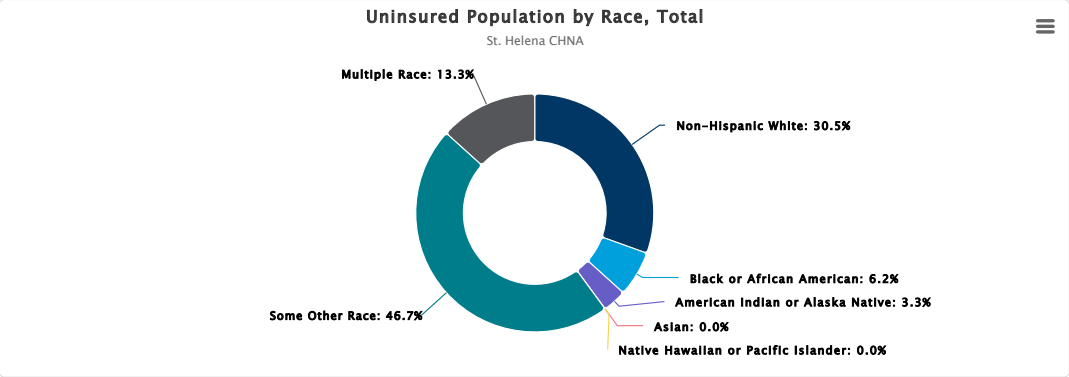


Uninsured Population by Race, Total

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
St. Helena CHNA	300	61	32	0	0	460	131
Napa County, CA	2,286	194	136	572	30	2,003	1,623
Sonoma County, CA	7,942	395	438	598	134	10,725	4,380
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.



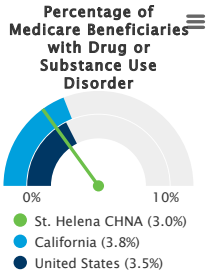
Risk Factors - Drugs & Alcohol - Substance Use Disorder

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 75 beneficiaries with substance use disorder. This represents a 3.0% 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
St. Helena CHNA	2,547	75	3.0%
Napa County, CA	15,492	452	2.9%
Sonoma County, CA	48,391	2,434	5.0%
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
- St. Helena 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
St. Helena CHNA	1.1%	1.2%	1.3%	1.5%	1.8%	2.3%	2.6%	3.0%
Napa County, CA	1.1%	1.2%	1.2%	1.5%	1.8%	2.3%	2.6%	2.9%
Sonoma County, CA	1.9%	2.3%	2.4%	2.6%	2.7%	3.6%	4.6%	5.0%
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
St. Helena CHNA	1.8%	9.8%
Napa County, CA	1.8%	9.7%
Sonoma County, CA	3.3%	16.7%
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 16.6% 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)
St. Helena CHNA	22,794	16.6%	No data
Napa County, CA	134,300	18.2%	20.4%
Sonoma County, CA	482,650	18.5%	20.7%
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 .

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
St. Helena CHNA	17.8%	17.5%	17.4%	16.0%	16.6%
Napa County, CA	17.8%	18.0%	17.2%	15.8%	18.2%
Sonoma County, CA	18.0%	17.7%	17.6%	17.5%	18.5%
California	17.3%	17.3%	16.8%	15.1%	18.1%
United States	16.4%	16.7%	15.5%	15.5%	16.6%

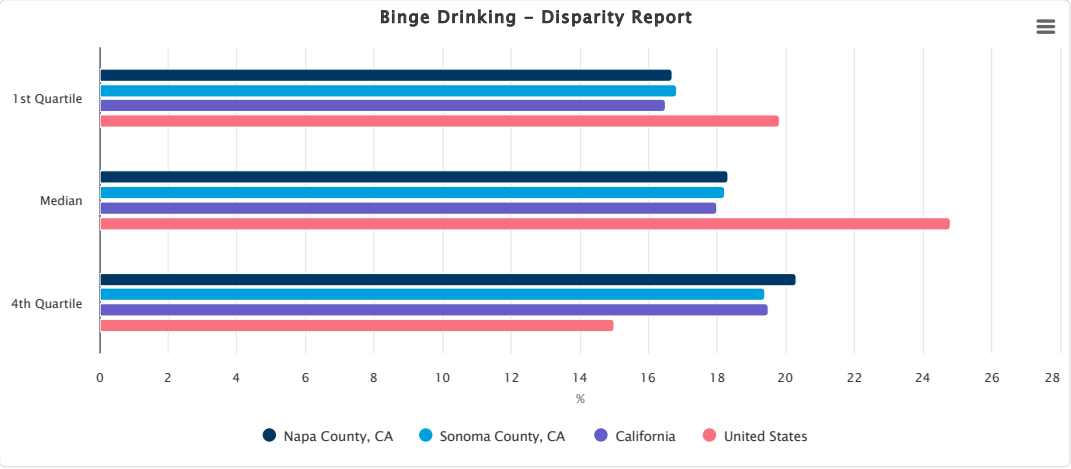
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022 .

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
Napa County, CA	16.70%	18.30%	20.30%
Sonoma County, CA	16.80%	18.20%	19.40%
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 .



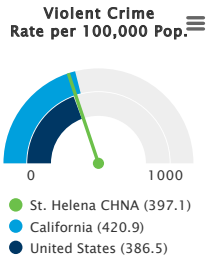
Risk Factors - Stress & Trauma - Violent Crime Rate

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, 93 violent crimes occurred in 2014 and 2016 (two years). The violent crime rate of 397.1 per 100,000 residents is lower 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.)
St. Helena CHNA	93	397.1
Napa County, CA	566	397.7
Sonoma County, CA	1,845	367.9
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.

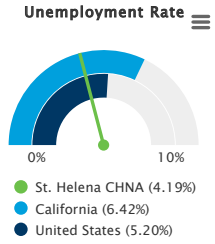


Risk Factors - Stress & Trauma - Unemployment

According to the most recent American Community Survey estimates, total unemployment in the report area is 487, or 4.19% 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
St. Helena CHNA	11,623	487	4.19%
Napa County, CA	71,753	3,643	5.08%
Sonoma County, CA	260,365	13,476	5.19%
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.



Unemployed Workers, Percent by Tract, ACS 2019-23

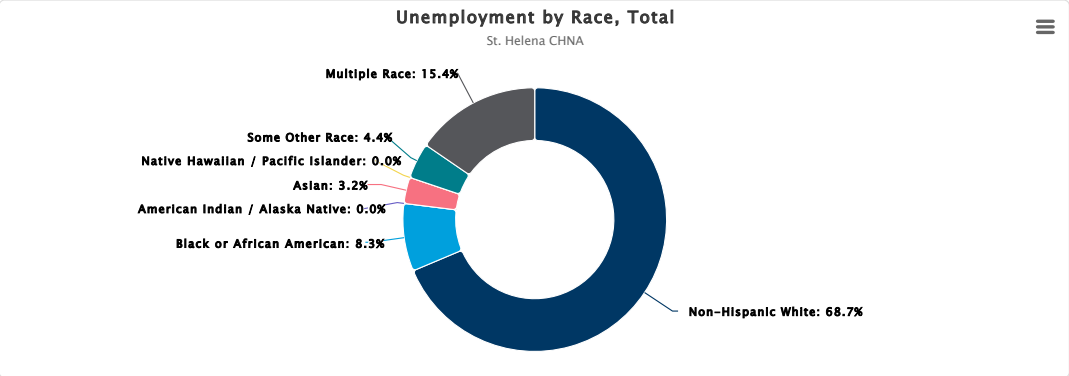
- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed
- St. Helena CHNA

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
St. Helena CHNA	298	36	0	14	0	19	67
Napa County, CA	1,909	91	30	184	6	537	510
Sonoma County, CA	7,879	296	110	395	21	1,882	2,315
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.

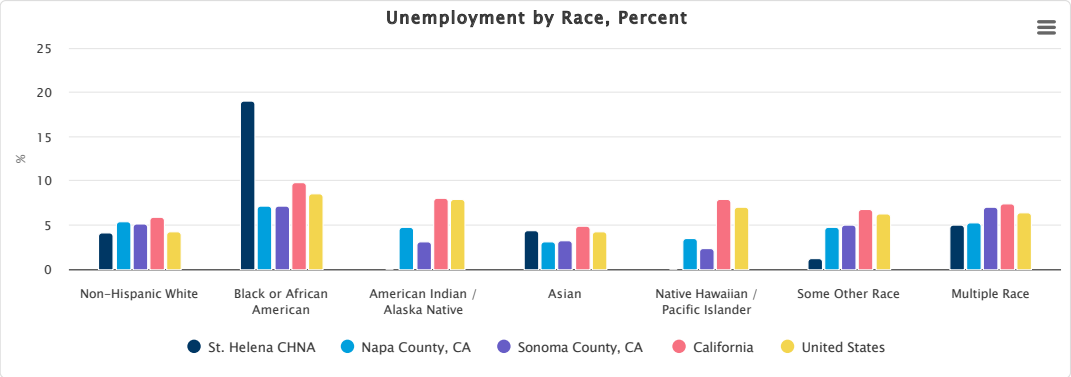


Unemployment by Race, Percent

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
St. Helena CHNA	4.13%	19.05%	0.00%	4.36%	0.00%	1.23%	4.95%
Napa County, CA	5.42%	7.11%	4.76%	3.07%	3.41%	4.79%	5.23%
Sonoma County, CA	5.09%	7.16%	3.06%	3.25%	2.32%	4.96%	6.95%
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.

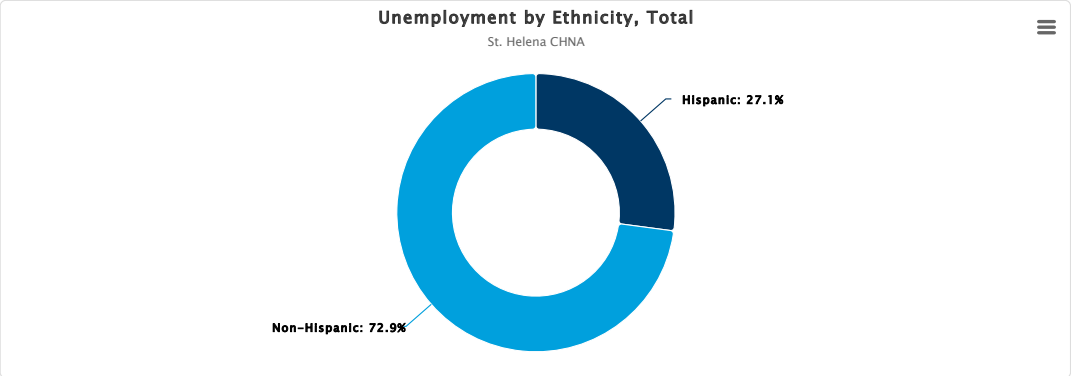


Unemployment by Ethnicity, Total

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

Report Area	Hispanic	Non-Hispanic
St. Helena CHNA	132	355
Napa County, CA	1,365	2,278
Sonoma County, CA	4,056	9,420
California	537,311	744,948
United States	1,889,916	6,869,401

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

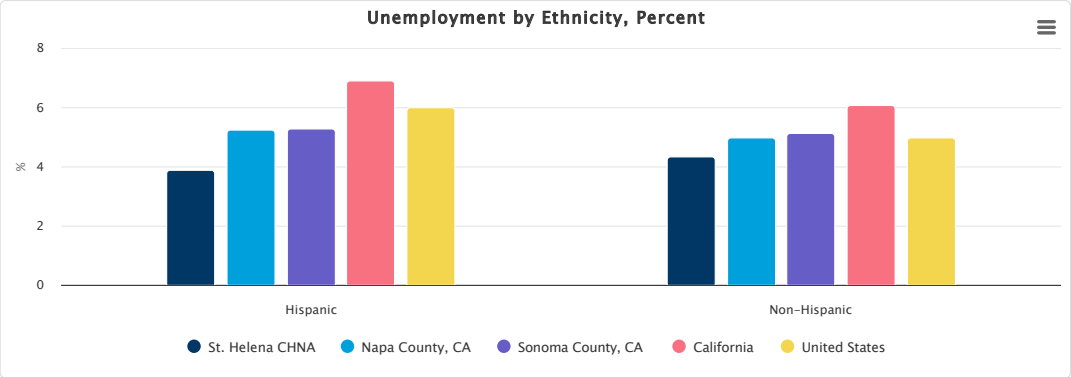


Unemployment by Ethnicity, Percent

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
St. Helena CHNA	3.85%	4.33%
Napa County, CA	5.24%	4.98%
Sonoma County, CA	5.28%	5.13%
California	6.87%	6.04%
United States	6.00%	4.97%

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



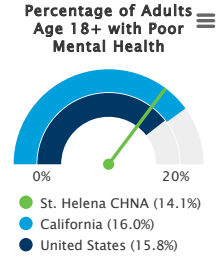
Health Outcomes - Anxiety & Depression - Poor Mental Health

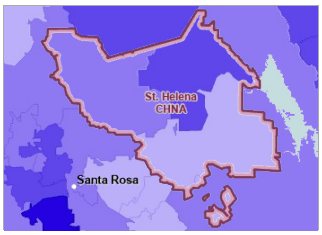
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Within the report area, there were 14.1% 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)
St. Helena CHNA	22,794	14.1%	No data
Napa County, CA	134,300	15.9%	17.2%
Sonoma County, CA	482,650	15.0%	16.3%
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
- St. Helena 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.

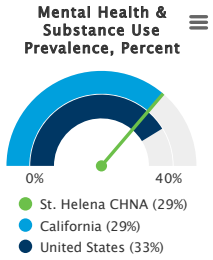
Report Area	2018	2019	2020	2021	2022
St. Helena CHNA	11.3%	11.5%	12.9%	13.7%	14.1%
Napa County, CA	11.5%	11.5%	13.0%	13.8%	15.9%
Sonoma County, CA	12.1%	11.9%	13.3%	14.2%	15.0%
California	12.6%	12.5%	14.0%	14.8%	16.0%
United States	12.7%	13.6%	13.5%	14.7%	15.8%

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
St. Helena CHNA	2,452	712	29%
Napa County, CA	14,883	4,316	29%
Sonoma County, CA	46,497	14,879	32%
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
St. Helena CHNA	1,188	1,265	28%	31%
Napa County, CA	7,215	7,668	28%	31%
Sonoma County, CA	20,984	25,513	27%	36%
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
St. Helena CHNA	31%	44%	19%	42%	23%
Napa County, CA	31%	44%	19%	42%	23%
Sonoma County, CA	33%	33%	19%	42%	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
St. Helena CHNA	29%	40%	26%
Napa County, CA	29%	40%	26%
Sonoma County, CA	32%	45%	27%
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 14 deaths due to suicide. This represents a crude death rate of 12.6 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)
St. Helena CHNA	22,333	14	12.6
Napa County, CA	135,486	85	12.6
Sonoma County, CA	486,901	376	15.4
California	39,222,534	21,240	10.8
United States	331,563,969	240,465	14.5

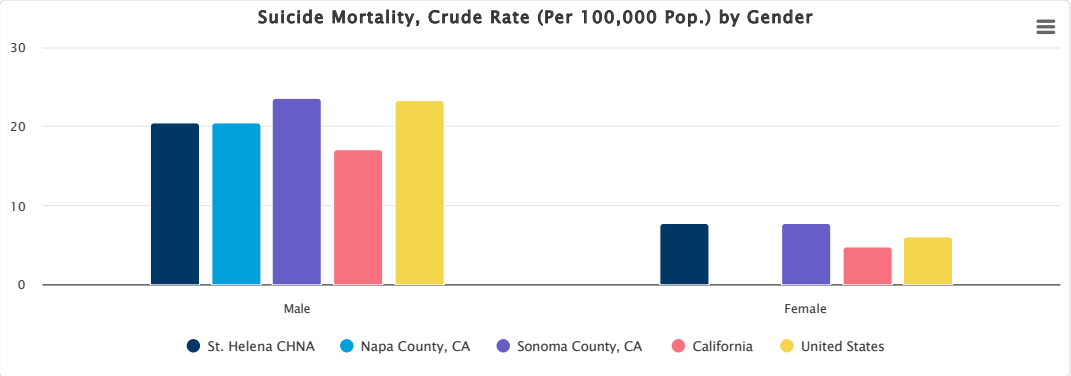
Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2019-2023.

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
St. Helena CHNA	20.4	7.7
Napa County, CA	20.4	No data
Sonoma County, CA	23.5	7.7
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.



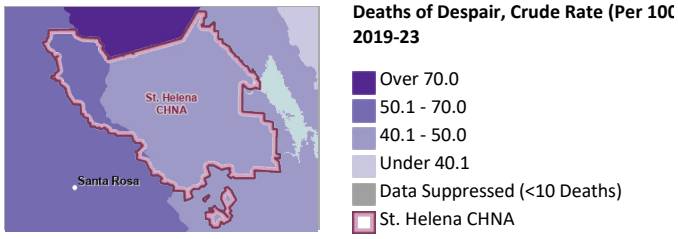
Health Outcomes - Deaths of Despair - Deaths of Despair

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 52 deaths of despair. This represents a crude death rate of 46.7 per every 100,000 total population.
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Report Area	Total Population, 2018-2022 Average	Five Year Total Deaths, 2018-2022 Total	Crude Death Rate (Per 100,000 Population)
St. Helena CHNA	22,333	52	46.7
Napa County, CA	135,486	315	46.5
Sonoma County, CA	486,901	1,438	59.1
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.

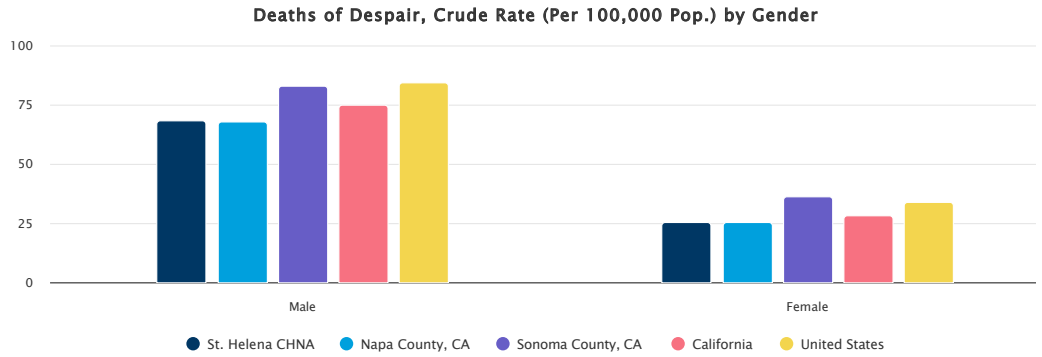


Deaths of Despair, Crude Rate (Per 100,000 Pop.) by Gender

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
St. Helena CHNA	68.2	25.3
Napa County, CA	67.9	25.1
Sonoma County, CA	82.9	36.1
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.

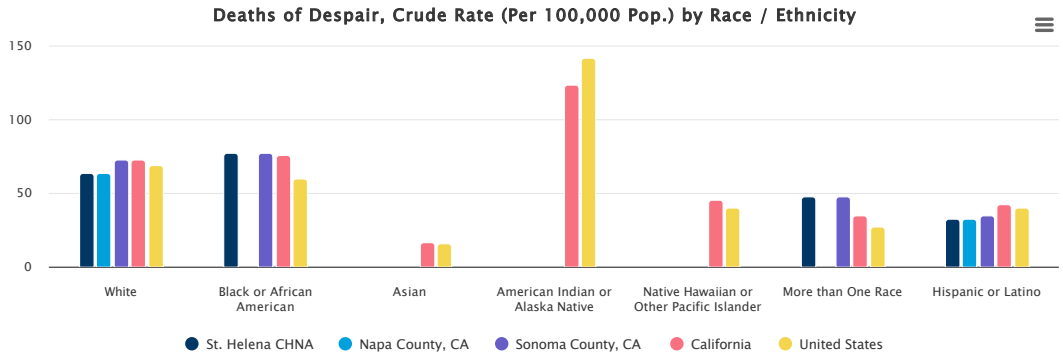


Deaths of Despair, Crude Rate (Per 100,000 Pop.) by Race / Ethnicity

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 combined race and Hispanic origin.

Report Area	White	Black or African American	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	More than One Race	Hispanic or Latino
St. Helena CHNA	63.3	77.0	No data	No data	No data	47.3	32.0
Napa County, CA	63.1	No data	No data	No data	No data	No data	32.0
Sonoma County, CA	72.0	77.0	No data	No data	No data	47.3	34.3
California	72.3	75.3	16.5	122.8	45.0	34.8	42.2
United States	68.3	59.7	15.7	141.1	39.9	26.8	40.1

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

countyofnapa.org/3256/Child-and-Family-Services

In the St. Helena service area, 8.8% of residents live within a half mile of public transit compared to 62.31% in California (Environmental Protection Agency, 2021). Focus group participants and key informants described how a lack of transportation has forced people to forgo or delay health care visits, which can be detrimental to long-term health outcomes.

Food Security

countyofnapa.org/382/Food-Assistance

Focus group participants and key informants noted there are not affordable grocery stores in Calistoga, and relying on the food bank means inconsistent access to healthy food options. In the St. Helena service area, 22.35% of the population has low food access (U.S. Department of Agriculture, 2019). The rate of SNAP-authorized retailers is 4.95 per 10,000 people, compared to 7.84 per 10,000 people in California (U.S. Department of Agriculture, 2025).

Mental Health

countyofnapa.org/3730/Behavioral-Health-Services-BHS

Focus group participants described how people are going to the emergency room for mental health issues because they can't get treatment elsewhere. In a community survey, 29.1% of respondents selected needing more mental health related resources to live better.

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

Climate & Natural Environment

countyofnapa.org/3734/Documents-and-Resources

napawatersheds.org/app_pages/view/4184

countyofnapa.org/3390/Good-Neighbor-Resources

The secondary data indicates a higher percentage of days with particulate matter 2.5 in the air, which contributes to poor air quality (Centers for Disease Control and Prevention, 2020). Focus group participants and key informants described how the devastating impacts of the wildfires continue to persist.

Financial Stability

countyofnapa.org/366/Cash-Assistance

Key informants noticed a missing middle class, highlighting that the job market is centered around agriculture or hospitality, neither of which have many high-paying jobs. The labor force participation rate is 59.74% (U.S. Census Bureau, 2023) and focus group participants noticed high turnovers for entry-level positions.

Housing

countyofnapa.org/434/Housing-Homeless-Services

Nearly one in five (19.41%) households experience severe housing cost burdens, spending 50% or more of total household income on housing alone (U.S. Census Bureau, 2023). Key informants described how addressing housing issues can enable people to make better decisions around food and health.

Health Conditions

countyofnapa.org/3240/Public-Health-Services-PHS

countyofnapa.org/3770/Comprehensive-Services-for-Older-Adults-

countyofnapa.org/672/Chronic-Disease-and-Health-Equity

In our service area, more than 1 in 10 people (11.8%) have been diagnosed with diabetes (CDC, 2022). Focus group participants and key informants expressed concern around obesity and diabetes, including an uptick in diagnoses with children.

Health Risk Behaviors

countyofnapa.org/672/Chronic-Disease-and-Health-Equity

Focus group participants described the increased prevalence of drug and alcohol abuse across all ages and key informants pinpointed that social acceptance and easy access to smoking, vaping and alcohol enables youth to engage in these health risk behaviors.

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

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 forty-seven (47) people participating. Focus groups were in-person, typically running 90 minutes.

Six (6) key informant interviews. Interviews were conducted virtually, running 60 minutes.

Participating Organizations

- Calistoga Joint Unified School District
- City of Calistoga
- County of Napa
- Health and Human Services
- Napa County Sheriff Department
- Our Town – St. Helena
- Adventist Health St. Helena
- UpValley Family Center

Represented Race/Ethnicity

- Hispanic
- Multi-race
- White

Represented Populations

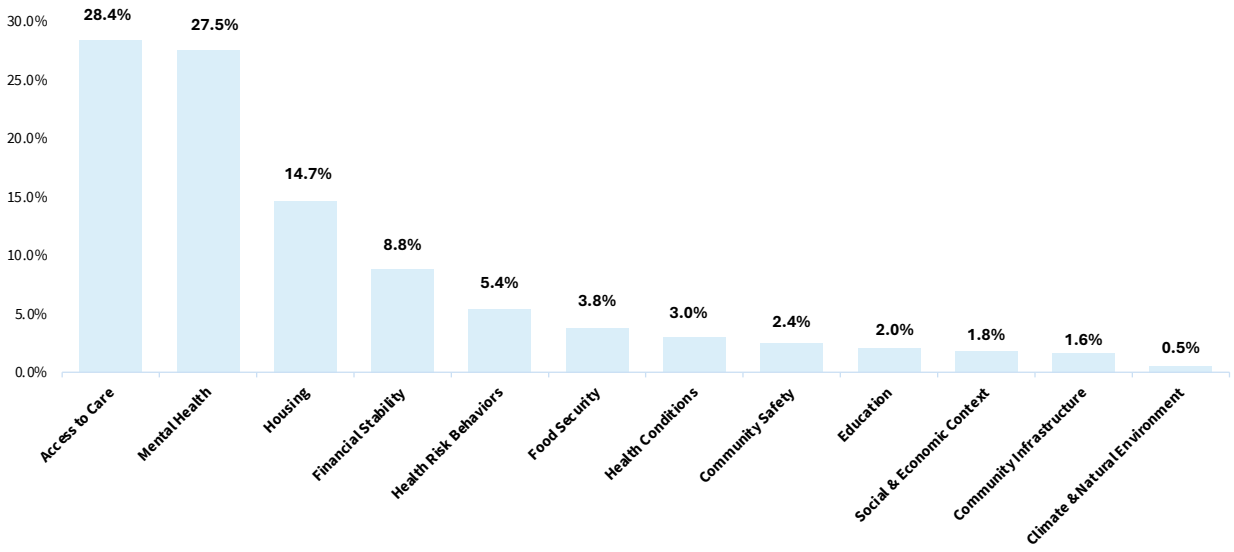
- Agricultural workforce
- Healthcare consumers
- Healthcare workforce
- Human services
- Individuals with substance use disorder
- Labor or workforce representative
- Medically underserved
- Men
- Minority Populations
- Women

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.

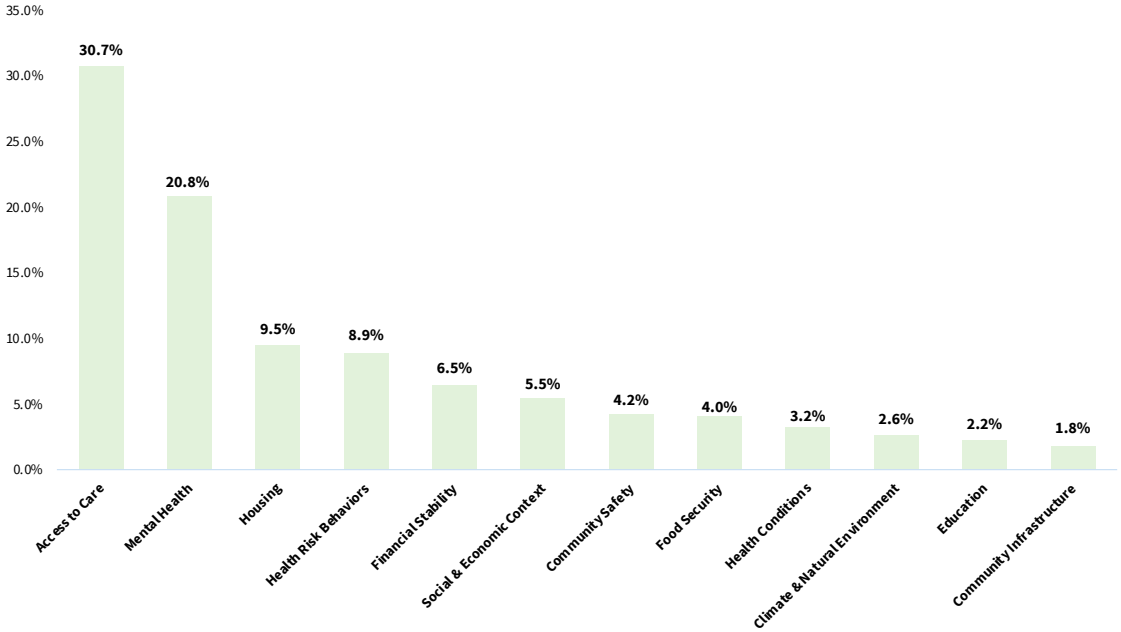
Focus Groups

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 St. Helena 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)
18.1%
California: 18.8%

Life Expectancy at Birth (2010-2015)
83.05
California: 80.32

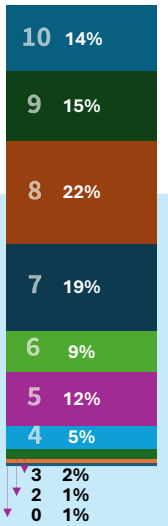
Food Security	Health Conditions	Financial Stability	Climate & Natural Environment	Access to Care	Housing
53	49	47	44	43	41

Mental Health	Health Risk Behaviors	Social & Economic Context	Community Infrastructure	Education	Community Safety
36	36	33	28	28	26

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.



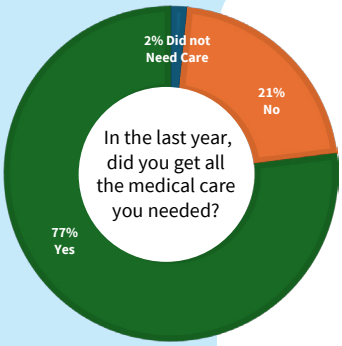
Imagine a 10-step ladder. At the top life is great, a 10. At the bottom, life is not good, a 0. Which step of the ladder are you standing on right now?

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

High cost of living	19.3%
High risk for natural disasters (fire, floods, earthquakes)	17.2%
Lack of affordable housing	14.7%
Access to affordable healthy food	8.7%
Not enough good jobs	8.3%
Can't get medical care	8.0%
Lack of safe roads, sidewalks, bike lanes	6.0%
Lack of transportation	4.6%
Bad air and/or water quality	2.8%
Limited access to social services for me or my family members	2.3%
No friends or connection to community	2.3%
Unsafe community	1.8%
Lack of good schools	1.8%
Limited childcare options	1.6%
Racism	0.7%
Grand Total	**100.00**

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

Aging problems (e.g. arthritis, hearing/vision loss, dementia, etc.)	20.7%
High blood pressure	9.7%
Vision/hearing problems	8.7%
Being overweight	8.3%
Teeth problems	8.3%
No health problems	7.7%
Problems with mobility	6.0%
Mental health problems (e.g. extreme sadness, fear, worry, anger or stress)	6.0%
Illness that spreads (like flu, COVID, TB)	5.0%
Diabetes/Kidney Disease	4.3%
Poor eating habits	4.3%
Heart disease/Stroke	4.0%
Asthma/COPD	2.7%
Cancer	2.0%
Respiratory/Lung Diseases	1.3%
Child/Partner Abuse	0.3%
Alcohol and/or drug misuse	0.3%
Learning problems	0.3%
Grand Total	**100.00**



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

Poor quality of doctors/nurses	20.5%
It costs too much	12.3%
Location of medical care	11.0%
Holistic treatments not available	11.0%
I do not have a primary care doctor	8.2%
Specialists not covered by insurance	8.2%
Inconvenient hours of operation	6.8%
There was no doctor that accepted my insurance	5.5%
I do not have health insurance	5.5%
Getting to the clinic was too hard	4.1%
I did not know where to get care	2.7%
I'm uncomfortable speaking with a doctor	2.7%
Doctor or clinic (healthcare provider) did not understand my language, culture or identity	1.4%
Grand Total	**100.0%**

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

Healthcare & Prescription Costs	21.3%
Housing Options	13.0%
Utilities/Internet	12.2%
Social/Community Events	11.8%
Parks, Recreation and Outdoor Activities	10.6%
Managing Stress and Depression	10.6%
Childcare or Senior Care	8.3%
Neighborhood Safety	4.7%
Local Food Banks	3.1%
Legal Services	2.4%
Personal Safety	2.0%
Grand Total	**100.0%**

St. Helena
Survey Responses
126

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.

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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.

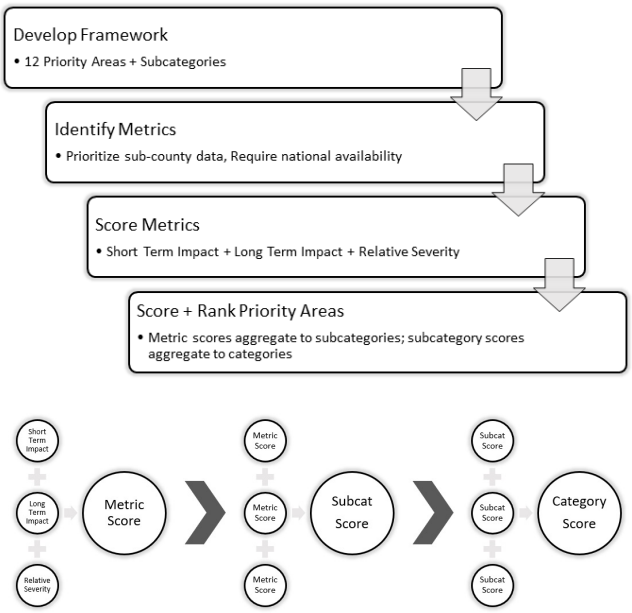

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

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.

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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
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For more information, please visit
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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.

Steve Herber, MD
President

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10 Woodland Road, St. Helena, CA 94574

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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?

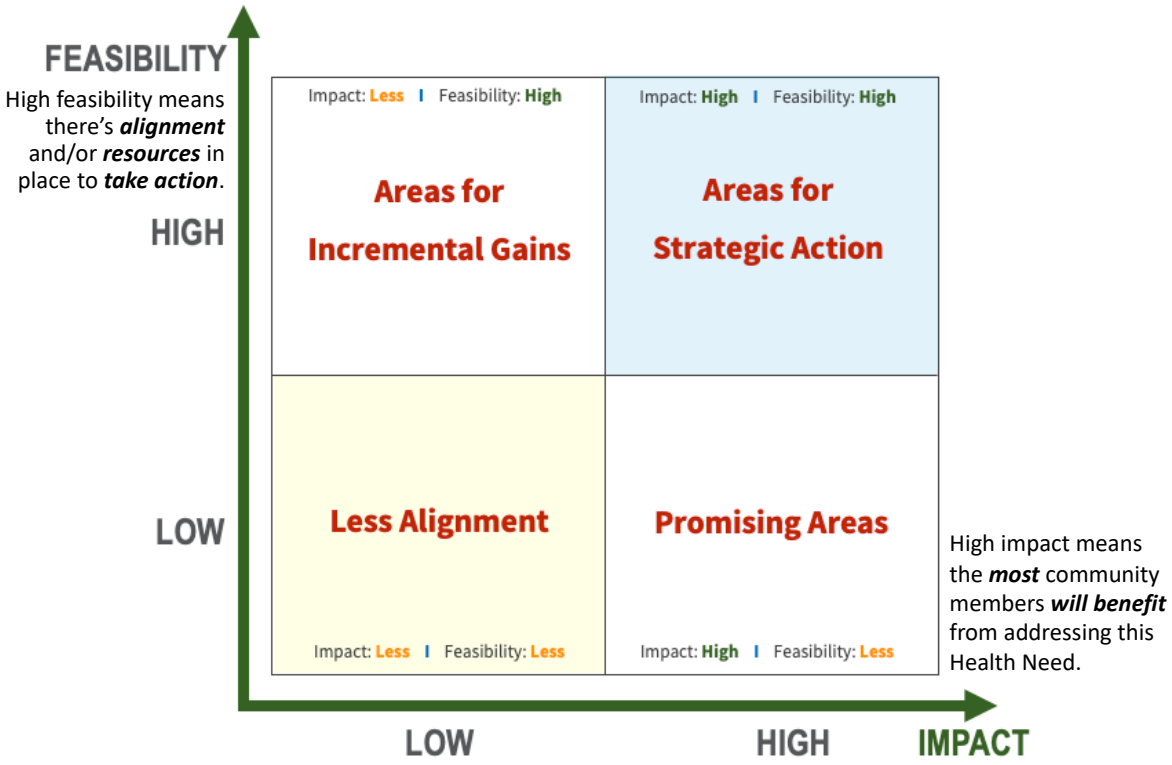
What does immediate success look like (1 - 3yrs)?

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



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