Saint Agnes Medical Center and

Fresno Surgical Hospital

Community Health Needs Assessment

This Community Health Needs Assessment was adopted by Saint

Agnes Medical Center Board of Directors on May 27,2022 Fresno

Surgical Hospital Board of Directors on November 15, 2022

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Introduction

Saint Agnes Medical Center (Saint Agnes) - The Sisters of the Holy Cross began their ministry in Fresno, California in 1894, with the opening of a boarding and day school for girls. In 1929, at the request of the local bishop, eight Holy Cross Sisters established the original Saint Agnes Hospital close to the downtown area on the corner of Fruit and Floradora avenues. As Fresno grew northward and the hospital outgrew its facilities, Saint Agnes Medical Center relocated to its present site in north Fresno in 1975. From the original 75 beds, Saint Agnes has grown to a current bed capacity of 436 licensed beds and cares for residents of Fresno, Kings, Madera and Tulare counties.

Saint Agnes Medical Center's programs give Valley residents greater access to needed primary and specialty care. This includes Saint Agnes Care, a nonprofit subsidiary comprised of primary, specialty and urgent care clinics, which includes a network of more than 80 providers at 20 locations in the cities of Fresno and Clovis. To provide better access and more convenient care for Valley residents, Saint Agnes Care Center has expanded and now houses the Brain & Spine and Orthopedic Institutes along with General Surgery, Metabolic and Bariatric Surgery and Cardiovascular Surgery all under the same roof. Saint Agnes also continues to expand its four accredited physician residency programs and in Fresno County's only nationally recognized Baby-Friendly Hospital.

Guided by the values first inspired by the Sisters of the Holy Cross, Saint Agnes strives to be a blessing to the people of the Central Valley – lifting spirits though faith, hope, love and healing. It is all part of the promise made more than 90 years ago – to care for patients and their loved ones with the highest quality, most compassionate health care. Saint Agnes' 2,867 staff and 428 active volunteers work diligently to serve the needs of 1.16 million patrons in its service area.

Our Mission - to serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Vision - to be the trusted health partner in Central California through its unrelenting pursuit of excellence.

Our Core Values

- *Commitment to those who are poor*
- *Integrity*
- *Justice*
- *Reverence*
- *Safety*
- *Stewardship*

Guiding Behaviors

- *We support each other in serving our patients and communities.*
- *We communicate openly, honestly, respectfully, and directly.*
- *We are fully present.*
- *We are all accountable.*
- *We trust and assume goodness in intentions.*
- *We are continuous learners.*

As Saint Agnes' physical footprint grows, it remains focused on maintaining important partnerships and building new relationships. In 2020, Saint Agnes entered into a new partnership with Dignity Health, United Surgical Partners International and physician owners of the Fresno Surgical Hospital and Summit Surgical to form an integrated health care delivery network unlike any other in the region.

Fresno Surgical Hospital (FSH) - is a fully licensed, Joint Commission-accredited hospital that delivers award-winning surgical care and patient satisfaction. We are a physician-owned hospital that focuses solely on providing advanced, affordable surgical care.

Each year, FSH serves approximately 12,000 patients in our Central California service area including: Fresno, Madera, Merced, Kings and Tulare Counties. Patients enjoy a non-traditional, hotel-like setting and a commitment to quality care and patient satisfaction. Twenty-seven private inpatient suites give patients and their families an environment that promotes relaxation, comfort and healing.

FSH was founded by two orthopedic surgeons, Alan H. Pierrot, MD and Thomas Thaxter, MD, who had a vision of improving healthcare. Originally named Fresno Surgery Center (FSC), the facility opened as an outpatient surgery center in 1984. It was the first facility in the United States to provide elective surgery and post-surgical care in a non-hospital setting.

In 1988, FSC was designated by the California State Legislature as the first participant in a pilot project and opened our post-surgical recovery care center. This expanded the scope of service to include overnight post-surgical care, the first facility in the nation to do so in a non-hospital setting.

In 1993, FSC sought to become a licensed acute-care hospital. Though only surgical patients are admitted, this hospital licensure enables it to serve inpatients (including Medicare patients) without restrictions on the length of their recovery stay.

In 2005, FSC earned and continues to hold the Joint Commission Gold Seal of Approval, which is considered the gold standard in health care and is an internationally recognized symbol of quality.

In 2006, Fresno Surgery Center was renamed Fresno Surgical Hospital. This change more appropriately reflected the surgical services provided and distinguished the facility as a licensed acute care hospital rather than as an ambulatory surgery center.

FSH Mission - To provide a high quality of care through compassion to all we serve by creating a supportive environment for our patients, clinical staff and employees.

FSH Vision - To become a hospital that is known for excellence in surgical care delivery and patient satisfaction. To be the first choice for Central Valley residents and healthcare practitioners.

Principles:

- Quality and Professionalism
- Compassion: A foundation of care
- Patient Satisfaction
- Physician Satisfaction
- Employee Satisfaction
- Employee Retention
- Employee Recruitment

Commitment To The Community

Saint Agnes Medical Center and Fresno Surgical Hospital (Fresno Surgical) are committed to providing a continuum of services that range from preventive to acute care, rehabilitation, and health maintenance. Saint Agnes and Fresno Surgical actively engage in promoting a holistic approach to healthful behavior, lifestyle, and well-being in mind, body, and spirit. The hospitals pride themselves on community involvement, community capacity building through collaborative efforts, relevant advocacy efforts, as well as offering programs and services that benefit the residents of its service area. Community Health and Well-being is rooted in the core beliefs that programs designed to improve access to healthcare and improve the health and lives of low-income persons and individuals who are marginalized should be a priority.

The hospitals Administration, Board of Trustees are committed to the strategic process of identifying, planning, implementing, and evaluating Community Benefit programs. Together they oversee the program, which includes review and approval of community benefit plans, regulatory reports and Mission Services Fund grant allocations. Community health programs are targeted to directly address prioritized community needs as outlined in Saint Agnes Medical Center's Community Health Needs Assessment (CHNA) report. Great care is given to ensure that all initiatives are in accordance with the policies and procedures of Trinity Health, Saint Agnes Medical Center and Fresno Surgical. They include:

- Supporting and implementing each hospital's mission and core values related to health services,
- Serving as a resource for Saint Agnes and Fresno Surgical by highlighting information relative to the unmet needs of the medically underserved communities within our service area,
- Offering recommendations and insight regarding the health service needs of Fresno, and Madera counties,
- Serving as a link between Saint Agnes and Fresno Surgical Board of Trustees and the Community Benefit planning process,
- Providing leadership for community benefit planning,
- Overseeing the process and selection of the Community Partner Grant Program.

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Previous Community Health Needs Assessment (CHNA)

The following summary is focused on the work accomplished by Saint Agnes in response to the previous CHNA. Fresno Surgical is not included since the affiliation of both hospitals did not exist during the last needs assessment.

Saint Agnes, in partnership with the Community Benefit Work group, commissioned the Hospital Council of Northern and Central California to conduct the 2019 CHNA for the four-county region of Fresno, Kings, Madera and Tulare counties. Beginning in 2011, the Hospital Council of Northern and Central California initiated a four county (Fresno, Kings, Madera, and Tulare) community health needs assessment process. The hospitals participating in the 2019 Central Valley Region's assessment worked to identify relevant key informants and topical focus groups to gather more insightful data and aid in describing the individual and unique community. Key informants and focus groups were deliberately chosen to represent medically underserved, low-income, or minority populations in our community. The goal of the targeted engagement was to better direct our resources and form strong partnerships. Results of the qualitative analysis, as well as a description of participants, can be found in the 2019 CHNA. The CHNA was made available for public comment both online and in written format. No comments were received.

Sources of data for this assessment included a mixture of secondary data and primary data. Secondary data sources include publicly reported state and nationally recognized data sources such as Community Commons, California Department of Public Health, and County Health Rankings & Roadmaps. A significant portion of the data for this assessment was collected through a custom report generated through Community Common's Engagement Network CHNA (https://engagementnetwork.org/assessment/). Other referenced sources include California Department of Public Health, County Health Rankings & Roadmaps, and California Environmental Protection Agency's Office of Environmental Health Hazard Assessment. When feasible, health metrics have been further compared to averages for state or national benchmarks, such as Healthy People 2020 objectives.

Primary data was collected through key informant interviews, focus groups, and online survey. Key informants and focus groups were purposefully chosen to represent medically underserved, low-income, or minority populations in our community. From March to October 2018, on behalf of the Hospital Council of Northern & Central California, HC2 Strategies, Inc. conducted multiple key informant interviews, focus groups, and administered an online survey for community members and organizations. Nearly 700 (680 total) people were surveyed to obtain input from the community in the form of 48 key informant interviews, 24 focus groups (with a total of 284 participants), and 348 online survey participants (including a Spanish option). Key informant interviews comprised key leaders in our community from an array of agencies, including those that serve children, homeless populations, LGBTQ+, veterans, seniors, tribal populations, African Americans, and Hmong and Spanish speaking populations. Other participating organizations represented public health agencies, law enforcement, health care organizations, funders, and school districts.

Saint Agnes Medical Center, in collaboration with Community Medical Centers and Valley Children's Healthcare, invited leaders representing public health and community-based sectors from Fresno, Kings, Madera and Tulare counties to participate in a CHNA-identified health needs ranking process. Most of these participants were surveyed in the primary data gathering phase of the 2019 CHNA report process. Public health and community leaders were tasked with ranking the needs that were most pressing in

their respective counties —based on health issues previously identified in our 2019 primary data collection phase. Participants in our collaborative health ranking session, were tasked with ranking the identified health needs based on the following criteria:

- Severity, magnitude, urgency
- Feasibility and effectiveness of possible interventions
- Potential impact on greatest number of people
- Potential health need score (included community stakeholder and resident feedback)
- Outcomes are measurable and achievable in a 3-year span
- Existing resources/programs

2019 - 2022 Prioritized Needs

1. Access to Care
2. Obesity/HEAL/Diabetes
3. Maternal and Infant Health
4. Mental Health
5. Economic Security
6. Oral Health
7. Substance Use/Tobacco
8. Violence and Injury Prevention
9. Climate and Health
10. CVD/Stroke
11. Asthma
12. HIV/AIDS/STIs
13. Cancer

To solicit written input on the CHNA and Implementation Strategy, Saint Agnes Medical Center made both documents available on the hospital's website https://www.samc.com/about-us/community-benefits/health-needs-assessments-and-implementation. They are posted for easy access and contact information for questions and comments have been included. The links on the website also include the federal IRS Form 990 tax return and an overview of Community Benefit at Saint Agnes. Additionally, Saint Agnes had printed copies available. No written comments on the last CHNA and Implementation Strategy have been received.

Outcomes and Successes

As outlined in the implementation strategy, Saint Agnes Medical Center focused on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:

- Access to Care
- Obesity/HEAL/Diabetes
- Mental Health
- Economic Security
- Substance Use/Tobacco
- And other emerging issues

Evaluating our efforts encourages accountability to the communities we serve and allows us to share our successes. This section presents selected outcomes for Fiscal years 2019-2022. These outcomes are related to priority needs that were selected during the 2019 CHNA cycle. The outcomes presented here

represent an overview and not a complete list. More detailed and complete findings can be found in our annual community benefit reports Reports, Assessments & Implementation Plans Fresno, California (CA), Saint Agnes Medical Center (samc.com)).

Saint Agnes provided community benefit to residents in its service area in a variety of ways to respond to the needs identified in the 2019 Community Health Needs Assessment. Samples include programs aimed at providing financial assistance to the poor, health care enrollment assistance, initiatives aimed at increasing access to health care, addressing Obesity/Healthy Eating/Diabetes, Mental Health, Economic Security, Substance Use/Tobacco and significant emerging issues. Following are examples of the outcomes of the investments made.

Access to Care

In keeping with Trinity Health's Values of Reverence, Commitment to Those Who Are Poor, Justice, Stewardship and Integrity, Saint Agnes focused on implementing strategies to address access to health within its service area – marked by a higher population than state average receiving Medicaid, percent of uninsured population, and more than a 30-point difference than the State in number of primary care physicians serving the service area.

Saint Agnes's financial assistance program continued to be a resource to eligible patients who met financial guidelines. Medi-Cal eligibility assistance is offered to patients and for those who meet the financial assistance criteria, a manageable payment plan is established. Between 2019 and 2022, more than 110,000 people benefited from free or reduced cost services. In addition, Saint Agnes provided community health services to more than 70,000 people who were either uninsured or underinsured.

In 2022, Saint Agnes' Graduate Medical Education program celebrated its fifth year by welcoming a new cohort of students into the Internal Medicine and Family Medicine residency program. In FY20, the program announced the accreditation of two new programs: Transitional Year and Emergency Medicine. Between 2019 and 2022, a total of $24 million has been invested and 38 residents engaged in the GME program.

The Fresno County Health Improvement Partnership (FCHIP) is a county-wide effort to implement policies, systems, and environments to improve health. Between 2019 and 2022, Saint Agnes has provided in-kind staff support to engage in its executive and leadership committees. In FY20, Saint Agnes led the Health Literacy Workgroup, where students in the medical pathways program at Washington Union High School engaged in projects and learning opportunities to advance health literacy among their peers.

Financial contributions to California State University Fresno's (CSUF) Mobile Health Unit provided a learning environment for nursing, public health, social work and physical therapy students. Between 2019and 2022, more than 1,200 students participate at clinic sites specifically funded by Saint Agnes.

Saint Agnes partnered with the Fresno County Department of Public Health, CSUF's Mobile Health and Nursing Program, Tzu Chi Medical Foundation, Cultiva la Salud, Leadership Counsel for Justice and Accountability, Calwa Parks and Recreation, LEAP, Centro Binacional para el Desarrollo Indigena, The Fresno Center, Centro la Familia, Exceptional Parents Unlimited, Black Wellness and Prosperity Center, Del Rey Unified School District, Fresno Unified School District, The City of Orange Cove, Orange Cove Unified School District, Kings County Unified School District, and the Office of Assemblyman Joaquin

Arambula to coordinate COVID-19 clinics, provide more than 12,000 vaccines, promote education and provide personal protective equipment to persons living and working in rural Fresno, including ones working in agriculture, education, childcare, and students and their families.

People who are medically vulnerable and who face barriers to resources that address clinical and social determinants of health have a much more difficult time managing their health. The Saint Agnes Health Hub (hub) seeks to impact the health and wellbeing of individuals who have complex care needs post-discharge. Community Health Workers provided nearly 8,000 direct linkages to primary care, specialty care, oncology care, dental care, prescription assistance programs, and with transportation to these services between 2019 and 2022.

Obesity/HEAL/Diabetes

The Food Research & Action Center notes that "Food insecurity — even marginal food security (a less severe level of food insecurity) — is associated with some of the most common and costly health problems and behaviors in the U.S. such as behavioral and social-emotional problems (hyperactivity), depression and diabetes." Between 2019 and 2022, Saint Agnes continued its involvement and support for a community-centered and integrated focus on health, healthy choices, and wellness and prevention.

Saint Agnes engaged residents and collaborated with neighborhood-based organizations, health care providers, public health, safety-net clinics, health educators and health plans by:

- Financially supporting diabetes prevention and management programs, including the implementation of the National Diabetes Prevention Program (DPP), and a Diabetes Education and Empowerment program (DEEP) with the California Health Collaborative (CHC). DPP is an evidence-based lifestyle change program that delays or prevents the development of type 2 diabetes among people at high risk. CHC works with clinics and medical providers to identify participants. DEEP is a licensed diabetes self-management education program that teaches diabetics how to control their disease and prevent its complications. Topics include diabetes risk factors, complications, nutrition, physical activity, use of the glucose meter and medications, building partnerships with a diabetes healthcare team, psychological effects of illness, problem-solving strategies, and how to access community diabetes resources. Participants meet once a week for 2 hours over a six-week period.

- Launching a chronic disease management program in 2021, through a grant awarded from Partners in Care, to address the challenges people face in living healthier lives. Saint Agnes extended the opportunity for residents and community members to become trained facilitators. A total of 8 facilitators were trained and more than 50 people within the first year were engaged in the program, providing individuals and their families the tools to combat obesity, diabetes, and manage their prescription medications.

- Participating in the Fresno Diabetes Collaborative, which provided tools for diabetes risk assessments and coordinated health symposiums for health professionals and community members.

More than 300 people have participated in Diabetes education programs funded and provided by Saint Agnes between 2019 and 2022.

Saint Agnes made financial contributions to Fresno Metro Ministry's Food to Share Program, Cultiva la Salud's food policy work, and Fresno Economic Opportunities Commission's (EOC) food distribution programs.

Through a growing network of food donors which include two school-districts and 49 community-based food receiver organizations, Food to Share rescued more than 540,000 pounds of nutritious food— that would otherwise have ended up in landfills and redistributed to families that faced daunting food hardship and lack the financial means to purchase healthy food, while also equipping them with the confidence and knowledge to utilize this food and take charge of their own health.

By working with parent leaders, Cultiva la Salud advocated for the continued operations of school meals during Spring Break at Fresno Unified. Fresno Unified has not typically provided school meals during this period. The local and statewide advocacy contributed to the district's decision to reconsider and offered school meals during these off-school hours to students and families.

The EOC food distribution program also ensured that families living in rural areas of Fresno County had access to healthy food through its food distribution program. More than 400 families benefited from the program.

The threat of COVID-19 and the need to isolate and quarantine, undermined access to food for many families. Saint Agnes community-based funded programs quickly pivoted to serve low-income families. The Seňoras Mayores served low-income, elderly, immigrant women with bi-weekly food and supplies. Every Neighborhood Partnership’s food distribution programs provide services to 700 families monthly.

People who are medically vulnerable and who face barriers to resources that address clinical and social determinants of health have a much more difficult time managing their health. The Saint Agnes Health Hub (hub) seeks to impact the health and wellbeing of individuals who have complex care needs post-discharge. Between 2019 and 2022, Community Health Workers provided more than 1,835 linkages to food resources, including CalFresh, food distributions, home delivery options, meals on wheels, the Community Food Bank to people with food insecurity.

Mental Health

Mental health is a health need in the Saint Agnes service area as marked by a high percentage of children who experience two or more adverse events, a high number of poor mental health days, and a high percent of youth who experienced suicidal ideation in the past year. A low number of mental health providers within the service area also marks mental health as a health priority. Additionally, mental health was the second most mentioned need among focus groups and key informants.

Saint Agnes’ service area ranks below the state of California average concerning mental health days. The average of poor mental health days (for a 30-day period) across the 4-county region was 3.9 days compared to the California average of 3.4 days.

Saint Agnes staff served as subject matter experts on the advisory councils for the Fresno Unified School District (FUSD) Health care Partnership Advisory Council, and for the Community Conversations on Mental Health and Suicide Prevention program, to address policy, systems and environmental changes.

People who are medically vulnerable and who face barriers to resources that address clinical and social determinants of health have a much more difficult time managing their health. The Saint Agnes Health Hub (hub) seeks to impact the health and wellbeing of individuals who have complex care needs post-discharge. Between 2019 and 2022, Community Health Workers provided nearly 3,000 linkages to behavioral and mental health services.

Economic Security

Saint Agnes paused activities provided through the main facility when COVID-19 mandates were established in early 2019 to mitigate the risk of infection for homeless women and women and children who were being served by the Holy Cross Center for Women. Clothing, showers, child and infant supplies and laundry services were still accessible to clients. Between 2019 and 2022, more than 28,000 encounters took place at Holy Cross.

Additionally, the Wellness Fund for the Fresno County Health Improvement Partnership was initially established through a financial contribution made by Saint Agnes/Trinity Health. The wellness fund increased capacity to organizations that addressed food insecurity, trauma and resilience and community engagement within vulnerable communities. The fund also provided critical resources such as cash assistance, utility payments, food, clothing, diapers, baby formula to families impacted by Covid-19. More than 500 families were provided assistance.

On September 30, 2018, SB 1152 was signed into law. The bill requires California hospitals to include a written homeless patient discharge planning policy and process within the hospital discharge policy that included a written plan for coordinating services, and referrals for homeless patients with the county behavioral health agency, health care and social service agencies in the region, health care providers, and nonprofit social service providers, as available, to assist with ensuring appropriate homeless patient discharge. In addition to clinical care, hospitals are required to provide every patient who has an anticipated need for long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. Also, hospitals are required to provide homeless patients a meal, unless medically indicated otherwise, and weather-appropriate clothing, if necessary.

Saint Agnes implemented a process by which homeless patients could be identified upon admission, assessed for clinical and social needs and connected to a Saint Agnes Health Hub Community Health Worker who could link individuals to agencies and resources post-discharge. Between 2019 and 2022, nearly $4,000 was invested in clothing, food, and housing to address needs for patients who identified as homeless through our emergency department in addition to being assisted by the health hub.

The Saint Agnes Health Hub seeks to impact the health and wellbeing of individuals who have complex care needs post-discharge. Between 2019 and 2022, Community Health Workers provided more than 13,000 linkages to social services, including housing, general relief, utility assistance, clothing, employment assistance, and workforce skills and education.

Substance Use/Tobacco

In 2019, after the pause of services at Holy Cross Center for Women, Saint Agnes assessed the needs of the community that surrounds the center. Through a series of focus group conversations and a survey, it was determined that the center would best serve the community with behavioral health and substance use programs. Saint Agnes solicited proposals from four agencies and through a discernment process and community benefit committee engagement, WestCare California, in partnership with Kings View were granted the opportunity to use the facility for outpatient services to families and individuals experiencing behavioral health and substance use disorders. The cost for the hospital to run this location is an average of $17,740 per month and is provided as an in-kind donation to both agencies.

Between 2019 and 2022, Community Health Workers at the hub completed more than 1,300 linkages to agencies that provided substance use disorder services.

And other emerging issues

Emergency Preparedness efforts toward addressing the COVID-19 epidemic Saint Agnes established a hospital incident command center (HICC) and engaged key leaders within the organization to establish decision-making protocols to ensure the safety of colleagues, patients and their families. Members of HICC worked directly with the CDC, California Department of Public Health and Fresno County Public Health to align with state and local guidelines. They also worked with the California Hospital Association and the Hospital Council to provide feedback and input on legislation, funding support and statewide guidelines. Public health education materials, and clinical protocols were vetted by subject matter experts and feedback was provided to Trinity Health, and local health agencies.

In the face of COVID-19, Saint Agnes recognized the importance in aligning strategic efforts to serve the healthcare needs of Fresno County and surrounding areas. Saint Agnes shared guidelines for testing and treating patients with COVID-19, and creating a safe environment for healthcare workers, patients and families affected by the virus. Saint Agnes partnered with the counties of Fresno, Madera, Kings and Tulare to develop and support strategies for addressing the virus and social needs experienced by families. A liaison role was established to work with the county health officer, and the various associations working with hospitals to address the need for PPE, ventilators, testing resources, and personnel.

Executive Summary

Purpose of the Community Health Needs Assessment

The Community Health Needs Assessment (CHNA) represents the commitment of Saint Agnes and Fresno Surgical to improve health outcomes in the community we serve through rigorous assessment of health status in our service area. This report serves as Fresno Surgical's first CHNA stemming from the affiliation with Saint Agnes, since the last CHNA. Resident and community leader stakeholder perspectives have been incorporated into the assessment process as well as the adoption of related implementation strategies to address priority health needs.

Our goal with this CHNA was not only to fulfill a legal requirement, but to also to partner for improved outcomes. The goals include:

- Engaging public health and community stakeholders including community-based organizations, low-income, minority and other under-served populations
- Assess and understand the community's health issues and needs with a high focus on priority zip codes
- Understand the risk factors and social determinants that impact health
- Identify community resources and opportunities to collaborate with partners
- Use findings to develop and adopt an implementation strategy based on the prioritized issues.

Data (Collaboration, CVHPI, etc.) Coordinator

Saint Agnes Medical Center is a member of the Hospital Council of Northern and Central California. Saint Agnes continued its tradition of partnering with Central Valley hospitals and the Hospital Council of Northern and Central California to conduct the CHNA for Saint Agnes and Fresno Surgical.

The Hospital Council Northern and Central California is a nonprofit hospital and health system trade association established in 1961, representing 197 hospitals and health systems in 50 of California’s 58 counties—from Kern County to the Oregon border. The Hospital Council served as the contracting agency for the 2022 Community Health Needs Assessment. Under the direction of the Central Valley hospitals, the Hospital Council engaged community-based organizations, including Cultiva la Salud, the Fresno Center, and United Way of Fresno and Madera Counties with a subcontract to Live Well Madera County to collect primary data.

The Central Valley Health Policy Institute (CVHPI) was engaged to conduct the qualitative and quantitative data analysis and provide a list of significant health needs for Fresno and Madera Counties.

Identified High Needs

Qualitative data was analyzed using a grounded theory approach to identify common topics of discussion and themes. All themes were grouped into broader, more inclusive social determinant of health (SDoH) domains. These domains included Economic Stability, Education Access and Quality, Health and Health Behavior, Healthcare Access and Quality, Neighborhood and Environment, Social and Community Context, and a specific domain on COVID-19-related issues. Focus group and key informant data were analyzed independently of each other. However, the same method was used to analyze both data sets.

Once a priority list of themes was developed using both the focus group and key informant interview data, a composite score was developed for each theme using items (quantitative data) from the community-wide survey. Composite scores were developed by computing the median percentage across the items that best match with each theme.

Significant Health Needs Identified – Fresno and Madera Counties

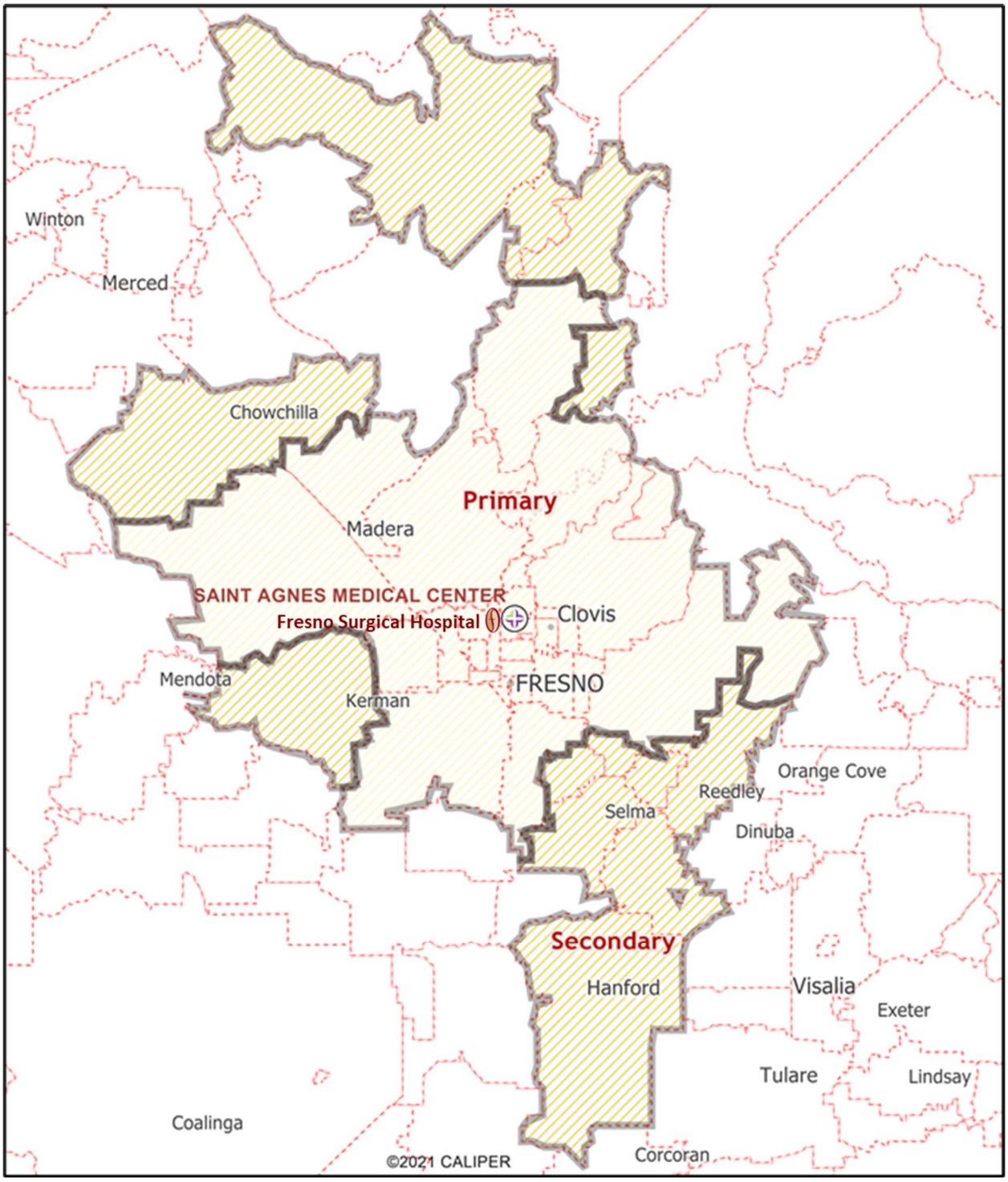
Domain A	**Healthcare Access and Quality**
	Expensive medical care
	Insurance barrier/Access to medical care
	Not enough providers/treatment locations/long wait times
	Lack of provider compassion/Discrimination/Distrust in medical system
Domain B	**Neighborhood and Environment**
	Safety/neighborhood crime
	Poor air quality/pollution
	Lack of transportation
	Homelessness
Domain C	**Economic Stability**
	Lack of affordable/acceptable housing
	Poverty
	Food Insecurity

Prioritization Process and Identified Needs

Forty-eight advisors were engaged, including residents and key stakeholders in the community. They were asked to review quantitative data and the significant health needs identified and provide feedback using the BPR scoring method to prioritize the needs. They also provided a list of resources and programs currently in place to address some of the needs.

The scores for each criteria of the health need were averaged and ranked by significance.

Top Health Needs	
Health Needs	**BPR Score**
Poverty	66.3
Poor air quality/pollution	60.6
Homelessness	58.8
Food insecurity	56.9
Safety/neighborhood crime	56.3
Lack of affordable/acceptable housing	53.6
Insurance barrier/access to medical care	53.3
Not enough providers/treatment locations/long wait times	50.0
Expensive medical care	44.4
Lack of provider compassion/Discrimination	44.0
Lack of transportation	36.3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Merced
Chowchilla
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SAINT AGNES MEDICAL CENTER
Fresno Surgical Hospital
Clovis
Mendota
FRESNO
Kerman
Orange Cove
Reedley
Selma
Dinuba
Secondary
Hanford
Visalia
Exeter
Tulare
Lindsay
Coalinga
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Community Profile

Geographic

According to the U.S. Geological Survey, the Central Valley, also known as the Great Valley of California, covers about 20,000 square miles and is one of the more notable structural depressions in the world. Occupying a central position in California, it is bounded by the Cascade Range to the north, the Sierra Nevada to the east, the Tehachapi Mountains to the south, and the Coast Ranges and San Francisco Bay to the west.

The Valley is a vast agricultural region drained by the Sacramento and San Joaquin Rivers. The Valley averages about 50 miles in width and extends about 400 mi northwest from the Tehachapi Mountains to Redding. Generally, most of the valley lies close to sea level and the land surface has very low relief but is higher along the valley margins.

The Central Valley can be divided into two large parts: the northern one-third is known as the Sacramento Valley and the southern two-thirds is known as the San Joaquin Valley. The San Joaquin Valley can be split further into the San Joaquin Basin and the Tulare Basin.

According to the U.S. Census Bureau Fresno and Madera counties cover 8,164 square miles and more than 1,5 million acres.

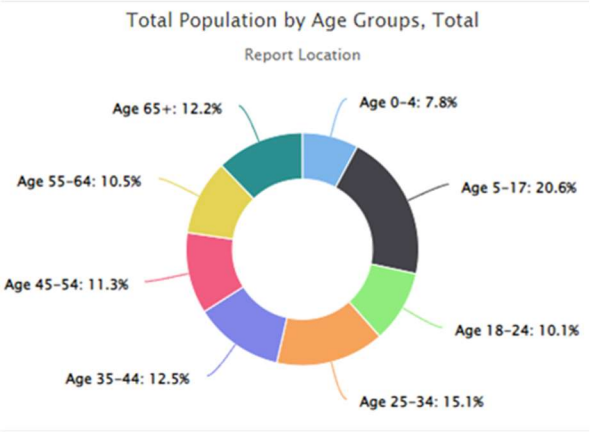
Competition for water resources is growing throughout California, particularly in the Central Valley. The Central Valley's population growth, along with anticipated reductions in Colorado River water deliveries, drought, and the ecological crisis in the Sacramento-San Joaquin Delta, have created an intense demand for water.

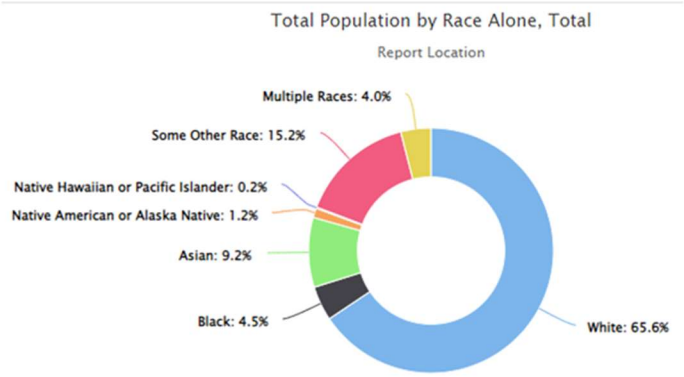
For the purposes of this Community Health Needs Assessment, Saint Agnes and Fresno Surgical Hospitals used a geographic approach focusing on the area from which most patients come for care. This area includes Fresno and Madera. By defining the geographic area and population, we were diligent to ensure that no groups, especially minority, low-income, or medically under-served, were excluded from the assessment process or data collection.

Population Demographics

According to the latest US Census Bureau, the report area has a total of 1,139,954 with 12.8% of the persons living within the report area identifying as non-citizens and over 50% identifying as Hispanic or Latino. The graph below reports the percentage of the population by age groups and race alone.

See Appendix D for additional graphs related to Income, Education and Ho





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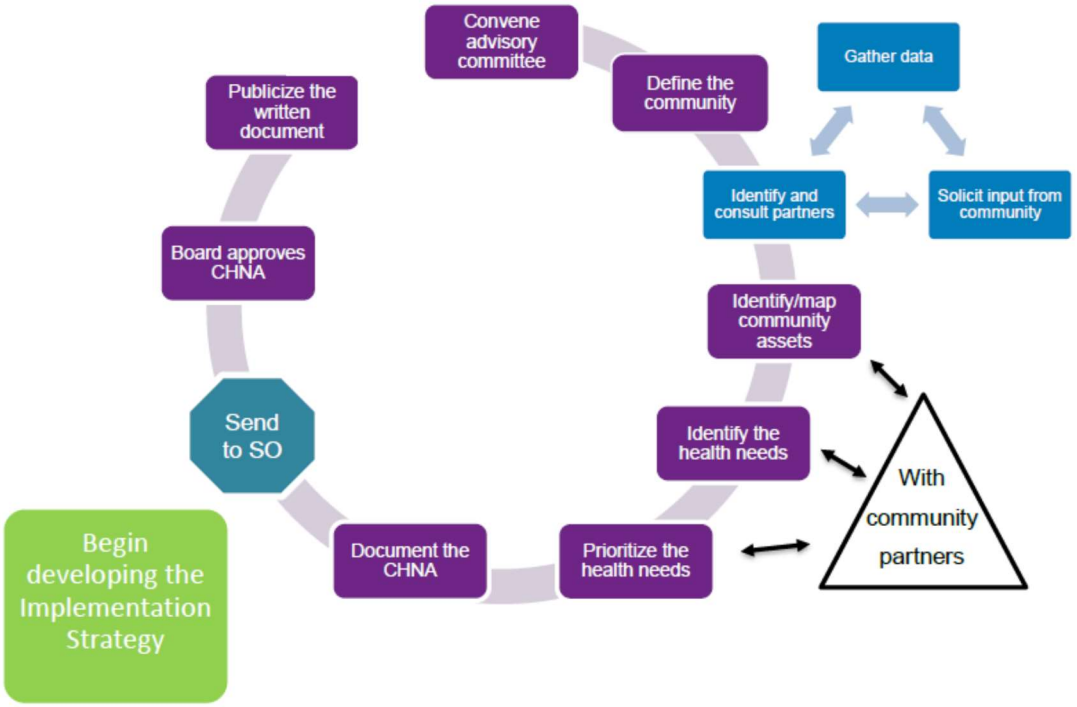
2022 Community Health Needs Assessment (CHNA)

The Patient Protection and Affordable Care Act (ACA), enacted March of 2010, added Section 501(r) to the Internal Revenue Code, which effects charitable hospital organizations that are 501(c)(3) tax-exempt. Section 501(r)(3) of the Code requires each separately licensed hospital facility to conduct a CHNA at least once every three tax years, beginning in 2011, and to adopt an implementation strategy to mee the community health needs identified though the CHNA.

The CHNA process included the following steps:



Saint Agnes and Fresno Surgical partnered with other Central Valley hospitals to commission the Hospital Council of Northern and Central California to conduct the CHNA. New to the 2022 CHNA process, is the engagement of the county Departments of Public Health for Fresno, and Madera Counties to collaborate as the CHNA Data Advisory Committee. The committee approached the CHNA process with an equity lens ensuring that populations, communities, and high priority zip codes challenged with health and healthcare disparities remained a focal point.

Health disparities, according to the Centers for Disease Control, are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Healthcare disparities typically refers to differences between groups in health coverage, access to care and quality of care.

High Priority Zip Codes are areas where at least 40% of the population in the community is Black or Hispanic and the average earnings for the community is at or below 200% of the federal poverty

guideline ($52,400 for a family of four). See Appendix A for a list of high priority zones assessed within the report area.

To ensure maximum reach, the committee directed the Hospital Council to contract with local community-based organizations (CBOs) serving areas of high need and whom already had a trusting relationship and strong community engagement in the identified communities.

Consultants & Independent Vendors

The Central Valley Health Policy Institute (CVHPI) was established in 2002 at California State University, Fresno to facilitate regional research, leadership training and graduate education programs to address emerging health policy issues that influence the health status of people living in Central California. CVHPI was contracted to analyze quantitative and qualitative data and provide the CHNA workgroup with a comprehensive data report for the regional area.

Cultiva La Salud (Cultiva) is a non-profit community-based organization founded in 2005. Cultiva is dedicated to creating health equity in the San Joaquin Valley by fostering changes in communities that support healthy eating and active living. Cultiva is among a growing number of programs in the nation who use a policy and environmental change approach to help community members gain access to healthy food, beverages, and safe places to be physically active. Services provided by Cultiva include leadership development training, health & wellness programs, COVID-19 education and awareness. Population the agency serves includes farmworkers, low-income residents in eight counties of the Central Valley (Kern, Kings, Madera, Merced, San Joaquin, Stanislaus and Tulare.

Every Neighborhood Partnership (ENP) is a non-profit community-based organization Founded in 2002 by a group of city leaders. Their purpose was to provide an outlet where the students at these schools could interact with positive role models during the weekend. It also provided an opportunity for volunteers from these churches to build relationships with the students. ENP's work focuses on neighborhood development, health & wellness programs, literacy programs, Saturday sports and church equipping. Target population includes youth, adult residents, church leaders within Fresno city.

The Fresno Center is a non-profit community-based organization founded in 1991 and serves Southeast Asian Hmong, Cambodian, Lao, Thai, Punjabi, indigenous Mexican and Vietnamese residents Fresno County. Services the Fresno Center provides includes expert translation and cross-cultural services, Medi-Cal health enrollment, tobacco cessation, immigration services, COVID relief, one-stop Center for mental health, community resources and crisis services.

Fresno Interdenominational Refugee Ministries (FIRM) is a faith-based community-based organization founded in 1994. FIRM's mission is to provide wrap-around services for refugees of Southeast Asian, Slavic and African origin. Services include after-school programs, refugee advocacy, mental health programs, & community gardens.

United Way of Fresno and Madera Counties (UWFM) is an agency that engages in nearly 1800 communities across more than 40 countries and territories worldwide. Their mission is to improve lives by mobilizing the caring power of communities around the world to advance the common good. Services include 2-1-1, 24/7 hotline, free tax preparation, outreach program, basic needs connections, COVID-19 education, and awareness. UWFM's CHNA role included working with grass-roots agencies, and residents to build community capacity for conducting assessments. UWFM collaborated with members of Live Well Madera.

Live Well Madera County (LWMC) is a community-based collaborative composed of countywide government, healthcare providers, health plans, business, education, law enforcement, community-based, and faith-based stakeholders that are committed to improving community wellness through focused aligned action. LWMC plays a crucial role in expanding access, addressing health equity, and making healthy behaviors and environments the social norm for the county's more than 150,000 residents.

Process and Methodology

For the purposes of this CHNA, the primary data collection took place between October 25, 2021 and December 10, 2021.

Primary Data

The CHNA Data Advisory Committee selected three methods for collecting primary data. They included a community-wide survey, key informant interviews and focus groups with specific populations. Prior to the collection of primary data, each organization was provided training and a data collection toolkit Appendix B. Agencies were assigned specific communities, populations, and key informants. Raw data was submitted electronically to the CHNA coordinator to track and deliver to the data analyst at the contracted agency.

Surveying the Community

Between October and December 2021, community-wide surveys were collected in Fresno and Madera counties. The survey included questions that describe the community, health questions and questions about the social determinants of health. Social determinants of health are the conditions around us that affect our health and quality of life. Community-Based Organizations and other groups offered the surveys online and in hard-copy format. They worked to collect responses from all zip codes and focused on medically underserved, low-income, and minority populations in the community.

The online survey was solicited by invitation, based on a convenience sampling. To ensure the survey sample reflected a wide variety of socioeconomic levels, age and race/ethnicity, and rural geographic regions, the survey was offered to community groups by Cultiva la Salud, Every Neighborhood Partnership and The Fresno Center. Hard copy surveys were also shared with community groups to facilitate broad based representation of seniors 65+ and underserved populations.

To secure input from all zip codes, especially the priority zip codes in each county, partners collecting data were emailed a weekly report tallying the number of surveys collected within each zip code. The

report was released every Friday between October 25 and November 30, 2021, to encourage outreach within communities with low survey counts. See Appendix C for the Community-Wide Survey questions

Community Focus Groups and Key Informant Interviews

Community-Based Organizations and other groups led the focus groups and interviews.

In Fresno County the focus group efforts were facilitated by contracted community-based organizations. In Madera County the work was coordinated by United Way of Fresno and Madera Counties who subcontracted with agencies from the Live Well Madera initiative to facilitate. Community members attended in-person or on Zoom, with more than half (56%) of the sessions being conducted in-person. CBOs aimed for 8-12 participants per session and when group participation did not reach its minimum of 8, attempts were made to convene additional sessions.

Demographic surveys were completed in-person or remotely. Focus group participants either completed them on paper or through SurveyMonkey online. When completed online, they did not state what focus group they participated in and not all participants completed the focus group survey.

There were eight different surveys that participants could complete:

- Child/Youth Ages 16-25
- General
- Homeless/Veteran/Disabled
- LGTBQ
- Parent/Caretaker
- People of Color
- Persons with disabilities
- Substance abuse

Key informants were identified as community leaders, local policymakers, business owners, religious leaders, and health care staff from public and private healthcare services. These individuals were asked questions about their organizations and the communities they serve.

Key informants represented various organizations. Interviewees who work with children and adolescents completed the Child/Youth Key Informant guide, and the remainder completed the General Key Informant guide.

In addition to the open-ended questions about the community, key informants shared information on their organizations. They also shared where they and their family receive care.

Incentives

Community-based organizations use different incentives to get responses from community members. The below table shows the reported responses by organization and survey type. Some organizations offered a larger incentive when needed to increase group size. Offering money or other incentives can increase response rates and may explain the number of responses by county.

County	Organization	Focus Group	Community-Wide Survey
Fresno	ENP	$20 Walmart gift cards	No incentives
Fresno	Fresno Center	$15 VISA gift cards *Offered $50 VISA gift cards to help fill small groups	No incentives
Fresno	Cultiva la Salud	$15 VISA gift cards	Offered entry into a $500 giveaway in conjunction with a COVID vaccine video.
Madera	UWFM	$15 Grocery Outlet and either a $10 Starbucks or Walmart gift card *Offered lunch, dinner, and $30 gift cards to help fill small groups.	Incentives included $5 Starbucks and Subway gift cards, goodie bags, hats, shirts, masks and other PPE giveaways.

Limitations

Community members who completed the surveys and focus groups were not randomly selected. The information in this report represents the views and experiences of people the data collection team was able to reach, and who chose to be involved.

Data Sources for Secondary Data:

Between, November 15, 2021 and January 31, 2022, secondary data was collected to describe the population living within the region that is being served. Previously published reports documenting regional health needs were reviewed to develop a list of data sources and commonly used indicators to describe the population. The review showed that demographic, socioeconomic, environmental, and health data were commonly used. The Central Valley Health Policy Institute analyzed the secondary data to determine the specific demographics, socioeconomic, environmental, and health outcomes to describe the Fresno and Madera counties.

Secondary data sources include data from publicly available county, state, and national agencies. Secondary data tables are provided in Appendix D by Social Determinant of Health domain.

Three direct sources were used for the secondary data analysis that CVHPI performed. The first was the American Community Survey (ACS) 5-year Estimates from the U.S. Census, the second was the Trinity Health Data Hub, and the third was Air Quality Index Report from the U.S. Environmental Protection Agency. The Trinity Health Data hub retrieves the educational data indicators we used from the ACS, so there are two direct sources of data that the secondary data.

U.S. Census American Community Survey 5-Year Estimates

The U.S. Census 5-year estimates are a compilation of the nationwide yearly American Community Survey, which samples approximately 3.5 million addresses. As a sample survey, the ACS provides a sampling error for the variables used is estimated using the percent margin of error. The sampling error percentages have been included in the secondary data that used the ACS as a data source. The only concerning margin of error is in the Economic Figures under the variable “percentage of families and people whose income in the past 12 months is below the poverty level.” However, there is the alternative variable that includes all people, not just families, that has a more reliable margin of error at the county level.

Trinity Health Data Hub

The Trinity Health Data Hub supports a network of hospitals and their community benefit teams by providing easy access to core health outcomes and behaviors. The Hub hosts two reports - a custom Community Health Needs Assessment and a Vital Sign report. Data are available by hospital service area, aggregate areas, and system wide. The CHNA report is comprised of specific indicators that were selected by the CHWB council and are required for all Trinity Health ministries to include in their CHNA data analysis. The indicators available on the data hub replace the previously distributed list of required indicators

U.S. Environmental Protection Agency Air Quality Index Report

AirData reports are produced from a direct query of the AQS Data Mart. The data represent the best and most recent information available to EPA from state agencies, who are required to report the data by going through an intense quality assurance process. The monitoring sites from whom the data is gathered are required to meet certain guidelines for operation to ensure the most accurate readings according to the Clean Air Act. The AirData reports only emit reports on data from the AQS Data Mart that is reliable enough or in enough quantity to be accurate enough for reporting. The indicators we chose for the secondary data analysis on the number of days the air was classified as Good, Moderate, Unhealthy for Sensitive Groups, Very Unhealthy, and Hazardous comes from monitoring sites in the designated counties. However, it is important to note that the number of these sites is limited, so currently there is not a way to analyze the air at any more granular level than for the area of an individual monitoring site. Therefore, the common way to report this data is through by county. This type of county-level and regional level analysis is used broadly in the literature using multi-level models to analyze the effect of air quality on the health of communities (See recent paper on air quality and influenza hospitalizations).

Process and Criteria for Identifying Significant Health Needs

Qualitative data was analyzed using a grounded theory approach to identify common topics of discussion and themes. All themes were grouped into broader, more inclusive social determinant of health (SDoH) domains. These domains included Economic Stability, Education Access and Quality, Health and Health Behavior, Healthcare Access and Quality, Neighborhood and Environment, Social and Community Context, and a specific domain on COVID-19-related issues. Focus group and key informant data were analyzed independently of each other. However, the same method was used to analyze both data sets.

Focus groups were organized to represent the perspective of community residents and to capture their health needs, concerns, and values. Views expressed by community residents within focus group discussions are principal to describing the needs of the community and that data collected via key informant interviews should be secondary to that of community residents. Themes from community resident focus group conversations were a natural starting point in developing the priority matrix shown above.

Themes gathered from focus group discussions (Appendix E) was compared to a list of themes gathered from key informant interviews. These themes are outlined within the summaries for each. The goal was to identify themes that were in agreement between the focus groups and the key informant interviews. A greater number of themes emerged from the focus group discussions in comparison to the key

informant interviews. This is primarily because focus group sessions were longer, and many more topics of discussion were covered. Within each domain, the themes were sorted descending from most frequently mentioned to least mentioned. At least three themes, within each domain, from the focus group data were cross referenced with the themes from the key informant interview data. If there was agreement between the focus group theme and the key informant interview theme, then the theme was placed as a high priority. In some cases, the key informant interviews did not yield three themes of agreement within a given domain. In this scenario the next highest theme identified from the focus group data would be placed on the high priority list.

Once a priority list of themes was developed using both the focus group and key informant interview data, a composite score was developed for each theme using items (quantitative data) from the community-wide survey. Composite scores were developed by computing the median percentage across the items that best match with each theme.

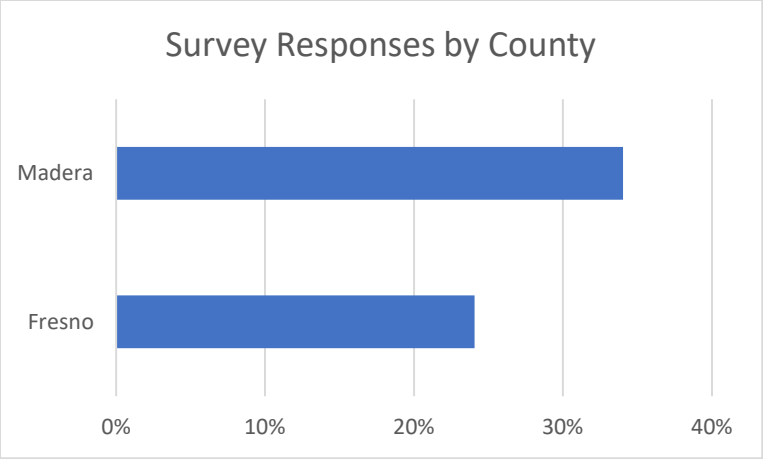
Significant Health Needs Identified – Fresno and Madera Counties

Domain A	**Healthcare Access and Quality**
	Expensive medical care
	Insurance barrier/Access to medical care
	Not enough providers/treatment locations/long wait times
	Lack of provider compassion/Discrimination/Distrust in medical system
Domain B	**Neighborhood and Environment**
	Safety/neighborhood crime
	Poor air quality/pollution
	Lack of transportation
	Homelessness
Domain C	**Economic Stability**
	Lack of affordable/acceptable housing
	Poverty
	Food Insecurity

CHNA Data Analysis

Community-wide Survey Analysis

The Community-wide survey was downloaded from SurveyMonkey to SPSS, where the data was cleaned. Some surveys were determined by the data analysts to be unusable due to zip codes that were outside the geographic region of study and were removed from the data pool. After merging self-reported zip code of residence with county of residence, the analysts found that 1,201 individuals were in Fresno County and 1,699 individuals were in Madera County. Among the 2,900 total respondents in both counties, a total of 24 were dismissed due to missing data. The final total of surveys collected for Fresno and Madera counties was 2,876.



As shown in the bar graph above, Madera had the highest number of responses. Fresno is the largest by population size, so Madera is overrepresented in this sample. (subscript to image)

The goal of the survey analysis was to look at differences in responses among the following groups:

- County
- Age group
- Gender
- Race/ethnicity and Hispanic origin
- Income
- Education

These differences helped in identifying community needs.

Most of the question responses are categorical, or category choices (instead of numbers). For example, choosing the language spoken at home. There are missing responses on questions throughout the survey, but a missing value analysis did not show any concerning patterns.

Some of the responses were numbers instead of categories. For example, the number of times people experienced discrimination. First, the average for each group was determined to find the mean. Likewise, the standard deviation was determined to identify how close all the responses are to the mean.

The survey results are organized by demographics and then the conditions that affect health and quality of life:

- Demographics
- Economic Stability
- Health and Health Behaviors
- Healthcare Access and Quality
- Neighborhood and environment
- Social and Community Context

There were three additional sections:

- General opinions
- Parent/Caretaker
- COVID-19 Specific questions

Demographic questions

Demographic questions describe *who* responded to the survey. Community members shared their age group, gender, marital status, household size, annual income, and education. There were also questions about language and employment.

Economic Stability

Economic stability questions help us understand what economic problems community members experienced. The questions in this section ask about difficulty paying for different resources or services that people need. When people cannot afford healthy food, housing, or other resources, this affects their health.

Health and Health Behaviors

This section includes questions about health, lifestyle, and health opinions.

Healthcare Access and Quality

Having access to good quality healthcare is another important part of the health of community members. This section includes questions that looked at how community members pay for their healthcare, what makes accessing healthcare difficult and their experiences of care.

Neighborhood and Environment

The neighborhood one lives in, the community one is a part of, and the places one works and plays impact health in many ways. This section includes questions about access to different resources and what changes community members would like to see in their community environment.

Social and Community Context

This section includes questions about interactions and treatment by other in the community which can affect health and wellbeing.

Parent and Caregiver Questions

Questions in this section focused on the needs and challenges faced by children and their families, and pregnant women and new moms.

General opinion questions

The overall goal of the community health needs assessment is to identify and prioritize the needs of community members. This section included general questions designed to identify what is working well in the community and what community members feel like those needs are.

COVID-19 Specific Questions

Over the last two years, the COVID-19 pandemic has changed all aspects of people's lives, from economic stability to how individuals live and learn in their communities. The survey includes questions about challenges and experiences related to the COVID-19 pandemic.

Questions Combined for Analysis

Question 6 and Question 8

Question 6: “Do you consider yourself Hispanic/Latino (such as Mexican American, Latin American, Central or South American, or Spanish American)?”

Question 8: “What race and/or nationality group do you most identify with?”

First, the analysts used the other responses in Question 8 to create new categories. This is shown as the Race, Nationality, Ethnicity results in the demographic questions. There is a lot of confusion of the difference between race, nationality, and ethnic origin. To clearly represent how community members identify themselves, those terms were not separated in this graph.

Next, a new combined race and ethnicity variable was created. This more closely matches the US Census categories and common secondary data methods. The new categories are:

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Pacific Islander
- Hispanic White
- Non-Hispanic White
- Bi-/Multi-Racial or Other

This was used to compare responses on the survey questions by race and ethnicity.

Question 63 and Question 64

Question 63: “During the COVID-19 pandemic, have you or your family found you needed help getting enough food, paying bills, rent or mortgage, finding childcare, or meeting with primary care providers?”

Question 64: “If YES, how often?”

Response options to question 63 were yes or no. The response options for question 64 ranged from “less than half the time” to “all of the time”. To compare the challenges in the community more clearly CVHPI combined questions 63 and 64 to show “not at all” as one of the response options.

Question 19

Question 19 asked one of the discrimination measures twice, "I was discouraged by a teacher or advisor from seeking higher education", so these responses were combined into one variable.

Questions Excluded from the Analysis

Question 7: Mexican ancestry

"If you are of Mexican ancestry, do you self-identify as being part of the Nahaus, Maya, Zapotec, Mixtec, Otomi, Totomac, Tzotzil, Mazahua, Mazatex, Huastec, Ch'ol, Chinantec, Purepecha, Mixe, Tlapanex, Tarahumara indigenous group?"

Responses to this question showed that people did not understand the response options. For example, 66.1% of all responses identified as Hispanic/Latinx, but 77.8% responded to this question as being Mexican. This is likely because there was no option to indicate not being of Mexican descent.

Focus Group Analysis

Focus groups were transcribed using Trint, an artificial intelligence program. The analysis team then checked the transcriptions for accuracy. The in-person groups tended to have more background noise and were more difficult to transcribe. In places where transcription was not possible, the transcripts were marked as "inaudible" or "crosstalk" and notes were used for the analysis.

Focus group sessions were held in four languages: English, Spanish, Hmong, Lao, and Mixteco. The transcripts in Spanish were translated into English. The Hmong and Mixteco audio recordings were not transcribed. Given the time constraints, and after speaking with members from the Mixteco and Hmong communities, we used the notes for the analysis instead. The Lao focus group did not have a recording and the notes were used for the analysis.

Transcripts were then uploaded to Dedoose, a program for qualitative analysis. The analysis team used a Grounded Theory approach. The team created a codebook with themes or ideas that were expected based on the questions and past research (a priori). Themes are ideas or topics shared by participants, also called codes. These codes or themes were applied to the interviews in Dedoose. Themes were added as the focus groups were coded.

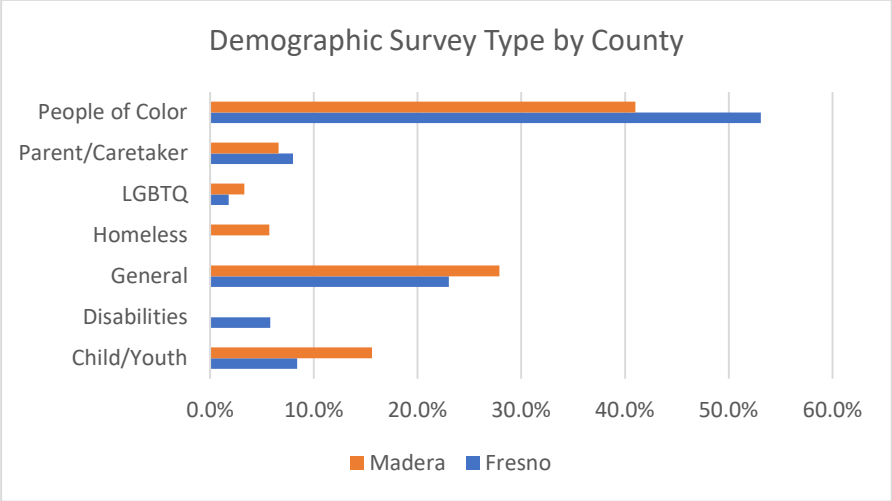
The Cohen's Kappa process was used to measure the agreement of codes which can range from 0 to 1, with 1 being perfect agreement. The range determined using this process was very high (.83) – indicating good agreement.

Finally, codes and themes were organized under the social determinant of health domains:

- Economic Stability
- Education Access and Quality
- Health and Health Behaviors
- Healthcare Access and Quality
- Neighborhood and Environment
- Social and Community Context

Focus group participants completed demographic surveys in-person or remotely, either on paper or through SurveyMonkey online. When completed online, they did not state what focus group they

participated in and not all participants completed the focus group survey. The information presented here is an overview of all responses.



The table above shows the responses per survey type by county.

There were eight questions that all focus groups answered. They were asked their age, gender, and the county they live in. They were also asked if they are Hispanic or Latino, and their race or ethnicity. Participants were also asked to pick which group(s) they belong to, with the option to pick all that apply.

A summary of the regional analysis is below. See Appendix E for the focus group code/theme frequencies, or how often different topics were mentioned in the focus groups by county. See Appendix-F for key informant interview relevant quotes for Social Determinants of Health Domains.

Note: Some topics had more questions and not all questions were answered in every focus group.

Good Things About the Community

When asked what they liked about their community, participants most often shared that they liked their neighborhood and environment because it is peaceful, safe, and centrally located. The next most common response was that they liked the social and community context. In particular, how close-knit and supportive friends and family are. They also shared that they love the diversity and shared culture in their communities.

Community Health Needs and Challenges

> *"My experiences were not the best when getting health care in my community. There is a shortage of doctors, long waiting this time, and the doctors do not seem to take my concerns about my health seriously." Fresno, Child-Youth, FG2, English*

Participants shared what community health issues they felt were the most concerning. In addition, they shared their experiences with healthcare in their communities. The social determinant of health most frequently discussed was Healthcare Access and Quality across all four counties. Participants specifically identified not having enough providers and treatment locations to take care of them, and insurance and cost barriers to care. In Madera, participants specifically identified that they have to travel for care and have transportation barriers. The next most

commonly discussed social determinant of health was Neighborhood and Environment. Participants shared concerns about safety and neighborhood crime, poor air quality, and homelessness.

How Community Members can Help

After sharing their concerns and identifying the biggest factors contributing to health, participants shared ideas for how their community can help. The most frequently shared ideas were for creating a more supportive Social and Community Context. Participants shared ideas around advocacy and teaching community members to speak up for their needs in town meetings and in other situations. They also suggested increasing awareness around resources and being more involved in the community in general. Neighborhood and Environment suggestions were the next most common. Suggestions included repurposing community spaces to be more usable, making choices that are good for the environment, and creating more community gardens and farmer's markets.

How Institutions can Help

Suggestions for how institutions can help came from responses to a general question about institutional support and a specific question about changes to healthcare. Participants commented the most frequently on Healthcare Access and Quality. The most frequent suggestions were to have more integrated healthcare teams that work together and share information. They also suggested that institutions find ways to attract and hire more providers, to improve scheduling (both making appointments and reducing wait times at appointments). They also suggested that institutions find ways to attract and hire more providers, provide affordable/universal care, and provide better translation/interpretation services. Under Neighborhood and Environment, the next most frequent social determinant of health, they suggested that institutions outreach directly to the community and that they improve local transportation.

When asked what specific institutions can help, participants were less clear and identified more general institutions, such as healthcare organizations (hospitals, clinics), community-based organizations, county and state agencies, religious organizations and the media.

Challenges and Needs of Children

Focus group participants shared the challenges and needs of children in response to two questions. One asked about general health concerns in the community and another was specifically about the challenges and needs of children. Not all focus groups responded to the question about children's needs. In Fresno, the most common challenge/need was in Neighborhood and Environment. This includes problems with neighborhood safety and the need for safe places to play and live, access to healthy food, and air quality concerns. Madera participants strongly felt that there needs to be more quality childcare and afterschool programs. They also felt that parent/caretaker health needs to be supported. Participants also shared concerns about Healthcare Access and Quality, with a focus on needing more mental health support and access to equitable care.

How to Improve the Health and Wellbeing of Children

When asked how to improve the health and wellbeing of children in their communities, participants responded the most under Social and Community Context. Suggestions included providing more resources, more playtime and activities, and more adult role models. The next most common suggestion was better and more accessible mental health support under Healthcare Access and Quality.

Challenges and Needs of Pregnant Women and New Moms

Some of the focus groups were asked about the challenges and needs of pregnant women and new moms. The two most common responses were about Social and Community Contexts, and the next was Health and Health Behaviors. Under Social and Community Context, participants shared that pregnant women and new moms do not have enough social support and information on pregnancy and parenting. Under Health and Health Behaviors, participants felt the biggest challenge was mental health.

Suggestions for How to Improve the Health and Wellbeing of Pregnant Women and New Moms

Focus group participants felt that the best way to help pregnant women and new moms is through social support, better access to healthcare services, help with food and job security.

Five-Year Vision

The last focus group question asked participants to share what they would like to see in their community in five years. The most common themes in Fresno were improvements to the Neighborhood and Environment. Participants hope to see that their communities are safer and have improved air quality. They also want to see better Healthcare Access and Quality with the overall healthcare system and standard of care improved and more integrated healthcare services. In Madera, the most common themes were improvements to the Neighborhood and Environment. Participants hope to see that their communities have better access to healthy food and are safer. They also want to see better overall health, and improved Healthcare Access and Quality. Specifically, they want to see a better overall healthcare system and standard of care and more integrated healthcare services.

Key Informant Interview Analysis

Key informants were identified as community leaders, local policymakers, business owners, religious leaders, and health care staff from public and private healthcare services. These individuals were asked questions about their organizations and the communities they serve.

Thirty-one key informant interviews were held within Fresno and Madera counties. Similarly, to focus groups, contracted organizations conducted the interviews. The key informant interviews were held virtually on Zoom. An interviewer facilitated the focus groups, and in some instances, they worked with a recorder/notetaker.

Key informants represented various organizations. Interviewees who work with children and adolescents completed the Child/Youth Key Informant guide, and the remainder completed the General Key Informant guide.

In addition to the open-ended questions about the community, key informants shared information on their organizations. They also shared where they and their family receive care.

Key informant interviews were transcribed using Trint, an artificial intelligence program. The analysis team then checked them for accuracy. Because the interviews were one-on-one and virtual, there were no problems with background noise. The key informant interviews were all in English. The transcripts are not included in the appendices to protect the privacy of the interviewees.

The rest of the analysis process used for the focus groups was used for the key informant interviews. The key informant interviews also included some quantitative questions (not open-ended) that we analyzed as well.

A summary of the regional analysis is below. Note: Some topics had more questions and not all questions were answered by every interviewee.

Health Issues and Factors that Lead to Health Issues

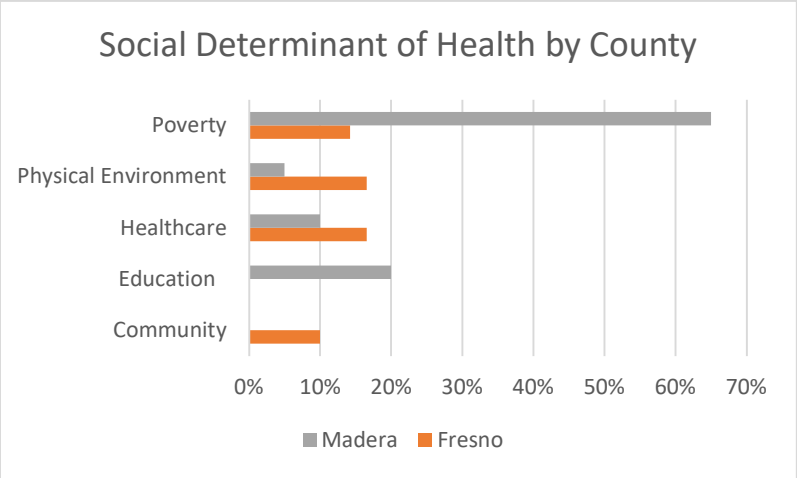
Key informants shared health conditions and factors that are the most concerning in their communities. The most common Health and Health Behavior problems identified were mental health issues, problems with women's health, and preterm birth and infant death. The most common factors that they shared led to health issues were Social and Community Contexts. Lack of resources and racism and discrimination were the two most common social factors. The next most common social determinant of health was Healthcare Access and Quality, followed by Economic Stability. Key informants shared that their communities distrust the medical system. Poverty and food insecurity were also identified as common factors leading to community health issues.

Three Biggest Community Health Problems

Key informants then selected the three biggest health problems in their community from a list. They also had the option to select "other" and share a response that was not one of the options. The three health problems that emerged as most important were mental health issues, diabetes, and domestic violence.

Social Determinants of Health Ranked

The figure below shows how interviewees responded when asked to rank the most important social determinant of health from the options provided.



What Works to Address Health Issues/Social Determinants of Health

Interviewees then identified what is already working to address health issues and social determinants of health. The top three responses in Fresno were collaborations with other organizations, education, and access to resources. In Madera, the top three responses were collaborations with other organizations, education, and communication.

How the Community can Address Health Issues/Social Determinants of Health

The most common theme for how key informants and their community can help was collaboration with other groups and sectors. They also shared community education and supporting other community members. Madera key informants shared that collaboration with other groups and sectors, community education about health problems and their impact, and advocacy could address health issues and SDOH.

Challenges and Needs of Children

The most common challenges and needs were under Health and Health Behavior and Social and Community Context. For Health and Health Behavior, the most common challenges were mental health issues and adverse experiences such as racism and lack of healthy habits. For Neighborhood and environment, interviewees identified the need for access to healthy foods, a stable home life, activities outside of school and transportation. Key informants also commonly identified access to medical care (particularly pediatricians) as a need.

Suggestions for How to Improve the Health and Wellbeing of Children

When asked how to improve the health and wellbeing of children in their communities, interviewees made suggestions related to a more supportive Social and Community Context. In particular, they identified the need for more social support, family involvement, and quality childcare. Key informants also frequently identified Neighborhood and Environment improvements. This included providing access to healthy food and bringing resources to neighborhoods (rather than having to find resources).

In Madera, suggestions included improved Education Access and Quality, such as education for families and improvements in school. Key informants also suggested improvements to Healthcare Access and Quality including more and better services.

Challenges and Needs of Pregnant Women and New Moms

The most common social determinant of health identified was Social and Community Context. The common themes identified as needs and challenges of pregnant women and new moms was focused around Social and Community Context. Interviewees identified the need for social support, long-term access to resources and support (not just during and right after pregnancy), quality childcare and the need for culturally appropriate services and support. For Health and Health Behaviors, key informants shared that high infant mortality and preterm birth, and mental health problems are important issues.

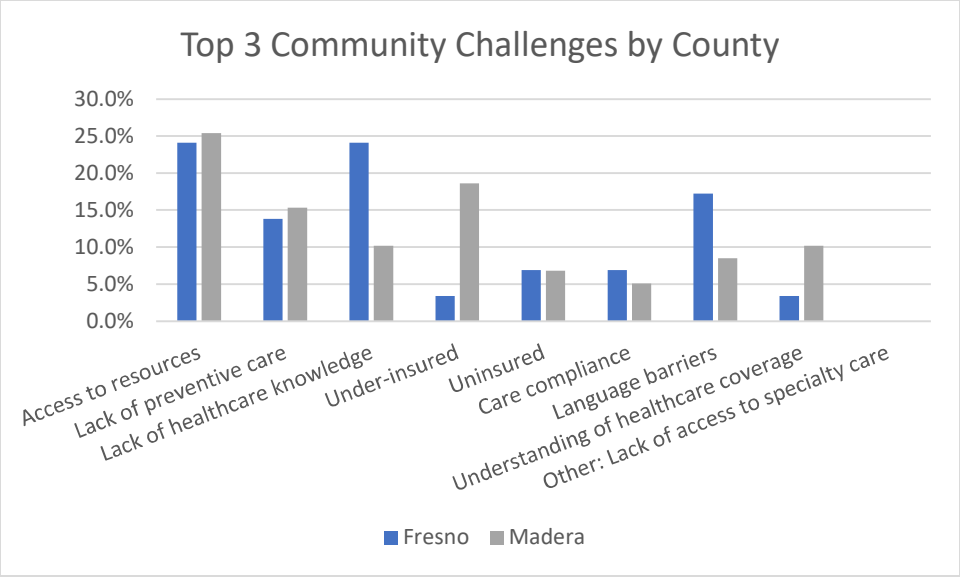
Suggestions for How to Improve the Health and Wellbeing of Pregnant Women and New Moms

Suggestions for how to improve the health and wellbeing of pregnant women and new moms were focused on Healthcare Access and Quality. Interviewees suggested more comprehensive healthcare, health education, and better access to healthcare and mental health support.

Top Community Health Challenges

Key informants identified the top community health challenges experienced by their clients and community. As shown in the figure below, the top challenges in Fresno County were access to resources, lack of healthcare knowledge, and language barriers.

While this was only brought up in one interview, it is important to note that one interviewee challenged the idea that healthcare knowledge should be a patient/client responsibility and stated that institutions need to take more responsibility in guiding community members.

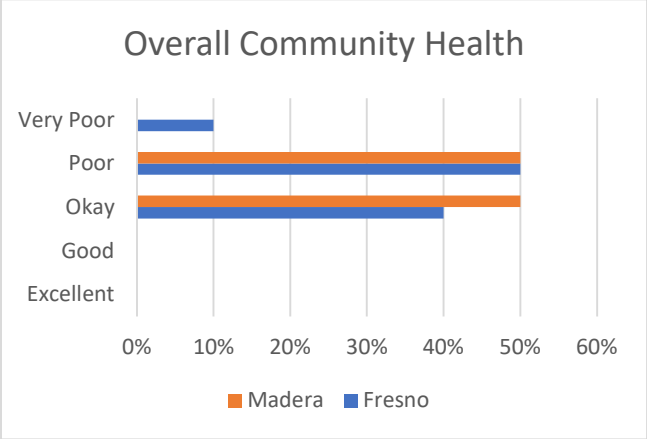


Problems in the Healthcare System that Impact Community Health

When asked specifically about problems in the healthcare system that impact community health, responses were more evenly distributed. The three most common themes were lack of interpreters and lack of providers and services overall. In Madera, they added cost of healthcare services, lack of access to quality care, and challenges navigating the healthcare system. These reflect common themes from the focus groups.

Overall Community Health

Overall community health ratings were different across the counties. As shown in the figure below, the most common response overall was that community health is “okay”. Fresno was the only county with the most “poor” responses. For Madera county, the responses ranged from “good” to “very poor” with the majority “okay”.



Five-Year Vision

At the end of each interview, interviewees shared their vision for what they hope to see in five years. The most common responses were for improvements in Healthcare Access and Quality and Health and Health Behaviors. For Healthcare Access and Quality, the most frequent response was that everyone has equal access to care. They also want to see an increase in the integration of traditional and cultural healthcare, expansion of quality services and more providers. For Health and Health behaviors, interviewees want to see a healthier community and reduced preterm birth.

Findings by Themes

Health Access and Quality

"So women's health, the state of women's health, and that's everything, mental health, physical health, before pregnancy, the high number of infant deaths that we have actually across race and ethnicity, but it's particularly bad among the Black population." - Fresno

Not enough providers/treatment locations/long wait times

An estimated 7 million Californians live in provider shortage areas, with shortfalls in access to primary, dental or mental healthcare providers *(*primary care shortage area is defined as having a population greater than 2,000 per provider) *(Let's get Healthy California, 2016)*. The shortage of health professionals impacts access to care, causing a significant delay in obtaining timely health services and resulting in barriers which negatively affect health outcomes. Access to comprehensive and quality healthcare services is important for physical, social, mental health, and overall quality of life. Access to care also promotes preventative measures, managing disease, and reducing unnecessary disability and premature death.

Report Area	Primary CareFacili-ties	Mental Health CareFacilities	Dental Health Care Facilities	Total HPSA Facility Designations
Saint Agnes Medical Center -Fresno	**62**	**58**	**56**	**176**
Fresno County, CA	**32**	**28**	**27**	**87**
Kings County, CA	14	12	11	**37**
Madera County, CA	**5**	**6**	**5**	16
Mariposa County, CA	3	3	3	**9**
Tulare County, CA	15	15	15	**45**
California	**440**	**401**	**392**	**1,233**
United States	3,979	3,617	3,432	11,028

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. May 2021. Source geography: Address

Within the report area, there is a total of 176 Health Professional Shortage Areas (HPSAs). "Health Professional Shortage Areas" (HPSAs), defined as having shortages of primary medical care, dental or mental health providers. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Additionally, long waiting times for patients are commonly seen in outpatient facilities, and this difficulty contributes to a range of public health issues, including impaired access to care, interruption of hospital work patterns, and patient dissatisfaction.

-	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Saint Agnes Medical Center -Fresno	**No data**	**No data**	**No data**	**No data**
Fresno County, CA	**1,008,654**	**233**	**754**	**74.75**
Kings County, CA	152,486	58	108	70.83
Madera County, CA	**156,255**	**34**	**118**	**75.52**
Mariposa County, CA	17,131	11	7	40.86
Tulare County, CA	473,117	110	292	61.72
California	**39,538,223**	**11,923**	**38,923**	**98.44**
United States	334,735,155	115,804	342,350	102.27

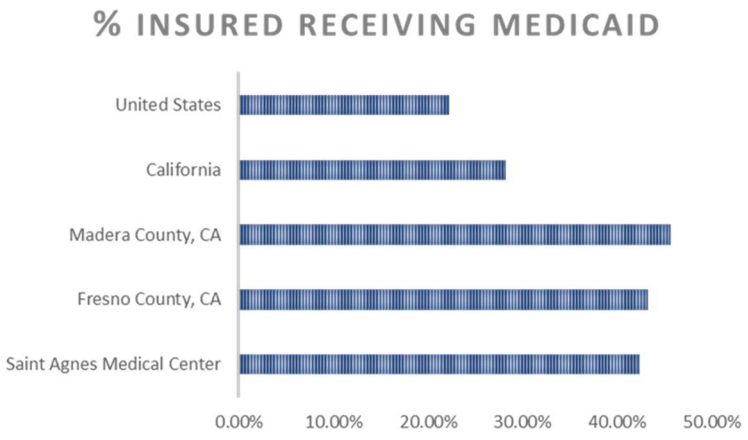
Note: This indicator is compared to the state average. Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). *May, 2021. Source geography: Address*

Expensive Medical Care

The U.S. spends more on health care than all the other wealthy democracies in the world, yet life expectancy in the U.S falls behind than that of other first world countries *(Freed, M., Ochieng, N., Sroczynski, N., Damico, A., Amin, K., 2021).* Many U.S. adults have difficulty affording various health care and dental costs. The cost of health care often prevents people from getting needed care or filling prescriptions. High health care costs also disproportionately affect uninsured adults, Black and Hispanic adults, and those with lower incomes. However, those who are covered by health insurance are not immune to the burden of health care costs. Nearly half (46%) of insured adults report difficulty affording their out-of-pocket costs, and one in four (27%) report difficulty affording their deductible (Freed, M., et. al, 2021). Difficulty paying medical bills can have significant health consequences for U.S. families. The following tables and graphs detail secondary data in the Saint Agnes Services Area that shows current trends that relate, expensive medical care.

Insurance barrier

Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities. Uninsured adults for example can be less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Vulnerable populations are particularly at risk for insufficient health insurance coverage.



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

Currently minorities account for more than half of the uninsured population *(Pavlova, A., Wang, C.X.Y., Boggiss, A.L. et al.,2021).* Out-of-pocket medical expenses may also lead to delayed or untreated needed care such as doctor visits, dental care, and medications. Inadequate health insurance coverage is one of the largest barriers to health care access *(Call, K., McAlpine, D,, Garcia, C., Shippee, N., Beeba, T., Adeniyi, T., et al., 2014).* Even if individuals have health insurance coverage, it may not cover all medical services and co-payments and monthly costs may be too high, which can deter important preventative and medical treatments.

Lack of Provider Compassion – Discrimination - Distrust

Compassion is defined as noticing the suffering of another and being motivated to alleviate it *(Pavlova, A., Wang, C.X.Y., Boggiss, A.L. et al., 2021).* Compassion is an important healthcare characteristic that predicts better patient outcomes. When physicians fail to show patients compassion, it can have a big impact on their mental and physical health. Compassion fatigue can be the result of physical, emotional, and spiritual exhaustion from the demands of being a physician.

Too much paperwork, too many long shifts, too little time to sleep, exercise, or reduced time spent relaxing with family and friends can be stressors that push health care providers into early retirement, career changes, or compassion fatigue. Consequently, a lack of compassion can affect patient well-being and a loss of professional motivation.

According to Healthy People 2020, discrimination is a socially structured action that is unfair or unjustified and harms individuals and groups. It can occur to protect more powerful and privileged groups at the detriment of other groups. Discrimination was identified during focus group sessions and key informant interviews as a barrier to good health. Experiences of discrimination can lead to unmet health needs and increase risk for mental health, and physical health complications. Discrimination by providers and staff – including socioeconomic, language and racial discrimination – was identified as a barrier to access to health and resources.

Racial Diversity (Theil Index)

"Language is another barrier. If then when they call and the person on the other line only speaks English. That's a challenge for them just trying to find, you know, who can either translate now it's who can translate for me, who can call, who can ask." -Fresno (Topic: Cultural Awareness)

The Theil Index measures the spatial distribution or evenness of population demographic groups in neighborhoods throughout the county. This indicator is presented as an index with values ranging between 0 and 1, with higher values indicating higher levels of segregation between neighborhoods as depicted in the table below.

Report Area	Non-Hispanic White Population	Non-Hispanic Black Population	Non-Hispanic Asian Population	Non-Hispanic AI / AN Population	Non-Hispanic NH / PI Population	Hispanic or Latino Population	Diversity Index
Fresno County, CA	27.92	4.55	11.26	0.62	0.13	55.52	0.17
Madera County, CA	32.02	2.73	2.37	1.15	0.08	61.65	0.24
California	36.39	5.62	15.86	0.41	0.37	41.34	0.52

Data Source: US Census Bureau, Decennial Census. University of Missouri, Center for Applied Research and Engagement Systems. 2020. Source geography: Block Group

Neighborhood and Environment

Transportation

Lack of access to public transportation can disproportionately harm older people and people with disabilities. It can also contribute to existing racial and economic disparities by decreasing mobility and forcing individuals to depend on costly car ownership. Research has shown that lack of transportation can result in missed or delayed health care appointments, poorer health outcomes, and increased health expenditures *(Heaps, W., Abramsohn, E., Skillen, E., 2021).* Inadequate public transportation can also increase social isolation, particularly for older populations and people with disabilities or others who do not drive. This can increase the risk for early mortality, depression, and dementia. In contrast, access to reliable public transportation can improve access to healthier food, vital services, employment, and recreational opportunities, all of which are important for health and well-being. Public transportation may also affect health more indirectly by providing access to health-promoting services and supports, including health care itself.

Households with No Motor Vehicle

Report Area	Total Occupied Households	Households with No Motor Vehicle	Households with No Motor Vehicle, Percent
Hospitals' Service Area	506,031	35,713	**7.06%**
Fresno County, CA	307,906	25,528	8.29%
Madera County, CA	44,881	2,001	4.46%
California	13,044,266	927,957	7.11%

Note: This indicator is compared to the state average. Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Commuter Travel Patterns - Public Transportation

Report Area	Total Population Employed Age 16+	Population Using Public Transit for Commute to Work	Percent Population Using Public Transit for Commute to Work	CALIFORNIA
Hospitals' Service Area	645,542.00	5,898.00	**0.91%**	**5.08%**
Fresno County, CA	395,689	4,408	1.11%	
Madera County, CA	54,942	264	0.48%	

Note: This indicator is compared to the state average. Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Homelessness

Homelessness can be defined as living on the streets, shelters, or couch surfing *(Choucair, B. and Watts, B., 2018)*. People who experience homelessness are exposed to higher rates of communicable disease (e.g. TB, respiratory illnesses, flu, hepatitis, etc.), violence, and malnutrition. Chronic health conditions such as diabetes, high blood pressure, and asthma can also become worse because there is no safe place to store medications properly and lack of financial resources may prevent people from obtaining the necessary medications, they need to manage their conditions *(Choucair, B. and Watts, B., 2018)*. Other factors that contribute to poor health are untreated behavioral health issues such as depression, alcoholism, or other substance use disorders.

The numerous health conditions among homeless individuals often lead to poor health, high stress, unhealthy and dangerous environments, and an inability to manage their health condition can often result in frequent visits to emergency rooms and hospitalizations. Homelessness has been on a steady rise in recent years. In 2020, Fresno County reported an increase of 45% in comparison to the previous year (*Fresno County, 2020*). In Madera County, there was a 3.4 percent increase overall over in 2020 from the previous year (*Lezin, N., 2021*). Given the many negative health factors associated with homelessness, stable housing is a key social determinant of health that directly impacts health outcomes.

Safety and Neighborhood Crime

Many people in the report areas expressed concern about living in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial/ethnic minorities and people with low incomes are more likely to live in places with these risks. In addition, some people are exposed to things at work that can harm their health, like secondhand smoke or loud noises.

Community safety reflects not only violent acts in neighborhoods and homes, but also injuries caused unintentionally through accidents. The chronic stress associated with living in unsafe neighborhoods can accelerate aging and harm health. Unsafe neighborhoods can cause anxiety, depression, and stress, and are linked to higher rates of pre-term births and low birthweight babies.

Incarceration Rate

The Opportunity Atlas estimates the percentage of individuals born in each census tract who were incarcerated at the time of the 2010 Census. According to the Atlas data, 1.2% of the report area population were incarcerated. The incarceration rate in the report area is higher than the state average of 0.9%.

Report Area	Total Population (2010)	Incarceration Rate
Hospitals' Service Area	1,542,827	**1.2%**
Fresno County, CA	930,450	1.1%
Madera County, CA	150,865	1.3%
California	37,253,956	0.9%

Note: This indicator is compared to the state average. Data Source: Opportunity Insights. 2018. Source geography: Tract

Economic Stability

"Poverty relates to people having less access to health care, less access to good-paying jobs. Less access to housing options. Less access to transportation, childcare, so all the barriers to have a productive and healthy life to me relates to poverty." - Madera

Poverty

Poverty is an important health issue because it creates barriers that impact health outcomes, life expectancy, and infant mortality rates, plus restricts the availability of resources that encourage healthy behaviors. These include healthy foods for proper nutrition, safe neighborhoods, utilities, clean air and water and housing. Saint Agnes Medical Center's service area has higher rates of unemployment as compared to the State, low levels of income and high rates of poverty.

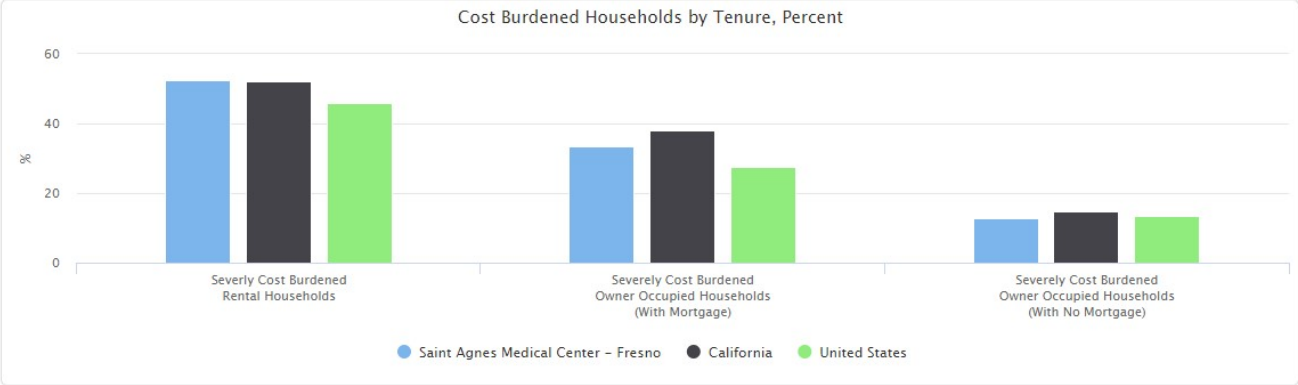
Poverty occurs when an individual or family lacks the resources to provide life necessities, such as food, clean water, shelter, and clothing. In 2022, the federal poverty income level is $13,590 for an individual younger than 65 years and $27,750 for a family of four. In the Saint Agnes service area, 8.1% of the civilian non-institutionalized population age 16 and older (non-seasonally adjusted) are unemployed.

Hospitals' Service Area (SA)					**Report Area (RA)**	**CA**
	SA	**White (RA)**	**Black**	**Latino**		
Unemployment	8.1%	N/A	N/A	N/A	7.5%	4.8
Median Household Income	$54,309	$67,503	$38,050	$46,139	55,777	$75,235
Poverty Children (200% FPL)	45.39%	N/A	N/A	N/A	57.35%	40.25%
Poverty	45.39%	N/A	N/A	N/A	44.84%	30.96%
No H.S. Diploma	24.83%	22.05	17.10	42.26	24.04%	16.69%

Affordable/Appropriate Housing

Access to affordable housing is linked to the health of every individual. It is the foundation for healthy, vibrant communities as well as inclusive economic growth. According to Children's Health Watch, unstable housing among families will cost the United States $111 billion over the next 10 years.

Focus groups and key informants identified affordable and lack of appropriate housing as a barrier to health in Fresno and Madera counties. Of the more than 500 thousand total households in the report area, 38.40% of the population live in cost burdened households. In other words, more than 30% of their total income pays for housing expenses for owners and renters.



U.S. Census Bureau American Community Survey (ACS) 2015-2019 5-year estimates

In the service area, more than 40% of occupied housing units experience one or more substandard conditions. These conditions include lack of complete plumbing facilities, lack of kitchen facilities, one or more occupants per room, mold and/or pests.

Report Area	Total Occupied Housing Units	Occupied Housing Units with One or More Substandard Conditions	Occupied Housing Units with One or More Substandard Conditions, Percent
Hospitals' Service Area	506,031	214,843	**42.46%**
Fresno County, CA	307,906	131,790	42.80%
Madera County, CA	44,881	17,564	39.13%
California	13,044,266	5,712,995	43.80%

Note: This indicator is compared to the state average. Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

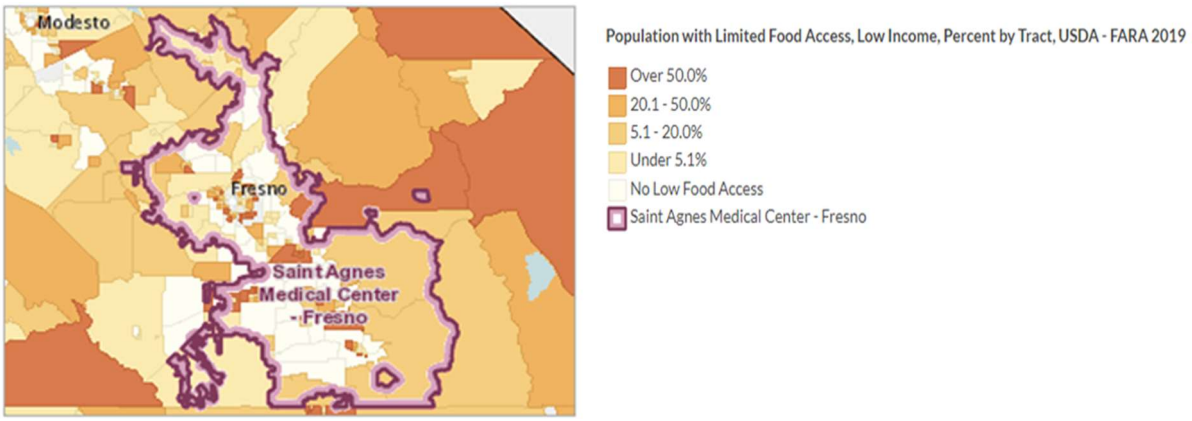
Food Insecurity

The US Department of Agriculture defines food insecurity as a lack of consistent access to enough food for active, healthy life – a disruption of food intake or eating patterns because of lack of money and

other resources. Food insecurity may reflect a household's need to choose between essential basic needs, such as housing or medical bills and purchasing nutritionally adequate foods.

Healthy dietary behaviors are supported by access to healthy foods, and Grocery Stores are a major provider of these foods. Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities. These health disparities include chronic diseases like obesity, and higher rates of diabetes.

Food Environment - Low Income & Low Food Access



Report Area	Total Population	Low Income Population	Low Income Population with Low Food Access	Percent Low Income Population with Low Food Access
Hospitals' Service Area	1,561,383	714,731	83,861	No data
Fresno County, CA	930,450	430,319	49,776	11.57%
Madera County, CA	150,865	65,387	8,175	12.50%
California	37,253,956	11,623,698	1,204,964	10.37%

Food Environment - Grocery Stores and Supermarkets

Understanding the retail food environment is also important to determine access to healthy foods and overall influences on dietary behaviors. Fresno is the second most food-insecure city in the United States. According to USDA, Fresno County has 12 areas that are classified as food deserts. Food deserts are urban neighborhoods and rural towns without ready access to fresh, healthy, and affordable food.

Report Area	Number of Establishments	Establishments, Rate per 100,000 Population
Hospitals' Service Area	353	**22.61**
Fresno County, CA	253	27.19
Madera County, CA	31	20.55
California	7,720	20.72

Note: This indicator is compared to the state average. Data Source: US Census Bureau, County Business Patterns. *Additional data analysis by* CARES. *2019. Source geography: County*

Chronic Conditions - Obesity (Adult)

The table below reports the number and percentage of adults age 18 and older who are obese, defined as having a body mass index (BMI) ≥30.0 kg/m², calculated from self-reported weight and height.

Report Area	Total Population (2019)	Adult Obesity (BMI ≥30.0 kg/m²) (Crude)	Adult Obesity (BMI ≥30.0 kg/m²) (Age-Adjusted)
Hospitals' Service Area	1,561,368	**34.75%**	No data
Fresno County, CA	999,101	37.10%	37.60%
Madera County, CA	157,327	32.30%	32.70%
California	39,512,223	27.54%	27.71%

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* ***500 Cities Data Portal****. 2019. Source geography: Tract****Show more details***

Prioritization Process

A team of 48 advisors comprised of residents, promotores, community health leaders, law enforcement, school health, county agency personnel, housing agency representative, youth, community-based organization leaders prioritized the identified health needs. These individuals were selected based on their knowledge and involvement in the Fresno and Madera communities.

Secondary data for this process was pulled from the Trinity Health Community Health Needs Assessment Data Report(trinityhealthdatahub.org), and the Fresno and Madera Counties' Point-in-Time (PIT) homeless count. The table below lists the data indicators used for each domain and need identified.

Significant Health Needs Identified – Fresno and Madera Counties		**Data Indicators for Domain**
Domain A	**Healthcare Access and Quality**	Insurance: Medicaid & Uninsured MH Providers PC Providers Federally Qualified Health Centers Health Provider Shortage Areas Recent Primary Care Visit Hospitalizations – Preventable Cond. Chronic Disease – Diabetes/Heart/HBP 30-day Readmissions Mortality – premature death Low Birth Weight
	Expensive medical care	
	Insurance barrier/Access to medical care	
	Not enough providers/treatment locations/long wait times	
	Lack of provider compassion/Discrimination/Distrust in medical system	
Domain B	**Neighborhood and Environment**	Homeless Children/Youth Just in Time – Commuter Patterns Households w/out vehicle Incarceration Rate Air Quality Mortality Homicide Violent Crime
	Safety/neighborhood crime	
	Poor air quality/pollution	
	Lack of transportation	
	Homelessness	
Domain C	**Economic Stability**	Housing costs -Burden, Overcrowding, Substandard housing,
	Lack of affordable/acceptable housing	

	Poverty	Tenure – Owner-Occupied, Renter-Occupied
	Food Insecurity	Unemployment Education – HS Diploma Student proficiency Reading level Food environment – Fast food restaurants, Grocery Stores and Supermarkets, Low income & low food access Chronic Conditions – Obesity (Adult), Diabetes (Adult) Poverty – population below 200% FPL Households receiving SNAP Area Deprivation Index Opportunity Index

Rating Process

The Basic Priority Rating (BPR) model was used to prioritize the health needs. This method was chosen because it considers the following four criteria:

A. Potential impact on the greatest number of people (0-10)

B. Severity, magnitude, and urgency of the need (The consequences of inaction (i.e the burden placed on the community, loss of life, quality of life, potential worsening of the problem and financial loss) (0-20)

C. The effectiveness of possible interventions (0-10)

D. PEARL: Propriety (0-1)

$$\textit{Basic Priority Rating (BPR)} = \frac{(A + B)\,C}{3} \times D$$

The BPR scoring is a weighting method that is used widely in public health research because it ranks each health needs using the above criteria in a mathematical process. A total of 48 community advisory members participated in the BPR scoring process. Twenty-seven advisory members were community representatives from Fresno County and 21 were representative of Madera County.

Ranked Top Health Needs

The scores for each criteria of the health need were averaged and ranked by significance.

Top Health Needs	
Health Needs	**BPR Score**
Poverty	66.3
Poor air quality/pollution	60.6
Homelessness	58.8
Food insecurity	56.9
Safety/neighborhood crime	56.3
Lack of affordable/acceptable housing	53.6
Insurance barrier/access to medical care	53.3
Not enough providers/treatment locations/long wait times	50.0
Expensive medical care	44.4
Lack of provider compassion/Discrimination	44.0
Lack of transportation	36.3

Advisory members were also asked to provide community assets and resources that currently address the issues in their community (Appendix G)

Closing

This Community Health Needs Assessments will serve as a guide for our investments and will help inform our business decisions. This report is a critical tool that helps us identify and measure community needs and assets. The input from our community lets us better tailor our engagement with communities and use our organizational resources to further community health at every opportunity.

This report will be used to define Implementation Strategies to respond to the health needs identified by our communities. Implementation Strategy reports to be posted in fall 2022. We welcome feedback on this assessment. Submit comments to:

Saint Agnes Medical Center

1303 E. Herndon Fresno, CA 93720

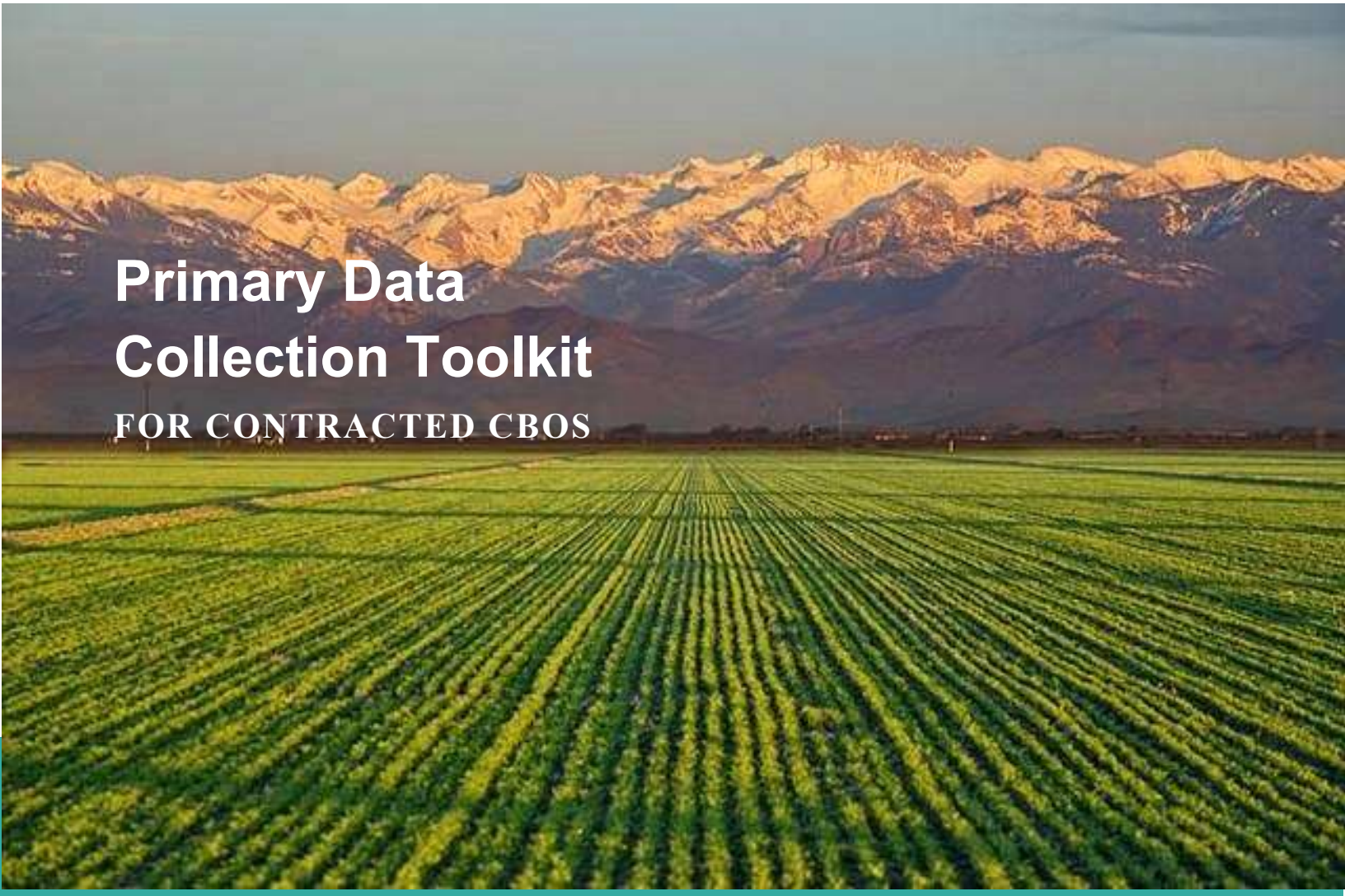
Ivonne Der Torosian, Vice President – Community Health and Wellbeing

email ivonne.dertorosian@samc.com

APPENDICES

Appendix A - High Priority Zip Codes

Fresno County	Madera County
93701	93638
93702	
93703	
93706	
93721	
93648	



Primary Data Collection Toolkit

FOR CONTRACTED CBOS

HOSPITAL COUNCIL NORTHERN & CENTRAL CALIFORNIA

With support from

Saint Agnes Medical Center

Community Health and Well-being Department

Lead Author:

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Updated September 2021

Acknowledgments

We appreciate the numerous local health departments and their partnerships across the Central Valley who have helped shape this toolkit. Their enthusiasm, experience, and insight in implementing community health assessment have greatly informed the development and updating of this toolkit.

We gratefully acknowledge the joint work of the Hospital Council Northern & Central California, Saint Agnes Medical Center and Community Regional Medical Center.

Public Health

The science and art of preventing disease, prolonging life, and promoting health through organized efforts of society.

C. E. A. Winslow (1920)

Table of Contents

Introductions

Who is this toolkit for

The primary data toolkit will be used by contracted Community-Based Organizations (CBOs) to collect primary data for Community Health Needs Assessment (CHNA) for Fiscal Year 2022. The four-county Fresno, Kings, Madera, Tulare county primary data gathering period will begin in Fall 2021. This toolkit is designed to guide CBOs on how to appropriately gather primary data. Primary data are those that are collected through community-wide surveys, key informant interviews and focus groups. A Community Health Needs Assessment (CHNA) uses data, resident and key informant input, to measure the relative health and social well-being of a community. The findings should inspire collective action and ensure meaningful, effective allocation of resources, both within the hospital and in the community.

Who is required to conduct a CHNA?

The Patient Protection and Affordable Care Act (ACA), enacted March of 2010, added Section 501(r) to the Internal Revenue Code, which effects charitable hospital organizations that are 501(c)(3) tax-exempt. Section 501(r)(3) of the Code requires each separately licensed hospital facility to conduct a CHNA at least once every three tax years, beginning in 2011, and to adopt an implementation strategy to meet the community health needs identified through the CHNA.

Sources of Primary Data

The three methods selected for primary data collection are:

1. Community-wide surveys
2. Key informant interviews
3. Focus groups

COMMUNITY-WIDE SURVEYS

Community-wide Surveys

The community-wide survey will consist of questions relating to demographic, racial and social equity, social determinants of health, healthcare access, lifestyle, and COVID-19. Surveys will be made available in digital and paper format in order to allow participants to self-report. Surveys should be collected from people ages 18+ and participants should reside in Fresno, Kings, Madera or Tulare Counties.

Delivery Methods

There are several options that the contracted agency can use to gather input. Each agency should determine its capacity and decide which method to use to get maximum input from the communities being surveyed.

Online surveys – The online survey options offer anonymity and on-demand access. The survey can be made available to wide groups, but it is important to note that not all community members may have access to the internet. If using this option, please assure that participants complete the survey to completion. The online survey link will be provided to you via email by the Project Coordinator.

The survey will close on November 19, 2021. Agencies should begin outreach efforts as soon as possible to ensure community awareness and completion of the survey as soon as their contract is signed.

Telephone surveys – Phone surveys can be randomized or conducted with targeted groups. Phone surveys can be more resource intensive, but typically have a high response rate and can be arranged to have a degree of anonymity.

Hard copy surveys/paper – Community members themselves can be recruited to collect hard copy surveys, so long as they participate in the training webinar that will be recorded and provided to all CBOs prior to collecting data. Printed surveys can be distributed at targeted locations or events. This method is typically low cost to produce but can incur staff time to compile responses for analysis. This method can increase accessibility for the widest representation of the community, especially those without phone or internet access. If the survey is being administered via paper, upload the paper version to the survey link that will be provided to you.

Marketing/Outreach

Some ways to market the survey include promoting at programs/events, to people who come into your office, your contacts or other email lists. Other county programs can also aid in administering surveys to their clients through text, advertised link on their websites, Twitter, Facebook, newspaper, TV, radio, press release, place flyers in public locations, etc.

Administering the Paper Survey

Do's & Don'ts

Do's

1. Follow script on the survey when engaging with participants
2. Clarify questions that the participant may have
3. Use the appropriate language for survey collection
4. Promote honest feedback by ensuring that your survey participants know and understand the risks and benefits of taking your survey. What happens to their data? How might you be able to use it to help them?

Don't

1. Paraphrase or change the way the question is being asked
2. Lead the participant to ask to answer a question a certain way

Eliminate bias when conducting the survey

When conducting surveys through telephone or hard-copy, it is important to be aware of bias from the person conducting the survey. Take a look at the do's and don'ts for conducting a survey.

KEY INFORMANT INTERVIEWS (KIIs)

Key Informant Interviews (KIIs)

KIIs involve interviewing a select group of individuals who can provide needed information, ideas, and insights on health issues affecting the community. Key informant interviews are essentially qualitative interviews. They are conducted using an interview guide that list the questions be covered during a session. The interviewer frames the questions in the course of interviews. The atmosphere in these interviews is informal, resembling a conversation among acquaintances. The interviewer subtly probes informants to elicit more information and take detailed notes. It is the unstructured nature of the interviews that invests them with special meaning and relevance in the present discussion.

KIIs can help determine not only what people do but why they do it. Such interviews are excellent for documenting people's reasons for their behavior and people's understandings or misunderstanding of issues. For example, well-designed key informant interviews can reveal local attitudes toward family planning, community health, and/or women's programs information that is necessary to plan effective interventions in these areas.

Outlined in this toolkit are the details for conducting a high-quality KII. In this guide you will find checklists for:

- Recruiting and preparing for participants
- Delivery methods

- Introductory remarks
- Conducting the KIIs
- During the KIIs
- Closing the KIIs
- Tips for probing reluctant key informants

You will also find the following tools to help you conduct the KIIs:

- Phone/email scripts
- Interview summary sheets

Recruiting and preparing for participants

For the purposes of this CHNA, a list of predetermined key informants will be provided to each contracted agency. CBO staff will be responsible for scheduling interviews.

Best practices for scheduling an interview

- ✓ Ensure the meeting is on the key informant's calendar
- ✓ Provide an online meeting link (for virtual KIIs) or call number
- ✓ For in-person interviews, please remember to maintain social distancing guidelines (appropriate mask-wearing and distancing)
- ✓ Call and/or email to begin initial recruitment is acceptable
- ✓ Provide the key informant with a doodle poll so that they may self-select a convenient time to meet with you. This will eliminate back and forth emails for meeting set-up

Delivery Methods

KIIs can take place via an online platform (Zoom, Webex, TEAMs etc.) or in -person. If you feel that a person in your region (government official, project staff, CBO directors, community organizer), should be interviewed for the CHNA process, but is not on the original list provided to you, please contact the Project Coordinator for further direction.

Introductory remarks

Your introductory remarks is a critical part of the interview, during which interviewers must establish rapport with key informants. Interviewers must create an atmosphere in which key informants are able to willingly communicate their views and opinions. It is helpful to begin an interview with a minute or two of general conversation.

Key informants should be approached carefully for an interview. It is often useful to have introductions from senior government officials, project or program staff, or other influential persons. Interviewers should briefly explain their background, the objective of the interview and the possible uses of the information and ideas provided by the key informant. They should also assure key informant their responses will remain confidential from any official report. As a rule of thumb, it is preferable to be brief and to the point, unless an informant seeks more detail. Except when interviewing technical experts, interviewers should minimize the use of jargon and technical terms. Also, interviewers must be sensitive to and familiar with local cultural norms and behavior. Nonverbal communication is also important in such interviews.

Recruiting/Schedule the Key Informant Scripts

Recruiting key informants phone script:

Good morning/afternoon _____ [KEY INFORMANT NAME], my name is [INTERVIEW NAME]. I'm calling to invite you to participate in a 40 to 60-minute key informant interview in support of the Hospital Council Community Health Needs Assessment. This project is a joint-effort between the local county health departments and hospitals in the four-county region of Fresno, Kings, Madera and Tulare counties that will help shape decisions for improvements. The interview can be conducted virtually or in-person. Your responses will remain confidential and with your permission, will be listed as a Key Informant in the appendix of the final needs assessment report.

This interview is completely optional. If you agree to participate, I will send you a link to a doodle poll where you can sign up for a time that is convenient for you.

(If the Key informant says yes) Thank you – can you please provide me with the best contact to email you the link.

(If they say no) Thank you, would you be open to answering a survey online to provide input?

Scheduling key informants email script:

Dear _____ (KEY INFORMANT NAME),
Thank you for agreeing to participate in a 60-minute (max) interview in support of the Hospital Council Community Health Needs Assessment. The discussion will focus on issues related to social influencers of health, the current environment and the health of the community.

Please complete the following doodle poll to select a time that is most convenient to you by [deadline]: [your doodle link here]

A calendar invite will be sent to you if you opted for a phone interview or, if you opted for a virtual interview, a link will be sent to you.

Stay well!

[FACILITATOR NAME]

REMINDER phone/email script key informant interview (send 1-2 days before interview):

Hi [Key informant name]

This is a friendly reminder that your Community Health Needs Assessment Interview with [Facilitator name] is at [time, Pacific Time] on [Date].

Location: (if in-person)

Phone [list number that will be called] or Virtual Link

Thank you.
[FACILITATOR NAME]

CLOSING email script Key Informant Interview (send immediately after interview):

Hi _____ (name),

Thank you for your time as a Key Informant to the Community Needs Assessment.

Please email me should you have any questions related to this process.

Respectfully,

[FACILITATOR NAME]

END OF PHONE/EMAIL SCRIPTS

Facilitating the Key Informant Interview: Bulleted outline

- Have the key informant sign the consent form
- State that the interview will be audio recorded
- Ask the participant to state their name, and organization into the recorder
- Ask participant to say their first name and spell out their last name and state their role with their organization or in the community
- Give the informant your full attention
- Let the participant know that you will be taking notes and ask their permission to record the session
- Take notes but do so as inconspicuously as possible.
- Use one of the KII Interview summary sheets
- Print out the KII interview summary sheet so you can refer to it without interrupting the rhythm of the conversation.

- Start the conversation with a casual opening, being careful to stay away from controversial topics
- Give the informant a chance to ask questions about the purpose of the interview
- Confirm that the informant has time for the interview; alert the informant how long the interview is expected to last; reschedule in case the length interview time is not convenient
- Be alert to whom else may be listening to the conversation
- Do not rush the informant, some people need time to reflect on sensitive questions or may pause between thoughts; rapid-fire questions can be disconcerting to the informant and may give the impression that the respondent's answers are too long or irrelevant.
- Repeat the main points of the informant's responses; You can use such phrases as, "So your feeling on this point is...is this correct?" or "Did I understand correctly that..." Summarizing shows that the interviewer is listening carefully.
- Stay neutral, even if you feel the participant is misinformed or the answers seem preposterous. Remember, the participants have a right to their opinions. The main objective of the interviews is to determine the participant's reasoning and understanding of an issue.
- Be careful of nonverbal cues that may indicate approval or disapproval of an informant's comments.
- Use exploratory questions such as "tell me more about that" to gain deeper understanding to generalizations or ask for specific incidents, events, or activities provide to use as anecdotes.

Closing the Key Informant Interview: Bulleted outline

- When the interview is complete, the interviewer should thank the key informant for their time and follow up with an email.
- Immediately after the interview ends, the interviewer will stop the recording and save the audio file onto their PC and complete an Interview Summary Sheet.
- Upload the audio recording and Interview Summary Sheet to Dropbox within 3 days of the interview being conducted. A link will be provided to your organization to upload documents. Label the file with the county location of interview, type of interview and date, for example: *Madera County –KII LGTBQ – 10.1.21*
- The Interview Summary Sheet is a useful aid in analyzing the interview data. It is a summary sheet stating the main findings of an interview. Each interview summary sheet should include the key informant's name and organization, the informant's main observations, and any insights and ideas that evolved during the interview.

TIPS: Probing Reluctant Key Informants

Even the best interviewers occasionally have difficulty getting informants to speak openly.

Some problems and possible solutions are given below.

Problem: Informant gives only yes or no answers.

Possible solutions:

- Phrase questions so that they cannot be answered with on word.
- Allow the informant more time for answers.
- Change the interview location if there is a possibility that outsiders are listening.
- Break questions down into simple components and phrase them in common language.
- If the key informant is a woman, have a woman interview her. Be sure that you are not in any way intimidating the respondent.

Problem: Informant does not give opinions.

Possible solutions:

- Assure the informant that all comments are confidential. If you notice interviewee's hesitation, ask him/her if there are reasons, they may be feeling uncomfortable with the interview.
- Find a private place for the interview and be sure no one else is listening.
- Recognize the informant may not have any opinions if the questions are on an
- unfamiliar topic.

Problem: Informant is hostile.

Possible solutions:

- Listen carefully to the informant's response and try to understand the reasons for the apparent hostility.
- Show understanding without being patronizing.
- Often, after the initial complaints, informants settle down to describe the events that contributed to these feelings.
- If the informant is particularly important, schedule another interview or try a different, perhaps less formal, location.
- Focus on subjects about which the respondent is willing to talk.
- If an informant continues to be uncomfortable, guarded, or hostile, continue long enough to be polite and terminate the interview.

FOCUS GROUP

Focus groups

Focus groups can reveal a wealth of detailed information and deep insight. When well executed, a focus group creates an accepting environment that puts participants at ease allowing them to thoughtfully answer questions in their own words and add meaning to their answers.

Surveys are good for collecting information about people's attributes and attitudes, but if you need to understand things at a deeper level then use a focus group. If you've ever participated in a well-run focus group, you'd probably say it felt very natural and comfortable to be talking with a group of strangers. A good focus group requires a lot more planning than merely inviting a few key people to casually share their opinions about a topic.

Below is an outline for conducting a high-quality focus group. In this guide you will find checklists for:

- Defining a focus group
- Moderator and Assistant Moderator duties
- Recruiting and preparing for participants
- Conducting the online/virtual focus group
- Focus group scripts

- TIPS: Probing Reluctant Focus Group participants
- Closing the focus group

Defining a focus group

- A focus group is a small group of 8 to 12 people led through an open discussion by a skilled moderator. The group needs to be large enough to generate rich discussion but not so large that some participants are left out. Twelve is the maximum number of questions for any one group but ten is ideal. Focus group participants won't have a chance to see the questions they are being asked.
- The focus group moderator nurtures disclosure in an open and spontaneous format. The moderator's goal is to generate a maximum number of different ideas and opinions from as many different people in the time allotted.
- The ideal amount of time to set aside for a focus group is anywhere from 45 to 90 minutes. Beyond that time, most groups are not productive, and the session becomes an imposition on participant time.
- Focus groups are structured around a set of carefully predetermined questions, but the discussion is free-flowing. Ideally, participant comments will stimulate and influence the thinking and sharing of others. Some people even find themselves changing their thoughts and opinions during the group.
- A homogeneous group of strangers comprise the focus group. Homogeneity levels the playing field and reduces inhibitions among people who will probably never see each other again.

Moderator Duties:

- Welcome participants as they arrive
- Lead the discussion
- Keep participants on track with the discussion
- Answer questions about the focus group
- Close the discussion in a timely manner

Assistant Moderator (Recorder) Duties:

- Help with equipment & refreshments
- Arrange the room / set up virtual meeting
- Welcome participants as they arrive
- Sit in designated location
- Take notes throughout the discussion
- Operate recording equipment
- Do not participate in the discussion
- Ask questions when invited
- Debrief with moderator

A focus group is NOT:

- A debate
- Group therapy
- A conflict resolution session
- A problem-solving session
- An opportunity to collaborate
- A promotional opportunity

Recruiting and preparing for focus group participants: Bulleted outline

- In an ideal focus group, all the participants are very comfortable with each other but none of them know each other.
- Select participants that with similar demographic ties (All men or women, seniors, youth, LGTBTQ, homeless, people of color group etc.)
- Focus groups participants can be recruited in a number of ways including:
    - Nomination – Key individuals nominate people they think would make good participants. Nominees are familiar with the topic, known for their ability to respectfully share their opinions and willing to volunteer about 2 hours of their time.
    - Random selection – If participants will come from a large but defined group (e.g. a business or nonprofit) with many eager participants, names can be randomly drawn from a hat until the desired number of verified participants is achieved.
    - All members of the same group – Sometimes an already existing group serves as an ideal pool from which to invite participants (e.g. Kiwanis Club, PTO, Chamber of Commerce).

You may select any of these methods for recruitment. Once a group of viable recruits has been established, call each one to confirm interest and availability. Give them times and locations of the focus groups and secure verbal confirmation. Tell them you will mail (or email) them a written confirmation and call to remind them two days before the scheduled group.

Tell participants that the focus group will take about one and half to two hours. Give them a starting time that is 15 minutes prior to the actual start of the focus group to allow for filling out necessary paperwork, having a bite to eat, and settling into the group.

- Arrange for a comfortable room in a convenient location with ample parking. Depending on your group, you may also what to consider proximity to a bus line. The room should have a door for privacy and table and chairs to seat a circle of up to 12 participants and the moderator and assistant moderator. Many public agencies (churches, libraries) have free rooms available.
- Taking public health directives into consideration due to current COVID-19 surge, ensure that in-person sessions take social distancing and masking considerations—especially for indoor settings. (see image 1)
- Arrange for food if possible, such as a beverage and light snack (cookies, cheese/crackers, veggie tray, etc.). It is OK to offer a full meal but be sure to add an additional 30 to 45 minutes to the entire process so that everyone can finish eating before the group begins. Following COVD-19 precautions minimize multi-touch points with food as much as possible.

Conducting the online/virtual focus group: Bulleted outline

- The focus group is conducted by a team consisting of a moderator and assistant moderator. The moderator facilitates the discussion; the assistant takes notes and runs the tape recorder.
- The ideal focus group moderator has the following traits:
    - Can listen attentively with sensitivity and empathy
    - Can listen and think at the same time
    - Believes that all group participants have something valuable to offer no matter their education, experience, or background
    - Can keep personal views and ego out of the facilitation
    - Is someone the group can relate to but also give authority to (e.g. a male moderator is most appropriate for a group of all men discussing sexual harassment in the workplace)
    - Can appropriately manage challenging group dynamics
- The assistant moderator must be able to do the following:
    - Run an audio recorder during the session of in-person
    - Record the virtual session if it is being conducted virtually
    - Record the session on your phone in case the recorder fails or the tape is inaudible
    - Note/record body language or other subtle but relevant clues
    - Allow the moderator to do all the talking during the group
- Both moderator and assistant moderator are expected to welcome participants, offer them food (if in-person), help them make their name tents, and direct them in completing pre-group paperwork.
- All participants should complete a consent form

- It is important to collect demographic information from participants if age, gender, or other attributes important for correlation with focus group findings. Administer the Focus Group Demographic survey before the focus group begins. (see for participant demographics forms)
- All demographic and consent forms are available in an online format. The Project Coordinator will distribute individual links to CBO partners.
- Once consent forms and demographic surveys are collected and reviewed for completeness, the focus group can begin. The moderator should use the prepared script to welcome participants, remind them the purpose of the focus group and also sets ground rules.

Focus group Scripts

Recruiting focus group participants:

English Script

Hello, my name is [YOUR NAME] from [Your organization] and I would like to invite you to participate in a focus group. Select local hospitals and county health departments in the Central Valley region have asked us to help get the opinions from county residents about your perceptions of local health issues affecting the community. They want to know what you like, what you don't like, and how programs might be improved. Your thoughts and opinions will help guide these organizations in making informed decision on projects that will affect the community in a positive way.
We are having discussions like this with several groups around the county.
A gift card will be provided to you for your participation. We really hope you will join us! Is this something you are interested in lending your voice?

(If the person says yes) Great! The Focus group will take place at [TIME/ LOCATION] can you please provide me with the best contact to email you the flyer? (If they say no) No problem, would you be open to answering a survey (community-wide survey) instead?

_____

Spanish Script

Hola, Mi nombre es [TU NOMBRE] de parte de [Your organization] y me gustaría invitartlo a participar en un grupo de enfoque. Unos hospitales locales y los departamentos de salud del condado en la región nos han pedido ayuda a obtener las opiniones de los residentes del condado sobre sus percepciones de los problemas de salud locales que afectan a la comunidad. Quieren saber qué le gusta, qué no le gusta y cómo se pueden mejorar los programas. Sus pensamientos y opiniones ayudarán a guiar a estas organizaciones a tomar decisiones informadas sobre proyectos que les gustaría desarrollar para la comunidad.
Estamos teniendo muchas charlas con varios grupos en todo el condado.
Se le proporcionará una tarjeta de regalo por su participación. ¡Realmente esperamos que se una con nosotros! ¿Es esto algo que le interesa prestar su voz?

(Si la persona dice que sí) ¡Muy bienl! El grupo de enfoque se llevará a cabo en [TIME/ LOCATION]. ¿Tiene un correo electrónico para enviarle el volante? (Si dicen que no) No problema, ¿Estaría dispuesto a responder una encuesta ((community-wide survey)?

Conducting the focus group In-person or virtually:

English Script

Good evening and welcome! Thank you for taking the time to join us to talk about health issues in the county. My name is [FACILITATOR NAME HERE] and assisting me is [ASSISTANT NAME HERE]. We're both with [YOUR ORGANIZATION NAME HERE], who has partnered with the Hospital Council and participating public health departments in the area to understand how hospitals and public health can better support the health needs of the community. They have asked us to help get some information from county residents about your perceptions of local health issues affecting the community. They want to know what you like, what you don't like, and how programs might be improved. We are having discussions like this with several groups around the county.
There are no wrong answers but rather different points of view. Please feel free to share your point of view, even if it differs from what others have said. Keep in mind that we're just as interested in negative comments as positive comments and at times the negative comments may be the most helpful.

We will be recording the session because we don't want to miss any of your comments. People often say very helpful things in these discussions and we can't write fast enough to gather them all down. We will be on a first name basis tonight but we want to assure you that we won't use any names in our reports. You may be assured of complete confidentiality. The reports will go back to the Project Coordinator of this project and then to the hospitals and public health departments to help them plan future programs. For your participation in this session, each household will receive a gift card at the end of our meeting. Well, let's begin!

Let's find out some more about each other by going around the table by doing an ice breaker. Tell us your name and where you live and what food reminds you of home?

Spanish Script

¡Buenas noches y bienvenido! Gracias por tomar el tiempo de unirse a nosotros para hablar sobre problemas de salud en el condado. Mi nombre es [FACILITATOR NAME HERE] *y me asiste* [ASSISTANT NAME HERE]. *Ambos estamos con [SU NOMBRE DE ORGANIZACIÓN AQUÍ], quien se ha asociado con el Consejo del Hospital y los departamentos de salud pública en el área para comprender cómo los hospitales y la salud pública pueden apoyar mejor las necesidades de salud de la comunidad. Nos han pedido que los ayudemos a obtener información de los residentes del condado sobre sus percepciones de los problemas de salud locales que afectan a la comunidad. Quieren saber qué le gusta, qué no le gusta y cómo se pueden mejorar los programas. Estamos teniendo discusiones como esta con varios grupos en todo el condado.*
No hay respuestas incorrectas sino puntos de vista diferentes. No dude en compartir su punto de vista, incluso si difiere de lo que otros han dicho. Tenga en cuenta que estamos interesados en los comentarios

negativos y los comentarios positivos y, en ocasiones, los comentarios negativos pueden ser los más útiles.
Estaremos grabando la sesión porque no queremos perdernos ninguno de sus comentarios. La gente suele decir cosas muy útiles en estas discusiones y no podemos escribir rápido como para recopilarlas todas. Esta noche nos pondremos por nombre, pero queremos asegurarles que no usaremos ningún nombre en nuestros reportes. Puede estar seguro de la confidencialidad total. Los informes volverán al Coordinador de este proyecto y luego a los hospitales y departamentos de salud pública para ayudarlos a planificar programas futuros. Por su participación en esta sesión, cada hogar recibirá una tarjeta de regalo al final de nuestra reunión.
¡Bien, comencemos!
Descubramos un poco más el uno del otro dando la vuelta a la mesa haciendo un rompehielos. Dinos tu nombre y dónde vives y qué comida te recuerda a casa.

TIPS: Probing reluctant focus group participants

The focus group moderator has a responsibility to adequately cover all prepared questions within the time allotted. She/he also has a responsibility to get all participants to talk and fully explain their answers. Some helpful probes include:

- "Can you talk about that more?"
- "Help me understand what you mean."
- "Can you give an example?"

It is good moderator practice to paraphrase and summarize long, complex or ambiguous comments. It demonstrates active listening and clarifies the comment for everyone in the group.

- Because the moderator holds a position of authority and perceived influence, she/he must remain neutral, refraining from nodding/raising eyebrows, agreeing/disagreeing, or praising/denigrating any comment made.
- A moderator must tactfully deal with challenging participants. Here are some appropriate strategies:
- Self-appointed experts: "Thank you. What do other people think?"
- The dominator: "Let's have some other comments."
- The rambler: Stop eye contact; look at your watch; jump in when they inhale.
- The shy participant: Make eye contact; call on them; smile at them.
- The participant who talks very quietly: Ask them to repeat their response more loudly.

Closing the focus group: Bulleted outline

- When the focus group is complete, the moderator should thank all participants and distributes the gift card incentive (if conducting in-person).
- Immediately after all participants leave, the moderator and assistant moderator should debrief while the recorder is still running and state the date, time (if more than one group per day), and type of group that was conducted (LGBTQ, Parents, Latinos, etc.).
- Create a folder with all documents (cover sheet, consent forms, demographic surveys, sign-in sheet, etc.) from that focus group and the audio recording to dropbox within 3 days of conducting the focus group. Label the file with location of focus group and type of focus group and date, for example (Madera County – FG LGBTQ – 10.1.21)

Tips: Note Taking

- **Note taking is a primary responsibility of the assistant moderator.** The moderator should not be expected to take written notes during the discussion.
- **Clarity and consistency of note taking.** Anticipate that others will use your field notes. Field notes sometimes are interpreted days or weeks following the focus group when memory has faded. Consistency and clarity are essential.
- **Field notes** contain different types of information. It is essential that this information is easily identified and organized.
    - **Listen for notable quotes, these are well-said statements that illustrate an important point of view.** Listen for sentences or phrases that are particularly enlightening or eloquently express a point of view. Usually, it is impossible to capture the entire quote. Capture as much as you can with attention to the key phrases. Use three periods ... to indicate that part of the quote was missing.
    - **Key points and themes for each question.** Typically, participants will talk about several key points in response to each question. These points are often identified by several different participants. Sometimes they are said only once but in a manner that deserves attention.

Other factors. Be sure to add points which might aid in later analysis, such as passionate comments, body language, or non-verbal activity. Watch for head nods, physical excitement, eye contact between certain participants, or other clues that would indicate level of agreement, support, or interest.

General Community Survey 2021

This survey is voluntary. Your answers are confidential. Your answers will be combined with those of other survey participants and used for research to improve the health of your community.

Esta encuesta es voluntaria. Sus respuestas son confidenciales. Sus respuestas van a ser combinadas con las respuestas de los otros participantes de los grupos de enfoque y serán usadas para mejorar la salud de la comunidad.

Demographics / Demografía

1. **What is your age?** ¿Cuál es tu edad?
   - ☐ **17 or younger /** años o menos
   - ☐ **25-34** ☐ **45-54** ☐ **64+**
   - ☐ **18-24** ☐ **35-44** ☐ **55-64**

2. **Gender: How do you identify?** ☐ **Man** Hombre ☐ **Woman** Mujer
   Género: ¿Cómo te identificas? ☐ **Non-binary** No binario
   ☐ **Other /** Otro: _____

3. **What is your current marital status?**
   ¿Cuál es su estado de matrimonio?
   ☐ **Married** Casado/a ☐ **Widowed** Viudo/a
   ☐ **Divorced** Divorciado/a ☐ **Separated** Apartado/a
   ☐ **Never married** Nunca casado/a

3. **Zip Code** Código Postal: _____

4. **What county do you live in?** ☐ **Kings** ☐ **Fresno** ☐ **Madera** ☐ **Tulare**
   ¿En que Condado vives?

5. **Do you consider yourself Hispanic/Latino (such as Mexican American, Latin American, Central or South American, or Spanish American)?**
   ¿Se considera hispano / latino (como mexicano-estadounidense, latinoamericano, centroamericano o sudamericano o hispanoamericano)?

   ☐ **Yes** sí ☐ **No**

6. **What race and ethnic group do you most identify with?**
   ¿Con qué raza y grupo étnico se identifica más?

   ☐ **White** Blanco
   ☐ **American Indian or Alaska Native** Indio americano o nativo de Alaska
   ☐ **Black or African American** Negro o afroamericano
   ☐ **Asian Indian** Indio asiático
   ☐ **Chinese** Chino
   ☐ **Filipino/a**
   ☐ **Japanese** Japonés
   ☐ **Vietnamese** vietnamita
   ☐ **Samoan** Samoano
   ☐ **Native Hawaiian** Nativo de Hawai
   ☐ **Middle Eastern or North African**
   ☐ **Other** Otro: _____

7. **How many people live in your household? _____**
   ¿Cuántas personas viven en su hogar?

8. **What language(s) do you speak at home?** ¿Qué idioma (s) habla en casa?
   ☐ **English** Inglés ☐ **Spanish** Español ☐ **Other** Otro _____

9. **How well do you speak English?** ☐ **Very well** ☐ **Well** ☐ **Not well** ☐ **Not at all**
   ¿Que tan bien hablas ingles? Muy bien Bien Mal Para nada

10. **How well do you <u>understand</u> English?** ☐ **Very well** ☐ **Well** ☐ **Not well** ☐ **Not at all**
    ¿Qué tan bien <u>entiendes</u> inglés? Muy bien Bien Mal Para nada

11. **What is your annual household income?** ¿Cual es tu ingreso anual?
    ☐ **Less than $10,000** Menos de $10,000
    ☐ **$10,000-$14,999**
    ☐ **$15,000-$24,999**
    ☐ **$25,000-$34,999**

☐ **$35,000-$49,999**

☐ **$50,000-$74,999**

☐ **$75,000-$99,999**

☐ **$100,000-$149,999**

☐ **$150,000-$199,999**

☐ **$200,000 or more** $ 200,000 o más

☐ **Don't know** No se

☐ **Prefer not to share** Prefiero no compartir

12. What is the highest school grade level you completed? ¿Cuál es el grado escolar más alto que completó?

☐ **Some high school** un poco de escuela secundaria

☐ **High school graduate or a GED** Graduado de secundaria o un GED

☐ **Some college or vocational courses** Algunos cursos universitarios o vocacionales

☐ **Associates Degree** Grado Asociado

☐ **Bachelor's Degree** Licenciatura

☐ **Graduate/Master's Degree or higher** Licenciatura / Maestría o superior

13. Do you currently work? ¿Estás trabajando? ☐ **Yes** sí ☐ **No**

13a. If so, what areas do you work in? Si es así, ¿en qué áreas trabaja?

☐ **Healthcare** Cuidado de la salud ☐ **Restaurant** Restaurante

☐ **Hotel/tourism** Hotel / turismo ☐ **Retail** Venta minorista

☐ **Business** Negocio ☐ **Media** Noticias

☐ **Education** Educación ☐ **Childcare** Cuidado de niños

☐ **Other** Otro:_____

14. What is your current employment status or working situation?

¿Cuál es su situación laboral o situación laboral actual?

☐ **Full-time employment** Empleo a tiempo completo

☐ **Part-time employment** Trabajo de medio tiempo

☐ **Temporary or contracted employment** Empleo temporal o contratado

☐ **Laid-off** Despedido

☐ **Unemployed and seeking work** Desempleado y buscando trabajo

☐ **Otherwise unemployed but not seeking work (ex: volunteering, disabled, unpaid primary care-giver, student, retired, etc.)** Está desempleado pero no busca trabajo (por ejemplo, voluntario, discapacitado, cuidador principal no remunerado, estudiante, jubilado, etc.)

Racial and Social Equity / Equidad racial y social

15. **Compared to other races, in the last year, when you went to the doctor, was your experience:** Comparado con otras carreras, en el último año, cuando fuiste al doctor, fue tu experiencia:
☐ **Worse than** Peor que ☐ **The same** La misma

☐ **Better than** Mejor que ☐ **Don't know** No se

16. **Have you ever felt discriminated against in any of the following ways because of your race, ethnicity, gender, age, religion, physical appearance, sexual orientation, disability status or other characteristics? (check all that apply)**
¿Alguna vez se ha sentido discriminado de alguna de las siguientes formas debido a su raza, origen étnico, género, edad, religión, apariencia física, orientación sexual, estado de discapacidad u otras características? (marque todo lo que corresponda)

☐ **I was discouraged by a teacher or advisor from seeking higher education**

Un maestro o asesor me desanimó de buscar una educación superior

☐ **I was denied a scholarship** Me negaron una beca

☐ **I was not hired for a job** No fui contratado para un trabajo

☐ **I was not given a promotion** No me dieron un ascenso

☐ **I was fired** fui despedido

☐ **I was prevented from renting or buying a home in the neighborhood you wanted**

Me impidieron alquilar o comprar una casa en el barrio que querías.

☐ **I was prevented from remaining in a neighborhood because neighbors made life so uncomfortable**

Me impidieron quedarme en un barrio porque los vecinos me hacían la vida muy incómoda.

☐ **I was hassled by the police** Fui molestado por la policía

☐ **I was denied a bank loan** Me negaron un préstamo bancario

☐ **I was denied or provided inferior medical care** Me negaron o me dieron una atención médica inferior.

☐ **I was denied or provided inferior service by a plumber, care mechanic, or other service provider**

Un plomero, un mecánico de cuidados u otro proveedor de servicios me dio un servicio inferior

☐ **I was discouraged by a teacher or advisor from seeking higher education**

Un maestro o asesor me desanimó de buscar una educación superior

☐ **None apply** Ninguno aplica

17. We'd like to understand how you feel you're treated by others. For each of the following statements, please leave a check mark whether the statement applies to you often, sometimes, rarely or never.

Nos gustaría saber cómo te sientes que te tratan los demás. Para cada una de las siguientes declaraciones, deje una marca de verificación si la declaración se aplica a usted con frecuencia, a veces, raramente o nunca.

	Statement Declaración	**Often** A menudo	**Sometimes** Algunas veces	**Rarely** Casi nunca	**Never** Nunca
17a.	**I am treated with less courtesy than other people** Me tratan con menos cortesía que a otras personas.				
17b.	**I receive poorer service than other people at restaurants stores** Recibo un servicio más deficiente que otras personas en restaurantes o tiendas.				
17c.	**People act as if I am not smart** La gente actúa como si no soy inteligente				
17d.	**People act as if they are afraid of me** La gente actúa como si me tuviera miedo				
17e.	**People act as if I am dishonest** La gente actúa como si soy deshonesto				
17f.	**People act as if I am not as good as they are** La gente actúa como que no soy tan bueno como ellos				
17g.	**I am called names or insulted** Me llaman apodos malos o me insultan				
17h.	**I feel threatened or harassed** Me siento amenazada o acosada				

Social Determinants of Health / Los determinantes sociales de la salud

18. Within the past 12 months, have you or anyone in your household had trouble paying for any of the following? (check all that apply)

En los últimos 12 meses, ¿usted o alguien de su hogar ha tenido problemas para pagar alguno de los siguientes gastos? (marque todo lo que corresponda)

- ☐ **Childcare** Cuidado de niños
- ☐ **Food** Comida
- ☐ **Medical care** Atención médica
- ☐ **Utilities** Utilidades
- ☐ **Transportation** Transporte
- ☐ **Housing** Alojamiento
- ☐ **Medication** Medicamento
- ☐ **None of these** Ninguno de esos

19. Within the past 12 months, the food we bought didn't last and we didn't have enough money to get more.

En los últimos 12 meses, la comida que compramos no duró y no teníamos suficiente dinero para comprar más.

- ☐ **Often true** A menudo cierto
- ☐ **Sometimes true** A veces es cierto
- ☐ **Never true** Nunca es verdad

20. What is your current living situation? ¿Cuál es su situación de vida actual?

- ☐ **I have a steady place to live** Tengo un lugar estable para vivir
- ☐ **I have a place to live today, but I am worried about losing it in the future**

  Tengo un lugar para vivir hoy, pero me preocupa perderlo en el futuro.
- ☐ **I do not have a steady place to live (I am temporarily staying with others**

  No tengo un lugar estable donde vivir (me estoy quedando temporalmente con otros
- ☐ **I am staying in a shelter** Me quedo en un refugio
- ☐ **Living outside** Viviendo afuera
- ☐ **In a car** En un auto
- ☐ **In an abandoned building** En un edificio abandonado
- ☐ **Bus or train station** Estación de bus o tren
- ☐ **In a park** En un parque

21. Are you experiencing any of the following issues with your current living arrangement? (check all that apply)
¿Está experimentando alguno de los siguientes problemas con su arreglo de vivienda actual? (marque todo lo que corresponda)

☐ **Bugs (e.g. roaches) or rodents** Insectos (por ejemplo, cucarachas) o roedores

☐ **General cleanliness** Limpieza general

☐ **Landlord disputes** Disputas de propietarios

☐ **Lead paint** Pintura con plomo

☐ **Unsafe drinking water** Agua potable insegura

☐ **Nonfunctioning appliances (stove, oven, refrigerator)**

Electrodomésticos que no funcionan (estufa, horno, refrigerador)

☐ **Leaks** Fugas

☐ **Unreliable utilities (e.g. electricity, gas, heat)**

Servicios públicos poco fiables (por ejemplo, electricidad, gas, calefacción)

☐ **Mold or dampness** Moho o humedad

☐ **Medical condition that makes it difficult to live in current home**

Condición médica que dificulta vivir en el hogar actual.

☐ **Overcrowding** Superpoblación

☐ **Threat of eviction** Amenaza de desalojo

☐ **Violence/safety concerns** Preocupaciones de violencia / seguridad

☐ **Other** Otro: _____

22. Are you worried that in the next two months, you may not have stable housing?
☐ **Yes** Sí ☐ **No**
¿Le preocupa que en los próximos dos meses no tenga una vivienda estable?

23. Do you have access to the internet using any of the following? (check all that apply)
¿Tiene acceso a Internet utilizando alguno de los siguientes? (marque todo lo que corresponda)

☐ **Cellular data plan for a smartphone or other mobile device**

Plan de datos móviles para un teléfono inteligente u otro dispositivo móvil

☐ **Broadband (high-speed) internet services such as cable, fiber optic, or DSL service**

Servicios de Internet de banda ancha (alta velocidad) como servicio de cable, fibra óptica o DSL

☐ **Satellite internet service** Servicio de Internet satelital

☐ **Dial-up internet service** Servicio de acceso telefónico a Internet

☐ **Other** Otro _____

24. In the past 12 months, has lack of reliable transportation kept you from going to (check all that apply):
En los últimos 12 meses, la falta de transporte confiable le impidió ir a (marque todas las opciones que correspondan):

☐ **Medical appointments** Citas medicas

☐ **Work / meetings** Trabajo / reuniones

☐ **Getting things for daily living** Conseguir cosas para la vida diaria

25. Do you have dependable access to the internet? ☐ **Yes** Sí ☐ **No**

26. How often do you see or talk to people that you care about and feel close to? (For example, talking to friends on the phone, visiting friends and family, going to church or club meetings)
¿Con qué frecuencia ves o hablas con personas que te importan y con las que te sientes cercano? (Por ejemplo, hablar con amigos por teléfono, visitar amigos y familiares, ir a reuniones de la iglesia o del club)

☐ **Less than once a week** Menos de una vez a la semana

☐ **1-2 days a week** dias por semana

☐ **3-4 days a week** dias por semana

☐ **5 or more days a week** o más días a la semana

Parent/Caretaker Cuidador/a

27. Do you care for one or more children under the age of 18? ¿Cuida a uno o más niños menores de 18 años?
☐ **Yes** Sí ☐ **No**
a. If no, skip questions 29 - 38 Si la respuesta es no, omita las preguntas 29 a 28

28. Do you care for a child under the age of 18 who has a lifetime illness or developmental disability? ¿Cuida a un niño menor de 18 años que tiene una enfermedad de por vida o una discapacidad del desarrollo?
☐ **Yes** Sí ☐ **No**

29. Do you take care of someone over the age of 18 who is elderly, has a lifetime illness, or has a physical or mental disability? ¿Cuida a alguien mayor de 18 años que es anciano, tiene una enfermedad de por vida o tiene una discapacidad física o mental?
☐ **Yes** Sí ☐ **No**

30. What are the greatest health issues negatively impacting children in the community?

¿Cuáles son los mayores problemas de salud que afectan negativamente a los niños de la comunidad?

31. What two things could we do to improve the overall health and wellbeing of children in the community?

¿Qué dos cosas podríamos hacer para mejorar la salud y el bienestar general de los niños en la comunidad?

32. What are the greatest needs of children and their families in your community?

¿Cuáles son las mayores necesidades de los niños y sus familias en su comunidad?

- ☐ **Access to pediatrician** Acceso al pediatra
- ☐ **Health insurance** Seguro de salud
- ☐ **Timely vaccinations** Vacunas a tiempo
- ☐ **Poverty** Pobreza
- ☐ **Homelessness** Desamparo
- ☐ **Child abuse/neglect** Abuso / negligencia infantil
- ☐ **Access to clean water** Acceso a agua limpia
- ☐ **Access to healthy food** Acceso a comida saludable
- ☐ **Connection to trusted adults**
  Conexión con adultos de confianza
- ☐ **Safe spaces for physical activity**
  Espacios seguros para la actividad física
- ☐ **Clean and safe housing**
  Vivienda limpia y segura
- ☐ **Affordable and reliable internet**
  Internet asequible y confiable
- ☐ **Mental health and substance use disorder programs for parents**
  Programas de salud mental y trastornos por uso de sustancias para padres
- ☐ **Engaged parents**
- ☐ **Other** Otro _____

33. What resources are available to help address these issues identified above?

¿Qué recursos están disponibles para ayudar a abordar estos problemas identificados anteriormente?

34. What are the greatest behavior concerns children and adolescents face in your community?

¿Cuáles son las mayores preocupaciones que enfrentan los niños y adolescentes en su comunidad?

- ☐ **Mental health** Salud mental
- ☐ **Domestic violence** Violencia doméstica
- ☐ **Alcoholism** Alcoholismo
- ☐ **Motor vehicle injuries** Lesiones de vehículos de motor
- ☐ **Youth violence** La violencia juvenil
- ☐ **Suicide** Suicidio
- ☐ **Other** Otro _____

35. What are the greatest needs or challenges facing pregnant women and new moms in the community?

¿Cuáles son las mayores necesidades o desafíos que enfrentan las mujeres embarazadas y las nuevas mamás en la comunidad?

36. What are the greatest health issues negatively impacting pregnant women and new moms in the community? ¿Cuáles son los mayores problemas de salud que afectan negativamente a las mujeres embarazadas y las nuevas mamás en la comunidad?

37. What two things could we do to improve the overall health and wellbeing of pregnant women and new moms in the community? ¿Qué dos cosas podríamos hacer para mejorar la salud y el bienestar general de las mujeres embarazadas y las nuevas mamás en la comunidad?

Healthcare / Cuidado de la salud

38. Has a doctor, nurse, or other health professional ever told you that you had, or are at risk for, any of the following? (check all that apply) ¿Alguna vez un médico, enfermera u otro profesional de la salud le ha dicho que tenía o está en riesgo de tener alguno de los siguientes síntomas? (marque todo lo que corresponda)

- ☐ **Heart attack** ataque del corazón
- ☐ **Coronary heart disease** Enfermedad del corazón
- ☐ **Stroke** derrame cerebral
- ☐ **Asthma** Asma

☐ **Cancer**

☐ **Chronic obstructive pulmonary disease (C.O.P.D.)**

Enfermedad Pulmonar Obstructiva Crónica (EPOC.)

☐ **Arthritis** Artritis

☐ **High blood pressure** Alta presión

☐ **Emphysema, or Chronic bronchitis**

Enfisema o bronquitis crónica

☐ **Depression** Depresión

☐ **Kidney disease** Enfermedad del riñón

☐ **Diabetes**

☐ **Obesity** Obesidad

☐ **Other** Otro _____

39. How would you pay for urgent medical care (ED or Center) or a primary care visit?

¿Cómo pagaría por la atención médica de urgencia (servicio de urgencias o centro) o una visita de atención primaria?

☐ **Through employer** A través de la empleadora

☐ **Privately purchased** Comprado de forma privada

☐ **Medicare**

☐ **Medi-cal or other state program**

☐ **TRICARE, VA, or Military** TRICARE, VA o militares

Programa médico u otro programa estatal

☐ **Alaska Native, Indian Health Service**

Nativo de Alaska, Servicio de Salud Indígena

☐ **Tribal Health Services;** Servicios de salud tribales

☐ **I do not have healthcare coverage**

No tengo cobertura de salud

☐ **Other Otro** _____

40. I would not go to a doctor's visit , why not?

_____

No iría a una visita al médico, ¿por qué no?

41. Do you have any of the following barriers that make it difficult to access healthcare services or get medication? (check all that apply) ¿Tiene alguna de las siguientes barreras que dificultan el acceso a los servicios de salud o la obtención de medicamentos? (marque todo lo que corresponda)

☐ **Expensive healthcare or medication costs** Costos elevados de atención médica o medicamentos

☐ **Lack of transportation** Falta de transporte

☐ **Distance to nearest healthcare facility or pharmacy** Distancia al centro de salud o farmacia más cercanos

☐ **Making time for healthcare appointments** Hacer tiempo para las citas médicas

☐ **Other** Otro _____

42. What three things make it hard to get healthcare in your community? (Select 3)

¿Cuáles son las tres cosas que dificultan la obtención de atención médica en su comunidad? (Seleccione 3)

☐ **It is NOT hard to get healthcare**
NO es difícil obtener atención médica

☐ **No health insurance**
Sin seguro médico

☐ **Medi-Cal is too hard to use**
Medi-Cal es demasiado difícil de usar

☐ **No health care available at night or weekends**
No hay atención médica por la noche o los fines de semana.

☐ **Medi-Cal is too hard to get**
Medi-Cal es demasiado difícil de conseguir

☐ **The only place to go is the emergency room**
El único lugar a donde ir es la sala de emergencias.

☐ **Can't get off work to see a doctor**
No puedo salir del trabajo para ver a un médico

☐ **Covered California/Obama Care is too hard to get**
Obama Care es demasiado difícil de conseguir

☐ **Can't afford medicine**
No puedo pagar la medicina

☐ **Covered California/Obama Care is too hard to use**
Covered California / Obama Care es demasiado difícil de usar

☐ **Can't afford doctor office visits**
No puedo pagar las visitas del médico

☐ **Doctor appointments are scheduled too far out**
Las citas con el médico están programadas demasiado lejos

☐ **Doctor office staff is rude of unhelpful**
El personal de la clinica son groseros o inútil

☐ **Doctors and staff don't speak languages of our community**
Los médicos no hablan idiomas de nuestra comunidad

☐ **No transportation**
Sin transporte

☐ **Waiting time to see the doctor is too long**
El tiempo de espera para ver a la doctora es demasiado largo

☐ **Not enough doctors here**
No hay suficientes doctores aquí

☐ **High co-pays and deductibles**
Altos copagos y deducibles

☐ **Other** Otro _____

Lifestyle / Estilo de vida

43. In a usual week, which category best describes your level of physical activity?

(Examples of moderate-intensity activity include brisk walking, tennis, or raking the yard and examples of vigorous-intensity activity include jogging, running, carrying heavy items upstairs, shoveling snow, or participating in a strenuous fitness class.)

En una semana habitual, ¿qué categoría describe mejor su nivel de actividad física?

(Los ejemplos de actividad de intensidad moderada incluyen caminar a paso ligero, jugar al tenis o rastrillar el jardín y los ejemplos de actividad de intensidad vigorosa incluyen trotar, correr, cargar objetos pesados en el piso de arriba, quitar la nieve con pala o participar en una clase de ejercicio extenuante).

☐ **Inactive** Inactiva

(not getting any moderate- or vigorous-intensity physical activity beyond basic movement from daily life activities)

☐ **Insufficiently active** Insuficientemente activo

(doing some, but less than 150 minutes per week of moderate-intensity physical activity, or doing some, but less than 75 minutes per week of vigorous-intensity physical activity, or a combination)

☐ **Active** Activo

(doing 150 to 300 minutes per week of moderate-intensity physical activity)

☐ **Highly active** Altamente activo

(doing more than 300 minutes per week of moderate-intensity physical activity)

44. In a usual week, how many days do you eat at least 2 to 3 servings of vegetables and at least 2 servings of fruit in a day? (circle only one)

En una semana normal, ¿cuántos días come al menos 2 a 3 porciones de verduras y al menos 2 porciones de fruta en un día? (circule solo uno)

0 1 2 3 4 5 6 7

Your Opinions / Sus opiniones

45. How would you rate your health in general?

¿Cómo calificaría su salud en general?

☐ **Excellent**	☐ **Very good**	☐ **Good**	☐ **Fair**	☐ **Poor**	☐ **Don't know**
Excelente	Muy bueno	Bueno	Justo	Pobre	No se

46. What is your biggest health concern?

¿Cuál es su mayor problema de salud?

47. What three things would most improve your life?

¿Qué tres cosas mejorarían más tu vida?

☐ **Jobs** Trabajos

☐ **Affordable housing** Vivienda asequible

☐ **Criminal justice** Justicia penal

☐ **Neighborhood watch program** Programa de vigilancia vecinal

☐ **Internet access** acceso a Internet

☐ **Other** Otro _____

48. If you could change anything about the environment to make it healthier and safe, what 3 things would they be? Si pudieras cambiar algo sobre el medio ambiente para hacerlo más saludable y seguro, ¿qué 3 cosas serían?

☐ **More smoke-free places** Más lugares libres de humo ☐ **Water quality** Calidad del agua

☐ **Clean streets/sidewalks** Limpiar calles / aceras ☐ **Parks** Parques

☐ **Walking paths** Senderos para caminar ☐ **Clean air** Aire limpio

☐ **Other** Otro_____

49. What are the three behaviors that most affect health in your community?

¿Cuáles son los tres comportamientos que más afectan la salud en su comunidad?

☐ **Alcohol abuse**

Abuso de alcohol

☐ **Driving while drunk/on drugs, drug abuse**

Conducir en estado de ebriedad / drogas, abuso de drogas

☐ **Lack of exercise**

Falta de ejercicio

☐ **Poor eating habits**

Los malos hábitos alimenticios

☐ **Unsafe sex**

Sexo inseguro

☐ **Not getting 'shots' to prevent disease**

No recibir 'vacunas' para prevenir enfermedades

☐ **Teenage sex**

Sexo adolescente

☐ **Not using a mask/using a mask incorrectly**

No usar una máscara / usar una máscara incorrectamente

☐ **Smoking/tobacco use**

Tabaquismo / uso de tabaco

☐ **Not getting regular checkups by doctor**

No recibir chequeos regulares por la doctora

☐ **Using weapons/guns**

Usar armas / pistolas

☐ **Life stress/not able to deal with life stresses**

Estrés de la vida / incapacidad para lidiar con el estrés de la vida

☐ **Talk/texting and driving**

Hablar / enviar mensajes de texto y conducir

☐ **Other** Otro _____

50. In your opinion, is store window advertising of tobacco, alcohol and sugary beverages a problem in your community?

En su opinión, ¿la publicidad de tabaco, alcohol y bebidas azucaradas en los escaparates de las tiendas es un problema en su comunidad?

☐ **Not a problem**

No es un problema

☐ **A big problem** Un gran problema

☐ **A small problem** Un pequeño problema

☐ **A medium problem** Un problema medio

☐ **I don't know** No se

☐ **Other** Otro _____

51. What three community resources, services or organizations help keep your community healthy? ¿Qué tres recursos, servicios u organizaciones comunitarias ayudan a mantener saludable a su comunidad?

52. What are the five most important parts of a healthy thriving community?

¿Cuáles son las cinco partes más importantes de una comunidad próspera y saludable?

☐ **Clean and sage homes**

☐ **Safe place to raise kids**

Lugar seguro para criar niños

☐ **Community involvement**

Participación de la comunidad

☐ **Affordable housing**

Vivienda asequible

☐ **Good air quality**

Buena calidad del aire

☐ **Services for elders**

Servicios para ancianos

☐ **Good schools**

Buenas escuelas

☐ **Parks and recreation facilities**

Parques e instalaciones recreativas

☐ **Jobs**

Trabajos

☐ **Time for family**

Tiempo para la familia

☐ **Low crime and violence**

Baja criminalidad y violencia

☐ **Access to healthcare**

Acceso a la asistencia sanitaria

☐ **Inexpensive childcare**

Cuidado de niños económico

☐ **Access to healthy food**

Acceso a alimentos saludables

☐ **Diversity is respected**

Se respeta la diversidad

☐ **People know how to stay healthy**

La gente sabe cómo mantenerse saludable

☐ **Green/open spaces**

Espacios verdes / abiertos

☐ **Support agencies**

Agencias de apoyo

☐ **Other** Otro _____

53. What are two things that make you most proud of your community?

¿Cuáles son las dos cosas que lo hacen sentir más orgulloso de su comunidad?

54. What activities would energize you enough to become involved (or more involved) in building a healthy community?

¿Qué actividades le darían suficiente energía para involucrarse (o más) en la construcción de una comunidad saludable?

55. What are the two things you would like to improve in your community?

¿Cuáles son las dos cosas que le gustaría mejorar en su comunidad?

56. What strengths and resources are available in your community that help residents maintain or improve their overall health?

¿Qué fortalezas y recursos están disponibles en su comunidad que ayudan a los residentes a mantener o mejorar su salud en general?

57. Are there any additional services or resources that you think should be available to your community to help residents maintain or improve their overall health?

¿Existe algún servicio o recurso adicional que crea que debería estar disponible para su comunidad para ayudar a los residentes a mantener o mejorar su salud en general?

58. Please rate how well your neighbors and county work together to help solve community problems. (circle one)

Califique qué tan bien trabajan juntos sus vecinos y el condado para ayudar a resolver los problemas de la comunidad. (un círculo)

Excellent	**Very good**	**Good**	**Fair**	**Poor**	**Don't know**
Excelente	Muy bueno	Bueno	Justo	Pobre	No se

59. Please rate how well your county works to help solve community problems. (Should we specify county? County health or elected officials?)

Excellent	**Very good**	**Good**	**Fair**	**Poor**	**Don't know**
Excelente	Muy bueno	Bueno	Justo	Pobre	No se

COVID-19

60. During the COVID-19 pandemic, did you have trouble getting or accessing any of the following?

Durante la pandemia de COVID-19, ¿tuvo problemas para obtener o acceder a alguno de los siguientes?

☐ **Prescriptions** Prescripciones ☐ **Spiritual support** Soporte espiritual

☐ **Groceries** Comestibles ☐ **General healthcare/doctor** Salud general / médico

☐ **Exercise** Ejercicio ☐ **Time with family/friends** Tiempo con familiares / amigos

☐ **Other** Otro _____

61. During the COVID-19 pandemic, have you or your family found you needed help getting enough food, paying bills, rent or mortgage, finding child care, or meeting with primary care providers?

Durante la pandemia de COVID-19, ¿usted o su familia se dieron cuenta de que necesitaban ayuda para obtener suficientes alimentos, pagar las facturas, el alquiler o la hipoteca, encontrar cuidado infantil o reunirse con proveedores de atención primaria?

☐ **Yes** Sí ☐ **No**

61a. If YES, how often? En caso afirmativo, ¿con qué frecuencia?

☐ **All of the time**

Todo el tiempo

☐ **Most of the time**

La mayor parte del tiempo

☐ **About half the time**

Aproximadamente la mitad del tiempo

☐ **Less than half the time**

Menos de la mitad del tiempo

62. Since COVID-19 began, have you felt an increase of depression, anxiety, isolation, or other issues? Desde que comenzó COVID-19, ¿ha sentido un aumento de la depresión, la ansiedad, el aislamiento u otros problemas?

☐ **All of the time** Todo el tiempo

☐ **Most of the time** La mayor parte del tiempo

☐ **About half the time** Aproximadamente la mitad del tiempo

☐ **Less than half the time** Menos de la mitad del tiempo

☐ **Not at all** Para nada

63. Were you or anyone in your household tested for COVID-19?

¿Se le hizo a usted oa alguien de su hogar la prueba de COVID-19?

☐ **Yes** Sí ☐ **No**

63a. If YES, why? ¿Si es así por qué?

☐ **Had COVID-19 symptoms**

Tenía síntomas de COVID-19

☐ **Exposure to someone positive at home**

Exposición a alguien positivo en casa

☐ **Pre-surgery or procedure test**

Prueba previa a la cirugía o procedimiento

☐ **Exposure to someone positive at work**

Exposición a alguien positivo en el trabajo

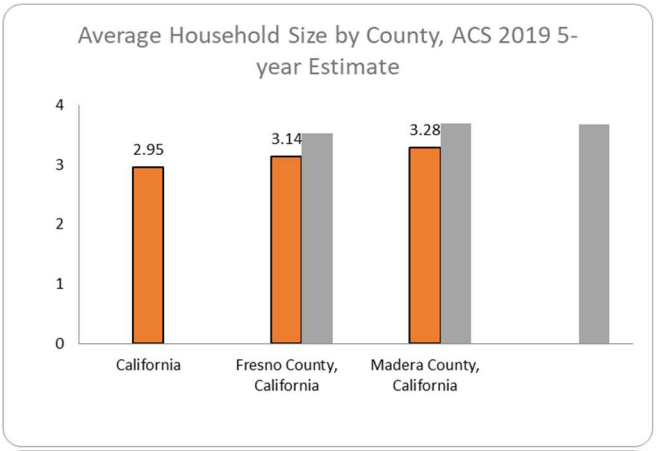
☐ **Other** Otro _____

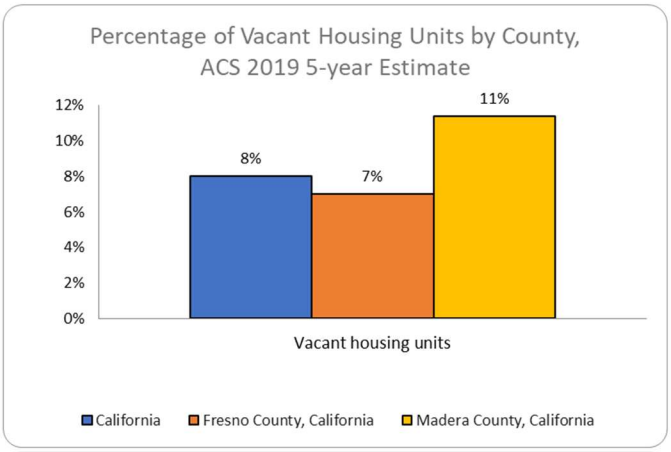
End of Survey/Fin de la Encuesta

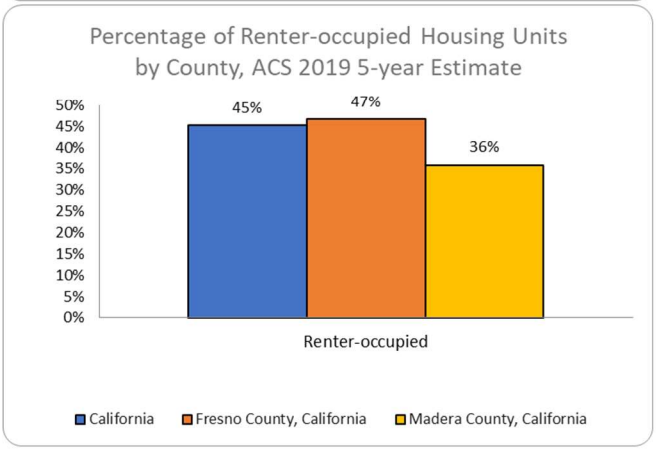
Thank You! / ¡Gracias!

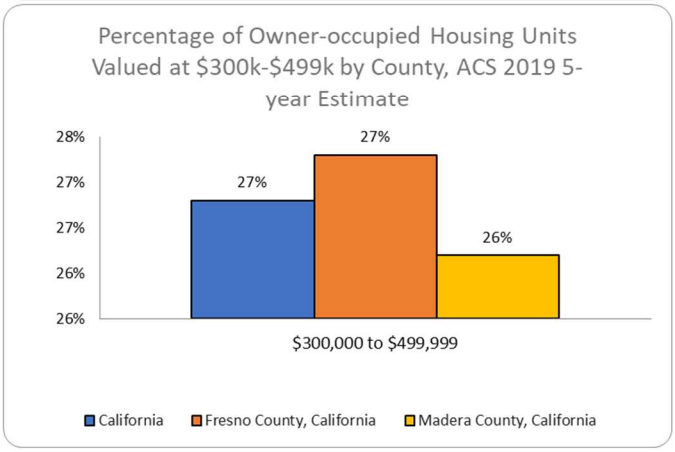
Appendix D – Secondary Data Graphs by Social Determinants of Health

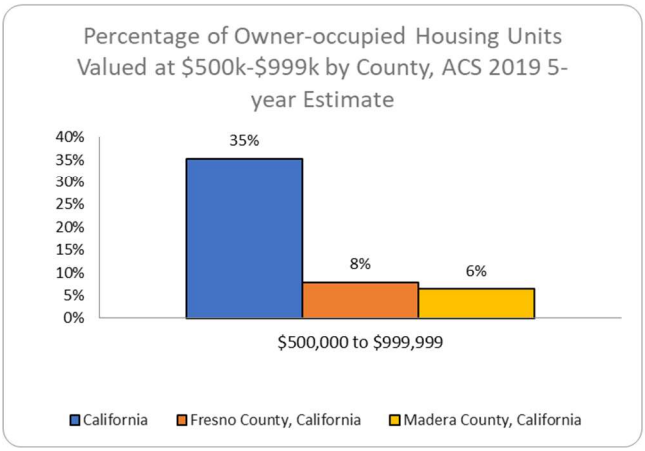
Housing







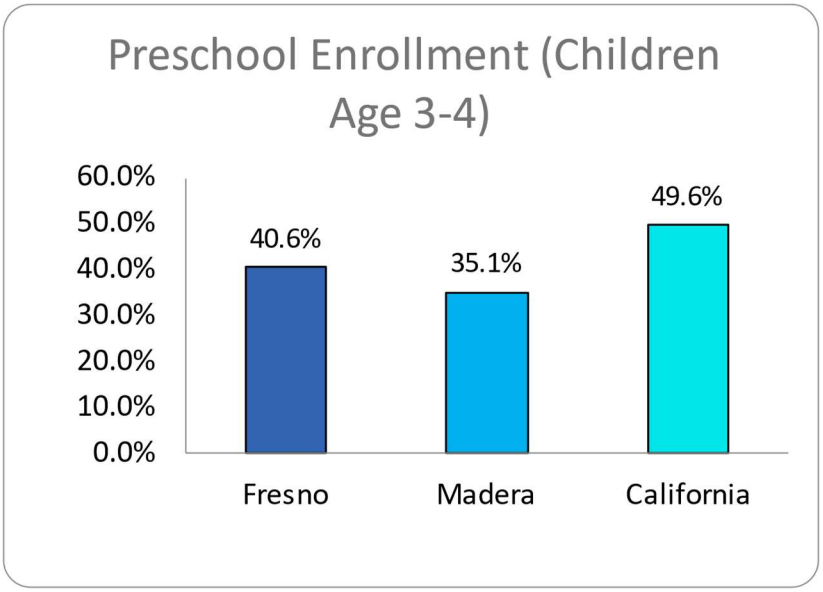


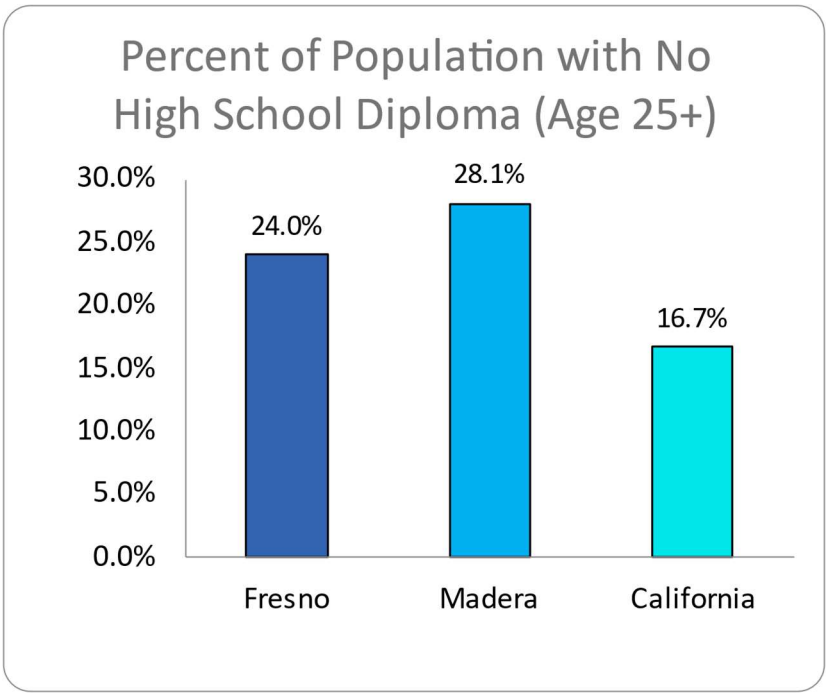


**Data Source: ACS (2019). 5 year estimates. Retrieved from https://www.census.gov/data.html*

Education

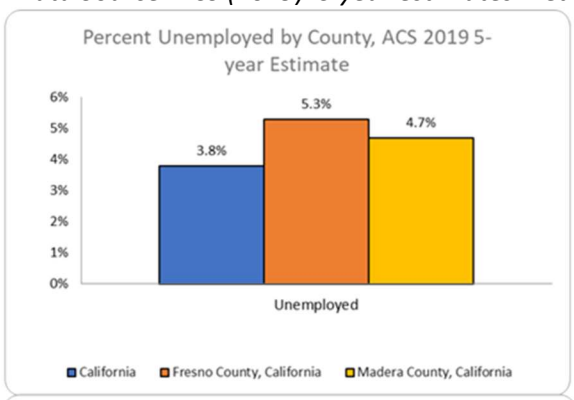
According to the US Census Bureau, 39.91% of the population age 3-4 is enrolled in school. This percentage is nearly 10% lower than the 49.64% average for the State of California. Of the population aged 25 and older 20.25% have obtained a Bachelor's level degree or higher compared to 33.93% for the State. Within the report area there are 172,605 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 24.60% of the total population aged 25 and older.
*Data Source: Trinity Health Data Hub (2021). Vital Signs Report. Retrieved from www.trinityhealthdatahub.org

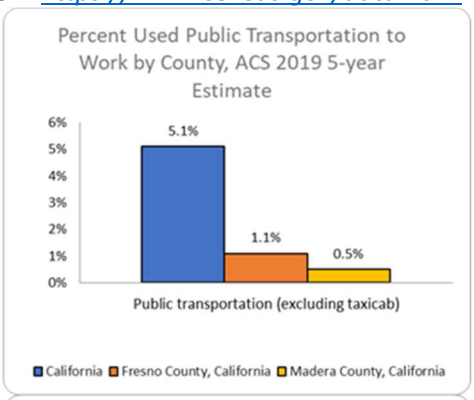


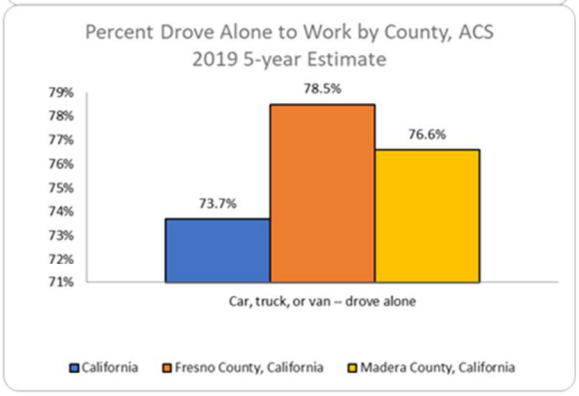


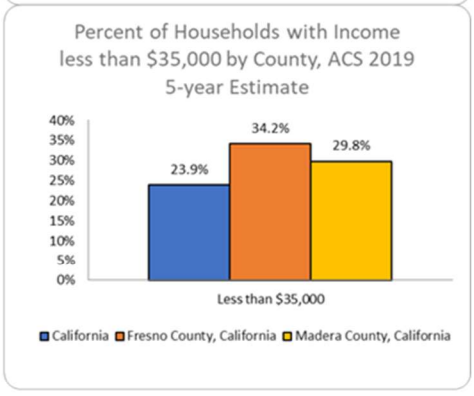
Economic Figures

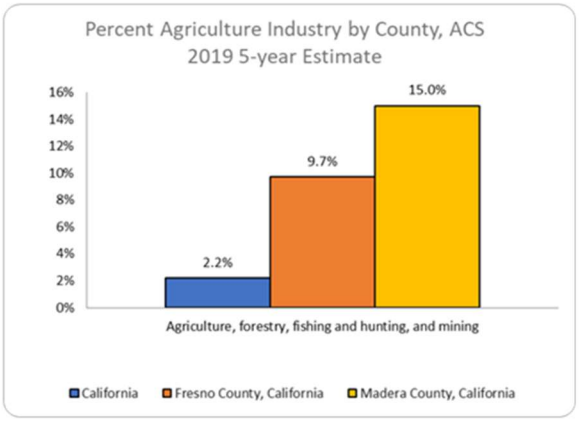
**Data Source: ACS (2019). 5 year estimates. Retrieved from https://www.census.gov/data.html*

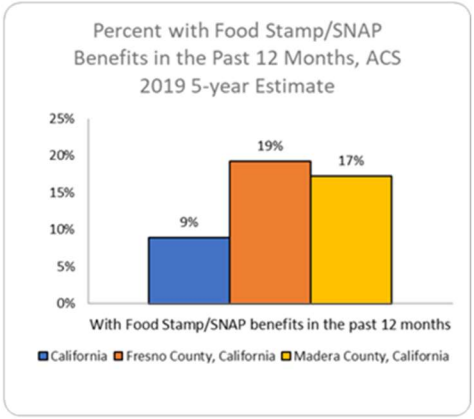


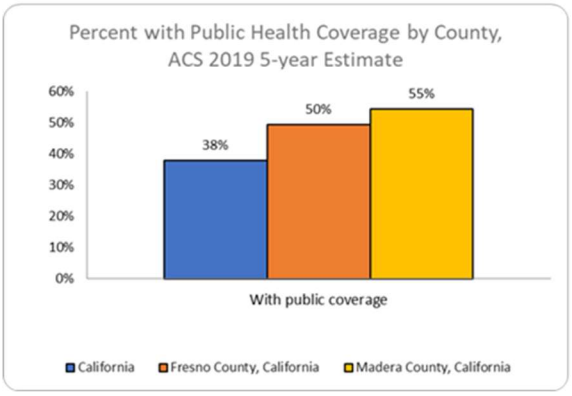


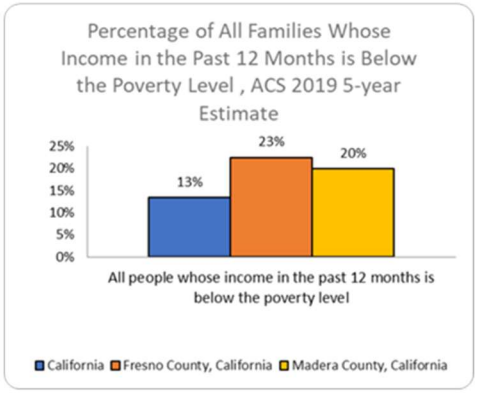




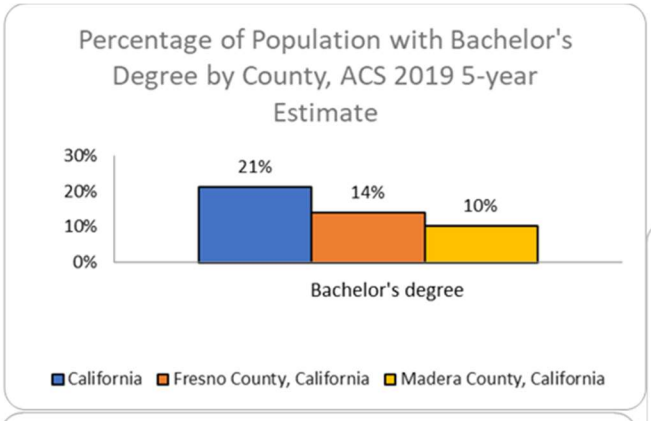


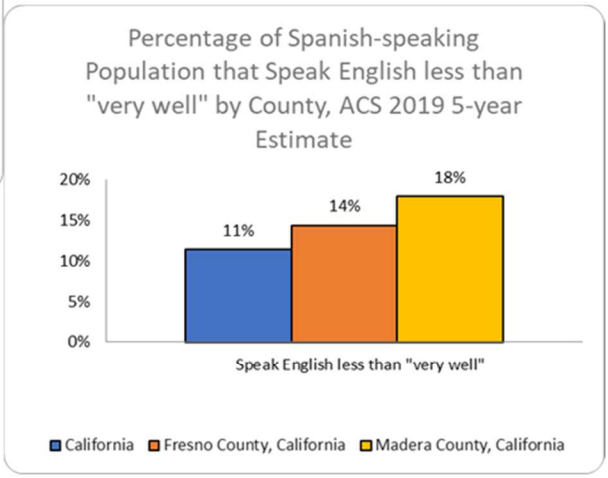


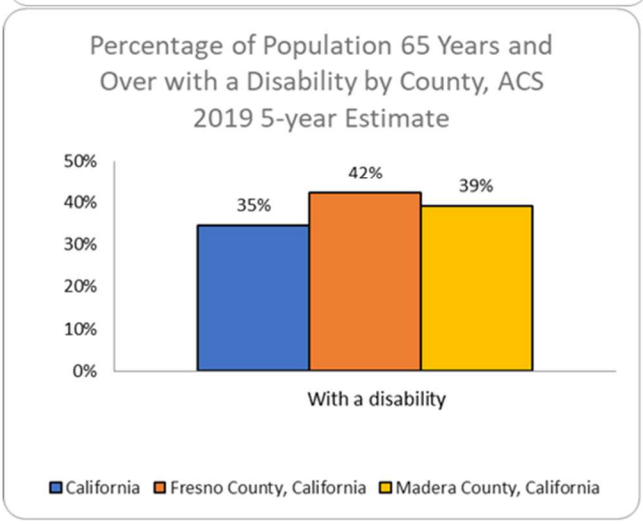


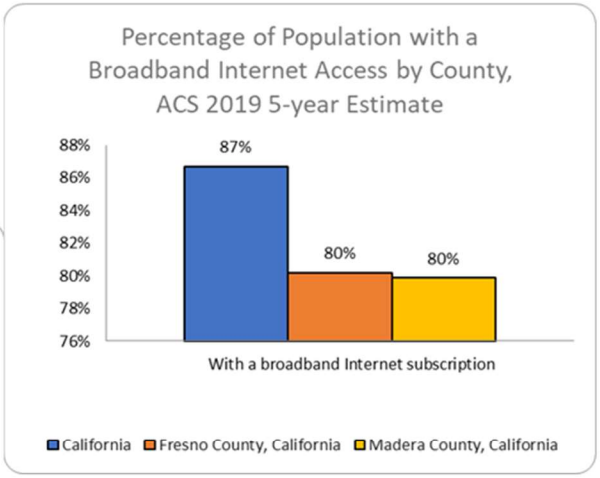


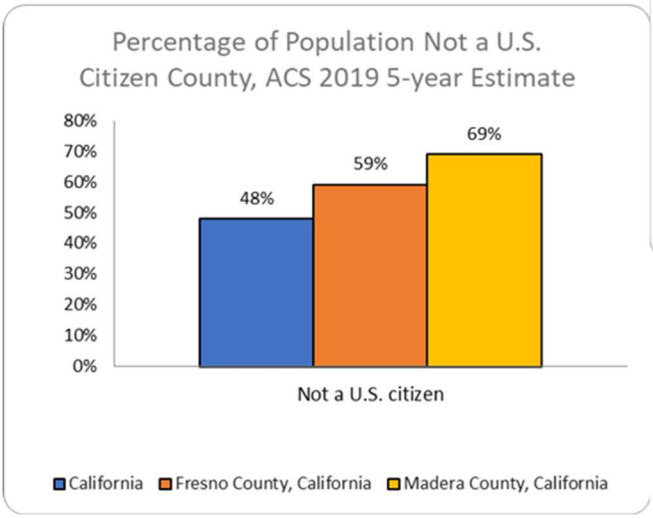
Social Figures











*Data Source: ACS (2019). 5-year estimates. Retrieved from https://www.census.gov/data.html

Health Indicators

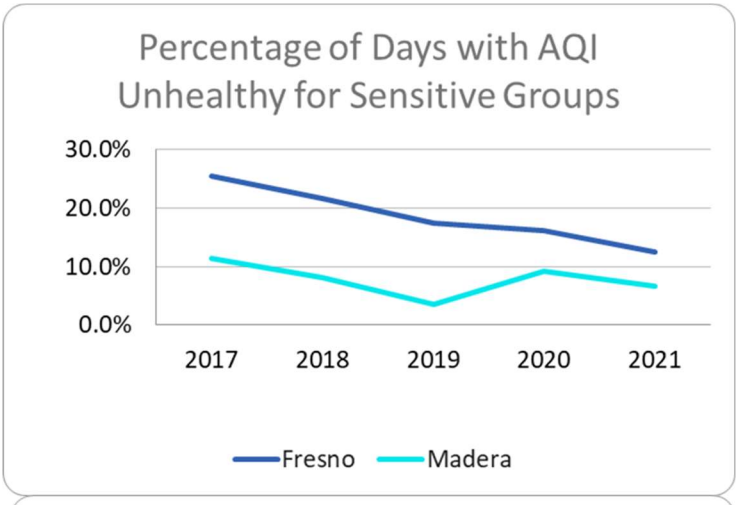
Health Indicators	California	Madera	Fresno
Adult Smoking	11%	17%	16%
Adult Obesity	24%	37%	33%
Food Environment Index	8.8	7.4	7.4
Physical Inactivity	18%	30%	23%
Access to exercise opportunities	93%	70%	78%
Excessive Drinking	18%	19%	19%
Alcohol Impaired Driving Deaths	29%	31%	27%
Sexually Transmitted Infections (Number of newly diagnosed chlamydia cases per 100,000 population)	585.3	584.5	720.6
Teen Births (Number of births per 1,000 female population ages 15-19)	17	33	30
Uninsured	8%	11%	9%
Primary Care physician (Ratio Physician:Person)	1250:1	2220:1	1490:1
Dentists (Ratio Dentist:Person)	1150:1	2310:1	1610:1
Mental Health Care providers (Ratio Provider:Person)	270:1	610:1	270:1
Preventable Hospital Care stays	3,358	3,386	3839
Mammography screening	36%	36%	38%
Flu vaccinations	43%	37%	44%
Air Pollution (Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5 Average in California is 8.1)	8.1	12.1	14.4

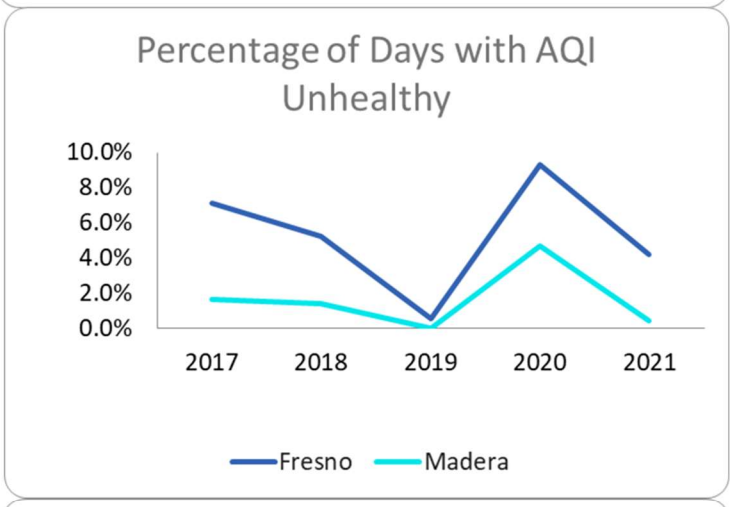
Sources: https://www.countyhealthrankings.org/explore-health-rankings
Data Sources they used: Behavioral Risk Factor Surveillance System (BRFSS) 2019 or 2018 data, Census Bureau 2019 or 2018 county population estimate data, and American Community Survey (ACS) 2015–2019 or 2014–2018 estimates.

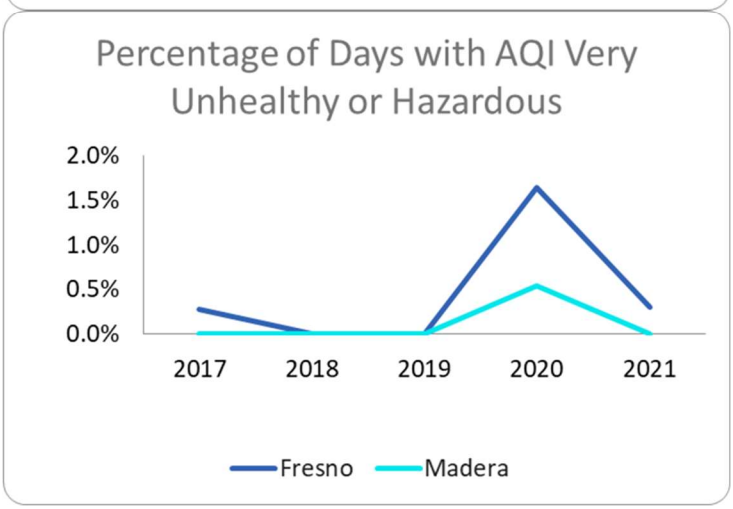
Other Health Indicators	California	Fresno	Madera
Asthma Prevalence (Age-adjusted rates per 10,000)	42.2	67.0	50.9
Diabetes Prevalence	9%	10%	12%
Cardiovascular Disease:	13.3	14.04	23.41
Years of Potential Life Lost (Premature deaths per 100,000)	5253	7000	6800
Life Expectancy	81.7	78.9	79.7
Infant Mortality (Per 1000 live births)	4	7	5

Sources:
https://oehha.ca.gov/calenviroscreen/report/calenviroscreen-40
https://trackingcalifornia.org/asthma/query
https://www.countyhealthrankings.org/app/california/2021/measure/outcomes/1/data
Sources they used:
Data on deaths and births were provided by NCHS and drawn from the National Vital Statistics System (NVSS)
Data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and from the US Census Bureau's Population Estimates Program were used to obtain county-level estimates of diagnosed diabetes, newly diagnosed diabetes, obesity, and physical inactivity.

Neighborhood & Environment







**Data Source: Air Quality Index Report (2017-2021). Environmental Protection Agency. Retrieved from https://www.epa.gov/outdoor-air-quality-data/air-quality-index-report*

County Health Rankings

2021 County Health Rankings for the 58 Ranked Counties in California

County	Health Outcomes	Health Factors
Alameda	14	6
Alpine	32	44
Amador	24	20
Butte	35	30
Calaveras	28	27
Colusa	29	48
Contra Costa	15	7
Del Norte	50	52
El Dorado	11	10
Fresno	46	51
Glenn	44	49
Humboldt	45	29
Imperial	27	58
Inyo	42	22
Kern	53	56
Kings	33	53
Lake	57	47
Lassen	48	42
Los Angeles	22	31
Madera	36	55
Marin	1	1
Mariposa	30	28
Mendocino	41	36
Merced	38	54
Modoc	55	50
Mono	19	17
Monterey	20	35
Napa	5	14
Nevada	17	8
Orange	6	9
Placer	3	2
Plumas	54	33
Riverside	25	32
Sacramento	26	24
San Benito	21	25
San Bernardino	43	40
San Diego	13	18
San Francisco	7	5
San Joaquin	39	43
San Luis Obispo	16	12
San Mateo	2	3
Santa Barbara	18	19
Santa Clara	4	4
Santa Cruz	9	15
Shasta	49	26
Sierra	40	34
Siskiyou	56	37
Solano	23	21
Sonoma	8	11
Stanislaus	34	39
Sutter	37	38
Tehama	51	46
Trinity	58	41
Tulare	47	57
Tuolumne	31	23
Ventura	12	16
Yolo	10	13
Yuba	52	45

For more information on how these ranks are calculated visit www.countyhealthrankings.org

Appendix E - Focus Group Code Tables and Frequencies

Good Things About the Community	Fresno	Madera	Total Report Area
Social and Community Context Totals	**97**	**28**	**125**
Close-knit community (family, friends, neighbors)	40	16	56
Diversity	24	0	24
Shared culture	22	2	24
Community involvement	8	8	16
Good support programs/services	3	2	5
Neighborhood and Environment Totals	**91**	**22**	**113**
Safe community	33	4	37
Peaceful community	29	5	36
Central/convenient location	17	7	24
Community Parks	6	1	7
Local transportation	4	0	4
Agriculture	2	2	4
Healthcare Access and Quality Totals	**25**	**11**	**36**
Good patient service	11	7	18
Provider listened to needs	6	4	10
Access to healthcare	2	0	2
Culturally aware	2	0	2
Affordable	2	0	2
Good healthcare for children	2	0	2
Economic Stability Totals	**7**	**4**	**11**
The cost of living	4	2	6
Available work/good jobs	3	2	5
Education Access and Quality Totals	**8**	**2**	**10**
Schools nearby	6	0	6
Good education	2	2	4

Community Health Needs/Challenges	Fresno	Madera	Total Report Area
Healthcare Access and Quality Totals	**510**	**156**	**666**
Not enough providers/treatment locations	74	16	90
Unable to get needed medical care (provider not able to handle the problem)	58	12	70
Expensive medical care	51	7	58
Insurance barrier to getting needed medical care	50	9	59
Long wait times at medical appointments	41	5	46
Lack of provider compassion/did not listen to needs	38	25	63
Language barriers to care	31	7	38
Discrimination by providers/staff (including socioeconomic, language, racial, etc.)	23	5	28
Distance to medical care/transportation barriers	21	28	49
Difficulty navigating the healthcare system	19	6	25
Difficulty getting an appointment/finding a doctor	19	4	23
Inefficient practices	13	2	15
Bad staff communication	12	2	14
Bad provider communication	11	10	21
Short appointments	11	2	13
Lack of culturally sensitive care	10	1	11
Excessive prescriptions	10	2	12
Lack of trust in providers/healthcare	8	5	13
Citizenship barriers to care	8	0	8
Doctors changing frequently	2	8	10
Neighborhood and Environment Totals	**155**	**30**	**185**
Safety/neighborhood crime	69	3	72
Bad air quality/pollution	41	9	50
Homelessness	34	5	39

Water quality	4	4	8
Access to food issues	4	1	5
Lack of transportation	3	8	11
Economic Stability Totals	**69**	**18**	**87**
Lack of affordable/acceptable housing	25	8	33
Job insecurity/low pay	18	2	20
Rent Increase/High rent costs	12	1	13
Program qualifications for aid are challenging	9	2	11
Food insecurity	5	5	10
Social and Community Context Totals	**48**	**10**	**58**
Lack of awareness of community resources	26	2	28
Stigma around mental health	8	0	8
Discrimination	6	0	6
Unclear citizenship process	4	4	8
Fear of deportation	3	0	3
Bad eating habits	1	4	5
COVID19 Totals	**47**	**8**	**55**
Reduced access to healthcare due to COVID-19	15	1	16
Distrust in doctors/vaccines	13	5	18
Reduced economic stability due to COVID-19	11	0	11
Confusion about COVID-19	8	2	10
Education Access and Quality Totals	**32**	**6**	**38**
Remote learning	12	1	13
Student mental health	9	0	9
Low quality education	8	5	13
Lack of equity	3	0	3
Health and Health Behavior Totals	**21**	**3**	**24**
Substance abuse	18	1	19
Concerns about chronic conditions	3	2	5

Suggestions for How Community Members can Help	Fresno	Madera	Total Report Area
Social and Community Context Totals	**136**	**55**	**249**
Advocacy	29	11	40
Being more involved	25	7	32
Increase awareness around resources (share info, etc.)	23	12	35
Advocating for policy change	21	5	26
Community support groups/meetings	16	7	23
Create/support community-based organizations	11	3	14
Voter education and access	5	1	6
Volunteering (community support suggestions)	4	6	10
Increase family-friendly events	2	3	5
Neighborhood and Environment Totals	**36**	**14**	**50**
Repurpose community spaces	30	11	41
Help the environment (Reduce pesticide use, responsible with campfires, pick up trash, etc.)	6	0	6
Community farmer's market/community gardens	0	3	3
Economic Stability Totals	**12**	**5**	**17**
Provide support for food	7	3	10
Donations	3	2	5
Job fairs/application support	2	0	2
Health and Health Behaviors Totals	**5**	**0**	**5**
Self-care	3	0	3
Community health education	2	0	2
Education Access and Quality Totals	**0**	**0**	**0**
Healthcare Access and Quality Totals	**0**	**0**	**0**

Suggestions for How Institutions can Help	Fresno	Madera	Total Report Area
Healthcare Access and Quality Totals	**146**	**30**	**176**
Improve scheduling (easier to make appointments, less wait time)	23	4	27
More doctors/health facilities (including incentivizing providers to come/stay, supporting local healthcare training)	22	6	28
Affordable care/universal health care	19	2	21
Better/more translation/interpretive services	15	3	18
More integrated healthcare team	12	7	19
Integrate alternatives to Western medicine	11	0	11
Navigation support	10	0	10
Training for providers and healthcare workers (discrimination in healthcare, LGBTQ+ needs, interpersonal training, cultural sensitivity)	8	3	11
Mobile/ At-home healthcare	6	1	7
Create/support laws to improve healthcare	4	0	4
Improved leadership	3	0	3
Accountability needed in practice	3	0	3
Equitable/culturally appropriate treatment	3	1	4
Provide more support for individuals with private insurance	3	0	3
Lower age of consent for vaccines	3	0	3
Reliable transportation to appointments	1	3	4
More centralized care	0	0	0
Neighborhood and Environment Totals	**28**	**18**	**56**
Outreach to community	14	4	18
Improve local transportation	14	14	28
Economic Stability Totals	**15**	**0**	**15**
Build/provide housing	11	0	11
Improve job conditions	4	0	4
Education Access and Quality Totals	**12**	**7**	**19**

Increase mental health education/ support	4	1	5
Increase food resources on campus	3	2	5
Decrease police presence on campuses	3	0	3
Equal funding across schools	2	0	2
Help with internet access	0	4	4
Social Support Totals	**11**	**3**	**14**
Offer more programs and services	9	2	11
Increase awareness of mental health to destigmatize	2	0	2
Religious organizations address social issues	0	1	1
Health and Health Behavior Totals	**0**	**0**	**0**
Suggestions for Which Institutions can Help	**Fresno**	**Madera**	**Total Report Area**
Community-based organizations	24	4	28
Healthcare organizations	22	3	25
County agencies	16	3	19
Religious organizations	8	2	10
State agencies	6	2	8
Media	1	0	1
Health Needs/Challenges of Children	**Fresno**	**Madera**	**Total Report Area**
Neighborhood and Environment Totals	**40**	**12**	**52**
Safety (safe places to play and live)	24	6	30
Access to healthy food	13	6	19
Environmental issues (air quality, water)	3	0	3
Healthcare Access and Quality Totals	**35**	**9**	**44**
Need mental health support	18	6	24
Access to equitable healthcare	17	3	20
Social and Community Context Totals	**32**	**22**	**54**
Bullying/peer harassment	12	2	14

Gangs	7	0	7
Childcare/after school programs	5	7	12
Need activities/nothing to do	4	6	10
Role models	3	2	5
Support parent/caretaker health	1	5	6
Health and Health Behavior Totals	**21**	**7**	**28**
Chronic conditions in children/youth (including asthma, diabetes)	11	2	13
Substance abuse	10	5	15
Education Access and Quality Totals	**12**	**3**	**15**
Need academic support/resources	12	3	15
Suggestions for How to Improve the Health and Wellbeing of Children	**Fresno**	**Madera**	**Total Report Area**
Social and Community Context Totals	**15**	**12**	**27**
Resources	9	5	14
Access to high quality childcare	3	0	3
Role models/support from adults	2	1	3
Support groups	1	1	2
More playtime/activities	0	5	5
Healthcare Access and Quality Totals	**9**	**1**	**10**
More/better mental health support	9	1	10
Education Access and Quality Totals	**7**	**1**	**8**
More support at school	5	1	6
Sex education	2	0	2
Health and Health Behavior Totals	**6**	**2**	**8**
Support healthy diets	5	2	7
Exercise/physical activity	1	0	1
Economic Stability Totals	**0**	**0**	**0**
Neighborhood and Environment Totals	**0**	**0**	**0**

Health Needs/Challenges of Pregnant Women and New Moms	Fresno	Madera	Total Report Area
Health and Health Behavior Totals	**11**	**5**	**16**
Mental health	7	3	10
Substance abuse	1	1	2
Lack of exercise	1	1	2
Diabetes	1	0	1
High blood pressure	1	0	1
Preterm birth	0	0	0
Social and Community Context Totals	**6**	**14**	**20**
Lack of information	4	3	7
Lack of social support	1	9	10
Support from the father (need)	1	1	2
Social judgment from others	0	1	3
Healthcare Access and Quality Totals	**4**	**0**	**4**
Health insurance	3	0	3
Healthcare access	1	0	1
Neighborhood and Environment Totals	**4**	**4**	**8**
Lack of access to healthy food	3	2	5
Environmental health issues	1	1	2
Lack of transportation	0	1	1
Education Access and Quality Totals	**3**	**1**	**4**
Need education on health	3	1	4
Economic Stability Totals	**0**	**3**	**3**
Financial challenges	0	3	3
Suggestions for How to Improve the Health and Wellbeing of Pregnant Women and New Moms	**Fresno**	**Madera**	**Total Report Area**
Social and Community Context Totals	**7**	**7**	**14**
Social support	4	6	10

Family planning services	3	1	4
Economic Stability Totals	**6**	**3**	**9**
Nutrition resources	5	1	6
Financial support	1	0	1
Job security	0	2	2
Healthcare Access and Quality Totals	**5**	**4**	**9**
Health care services	5	3	8
Women OBGYN	0	1	1
Neighborhood and Environment Totals	**1**	**2**	**3**
Improved environment	1	1	2
Transportation/mobile services	0	1	1
Education Access and Quality Totals	**0**	**1**	**1**
Classes for pregnant women	0	1	1
Health and Health Behavior Totals	**0**	**0**	**0**
5-Year Vision	**Fresno**	**Madera**	**Total Report Area**
Neighborhood and Environment	**60**	**14**	**74**
Safer community	17	3	20
Improved air quality/less pollution (cleaner community)	13	1	14
Access to healthy affordable food	10	6	16
Improved city infrastructure and repairs	9	1	10
Improved public transportation	6	1	7
More/closer stores/services	3	1	4
More recreational space	2	1	3
Healthcare Access and Quality	**56**	**12**	**68**
Improved healthcare system/standard of care	42	7	49
More integrated healthcare	5	4	9
Patient and caring providers	4	0	4
Advancements in medicine	3	0	3

Culturally competent providers	2	1	3
Health and Health Behavior	**25**	**11**	**36**
Better overall health of community	14	7	21
COVID-19 decline/ increased vaccination rates	8	1	9
Improved mental health	3	3	6
Economic Stability	**17**	**9**	26
Less homelessness	7	3	10
Increased job/internship opportunities	4	0	4
Better living conditions	3	1	4
More low-income housing	2	2	4
Improved economy	1	1	2
More apprenticeship programs	0	2	2
Education Access and Quality Totals	**14**	**8**	22
Better education	14	8	22
Social Community Context	**34**	**10**	44
More supportive community/social support	14	5	19
Better use of available resources	7	2	9
Mutual aid	5	1	6
More accessible government/leadership	4	0	4
Immigrants treated better	3	0	3
Less stigma around mental health	1	0	1
Community unity	0	1	1
Less stigma around LGBTQ+ community	0	1	1

Appendix F – Key Informant Interview Quotes

	Quotes
Social and Community Context Totals	
Lack of resources	"I think the number of families and parents don't have access to good health care because they were unaware that there are resources in the community." - Madera "I went kind of broad in this response and what I what I included was poverty. And. Lack of community resources and low educational attainment all contribute to what are the majority of the chronic health conditions that that we see. You know, I I wouldn't say that we're unique in that diabetes and hypertension and high cholesterol are the number that the top three. I think that other probably other geographic areas that resemble ours would probably describe the same conditions. And as I said, you know, I think some of these more socioeconomic drivers are what contribute to it." - Madera
Racism and discrimination	"Racism in our red lining in the way that we build factories in some places and not others? So racism, that's the easiest way to say it." - Fresno "I'd say the biggest one that I regularly am confronted with is the air quality and particularly in unincorporated and disadvantaged communities where there are a lot of low income folks and we're like the communities have been impacted by environmental racism. There is disproportionate air pollution burdens on unincorporated communities of color in the San Joaquin Valley. And so the work I do with residents in Madera county deals with a lot of disproportionate exposure to pesticides and like diesel exhaust and methane emissions from the family landfill and just other pollution sources that impact resident health and wellness." - Madera
Cultural differences (inlcluding language barriers/differences)	"Language is another barrier. If then when they call and the person on the other line only speaks English. That's a challenge for them just trying to find, you know, who can either translate now it's who can translate for me, who can call, who can ask." -Fresno
Rural areas lack support/services	"So one of the biggest challenges that I see the community in Madera face is access. Well, we have it's a it's a large county, geographically speaking, the community is spread out and in, like, little pockets. And so you do have your rural areas in your urban, but they also also have what I would think mountain area communities that are very different from what most people understand. It's rural. So access to services would be perhaps one of the the giant." - Madera
Powerlessness	"Powerlessness and I mean, that revolves around poverty." - Fresno
Mental health stigma	"You can really see a lot of people trying to just sustain you know their mental health, you know? So for me, I believe that is a concern. You know, it's just, you know, and just to break the the stigma of the word mental health, you know, it could be, you know, people don't understand that depression, even the sadness or just you have somebody to talk to, it's OK, you're not. You don't have to be looked down upon just because you need help." -Madera

Lack of prioritizing underserved individuals	"Lack of investment and prioritization of the individuals that we serve. We saw that last year or earlier this year and the prioritization of vaccination tiers in California. Individuals with disabilities were put to the end of the line, and we kept maintaining that despite the fact that they were prioritizing people over 65 years of age, that age did not equal risk and that many of the individuals with disabilities that ended up in the hospital with COVID had, in some cases, 10 10 times as as much risk of dying from COVID. So unfortunately, prioritization of the individuals we serve, unfortunately, is oftentimes not at the level that we believe it should be." - Fresno
Fear related to citizenship	"Our immigration system, like people don't really put like our finger on the fact that when there's fear about, you know, who to talk to and what supports to access, I think that that goes like it's like top of mind and everything else follows. 'I will not seek any support. I will not even engage in learning more about any program or service that might be available because I am fearful that someone will come knocking on my door one, or two that in the future, if things get better when it comes to this whole thing about me or my family like legalizing our status because we have a lot of families that worry about that in our county, that in the future will affect me. And it will, you know, they will know that I accessed X service five years ago and this will not be good. And this might be the difference between me being able to God have a Social Security and a legal permanent resident card in my wallet.' I think that is an underlying thing, that it's it's just really, really deep and people don't really bring it up as much, I feel. And what is already working well, I think I brought I brought up there's there's enough people, there's a lot of initiatives that are, I think, that give me hope that our starting to focus on what else can we be doing to kind of level the playing field?" - Fresno
Healthcare Access and Quality Totals	
Distrust in medical system	"Without trust in a system and trust with the people you work with, it's it's not going to work." - Fresno
Doctor shortage (including specialists)	"The question is, who is going to do that? Who's going to improve this, who is going to bring this who's going to bring us more doctors who can take care of these patients. The hospital doesn't have any resources and the health department I don't think is really looking into it." -Madera
Cost of healthcare	"I also think access to the proper health care coverage. While at the same time is affordable. I think they have access to health care. It's how they pay for it, what they can afford to pay for. I think oftentimes people don't take their children to the doctor, they don't take themselves to the doctor because of the cost element. Or maybe the child has a cold goes into bronchitis, before you know it they or a senior has pneumonia. And one of their reasons for holding out is because of cost. And I also feel it's the same thing with prescription medications as a result of going to the doctor if they are not properly covered, then the medications that they need are sometimes simply out of their reach because of the cost." - Madera
Early intervention	"I think that what the what I and I and I'm not sure that I did justice in fitting it in there, but I think it's important to keep in mind that children with special needs require a lot of support, a lot of emphasis on early intervention and attention that even though it's not necessary and sometimes it doesn't fall under a health issue or situation that children with special needs often times go unnoticed or under the radar. And we tend to forget that it's important to address their needs as much as any other aspect of our community health." -Madera

Economic Stability Totals	
Poverty	"I think poverty has a lot to do with. It's a lack of education. And at the same time, if a person is educated, that doesn't necessarily mean that they have the wherewithal or the means or an understanding of how to receive treatment. So for example, even if a person understands the challenges of doing something, that doesn't necessarily mean that they have the means to treat it or to receive help, to try to treat it. And I think some of that has to do with poverty. Some of it has to do with with with an understanding, some of it's generational poverty. And at the same time, some of it has to do with simply a lack of resources both money for treatment, but and also transportation and timing to go do it. And that's always a challenge for a lot of people." - Madera "Poverty relates to people having less access to health care, less access to good-paying jobs. Less access to housing options. Less access to transportation, childcare, so all the barriers to have a productive and healthy life to me relates to poverty." - Madera "Poverty is the underlying factor to everything, all of these others are ultimately come down to poverty." -Madera
Food insecurity	"Maslow's hierarchy you know, are they? Do they have access to food and a whole lot of food insecurity? So I think that's one issue." – Madera
Lack of acceptable/affordable housing	"The only other thing I can think of is, I guess I'll say two things, one something that I think is taking a big toll on people's mental health and even physical health due to the stress it causes, is the lack of affordable housing. And so when I am working with families who are going through evictions, people get so physically sick from the stress of that because oftentimes they aren't able to find anywhere else to live. And there have been some really like difficult and sad phone calls I've had with people this year about that." - Madera
Economic insecurities	Not a great quote option, just economic insecurities mentioned.
Low-income employment	Not a great quote option, just low-income employment mentioned.
Income inequality	"I would say we, you know, our region, we live in a region that is very ag-based, and that means a very stark difference between the haves and the have nots. So we we have a lot of work that is attached to agriculture that has a huge impact." -Fresno
Health and Health Behavior Totals	
Mental health issues	"I think I think mental health is a big issue, I think for everyone. And so I think one of the challenges that I think we solve for and that we base is both as a community but as a country is that we're exposed to so much. That's not necessarily always healthy." - Madera
Poor nutrition	"I also do feel that, you know, and it's sometimes I think it's really over discussed that proper eating habits, teaching our children and our seniors, making sure that they're eating nutritiously to support their health." - Madera
Substance abuse	"So I would definitely say that anything dealing with drugs and alcohol that continues to be very prevalent, especially in lower socioeconomic, they see their parents, they see, you know, the adults doing it and especially in small towns, you know, away from the city, you gather with neighbors or you gather. And that's what you see. And so I would say alcohol, smoking, you know, drugs. Just a couple of weeks ago, I know there was an, you know, we've had, you know, a death, you know, near a town here. I'll do, you know, kind of revolving around those issues." - Fresno

Obesity	"And at the same time, I think obesity for all the members of society, you know, for all the ethnicities, I think is a major challenge. And I think a lot has to do with our lifestyles." - Madera
Addiction	Not a great quote option, just addiction mentioned.
Problems with women's health	"So women's health, the state of women's health, and that's everything, mental health, physical health, before pregnancy, the high number of infant deaths that we have actually across race and ethnicity, but it's particularly bad among the Black population." - Fresno
Preterm birth/infant death	"Poor birth outcomes. And then in the other I I kept thinking all the root causes of poor, poor birth outcomes. So if babies are not reaching their first year, you know their first birthday, there's environmental concerns there there are. I just like all of the things that I mentioned to you earlier, impact the health and well-being or the health problems in our community. If there's not enough healthy food options, if there's not enough safe spaces to take walks to exercise, to feel comfortable, if I don't know where to go for help, if if I feel disrespected when I go into a doctor's office because my race or my skin color and I been, I choose not to continue going to my prenatal care appointments, for example, or if I go to the hospital and I'm treated as less than because I don't speak English, and I try to figure out ways to communicate with the nurse about my pain, I I will not go to any preventative measure or any preventative care clinic until I absolutely have to, because my experiences have been horrible. So I think and it all starts with the, you know, the baby in the womb. So to me, any of these other things, you know, child abuse and neglect, like if I don't have access to like a good job and I'm worried about keeping the lights on the lights on in the apartment of daily, like getting kicked out, you know, being having to worry about my housing. Then more than likely, there will be some me like losing my temper and my children will suffer in child abuse and child neglect issues, you know, just like even substance abuse I think you have in here. So none of these to me spoke as like, Oh yes, this one and this one and this one, I really, really felt that it all starts with poor birth outcomes and all of the root causes that come, that surround a pregnant mom in Fresno County, feeling lonely or feeling helpless, and how that will impact all of us. And I go back to how if we don't realize that we are not connected to my role in making sure that that baby is in that mom, you know, that mom makes it and that baby makes it to at least her first birthday, and she feels supported and knows where to go. Our systems will continue to be dealing with the treatment and like this. You know, the other sign of prevention, which is, you know, we are already we didn't go upstream enough and now we're dealing with all the downstream countries." - Fresno
Trauma	"The biggest, the greatest need. Well, a lot of them are facing definitely alcohol and drug addiction issues, alcoholism, drug abuse, depression, anxiety. Post-Traumatic stress disorders, trauma due to child abuse, child neglect, or being witnesses of domestic violence. All of that trauma affects our kids in foster-care, having to be placed in the foster care system and jumping from one home to the other and causing in our field. We call it attachment disorders. And those become very, very difficult to help repair due to the impact on these children." - Madera
Neighborhood and Environment Totals	
Housing issues	"It concerns me believe and situation and people not having enough like living in overcrowded housing, not having the right ventilation. You know, when the heat in Fresno or when the cold in Fresno gets there." - Fresno

Lack of safe spaces (i.e. no safe parks, lack of gyms)	"When the physical environment doesn't lend itself to being out in the community, you know, having safe parks, having basketball courts that are kept up to date, you know, when when things are run down and you don't have the physical environment that that is in place for healthy activities to occur, then you know, unhealthy activities are going to take place." - Madera
Transportation	"Well, the first one as far as transportation. And again, I'm thinking more of the rural communities that we serve. There are services within the city of Fresno. But once you get out to the outer towns, the counties. If a if a person needed to see someone who specialized, for example, the breast cancer screening, they would have to call someone who's coming from Fresno from the city of Fresno to pick them up. And our parents still are or the families that we serve still don't know exactly like either, a phone number to call. How do they access even transportation if they did want it? Who do they call it? That information isn't out there is. It's not out there for them to have." - Fresno
Education Access and Quality Totals	
School graduation rates	"And when your overall community isn't graduating at the rate it can be if your overall community is lower income to it, a percentage so much higher than other areas of California. And obviously the folks that are in our child welfare system, which is at the bottom tier, that would end up being much more susceptible to unfortunate health outcomes. If you want to say it that way." - Madera

Appendix G - Community Assets and Resources

Identified Needs	Community Assets and Resources
Expensive medical care	**Rural mobile units, FQHCs low sliding fees, Community low-income clinics, Tzu Chi Foundation (Schools), Proyecto Orale (Mujeres Campesinas)**
Not enough providers/treatment locations/long wait times	**Mobile units, GME programs, promotora in-home visits, CVRC, patient navigators, Black Wellness & Prosperity Center (BWPC)-training providers,**
Lack of provider compassion/Discrimination	**FQHC quality control program to address patient complaints, in-house training programs, Access to cultural healthcare program at the Fresno Center to provide cultural training, ACEs Aware Initiative, West Fresno Family Resource Center, Centro La Familia - culturally sensitive medical care, Black Infant Health, BWPC - training for providers, Cultural Brokers, Another Level Training Academy**
Insurance barrier/access to medical care	**Insurance enrollment with mobile unit and at clinics and medical offices, FQHCs low sliding fees**
Safety/neighborhood crime	**Advanced Peace Initiative - Fresno EOC, Street Saints, Fresno United - deals with safety and health and neighborhood violence, Public Safety and Action Convening, Police programs**
Poor air quality/pollution	**Leadership Council, Fresno Building Healthy Communities (BHC), Dr. Venice Curry, Central California Environmental Justice Network, Youth Leadership Institute, Central Valley Urban Institute, Central Valley Air Coalition, Transform Fresno, The HIVE Foundation, San Joaquin Valley Air Pollution Control District**

Lack of transportation	**Innovation Transportation Matt Gillian (clean quality electric vehicles), Fresno Black Chamber (FBCC)- shared mobility program for hub stations (rent cars for a day), FAX - is responsive to needs. PACE - for elderly to go to medical appointments, Black Uber for Children. Medi-Cal patient transport program, Dollar Ride program, transportation vouchers, Madera County Transportation Commission, 5 Tesla's in Huron, Fresno Economic Opportunities Commission (EOC) - free transportation**
Lack of affordable/acceptable housing	**SW Fresno Development Corporation, Fresno Housing Authority, City of Fresno programs, CV Urban Institute, Leadership Council, County programs are addressing through Madera County Behavioral Health - housing units with behavioral health issues, Community Action Partnership of Madera County, Madera Rescue Mission, Madera Hospital patient navigators, Adult protective services (continuous room rental), Reading &Beyond, Centro La Familia, Jakara Movement, West Fresno Family Resource, Education Leadership Foundation - working together to help assist people behind in rent and electricity. Special Housing programs increasing, Self-Help in Madera,**
Poverty	**Every Neighborhood Partnership, Fresno EOC, Centro La Familia, Fresno Housing Authority, Fresno BHC, Live Well Madera - Growing Healthy Families Program Madera Unified School District referral book, Workforce Development Programs, Gift cards being given out by Calfresh at schools, Fresno State - WorkforceConnect, Proteus Workforce, Fresno/Reedley City College trainings for CA residents,**
Food insecurity	**Food Bank USDA program, Faith Based Orgs, Saint Rest EDC, Fresno Metro, CalFresh, Food pantries in rural and metro Madera County, Fresno Madera Agency for Aging delivers food to elderly, Cultiva La Salud delivers food, Madera County Food bank, Familias en Action in 93702**
Homelessness	**Fresno Madera Continuum of Care, Poverello House, City of Fresno Homeless Task Force, CAPMC, Self-Help, Churches, Service agencies (police, sheriff withing with CBOs), Fresno Madera Rescue Mission**