
COMMUNITY BENEFITS REPORT 2011



*Adventist Medical Center
Selma*



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EXECUTIVE SUMMARY

Adventist Medical Center – Selma (AMC-S) is operated as a service of Adventist Medical Center – Hanford as part of the Adventist Health/Central Valley Network (AH/CVN), a faith-based network of four hospitals, 23 rural health clinics and more than 20 other service locations that specializes in providing access to personal, high-quality health care services in more than 18 rural communities in California’s Central Valley. The network sees more than a million health care interactions a year throughout a 2,500-square-mile region.

As a nonprofit community hospital, AMC-S is committed to offering care to those in need without regard to their financial status or level of insurance. The hospital provides comprehensive care to the poorest congressional district in the nation.

Adventist Medical Center - Selma a 57-bed acute-care hospital in Fresno County, provides a comprehensive range of services, centers and programs: Services include:

- 24-hour emergency department with 8 licensed beds
- Birthing center with five LDRP suites
- Direct observation unit
- Laboratory
- Diagnostic imaging with CT, MRI and digital mammography
- Cardiology department
- Pharmacy
- Inpatient and outpatient surgery

The hospital offers a workforce of:

- 2,768 employees
- 484 physicians
- 167 volunteers

Its community partners include:

- Chambers of Commerce of Selma, Parlier, Dinuba and Reedley
- Selma Senior Center
- Reedley Downtown Association
- Reedley Kiwanis Club
- Reedley Community Services Department

The network took a major step toward preserving rural health care services in southeastern Fresno County when it took over operations of Sierra Kings District Hospital (SKDH) in Reedley, Calif., and its five rural health clinics in November 2011. SKDH, a 49-bed acute-care hospital serving a rural region, was in bankruptcy and in danger of closing.

SKDH's services include:

24-hour emergency department with 10 beds
Family Birth Center with 20 large private rooms
Inpatient and outpatient surgery
Laboratory
Medical imaging, including CT, MRI, digital mammography, X-ray, ultrasound and bone-density

AH/CVN's Primary Service Area (PSA) and Community Benefit Area encompasses about 2,500 square miles in Kings, southern Fresno and eastern Tulare counties.

Communities and ZIP codes include:

Armona 93202	Fowler 93625	Lemoore 93245
Avenal 93204	Hanford 93230	Parlier 93648
Caruthers 93609	Kettleman City 93239	Reedley 93654
Coalinga 93210	Kingsburg 93631	Sanger 93657
Corcoran 93212	Huron 93234	Selma 93662
Dinuba 93618	Laton 93242	Stratford 93266

Our secondary markets include communities and ZIP codes:

Del Rey 93616	Raisin 93652	Visalia 93277
Fresno 93706	Riverdale 93656	Visalia 93291
Fresno 93725	Tulare 93274	Visalia 93292

In 2011, our community benefit programs included direct medical services; preventative care, education and intervention; and collaboration with various community partners to deliver a greater impact to the communities we serve. The following are the hospital's Community Benefit Priorities/Initiatives, which were established in collaboration with community partners:

1. Increase awareness and education to a large indigent population on diabetes, nutrition and childhood obesity.
2. Increase the availability of primary care, specialty, mental health and physical therapy services in the Valley by recruiting more health care professionals and communicating their availability; by opening clinics in underserved areas; and by increasing specialty services.
3. Implement our newly adopted vision to become the health care system of choice by providing the highest quality care to the community.

MISSION, VISION AND VALUES

Our Mission

To share God's love by providing physical, mental and spiritual healing.

Our Vision

To be a regional health care network that is recognized as the best place to receive care, the best place to practice medicine and the best place to work.

Our Values

Heartfelt Compassion

Inner Integrity

Enthusiastic Respect

Vital Quality

Thoughtful Stewardship

Loving Family

Human Wholeness

Personal Contribution

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

Adventist Medical Center - Selma has a long history of caring for our communities.

The hospital was renamed Adventist Medical Center – Selma in 2011 to reflect its connection to the newly built Adventist Medical Center – Hanford and its ties to all Adventist Health services in the Valley and Western states.

As the only community hospital in Selma and nearby Kingsburg, AMC-S has the opportunity to improve the health of the people in our community through increased health education and access to services.

A number of programs that respond to the health needs of our community provide real support and assistance. In addition to the regular ongoing programs, we are able to respond to concerns and needs, initiating new services that can provide the necessary help. This report will provide information about the programs and services that we provided to our communities in 2011.

ORGANIZATIONAL COMMITMENT

Governance and Management Structure

The Governing Board works in harmony with hospital administration and community leaders, for the welfare of the people in Kings, southern Fresno and eastern Tulare counties. The Board provides oversight to the hospitals in activities that benefit the county, which is plagued with high unemployment and poverty rates.

The composition of the Governing Board includes two hospital executives, six physicians, a registered nurse and twelve community members. They are:

Scott Reiner, Chairman
Ramiro Cano
Dawn Bickner
David (Bud) Dickerson
Richard K. Ellsworth, DO
Wayne Ferch
Kenneth Gibb

Robert Hansen
George Johnson
Larry M. Jorge
Mary Ann Landis
Adam Mackey
Grant Mitchell, JD

Gloria Pierson, RN
Nicholas Reiber, MD
Daniel Schlund, MD
Ashok Verma, MD
J. Darrick Wells, MD
Annie Wong, MD

Community Benefit Committee

The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit. The Community Benefit Committee provides leadership in planning and directing the activities of our Community Benefits Program.

Wayne Ferch
President & CEO

Charles Sandefur
Vice President, Mission and Community Development

Christine Pickering
Director, Marketing & Communications

Community Benefit Planners and Reporting Managers

The following individuals participate as Community Benefit Planners and Reporting Managers:

Charles Sandefur
Vice President, Mission and Community Development

Carla Smith
Director, Accounting

Christine Pickering
Director, Marketing & Communications

Community Needs Assessment Committee

The Community Needs Assessment Committee met three times in 2010 and early 2011 to plan and review the Community Needs Assessment, which was used in the 2011 Community Benefit Plan and Report. Members included:

Mike Bertaina
Hanford Chamber interim president and American Cancer Society leader

Mike Derr
Selma City Council Member

Randy Dodd
Vice President, Adventist Health / Central Valley Network

Michael Mac Lean, MD
Kings County Public Health Officer

Christine Pickering
Marketing and Communications Director, Adventist Health/Central Valley Network

Richard L. Rawson
President/CEO, Adventist Health/Central Valley Network

Sarah Reid
Community Services Superintendent, City of Reedley

The Community Needs Assessment Committee worked under the guidance of the Central Valley Health Policy Institute, including:

Marlene Bengiamin, Ph.D.
John Capitman
Armando Cortez
Kudzai Nyandoro

As a result of their work, a Community Needs Assessment identified areas of focus, which were reflected in the Community Benefit Plan for 2011.

Community Benefit is characterized as programs or activities that promote health and healing in response to identified community needs.

COMMUNITY NEEDS & ASSETS ASSESSMENT PROCESS AND RESULTS

BACKGROUND

The Patient Protection and Affordable Care Act (PPACA) imposes new requirements on non-profit hospitals. Hospitals must comply with requirements regarding community health needs assessments, financial assistance policies, charges, billing and collections. The nonprofit hospital provisions of PPACA do ***not*** exempt any hospitals from its requirements. Thus, hospitals currently exempt from community benefit reporting pursuant to state law (SB 697) must now develop a community health needs assessment and report community benefits. This includes small and rural, children's charitable, public and other hospitals.

The Hospital Council of Central California contracted with the Central Valley Health Policy Institute and California State University, Fresno, to conduct a community-wide needs assessment of their service area. This report provides a health snap-shot of the Hospital Council service area covering Fresno, Madera, Kings and Tulare Counties using secondary quantitative data; explores needs, strengths and challenges; and identifies priorities for action using primary qualitative data.

Methods – Our approach to community benefit assessment

For the purpose of this report we adopt three types of communities that the World Health Organization and UNICEF defined as:

1) **An area or neighborhood** – a “group of people living together within a fixed geographic location.”

2) **Social relationships** – “a set of social relationships mostly taking place within a fixed geographic location.”

3) **Identity or common interest** – “a shared sense of identity such as groups of substance users.”

Assessment is defined as “a systematic set of procedures undertaken for the purpose of setting priorities and making decisions about program or organizational improvement and allocation of resources,” according to *Planning and Conducting Needs Assessments: A Practical Guide*, written by B.R. Witkin and J.W. Altschuld. This approach is broader than needs assessments in the sense that we include not only needs, but other factors related to health challenges and community strengths.

We used quantitative and qualitative data to provide a more complete picture of the issues being addressed, the target audience and the strengths, challenges and opportunities in the service areas.

Quantitative:

Through the use of the Central Valley Health Policy Institute (CVHPI) Data Warehouse, we provide an analysis of birth, death and hospitalization data for the service area. Population-adjusted rates of receipt of appropriate pre-natal care, low birth weight, and pre-term births are described for each ZIP code in the service area and overall. Population-adjusted rates for hospitalizations for selected acute and chronic conditions, a composite measure of primary care sensitive/avoidable hospitalizations, pre-mature deaths overall, and pre-mature deaths for specific conditions are described for each ZIP code in the service area and overall. Using available California Health Interview Survey, school fitness testing, reportable health events, and other data source, we provide estimates of chronic disease and high-risk health behaviors for the service area or the most accurate available geographic areas within the service area. We also provide the most recent available estimates of demographic, educational attainment, and economic opportunity information for the service area.

Qualitative:

A focus group of public health and health care leaders representing school district, hospitals, clinics, county public health, non-profit organizations, and funders participated in two focus groups (one in each county). There were three facilitators conducting the focus group: a lead facilitator in charge of group process and schedule and two note takers (detailed recorder and a synthesizer to record and project the analysis and discussion points for the stakeholders' validation).

Five areas were discussed relevant to Community Health and Well Being:

1. Primary Care/Access to Care/ Uninsured/Indigent/Implementation new national policy/ undocumented etc.
2. Hospital /Emergency services
3. Chronic Disease Management
4. Prevention Services, Policies, Environments/ Clean Air/water
5. Public Safety/Behavioral Health, Housing/ transportation/community development/economic/schools/social services for children, youth and families /Places to play/a Access to healthy food)

These areas were used to 1) identify conditions and opportunities in each area that supports Community Health and Well Being and respective policies needed to sustain these efforts; 2) identify conditions and opportunities that inhibit Community Health and Well Being and the policies or practices needed to change these; and 3) rank priorities for action.

RESULTS – QUANTITATIVE:

Demographic characteristics of Adventist Health Service Area

Age

Table 1 depicts the demographic characteristics for Fresno, Kings, Madera and Tulare Counties. In 2007, the Valley had higher percentages of residents who were under 17 years of age (30.3%), than California as a whole (25.5%) (RAND California, 2007a). The presence of a higher proportion of persons under age 17 has implications for family economic well-being and the financing of public services. Madera had a higher proportion (35.4%) of younger (under 17) residents than the SJV and the state. Fresno had the higher proportion of residents age 65 and older (10.3%) than the region. Kings had a higher proportion of adults age 18-64 (65.1%) than the San Joaquin Valley (SJV) and the state as a whole.

Ethnic Background

Hispanic/Latino residents were the largest racial/ethnic group in the San Joaquin Valley in 2009. They represent about 47.2% of the entire population in the Valley. Following Hispanic/Latino residents are White, non-Hispanic residents, comprising about 39.2% of all residents in the region. The Valley has a lower proportion of non-Hispanic Whites than California as a whole, 42.3%. The next largest ethnicity group is Asian, estimated at 5.9%, less than the state at 12.5%. African-Americans follow with a 5.1%, American Indian 2.0%, multi-racial population 2.4% and Pacific Islander at 0.3% (U.S. Census Bureau, American Community Survey, 2009). In 2009, Fresno, Kings and Madera had higher percentages of Latino residents (48.7%, 49.3%, and 50.8% respectively) than the state (36.6%). The percentage of African Americans in Kings County was higher (8.3%) than the SJV (5.1%) and the State (6.7%). Fresno County had a higher proportion of Asian residents (8.7) than the SJV (5.9%). Despite the lower percentage of Asian residents, the Central Valley had the largest concentration of Laotian and Hmong refugees in the United States (The California Endowment, 2002). In 2000, San Joaquin Valley residents represented over 70 ethnicities and spoke approximately 105 languages, making the region among the most culturally diverse in California and the nation.

The Economy

Today, the San Joaquin Valley is still one of the least affluent areas of California. Per-capita income is well below the national average, and poverty, in both urban and rural areas, is a significant problem. Valley residents have among the lowest per capita personal incomes, higher rates of unemployment and more residents living below the Federal Poverty Level (FPL) than California as a whole. In 2008, Madera County had the lowest per capita income in the Valley and all three counties had a higher unemployment rate than the state (11.4%), with Fresno County having the highest annual unemployment rate at 15.1%; the San Joaquin Valley has an average annual unemployment rate at 15.6% (U.S. Bureau of Economic Analysis, 2009). Though the Valley as a whole has a higher percentage of residents living below the FPL than California, Fresno (24.0%), Kings (23.9%), and Madera (19.2%) by far have exceeded the state percentage of 15.7% (UCLA Center for Health Policy Research, 2007).

Table 1 - Demographic Characteristics

Demographic Characteristics	Fresno	Kings	Madera	Tulare	San Joaquin Valley	California
Population¹	909,153	149,518	148,333	426,276	3,862,937	36,756,666
Population per Square Mile⁵	154	107	70	89	184	237
% White, non Hispanic¹	35.4%	37.4%	40.3%	35.8%	39.2%	42.3%
% Hispanic/Latino¹	48.7%	49.3%	50.8%	57.5%	47.2%	36.6%
% American Indian¹	2.0%	2.2%	3.3%	1.9%	2.0%	1.2%
% Asian¹	8.7%	3.2%	2.1%	3.5%	5.9%	12.5%
% Pacific Islander¹	0.2%	0.3%	0.3%	0.2%	0.3%	0.4%
% African American¹	5.8%	8.3%	4.5%	1.9%	5.1%	6.7%
% Multirace¹	2.1%	2.0%	2.2%	1.7%	2.4%	2.6%
% 0-17 Years²	29.8%	27.2%	35.4%	31.8%	30.3%	25.5%
% 18-64 Years²	60.3%	65.1%	55.8%	58.6%	59.0%	63.3%
% Over 65 years²	9.9%	7.7%	8.8%	9.6%	9.5%	11.2%
Per Capita Personal Income³	\$30,997	\$26,734	\$26,524	\$28,610	\$29,227	\$42,325
% 25 years without High School Diploma¹	26.8%	30.8%	31.4%	32.4%	29.3%	19.7%
Annual Unemployment Rate⁴	15.1%	14.6%	13.8%	18.4%	15.6%	11.4%
% of Total Population Below 100% of FPL²	24.0%	23.9%	19.2%	25.8%	21.4%	15.7%
% of Children Under 18, in Families with Income Below 100% of the FPL²	31.4%	34.8%	34.8%	36.4%	29.9%	20.5%

Sources:

1. U.S. Census Bureau. American Community Survey 2009
2. UCLA Center for Health Policy Research, 2007.
3. U.S. Bureau of Economic Analysis, 2008
4. California Employment Development Department, Labor Market Information Division, 2009.
5. US Census Bureau. Population Finder 2009.

Uninsured

In 2007, 23.8% of nonelderly Californians, ages 18-64, or 5,468,000 adults, reported not having health insurance the entire or part of the year prior to being surveyed. In 2009, the percentage of nonelderly adults without health insurance escalated to 26% or 5,855,000 adults. The percentage of San Joaquin Valley (8 counties) nonelderly adults who reported not having health insurance for the entire 2007 year or part of the year prior to the survey was higher than the state at 29.3% (662,000 persons). *UCLA Center for Health Policy Research, 2003; 2009*. Madera had the highest rate among the four counties with adults not insured part of the year at 38% (Table 2).

Table 3 shows Californians by county and insurance status or type. In all four counties, residents without health insurance grew to above the statewide average of 24.3%, according to 2009 estimates. As in 2007, Madera County had the largest total percentage of uninsured residents, with 32% nonelderly adults and children uninsured all or part of the year. The rate of job-based coverage in Madera County was relatively low, at 34.4%. These figures reflect the benefits of some of the lowest unemployment rates in the state

Table 2 - Percent Non-Elderly adults with no insurance or insured only part of the past year - 2007

STATE/COUNTY	AGE (0-11)	AGE (12-17)	AGE (18-64)
California	9.1	9.9	23.8
Fresno	5.4	16.2	24.7
Kings	7.5	23.8	28.0
Madera	10.4	9.6	38.0
Tulare	8.2	10.8	28.6

Source- California Health Interview Survey 2007

Table 3 - Insurance Status and Type during the Past 12 Months by Region and County, Ages 0-64, California, 2009

State/County	Job based coverage All year	Medi-Cal Healthy Families All year	Other Coverage All Year*	Uninsured All or part year	Total Population
California	50.1	16.3	9.3	24.3	34,387,000
Fresno	43.2	27.6	4.8	24.4	875,000
Tulare	33.0	32.4	9.0	25.6	414,000
Kings	40.9	23.4	7.5	28.3	149,000
Madera	34.4	27.5	6.1	32.0	140,000

Source: Rates are predicted estimates from a simulation model based on the 2007 California Health Interview Survey and 2007/2009 California Employment Development Department data.

Prenatal Care

The percentage of California babies born at low birth weight increased from 6.1% in 1995 to 6.8% in 2009. At the county level, that figure ranged from 5.9% in Tulare County to 7.3% in Fresno County in 2009. In 2009, none of the four counties met the Healthy People 2010 objective of 5% or fewer low birth weight infants.

California's infant mortality rate declined from 5.9 per 1,000 live births in 1996-98 to 5.2 in 2005-07. In 2005-07, the infant mortality rate ranged from 5.4 in Madera County to 6.2 in Fresno County. The most common reasons for infant deaths are congenital defects and disorders related to pre-term birth and low birth weight.

In California in 2009, 18.7% of infants were born to mothers who received late or no prenatal care in the first trimester of pregnancy. This figure declined from 1995 to 2003, increased from 2004 to 2008 and declined slightly in 2009. At the county level, the percentage of mothers who received no or late prenatal care ranged widely, from 17.3% in Fresno County to 28.9% in Madera County in 2009. None of the four counties met the Healthy People 2010 objective that at least 90% of infants' mothers receive prenatal care beginning in the first trimester.

Table 4 - Percent Low birth weight, Preterm Birth, Late/No Prenatal Care by County

STATE/COUNTY	% LOW BIRTH WEIGHT *	INFANT MORTALITY**	LATE PRENATAL CARE***
California	6.8	5.2	18.7
Fresno	7.3	6.2	17.3
Kings	6.4	5.9	28.4
Madera	6.3	5.4	28.9
Tulare	5.9	5.9	24.2

Source: Kidsdata.org

Retrieved December 10, 2010, from <http://www.kidsdata.org/Data/Topic/Table.aspx?gsa=1&ind=301>

*2009 **2005-2007; ***2009

Health Fitness Zone:

Table 5 shows percentage of 5th and 9th grade students who are not in the Health Fitness Zone, according to a comprehensive battery of tests developed by FITNESSGRAM to test the physical fitness for students in California public schools. The results for California and the four counties' students in the Class of 2009 cohort grade five and grade nine students scoring in the HFZ are shown in Table 5. Students from Fresno and Tulare show similar HFZ achievement to the California students on six out of six fitness standards. However, the percentage of students from Kings County (especially 5th grade) who didn't achieve the HFZ in six out of six fitness standards was much higher than students from California. Percentage of students from Madera County for 5th was higher than the state on one out of the six standards and for the 9th grade was higher than the state on two out of the six fitness standards.

Table 5 - 2008-09 Percent California/San Joaquin Valley Counties Fifth and Ninth Grade Students NOT in Health Fitness Zone

Physical Fitness Area	California		Fresno		Kings		Madera		Tulare	
	5 th	9 th								
School Grade										
Aerobic Capacity	34.3	37.0	32.0	39.6	46.3	41.6	34.5	43.9	37.1	32.4
Body Composition	31.6	30.2	35.4	32.0	37.0	34.3	36.2	35.4	35.4	31.0
Abdominal Strength	19.9	14.0	20.1	13.8	24.4	11.5	24.2	17.1	18.8	9.5
Trunk Extensor Strength	11.8	9.3	11.9	8.2	19.5	10.0	12.8	9.7	8.5	6.7
Upper Body Strength	30.2	23.2	25.6	23.8	43.0	23.1	30.7	21.1	34.5	26.8
Flexibility	29.2	19.0	28.8	21.3	34.2	20.9	34.7	22.1	27.1	16.3

Source: California Department of Education- Statewide Assessment Division.
Retrieved December 10, 2010, from <http://data1.cde.ca.gov/dataquest/>

Chronic Disease and Risk Behavior

Table 6 shows state and county-level data for chronic diseases. With the exception of Tulare County, Fresno, Kings and Madera counties have notably higher percentages for asthma than the state. The proportion of adults reporting diabetes in the four counties is higher than California. Fresno, Madera and Tulare report higher proportions of high blood pressure than the state, and Madera County has a higher percentage of heart disease than the state.

Table 6 - Percent Chronic Conditions by Age for California and San Joaquin Counties

Chronic Condition	State/County	Age 0-17	Age 18+
Asthma	California	15.4%	13.0%
	Fresno	19.2%	18.0%
	Kings	20.0	15.2
	Madera	16.0	15.5
	Tulare	15.6	11.9
Diabetes	California	-	7.8
	Fresno	-	10.5
	Kings	-	10.4
	Madera	-	8.1
	Tulare	-	11.3
High Blood Pressure	California	-	26.1
	Fresno	-	28.4
	Kings	-	23.5
	Madera	-	28.3
	Tulare	-	27.3
Heart Disease	California	-	6.3
	Fresno	-	6.1
	Kings	-	5.6
	Madera	-	8.4
	Tulare	-	6.5

Table 7 shows state and county-level data for risk health behavior for adults and seniors. All four counties have higher proportions of overweight or obese and sedentary lifestyle for adults and seniors than the state. Smoking habits are higher for the state (14.3%) than Fresno County and lower than Tulare, Madera and Kings Counties (15.3, 16.2, and 17.3, respectively).

Table 7 - Percent Risk Health Behavior by Age for California and San Joaquin Counties

Health Behavior	State/County	12-64	65+
Overweight or Obese	California	51.4	56.3
	Fresno	57.6	66.2
	Kings	57.1	68.7
	Madera	60.7	68.6
	Tulare	61.1	69.5
Did not visit park or other open space	California	27.6	55.4
	Fresno	34.6	73.8
	Kings	40.9	63.7
	Madera	38.7	71.4
	Tulare	34.6	69.2
Current Smoker	California	14.3	6.4
	Fresno	10.7	5.8
	Kings	17.3	9.8
	Madera	16.2	9.5
	Tulare	15.3	7.8

The raw data for Tables 8 to 16 were obtained from several sources, including the Office of Statewide Health Planning and Development (OSHPD), California birth and death records. This data is housed in the Central Valley Health Policy Institute, California State University data warehouse.

Hospitalization Rates

2006- 2007 Selma Health Service Area Compared to the San Joaquin Valley and California

Table 8 compares hospitalization rates per 100,000 for the Selma service area to the San Joaquin Valley and California for 2006/2007. Overall, the Selma service area had similar rates of hospitalizations to the Valley and the state for all conditions. The Selma service area had a 0.03% lower rates in hospitalization (10,944.8 per 100,000) compared to the San Joaquin Valley (11,237.5 per 100,000) and a 0.03% higher rates in hospitalization than the state (10,612.8). The Selma service area had higher hospitalization rates than the Valley for pediatric asthma (0.47). Selma service area had higher hospitalization rates than the Valley and the state for diabetes all ages (0.12 and 0.18), and birth and pregnancy related hospitalization (0.15 and 1.87) respectively. Selma service area had higher rates than the state for acute bronchitis (0.71), asthma all ages (0.32), pneumonia (0.22) and pancreatic disorder (0.25). Selma service area experienced less avoidable hospitalization than the Valley and the state.

Selma Health Services Area vs. California Comparison by Year 1999/2000 to 2006/2007

Table 9 displays the hospitalization rates per 100,000 for the Selma service area from 1999/2000 to 2006/2007 and compares to California for the same period of time. Among all hospitalizations, there was no increase in the rates over the six-year period for Selma and a 0.10 increase for California. Selma service area and the state hospitalization rate increased for all respiratory (0.51 and 0.98), acute renal failure (1.47 and 1.27) and osteoarthritis (0.33 and 0.35), respectively. Both Selma and the state rates of avoidable hospitalization decreased over the six-year period (0.24 and 0.16) respectively.

Selma Service Area Race Comparison, 2006-2007¹

Table 10 compares hospitalization rates per 100,000 by race/ethnicity for the Selma service area in 2006/2007. Rate ratios are displayed for Non-Latino compared to Latino, Whites compared to Blacks, and high/low proportions of hospitalization rates in the Selma service area. The high/low proportions are a calculation of the highest hospitalization rate divided by the lowest hospitalization rate within the Selma service area. Overall, Non-Latinos face much higher rates of hospitalization (more than double) than Latinos. Non-Latinos are hospitalized at notably higher rate for pediatric asthma, acute bronchitis, birth and pregnancy-related hospitalization, appendicitis, diabetes for all ages, all respiratory and alcohol-related mental illness than Latinos. Non-Latinos also experience more avoidable hospitalization visits (.91) than Latinos. While African Americans and Whites have similar overall hospitalization rates with African Americans at about than a third higher, there are some noteworthy differences. African Americans experience hospitalization rates that are double or more than those for Whites for acute bronchitis, younger than 19 years of age diabetes, appendicitis and osteoarthritis. Whites seem to experience less avoidable hospitalization than African American.

¹ Race rate comparison should be interpreted/viewed with caution due to small numbers

Table 8 - 2006/2007 Hospitalization Rates per 100K- Selma Health Service compared to the San Joaquin Valley and California

Hospitalization Rates per 100K Population (06/07 Selma Area Compared to the San Joaquin Valley and California)					
Condition	06/07 Hospitalization Rate Selma ZIPs	06/07 Hospitalization Rate SJV	06/07 Rate Ratio Selma compared to SJV (CI 95%)	2007 Hospitalization Rate CA	2007 Rate Ratio Selma ZIPs compared to CA (CI 95%)
All Cancer	374.0	447.8	0.84 (0.80-0.87)	465.2	0.80 (0.78-0.83)
Lung Cancer	22.5	28.0	0.80 (0.67-0.96)	30.6	0.74 (0.64-0.84)
Breast Cancer	21.9	24.7	0.89 (0.74-1.06)	28.1	0.78 (0.68-0.89)
Colon, Rectum, Anal Cancer	29.3	33.1	0.88 (0.75-1.03)	38.6	0.76 (0.67-0.86)
All Cardiovascular	1184.3	1310.6	0.90 (0.88-0.93)	1230.7	0.96 (0.94-0.98)
Acute Myocardial Infarction	146.6	152.9	0.96 (0.89-1.03)	146.6	1.00 (0.95-1.06)
Heart failure	229.4	252.5	0.91 (0.86-0.96)	229.2	1.00 (0.96-1.05)
Coronary Atherosclerosis	219.2	259.4	0.84 (0.80-0.89)	196.1	1.12 (1.07-1.16)
Hypertension	15.7	17.2	0.91 (0.73-1.13)	26.5	0.59 (0.51-0.69)
All Respiratory	775.1	850.6	0.91 (0.88-0.94)	661.4	1.17 (1.14-1.20)
Asthma All Age	113.5	101.3	1.12 (1.03-1.21)	85.7	1.32 (1.24-1.41)
Pediatric Asthma	132.3	90.2	1.47 (1.29-1.66)	ND	
Pneumonia	315.5	340.6	0.93 (0.88-0.97)	257.8	1.22 (1.18-1.27)
COPD	68.2	89.5	0.76 (0.69-0.84)	100.0	0.68 (0.63-0.74)
Acute Bronchitis	61.4	62.1	0.99 (0.89-1.10)	35.8	1.71 (1.57-1.87)
All Mental Disorders	269.1	388.3	0.69 (0.66-0.73)		ND
Mental Retardation	192.0	294.9	0.65 (0.61-0.69)	402.6	0.48 (0.46-0.50)
Alcohol Related Mental	77.1	93.4	0.83 (0.75-0.91)		ND
Diabetes All Age	162.3	144.5	1.12 (1.05-1.20)	138.0	1.18 (1.11-1.24)
Diabetes 0-19	12.5	21.0	0.59 (0.38-0.88)		
Birth & Pregnancy Related	4496.8	3919.7	1.15 (1.13-1.16)	1565.0	2.87 (2.84-2.90)
Injury & Poisoning	687.9	783.6	0.88 (0.85-0.91)	788.9	0.87 (0.85-0.89)
Other Conditions					
Urinary Tract Infection	94.9	96.4	0.98 (0.90-1.07)	135.0	0.70 (0.66-0.75)
Acute Renal Failure	83.4	98.1	0.85 (0.77-0.93)	82.8	1.01 (0.94-1.08)
Appendicitis	117.9	119.7	0.99 (0.91-1.06)	94.2	1.25 (1.17-1.33)
Pancreatic Disorders	93.8	93.8	1.00 (0.92-1.09)	80.5	1.16 (1.09-1.25)
Osteoarthritis	147.5	176.6	0.84 (0.78-0.90)	181.0	0.82 (0.77-0.86)
Ambulatory Care Sensitive Admissions	960.2	995.6	0.96 (0.94-0.99)	1040.3	0.92 (0.90-0.94)
All Hospitalizations	10944.8	11237.5	0.97 (0.97-0.98)	10612.8	1.03 (1.02-1.04)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Table 9 - Selma Health Service Area Hospitalization Rate Per 100K vs. California Comparison by Year 1999/2000 to 2006/2007

Hospitalization Rates per 100K Population (Selma Area vs. California Comparison by Year 99/00 to 06/07)						
Condition	99/00 Hospitalization Rate Selma ZIPs	06/07 Hospitalization Rate Selma ZIPs	Selma Area 06/07 vs. 99/00 (CI 95%)	1999 Hospitalization Rate CA	2007 Hospitalization Rate CA	Rate Ratio CA 2007 hospitalizations vs. 1999 (CI - 95%)
All Cancer	439.4	374.0	0.85 (0.81-0.89)	481.2	465.2	0.97 (0.96-0.97)
Lung Cancer	22.7	22.5	0.99 (0.82-1.18)	41.2	30.6	0.74 (0.73-0.76)
Breast Cancer	34.3	21.9	0.64 (0.53-0.76)	34.6	28.1	0.81 (0.80-0.83)
Colon, Rectum, Anal Cancer	39.0	29.3	0.75 (0.64-0.87)	46.8	38.6	0.83 (0.81-0.84)
All Cardiovascular	1295.2	1184.3	0.91 (0.89-0.94)	1399.3	1230.7	0.88 (0.88-0.88)
Acute Myocardial Infarction	189.9	146.6	0.77 (0.72-0.83)	194.1	146.6	0.76 (0.75-0.76)
Heart Failure	244.3	229.4	0.94 (0.89-0.99)	254.0	229.2	0.90 (0.90-0.91)
Coronary Atherosclerosis	308.9	219.2	0.71 (0.67-0.75)	281.0	196.1	0.70 (0.69-0.70)
Hypertension	10.4	15.7	1.51 (1.21-1.86)	13.4	26.5	1.98 (1.94-2.02)
All Respiratory	935.2	775.1	0.83 (0.80-0.85)	946.9	661.4	0.70 (0.70-0.70)
Asthma All Age	117.6	113.5	0.97 (0.89-1.04)	121.5	85.7	0.71 (0.70-0.71)
Pediatric Asthma	185.9	132.3	0.71 (0.63-0.80)	ND	ND	ND
Pneumonia	388.0	315.5	0.81 (0.78-0.85)	403.4	257.8	0.64 (0.64-0.64)
COPD	104.7	68.2	0.65 (0.59-0.72)	193.9	100.0	0.52 (0.51-0.52)
Acute Bronchitis	113.7	61.4	0.54 (0.48-0.60)	67.5	35.8	0.53 (0.52-0.54)
All Mental Disorders	267.6	269.1	1.01 (0.95-1.06)			
Mental Retardation	185.0	192.0	1.04 (0.98-1.10)	429.3	402.6	0.94 (0.93-0.94)
Alcohol Related Mental	82.6	77.1	0.93 (0.85-1.03)			
Diabetes All Age	133.5	162.3	1.22 (1.14-1.30)	134.7	138.0	1.02 (1.02-1.03)
Diabetes 0-19	22.3	12.5	0.56 (0.36-0.83)			
Birth & Pregnancy Related	4048.3	4496.8	1.11 (1.10-1.12)	1469.5	1565.0	1.07 (1.06-1.07)
Injury & Poisoning	740.7	687.9	0.93 (0.90-0.96)	856.3	788.9	0.92 (0.92-0.92)
Other Conditions						
Urinary Tract Infection	100.0	94.9	0.95 (0.87-1.03)	131.5	135.0	1.03 (1.02-1.04)
Acute Renal Failure	33.7	83.4	2.47 (2.25-2.71)	36.5	82.8	2.27 (2.24-2.29)
Appendicitis	117.8	117.9	1.00 (0.93-1.08)	98.2	94.2	0.96 (0.95-0.97)
Pancreatic Disorders	76.7	93.8	1.22 (1.12-1.33)	71.1	80.5	1.13 (1.12-1.15)
Osteoarthritis	110.8	147.5	1.33 (1.24-1.43)	133.9	181.0	1.35 (1.34-1.36)
Ambulatory Care Sensitive Admissions	1259.4	960.2	0.76 (0.74-0.78)	1238.0	1040.3	0.84 (0.84-0.84)
All Hospitalizations	10906.8	10944.8	1.00 (1.00-1.01)	9631.7	10612.8	1.10 (1.10-1.10)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

**Table 10 – Selma Health Service Area Hospitalization Rates Race Comparison
2006/2007**

Hospitalization Rates per 100K Population <i>(06/07 Hospitalization Rates Race Comparison)</i>				
Condition	Raw count Non- Hispanic hospitalizations Selma ZIPs	Rate Ratio Non- Hispanic vs. Hispanic hospitalizations Selma ZIPs (CI - 95%)	Raw count White hospitalizations Selma ZIPs	Rate Ratio White vs. Black hospitalizations Selma ZIPs (CI-95%)
All Cancer	804	1.63 (1.52-1.74)	1014	1.10 (1.03-1.17)
Lung Cancer	22	0.51 (0.32-0.78)	64	0.76 (0.58-0.97)
Breast Cancer	55	1.65 (1.24-2.76)	66	0.88 (0.68-1.12)
Colon, Rectum, Anal Cancer	87	2.24 (1.79-2.76)	103	1.68 (1.37-2.04)
All Cardiovascular	3357	1.88 (1.82-1.94)	3405	0.78 (0.76-0.81)
Acute Myocardial Infarction	405	1.92 (1.74-2.12)	405	1.05 (0.95-1.16)
Heart Failure	604	1.91 (1.76-2.07)	617	0.52 (0.48-0.57)
Coronary Atherosclerosis	590	1.36 (1.26-1.48)	696	1.03 (0.95-1.11)
Hypertension	37	1.36 (0.96-1.87)	40	0.33 (0.23-0.45)
All Respiratory	2558	2.72 (2.61-2.82)	2452	1.00 (0.96-1.04)
Asthma All Age	420	4.06 (3.68-4.47)	356	0.67 (0.60-0.74)
Pediatric Asthma	197	10.52 (9.10-12.10)	187	1.11 (0.96-1.28)
COPD	107	0.79 (0.65-0.96)	253	0.84 (0.74-0.95)
Pneumonia	1060	2.63 (2.48-2.80)	999	1.11 (1.04-1.18)
Acute Bronchitis	286	8.82 (7.83-9.90)	233	3.81 (3.34-4.33)
All Mental Disorders	905	2.86 (2.68-3.05)	474	0.53 (0.48-0.58)
Mental Retardation	611	2.51 (2.31-2.71)	311	0.45 (0.40-0.50)
Alcohol Related Mental	294	4.04 (3.59-4.53)	163	0.81 (0.69-0.94)
Diabetes All Age	621	4.29 (3.96-4.64)	367	0.62 (0.56-0.69)
Diabetes 0-19	17	3.85 (2.24-6.16)	14	2.42 (1.32-4.05)
Birth & Pregnancy Related	20432	7.89 (7.78-8.00)	12311	2.46 (2.42-2.51)
Injury & Poisoning	2272	2.75 (2.64-2.87)	1723	1.19 (1.13-1.24)
Other Conditions				
Urinary Tract Infection	245	1.94 (1.71-2.20)	311	1.27 (1.13-1.42)
Acute Renal Failure	232	1.92 (1.69-2.19)	206	0.49 (0.43-0.56)
Appendicitis	530	8.29 (7.60-9.03)	307	4.35 (3.88-4.87)
Pancreatic Disorders	375	3.84 (3.46-4.25)	243	1.03 (0.91-1.17)
Osteoarthritis	358	1.38 (1.24-1.53)	540	3.28 (3.01-3.57)
Ambulatory Care Sensitive Admissions	3455	1.91 (1.84-1.97)	5174	0.72 (0.70-0.74)
All Hospitalizations	41638	3.92 (3.88-3.96)	30091	1.36 (1.34-1.38)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Age-Adjusted Death Rate

Selma Health Service Area and California Comparison for 1999/2000 to 2006/2007

Table 11 examines change in age-adjusted death rates (AADR) per 100,000 between 1999/2000 and 2006/2007 for the Selma service area ZIP codes and compares to California for the same time period. While overall age-adjusted death rates decreased for both the Selma service area and California, there were some causes of death that showed increases. In the Selma service areas, increased age-adjusted death rates were notable for homicide, suicide and Alzheimer's disease. Compared to California as a whole, the Selma service area experienced more improvement than California overall only for heart failure AADR.

AADR – Selma Health Service Area compared to the San Joaquin Valley and California for 2006/2007

Table 12 compares 2006/2007 age-adjusted death rates per 100,000 for the Selma service area ZIP codes to the eight San Joaquin Valley counties and California. Overall, the Selma services area experienced .45 less AADR than the valley and .34 more than the state. Selma service age-adjusted death rates were higher for MVA, heart failure, and diabetes than the state as a whole.

AADR – Selma Service Area Race Comparison²

Table 13 examines racial/ethnic and place disparities in age-adjusted death rates. Overall, non-Latinos experienced similar death rates to Latinos. Latinos experience notably higher rates of AADR for motor vehicle accidents, diabetes, heart failure, colon, rectum, anal cancer and pneumonia than Non-Latinos. Age-adjusted death rates for African Americans compared to Whites are also shown. Overall African Americans face slightly lower age-adjusted death rates compared to Whites (.07 lower), mostly linked to higher deaths for motor vehicle accidents.

² Race rate comparison should be interpreted/viewed with caution due to small numbers

Table 11 - AADR Selma Area and California Comparison by Year 1999/2000 to 2006/2007

Mortality - Age-Adjusted Death Rates (AADR) per 100K Population (AADR Selma Area and California Comparison by Year 1999/2000 to 2006/2007)						
CONDITION	99/00 Selma Area	06/07 Selma Area	Selma Area 99/00 vs. 06/07 (CI - 95%)	99/00 Calif.	06/07 Calif.	California 99/00 vs. 06/07 (CI - 95%)
All Cancer	104.8	94.5	0.90 (0.84-0.97)	187.1	166.4	0.89 (0.88-0.89)
Lung Cancer	24.2	20.8	0.86 (0.72-1.01)	48.6	40.6	0.84 (0.83-0.85)
Breast Cancer	6.0	7.8	0.98 (0.98-1.71)	14.1	12.2	0.87 (0.85-0.88)
Colon, Rectum, Anal Cancer	9.6	8.4	0.87 (0.66-1.12)	17.8	15.1	0.85 (0.83-0.86)
All Cardiovascular	140.3	112.9	0.80 (0.75-0.86)	227.3	177.6	0.78 (0.78-0.79)
Acute myocardial infarction	46.3	25.9	0.56 (0.49-0.64)	56	35.7	0.64 (0.63-0.65)
Heart Failure	10.3	8.6	0.83 (0.65-1.05)	9.9	12.2	1.23 (1.21-1.26)
Atherosclerotic Cardiovascular Disease	8.1	4.8	0.59 (0.41-0.83)	28.8	21.1	0.73 (0.72-0.74)
Injury and Violence						
Homicide	4.0	6.1	1.52 (1.14-1.98)	5.8	6.4	1.10 (1.07-1.14)
Suicide	4.0	4.6	1.17 (0.83-1.60)	9.5	9.3	0.98 (0.96-1.00)
MVA	15.8	16.3	1.03 (0.87-1.21)	9.5	11.1	1.17 (1.14-1.19)
All Respiratory	45.0	42.0	0.93 (0.83-1.04)	80.3	66.1	0.82 (0.82-0.83)
Pneumonia	11.5	12.5	1.08 (0.88-1.32)	25.5	19	0.75 (0.73-0.76)
Alzheimer's Disease	5.7	12.7	2.24 (1.84-2.72)	13.1	22.2	1.69 (1.67-1.72)
Diabetes	21.6	25.4	1.17 (1.01-1.36)	21	21.9	1.04 (1.03-1.06)
All Deaths	810.9	438.3	0.54 (0.52-0.56)	751.7	664.1	0.88 (0.88-0.89)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Table 12 - Selma Area AADR compared to the San Joaquin Valley and California 2006/2007

Mortality - Age-adjusted Death Rates (AADR) per 100K Population (06/07 AADR Selma Area compared to the San Joaquin Valley and California)					
CONDITION	06/07 Selma Area	06/07 SJV	06/07 Selma Area vs. SJV (CI- 95%)	06/07 AADR California	06/07 Hanford Area vs. California (CI - 95%)
All Cancer	94.5	176.1	0.54 (0.50-0.58)	166.4	0.57 (0.53-0.61)
Lung Cancer	20.8	46.1	0.45 (0.38-0.53)	40.6	0.51 (0.43-0.60)
Breast Cancer	7.8	12.5	0.63 (0.47-0.82)	12.2	0.64 (0.48-0.84)
Colon, Rectum, Anal Cancer	8.4	15.5	0.54 (0.41-0.69)	15.1	0.56 (0.42-0.71)
All Cardiovascular	112.9	219.8	0.51 (0.48-0.55)	177.6	0.64 (0.60-0.68)
Acute Myocardial Infarction	25.9	43.9	0.59 (0.51-0.68)	35.7	0.73 (0.63-0.83)
Heart Failure	8.6	16.8	0.51 (0.40-0.64)	12.2	0.70 (0.55-0.88)
Atherosclerotic Cardiovascular Disease	4.8	20.0	0.24 (0.17-0.33)	21.1	0.23 (0.16-0.32)
Injury and Violence					
Homicide	6.1	7.1	0.86 (0.65-1.12)	6.4	0.95 (0.72-1.24)
Suicide	4.6	10.0	0.46 (0.33-0.63)	9.3	0.50 (0.36-0.68)
Motor Vehicle Accident	16.3	19.5	0.83 (0.70-0.98)	11.1	1.46 (1.24-1.72)
All Respiratory	42.0	83.7	0.50 (0.45-0.56)	66.1	0.63 (0.57-0.71)
Pneumonia	12.5	20.7	0.60 (0.49-0.73)	19.0	0.66 (0.54-0.80)
Alzheimer's Disease	12.7	22.8	0.56 (0.46-0.67)	22.2	0.57 (0.47-0.69)
Diabetes	25.4	31.8	0.80 (0.69-0.92)	21.9	1.16 (1.00-1.34)
All Deaths	311.4	793.2	0.39 (0.38-0.41)	664.1	0.47 (0.45-0.49)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Table 13 – Selma Service Area Rates (AADR) Race Comparison 06/07

Mortality - Age-adjusted Death Rates (AADR) per 100K Population (06/07 AADR Race Comparison)				
CONDITION	06/07 Raw Death Counts Non- Hispanic	06/07 AADR Ratio Non Hispanic vs. Hispanic (CI – 9%I)	06/07 Raw Death Counts Whites	06/07 AADR Ratio Whites cvs. Blacks (CI - 95%)
All Cancer	411	0.64 (0.58-0.70)	577	0.52 (0.48-0.56)
Lung Cancer	106	1.04 (0.85-1.26)	119	0.45 (0.37-0.54)
Breast Cancer	32	1.04 (0.71-1.47)	47	0.49 (0.36-0.65)
Colon, Rectum, Anal Cancer	38	0.59 (0.42-0.81)	52	0.54 (0.41-0.71)
All Cardiovascular	669	0.89 (0.82-0.96)	756	0.41 (0.38-0.44)
Acute Myocardial Infarction	153	0.85 (0.72-1.00)	174	0.48 (0.41-0.55)
Heart Failure	44	0.46 (0.34-0.62)	62	0.20 (0.15-0.26)
Atherosclerotic Cardiovascular Disease	26	1.36 (0.89-2.00)	28	0.70 (0.46-1.01)
Injury and Violence				
Homicide	20	0.82 (0.50-1.27)	40	0.25 (0.18-0.35)
Suicide	21	1.07 (0.66-1.63)	36	0.71 (0.50-0.98)
Motor Vehicle Accident	37	0.36 (0.25-0.49)	138	3.40 (2.86-4.02)
All Respiratory	231	1.03 (0.90-1.17)	265	0.71 (0.62-0.80)
Pneumonia	68	0.69 (0.53-0.87)	84	0.81 (0.64-1.00)
Alzheimer’s Disease	85	1.37 (1.10-1.70)	96	1.02 (0.83-1.25)
Diabetes	82	0.34 (0.27-0.42)	151	0.55 (0.46-0.64)
All Deaths	3572	0.99 (0.96-1.03)	4715	0.93 (0.91-0.96)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Years of Potential Life Lost

Years of Potential Life Lost (YPLL) Rates -Selma Service Area and California Comparison for 1999/2000 to 2006/2007

Table 14 shows change in years of potential life lost (YPLL) before age 65/10,000 between 1999/2000 and 2006/2007 for the Selma service area and compares to California for the same period of time. This offers another perspective on the burden of disease by focusing on early deaths. While the Selma service area experienced an increase (0.11) in productive years lost, the state experienced a reduction (0.04) in these early deaths. Further, the Selma service area experienced greater increase over this period than did California in YPPLs associated with pneumonia and homicide. California experienced higher increases in motor vehicle accidents and Alzheimer's disease.

YPLL Rates - Selma Service Area Compared to the San Joaquin Valley and California for 2006/2007

Table 15 compares YPPLs/10,000 in the Selma service area to the San Joaquin Valley and California for 2006/2007. The Selma service area and the San Joaquin Valley experienced similar rates of early deaths. Overall, the Selma and SJV service areas are notably higher (37%) than California as a whole in years lost before age 65. However, the Selma and the Valley service areas are losing notably less years of life before age 65 than California for acute myocardial infarction (AMI), heart failure, all respiratory conditions, homicide, motor vehicle accidents, Alzheimer's disease and diabetes.

YPLL Rates -Selma Service Area Race Comparison³

Table 16 examines inequalities by race/ethnicity and place for YPPLs/10,000 in the Selma service in 2006/2007. Rate ratios are displayed for Non-Latino compared to Latino, Whites compared to Blacks and high/low proportions of YPLL rates in the Selma service area. The high/low proportions are a calculation of the highest YPLL rate divided by the lowest YPLL rate within the Selma service area. Although Non-Latinos experienced an overall lower age-adjusted death rate than Latinos, their YPPL rates were notably higher for lung cancer, colon, rectal and anal cancer, all cardiovascular (especially atherosclerotic), all respiratory (especially pneumonia), homicide, suicide and diabetes. African Americans have an overall lower rate of YPLL (46% lower) compared to Whites, but they are notably higher for AMI and homicide.

³ Race rate comparison should be interpreted/viewed with caution due to small numbers

**Table 14 - YPLL Selma Area and California Comparison by Year
1999/2000 to 2006/2007**

Years of Potential Life Lost (YPLL) per 10K Population (YPLL Selma Area and California Comparison by Year 1999/2000 to 2006/2007)						
Condition	99/00 YPLL Selma Area	06/07 YPLL Selma Area	YPLL Selma ZIPs 99/00 vs. 06/07 (Rate Ratio) (CI - 95%)	00/99 YPLL CA	06/07 YPLL CA	YPLL CA 99/00 vs. 06/07 (Rate Ratio)
All Cancer	83.388	58.0	0.70 (0.67-0.72)	59.5	54.5	0.92 (0.91-0.92)
Lung Cancer	13.547	4.0	0.29 (0.26-0.34)	9.4	7.3	0.78 (0.78-0.79)
Breast Cancer	6.2738	6.1	0.97 (0.87-1.08)	7.1	6.1	0.86 (0.85-0.87)
Colon, Rectum, Anal Cancer	4.3172	3.0	0.69 (0.59-0.81)	4.3	4.4	1.02 (1.01-1.03)
All Cardiovascular	60.562	29.8	0.49 (0.47-0.52)	37.2	34.5	0.93 (0.92-0.93)
Acute Myocardial Infarction	16.588	6.1	0.37 (0.33-0.41)	7.3	5.5	0.75 (0.74-0.76)
Heart Failure	1.0846	1.6	1.49 (1.19-1.84)	0.5	0.9	1.63 (1.59-1.68)
Atherosclerotic Cardiovascular Disease	1.51	2.0	1.34 (1.09-1.61)	4.7	5.2	1.12 (1.11-1.13)
All Respiratory	22.835	15.8	0.69 (0.65-0.74)	11.4	9.7	0.85 (0.84-0.85)
Pneumonia	5.4656	6.8	1.25 (1.12-1.38)	3.4	2.7	0.78 (0.77-0.79)
Injury and Violence						
Homicide	24.985	34.8	1.39 (1.33-1.46)	20.6	22.7	1.10 (1.10-1.11)
Suicide	29.582	16.9	0.57 (0.53-0.61)	18.0	17.5	0.98 (0.97-0.98)
Motor Vehicle Accident	112.52	85.5	0.76 (0.74-0.78)	24.8	29.7	1.20 (1.19-1.20)
Alzheimer's Disease	0	0.4	ND	0.07	0.1	2.01 (1.89-2.14)
Diabetes	11.824	10.4	0.88 (0.81-0.96)	5.7	6.2	1.08 (1.07-1.09)
All Other Deaths	317.76	347.6	1.09 (1.08-1.11)	158.1	145.9	0.92 (0.92-0.92)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Table 15 – Selma Service Area YPLL compared to the San Joaquin Valley and California 2006/2007

Years of Potential Life Lost (YPLL) per 10K Population (06/07 YPLL Selma Area compared to the San Joaquin Valley and California)					
CONDITION	06/07 YPLL Selma Area	06/07 YPLL SJV	06/07 YPLL Selma Area vs. SJV (CI- 95%)	06/07 YPLL California	06/07 YPLL Selma Area vs. CA (CI - 95%)
All Cancer	58.0	56.0	1.03 (1.01-1.06)	54.5	1.06 (1.03-1.09)
Lung Cancer	4.0	7.8	0.51 (0.47-0.56)	7.3	0.54 (0.50-0.59)
Breast Cancer	6.1	6.0	1.02 (0.93-1.11)	6.1	0.99 (0.90-1.09)
Colon, Rectum, Anal Cancer	3.0	4.4	0.67 (0.60-0.76)	4.4	0.68 (0.61-0.76)
All Cardiovascular	29.8	39.5	0.76 (0.73-0.78)	34.5	0.87 (0.84-0.90)
Acute Myocardial Infarction	6.1	7.5	0.82 (0.76-0.88)	5.5	1.11 (1.04-1.20)
Heart Failure	1.6	1.3	1.28 (1.11-1.46)	0.9	1.88 (1.64-2.16)
Atherosclerotic Cardiovascular Disease	2.0	5.1	0.40 (0.33-0.47)	5.2	0.39 (0.32-0.46)
All Respiratory	15.8	17.0	0.93 (0.88-0.98)	9.7	1.64 (1.56-1.72)
Pneumonia	6.8	5.2	1.30 (1.20-1.41)	2.7	2.55 (2.34-2.76)
Injury and Violence					
Homicide	34.8	25.8	1.35 (1.29-1.40)	22.7	1.53 (1.47-1.60)
Suicide	16.9	19.5	0.87 (0.82-0.91)	17.5	0.96 (0.91-1.01)
Motor Vehicle Accident	85.5	54.9	1.56 (1.52-1.59)	29.7	2.88 (2.81-2.95)
Alzheimer's disease	0.4	0.2	2.40 (1.69-3.31)	0.1	2.72 (1.92-3.75)
Diabetes	10.4	8.5	1.23 (1.15-1.33)	6.2	1.69 (1.57-1.82)
All Deaths	440.3	420.4	1.05 (1.04-1.06)	320.6	1.37 (1.36-1.39)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Table 16 – Selma Service Area YPLL Race Comparison 2006/2007

Years of Potential Life Lost (YPLL) per 10K Population (06/07 YPLL Race Comparison)				
CONDITION	06/07 Non Hispanic Raw YPLL	06/07 YPLL Non-Hispanic vs. Hispanic (CI - 95%)	06/07 White Raw YPLL	06/07 YPLL White vs. Black (CI - 95%)
All Cancer	1023.0	1.21 (1.14-1.29)	2650	1.25 (1.20-1.30)
Lung Cancer	156.0	6.43 (5.46-7.52)	121	0.41 (0.34-0.50)
Breast Cancer	136.0	1.95 (1.64-2.31)	268	1.31 (1.15-1.47)
Colon, Rectum, Anal Cancer	114.0	4.21 (3.47-5.06)	115	4.20 (3.47-5.05)
All Cardiovascular	856.0	2.11 (1.97-2.26)	1292	0.64 (0.60-0.67)
Acute Myocardial Infarction	165.0	1.63 (1.39-1.90)	303	0.81 (0.72-0.91)
Heart failure	26.0	0.69 (0.45-1.01)	85	ND
Atherosclerotic Cardiovascular Disease	62.0	4.53 (3.47-5.81)	95	1.89 (1.53-2.32)
All Respiratory	377.0	1.51 (1.36-1.67)	693	1.25 (1.15-1.34)
Pneumonia	185.0	2.83 (2.44-3.27)	327	1.79 (1.60-2.00)
Injury and Violence				
Homicide	612.0	1.42 (1.31-1.54)	1371	0.60 (0.57-0.63)
Suicide	327.0	1.37 (1.23-1.53)	803	2.80 (2.61-3.00)
Motor Vehicle Accident	898.0	0.56 (0.52-0.59)	4286	10.93 (10.60-11.26)
Alzheimer’s disease	20.0	ND	20	ND
Diabetes	179.0	1.25 (1.07-1.44)	504	3.35 (3.06-3.65)
All Deaths	7742.2	0.50 (0.49-0.52)	20801	0.54 (0.53-0.55)

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Avoidable Hospitalization

Table 17 also presents data on ambulatory care sensitive condition hospitalizations – so-called “avoidable hospitalizations” – that provide an indicator of the performance of the health system in managing health conditions through primary care. These measures have been developed over many years by the Agency for Healthcare Research and Quality (AHRQ) in collaboration with California and other states. Only data on the ASCS hospitalizations for which there was comparable California data is presented. As Table 17 indicates, the Adventist Health service area ZIP codes have generally higher rates for these avoidable hospitalizations than does the state. Adventist Health service area ZIP codes were higher than California in 2006/2007 for 10 out of 12 indicators, and most notably for amputations of lower extremities (88%), angina without procedure (64%), diabetes short-term complications (50%), diabetes long-term complications (48%) and chronic obstructive pulmonary disease (COPD) (29%). Avoidable hospitalizations rates were lower than for California for two conditions: dehydration (12%) and urinary tract infections (UTI) (5%). The dehydration difference is the noteworthy exception to the pattern of higher avoidable hospitalization for the Adventist Health service area and perhaps reflects more adaptation to extremely high temperatures.

Table 17: Prevention Quality Indicators (PQI)4 Hospitalization Age-Adjusted Rates per 100K Population

Prevention Quality Indicators (PQI)1 Hospitalization Age-Adjusted Rates per 100K Population			
Avoid Hosp CA ASCS List	2007 CA Hospitalization Rate	06/07 Adventist Health ZIPs Hospitalization Rate	Adventist Health ZIPs vs. CA Rate Ratio (CI - 95%)
Hypertension	24.37	27.12	1.11 (.95 -1.30)
Congestive Heart Failure	225.59	276.11	1.22 (1.17 -1.28)
Adult Asthma	55.71	65.31	1.17 (1.06 -1.2)
Bacterial Pneumonia	185.86	194.05	1.04 (1.00 -1.09)
COPD	79.39	102.34	1.29 (1.19 -1.39)
Urinary Tract Infection	106.18	89.83	0.85 (0.79 -.91)
Lower Extremity Amputation	21.02	39.52	1.88 (1.65 -2.13)
Angina Without Procedure	20.90	34.22	1.64 (1.42 -1.88)
Dehydration	52.58	46.33	0.88 (0.80 -.97)
Perforated Appendix	21.88	23.15	1.06 (0.89 -1.25)
Diabetes Short-Term Complications	33.33	49.93	1.50 (1.33 – 1.68)
Diabetes Long-Term Complications	78.91	116.40	1.48 (1.37 – 1.59)

Source: Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Mental Health

The World Health Organization has declared that mental disorders have “staggering economic and social costs,”³ yet they remain a low priority for public financing in health systems, globally as well as in California.⁴ This low priority contradicts public opinion; nearly all Americans (96%) think health insurance should include coverage for mental health treatment and the vast majority of Americans (89%), regardless of political affiliation, want to end insurance discrimination against people with mental health disorders.⁵ Mental disorders cost more than \$150 billion annually from loss of productivity and the direct and indirect costs of health care. Yet with proper treatment, 75 % of people with mental disorders recover completely, surpassing the 50% recovery rate for other medical problems.⁶

Community leaders, providers, stakeholders and residents focus groups discussed the magnitude, suffering and burden of behavioral and mental health for children and their families in terms of the staggering costs of disability and human and monetary costs for individuals, families, schools, the

⁴ *The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care-sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.*

health care system and the communities. A notable consensus among all on the shortages and the dire need to expand the services was reached. “Children and their families impacted by mental health problems have multiple risk factors, including family violence, substance abuse, health issues and poverty, which contribute to family dysfunction,” noted one of the participants. However, there was a clear and unequivocal message that because mental health has been neglected for too long, no one organization can make an impact alone and that there needs to be major investment at the local and state levels to encourage collaborative investments. The following mental health data is taken from a report by Capitman & Nyandoro⁷.

Table 18 uses data from the Mental Health Services Act (MHSA) plans for the five counties to provide a high and low estimate of the Serious Emotional Disability/Serious Mental Illness (SED/SMI) population and psychiatric caseloads.^{11, 12} We project the potential number of additional psychiatrists that may be needed to meet the needs of unserved SED/SMI population groups. For example, Table 1 suggests that between 19.8 and 24.7 new full-time equivalent psychiatrists serving the SED and SMI population groups are needed in Fresno County and between 66.0 and 84.4 are needed for the five-county region as a whole. Additional staff needed for a Behavioral Health Services Center (BHSC) who cares for the entire unserved SED/SMI population group could be computed in the same manner. Though not exact, these figures give an idea of the potential size and scope of the possible regional Five-County Behavioral Health Services Center.

Table 18- San Joaquin Valley Five-County Full-Time Equivalent (FTE) Psychiatrist Needs

County	⁸ SED SMI Served	⁹ FTE Psychiatrists	¹⁰ Caseload	¹¹ SED/ SMI Unserved Low	⁸ SED/ SMI Unserved High	¹² Need Range for FTE Psychiatrists
Fresno	21,157	14.0	1,511	29,976	37,302	19.8-24.7
Kings	3,439	3.0	1,146	5,178	7,172	4.5-6.3
Madera	2,842	6.3	451	4,924	7,415	10.9-16.4
Merced	5,492	11.1	495	8,422	9,934	17.0-19.9
Tulare	8,619	9	958	14,721	19,014	15.4-19.8
Total	41,549	43	957	63,221	80,837	66.0-84.4

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Table 19 uses data from the Central Valley Health Policy Institute to calculate the number of seriously mentally ill homeless persons in these five counties. According to Table 2 below, there are approximately 7,494 homeless people in Fresno; of these, 1,559 suffer from serious mental illness. We used a conservative estimate of the homeless population from national data and a study from Los Angeles to estimate the proportion of homeless persons with SMI/SED.¹³ Table 2 also reflects that approximately 15,805 persons in all five counties are homeless and 20.8 % or 3,288 of them are seriously mentally ill.¹ Given figures as high as this, it is unlikely that a new BHSC located at the Community Medical Center could serve all homeless SED/SMI in the region.⁸ Additionally, if we consider the other populations who may need crisis temporary inpatient and transitional care services, there is clearly more than enough demand for the services that would be offered.

Table 19 - San Joaquin Valley Five-County Homeless Population with Serious Mental Illness

County	Total Population	Homeless Percentage	Homeless Population	SMI/SED Percentage	SMI/ SED Homeless Population
Fresno	749,407	1%	7,494	20.8%	1,559
Kings	129,461	1%	1,295	20.8%	270
Madera	123,104	1%	1,231	20.8%	256
Merced	210,554	1%	2,106	20.8%	438
Tulare	368,021	1%	3,680	20.8%	766
Total	1,580,547	1%	15,805	20.8%	3,288

Source: Central Valley Health Policy Institute. California State University Fresno (2010)

Definitions

Age-Adjusted Rate	Measure that controls for the effects of age differences on health event rates
Ambulatory care sensitive conditions (ACSCs)	Conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.
Confidence Interval	If the same population is sampled on numerous occasions and interval estimates are made on each occasion, the resulting intervals would bracket the true population parameter in approximately 95% of the cases
FITNESSGRAM	Protection against the diseases that result from sedentary living
Health Fitness Zone	Established by The Cooper Institute of Dallas, Texas, represent levels of fitness
Infant Mortality	Number of deaths of children under one year of age per 1,000 live births
Late Prenatal care:	Infants whose mothers did not receive prenatal care in the first trimester of pregnancy
Low Birth Weight	Percentage of infants born at low birthweight, which is defined as less than 2,500 grams
Prevention Quality Indicators (PQI)	The PQIs are measured as rates of admission to the hospital for ambulatory care sensitive conditions in a given population
Years of Potential Life Lost	Estimate of the average time a person would have lived had he or she not died prematurely (before age 65)

RESULTS – QUALITATIVE

The findings from the focus group sessions that the Central Valley Health Policy Institute conducted provide valuable guidance for identifying the key challenges and opportunities that Adventist Health faces in preparing to launch priorities to promote health and well-being for the Central Valley residents. The insights from these diverse qualitative data provide an important foundation for informing the upcoming period by establishing priorities for action for the next three years. We conducted four sets of focus groups. Two of these involved residents from Kings County and Hanford communities. The other two involved clinicians and executives. We also conducted one telephone interview with a physician who serves as the chief medical officer for Adventist Health/Central Valley Network.

Focus Group General Introductions

Process – General introductions for the focus group of community residents and representatives (Southern Fresno: Selma, Kingsburg, Fowler, Caruthers, Kerman, Sanger, Parlier, Reedley and Dinuba) generated the following challenges, successes and opportunities:

Successes

Collaboration/partnerships/small, knit community

- Adventist Health (AH) is big help
- Care provided
- Clinic across the street in Dinuba
- Cardiologist has been brought on and some specialists – good
- Work close with AH

Challenges

- Lack of urgent care/weekend coverage
- Lack of specialty care/risk and we have to transport to other area where services are available.
 - Specialty service for kids' asthma
 - Diabetes care specialization
 - Counseling services and psychologists/mental health
 - Children care/injury... don't need to drive an hour for care... specialty care needs to be closer to home.
 - Need to focus on health care for seniors? Lost as to where and what senior care in the future
 - Children clinic is important
 - Alcoholic services for youth
- Family planning services
- Teen pregnancy
- Physician coverage
- Uninsured
- Obesity prevention
- Healthy fruits and vegetables access
- Lack of services / education/knowledge about services available

Opportunities

- Interested in partnering with Selma in doing immunization

Focus Group Sessions

Process – We start with a list of nine areas relevant to Community Health and Well Being:

1. Primary care/access to care
2. Specialty care access/coordination with primary care – all insurance categories
3. Uninsured/Indigent/Implementation new national policy/ undocumented etc.
4. Chronic disease management
5. Breast cancer care
6. Prevention (services, policies, environments) – specifically access to short-term health education – for example, diet, exercise, health info etc.
7. Hospital /Emergency services
8. Public Safety/Behavioral Health
9. Expectations – for access, services, quality of life--understanding rights, civic engagement (where's the rage)

These areas were used to a) Identify conditions and opportunities in each area that supports Community Health and Well Being and respective policies needed to sustain these efforts; b) Identify conditions and opportunities that inhibit Community Health and Well Being and what policies or practices are needed to change these; c) Rank priorities for action; and d) Identify strategies.

- Stakeholders were divided into three small groups with a facilitator, and each took three issues to discuss. Detailed notes were recorded by a stakeholder and facilitator in each group.
- Groups were given 20-30 minutes to brainstorm and fill out supports, inhibitions and opportunities for policies relevant to the health and well-being chart, initiative or effort. They were encouraged not to rule out any ideas.
- Groups were reconvened to share results.
- The lead facilitator kept the flow of the discussion while two other facilitators took notes (one took detailed notes and the other created themes and projected them so the stakeholders could add/edit/modify as needed).
- Groups' ideas and perceptions were then reiterated by calling for the top priorities for action.

Focus Group Results

Tables 20 and 21 identify conditions and opportunities in Southern Fresno communities that support/inhibit Community Health and Well Being (CHWB) and respective policies needed to sustain/change these efforts.

The group was then asked to identify and highlight the issues that stood out most from Tables 20 and 21, reach consensus on and rank three to four priorities for action and identify strategies to address these priorities. The following is the group's highlights for priorities and strategies:

What Stands Out?

- Lack of urgent care/Quality of urgent care available –especially Reedley facility
- Breast cancer care — and other cancer as well... even Fresno is not enough?
- Lack of understanding of indigent care programs
- Public transportation – lack and cost –to get to big cities
- Gaps for coverage – those in the middle fall through the cracks – 19-24 yrs old lack of types jobs that offer insurance coverage
- Better marketing/education for health care management... services – access – fear of seeking care (undocumented) the available coverage and qualifications
- Medical outreach – flyers – mail in information
- Mental health – access
- X-ray facility
- Physical therapy – occupational therapy--few or none at all
- Collaborative work with the schools and family
- Senior care/living – age-appropriate marketing for knowledge/access

Priorities for Action

- Urgent Care/non-urgent care follow-up – structuring – increased services in Reedley
- Behavioral Health – expand access, address stigma
- Better coordination between schools/social services and health care providers
- More focus on patient education/support particularly for low-education/limited English proficiency and rural population

Strategies

- Work to collaborate with the school and family on behavioral health
- Educate/encourage preventative care – families could get information through the schools – integrate free immunization... nutrition... vision/dental/ primary care facility into the school system?
- Expand practice to make it easier access for behavioral health.
- Recognize the differences between the different towns/communities... what works for which.

Table 20- Kings, Hanford, and South Fresno Communities Policies and Environments in Support of Community Health and Well-being (CHWB)

	Identify conditions and opportunities that support community health and well-being (CHWB)	What policies or practices are needed to sustain and grow these
Primary Care/Access to Care	Some of the clinics—Parlier clinic – they have family planning service but they don’t have the day after pill. Clinic in Selma provides good information to patient/doctors are skilled Walk-in availability at Reedley clinic Telemedicine at Dinuba clinic	Increase X-ray availability in clinic sites Support easy telephone access to doctors for those making referrals
Specialty care access/coordination with primary care – all insurance categories	Access – more than one local nutritionist for diabetes/diet care. School farm stand to support healthy eating at the school level We are building a mental health service building Adventist health clinic—pediatrics and dental clinic. Implementing the CA School wellness policy –nutrition and Physical activity. More people qualify for Medi-Cal because of low income United health accepts Medi-Cal patients. Enhanced 211 is a source of information on finding care Lots of support groups are available	Created a model and done needs assessment and recommended a farm stand –worked with school district and farmers... MOU to start—advertised and worked with the chambers of commerce. Added additional requirement to the PA component for joint use and made the state guidelines stricter regarding soda and sugar and salt intake... less unhealthy meals. Need to expand access/availability and reduce stigma around behavioral health care Need better coordination between mental health providers and schools—same for kids with complex medical needs Need support groups for those with behavioral health needs Expand use of electronic health record to improve coordination
Uninsured/Indigent/Implementation new national policy/ undocumented etc.	Some advocacy for those with limited English/less educated re care management Dinuba/Kingsburg/Selma/ Parlier/Fresno/Tulare Counties have annual Fire-Med Program —includes ambulance rides Presence of Community Health Centers	Need expanded access to care and increased resources for advocacy for those with limited English/less educated re care management Fire-Med program is self-funded. People need to buy into program. Costs \$55/yr. Availability of specialty services; Need to inform community of available services.
Chronic Disease Management	Obesity, lack of healthy foods	
Breast Cancer Care	Nothing – very limited	Need women health center
Prevention (Services, Policies, Environments) – specifically access to short-term health education – -for example, diet, exercise, health info etc.)	Private health/fitness clubs Senior Center in Selma and Senior health fairs Schools districts are doing health education	Need affordable options and health insurance to cover Need community endorsements. Needs permanent funding streams for sustainability of services and follow-up care. Need for other non-healthcare providers to send prevention messages

Hospital /Emergency services	Ok and available for something simple Workman's comp/injuries get appropriate timely response	people with special needs/complex problems are scared to use ER
Public Safety/Behavioral Health	<p>Youth alcohol support—Friday night live youth counsel to focus on underage drinking.</p> <p>Youth leadership counsel to develop young people leadership around violence control –teenage pregnancy prevention.. Working with adults</p> <p>Dinuba started teen pregnancy program –new and we will see how it works...</p> <p>Gang awareness program – county supported –needs more development.</p> <p>Boys and girl club programs – community sponsored – schools are involved in that. Keep kids out of trouble...</p> <p>Gang injunction- community based – sue the gangs –if two or more are seen together they are arrested. Working on making it a city-wide initiative.</p> <p>Summer fun –full day of activity –5-15 yrs old. Age appropriate activities.</p> <p>Peer counseling class at the schools – for credit... teach students about how to help each other.</p>	Need to improve/support better treatment of paramedics by Selma site staff...Improve coordination between emergency response and clinic/hospital sites
Expectations – for access, services, quality of life – understanding rights, civic engagement (where's the rage) – visioning --	Long waiting times, especially in ER	Adventist needs marketing around waiting times.

Table 21- Southern Fresno Communities Policies and Environments that Inhibit Community Health and Well-being (CHWB)

	Identify conditions and opportunities that inhibit community health and well-being (CHWB)	What policies or practices are needed to change these
Primary Care/Access to Care	Family PACT not known/available to small communities Need X-ray in Reedley Need improved transportation to hospitals and services outside of area	Uninsured need to be treated based on need...not the last in line at ER or clinic Lower cost insurance plans are needed
Specialty care access/coordination with primary care – all insurance categories	Not much for specialty care Need to attract specialists to the area Because of rurality we have to drive to other areas for service. Public and private transportation is a huge challenge Reimbursement rate for practitioners is low so they are less willing to accept Medi-Cal. Young adults (19-24) coverage insurance coverage is gone and no decent jobs available that offers coverage. losing mental health services	
Uninsured/Indigent/Implementation new national policy/ undocumented etc.	Fear of being reported because of undocumented status Lack of understanding of indigent care programs – people don't understand why they are being turned away Lack of knowledge on how to access care. i.e. people may not know whether to go to ER or urgent care or primary care.	Education of the availability of healthcare services/programs that serve all populations Need information that clarifies indigent care programs Education on when and how to access care
Chronic Disease Management	Information not available in Spanish Need behavioral support for persons with chronic conditions – interplay of psych and physical challenges not addressed well No possible referrals for MH services – so district bears unnecessary costs Over-prescription of anti-depressants without accompanying cognitive treatments – no counseling available	Need aggressive outreach/training and support for self-management – basic information is not getting to people Need more autism support groups Need to educate parents, teachers and others on ADHD, autism, etc
Breast Cancer Care	Nothing exists in Sanger, Dinuba...we go to Selma or Visalia for mammograms	There is huge need for breast cancer care as well as other cancer care.
Prevention (Services, Policies, Environments) – specifically access to short-term health education – for example, diet, exercise, health info etc.)	Mobile Community – residents constantly moving in and out of area Lack of AOD outpatient services	For Adventist, community outreach needs to be done throughout the year because residents moving in and out of area.
Hospital /Emergency services	“If you want to die, go to Reedley” is a broadly shared view Long waiting times in ER – often when there don't seem to be other patients waiting. Many lose patience and give up. People ask ambulance driver...just don't take me to Reedley	Need more urgent care

Public Safety/Behavioral Health	Not enough known about resources	Education
Expectations – for access, services, quality of life – understanding rights, civic engagement (where’s the rage) – visioning -	<p>“We don’t care” attitude... people don’t have expectations until it happens to them.</p> <p>Residents aren’t civically engaged. They don’t care – the expectation is that public services will always be there.</p>	Need for a platform to be heard, i.e. like community benefit FG’s, town hall meetings, etc.

**Table 22 – Total Adventist Health Service Area
Summary of Quantitative and Qualitative Findings**

Condition	Differences by Place	Differences over Time	Differences by Race	Stakeholder Perspectives
Cancer	<u>Hospital</u> Lower than SJV and CA <u>Mortality</u> Slightly lower than SJV and similar to CA	<u>Hospital</u> Slight reduction (9%). Better than CA (3%) <u>Mortality</u> Similar reduction (~8%) to CA	<u>Hospital</u> Higher for Latinos and African Americans <u>Mortality</u> 46% lower for Latinos Slightly higher for African American	Limited access to cancer care outside central Fresno Difficult access to screening/prevention services for uninsured
Cardiovascular	<u>Hospital</u> Slightly lower than SJV Similar to CA <u>Mortality</u> 10% lower than SJV 11%) Higher than CA	<u>Hospital</u> Slight reduction (4%) Less reduction than CA (12%) <u>Mortality</u> Large reduction (~19%) Similar reduction to CA	<u>Hospital</u> Much higher for Latinos Lower for African Americans <u>Mortality</u> 88% lower for Latinos 26% higher for African Americans	Inadequate supports for healthy eating and physical activity. Rural communities/ communities of color face more barriers. Difficult access to screening/prevention/self-management services for uninsured, rural residents and communities of color Limited access to specialty care – insurance, shortage, transportation as barriers
Diabetes	<u>Hospital</u> Slightly higher than SJV (2%) and CA (7%) <u>Mortality</u> 15% higher than SJV. 67% higher than CA	<u>Hospital</u> 15% increase. Higher increase than CA (2%) <u>Mortality</u> Reduction of 16% Very slight increase in CA	<u>Hospital</u> Notably higher for Latino and lower for African American <u>Mortality</u> Much higher for Latinos and African Americans.	Inadequate supports for healthy eating and physical activity. Rural communities/ communities of color face more barriers.
Respiratory	<u>Hospital</u> Lower than the SJV (12%) and higher than CA (13%) <u>Mortality</u> Lower than the SJV and slightly higher than CA.	<u>Hospital</u> Reduction of 15%. Less than Ca (30%) <u>Mortality</u> Similar reduction to CA (~12%)	<u>Hospital</u> Much higher for Latinos. Slightly lower for African American <u>Mortality</u> Much lower for Latinos and African Americans.	Lack of funding for school nurse. Need to educate parents.
Mental Health	<u>Hospital</u> Lower than the SJV (30%) no comparison data for	<u>Hospital</u> Slight reduction. No data for CA <u>Mortality</u>	<u>Hospital</u> Much higher for Latinos. Much lower for	Need to work on the stigma. Challenge in ability to serve and manage the numbers.

	CA <u>Mortality</u> NA	NA	Africans Americans <u>Mortality</u> NA	Need to overcome health professional shortage. Need services for parents who are abusing substance or unemployed... the implications for parenting.
Injury/Accidents	<u>Hospital</u> Lower than the SJV and CA (15%) <u>Mortality</u> ND	<u>Hospital</u> Slight reduction. Similar to CA. <u>Mortality</u> ND	<u>Hospital</u> Twice as much higher for Latinos. 21% higher for African Americans. <u>Mortality</u> ND	Alcohol and substance abuse services for youth and parents. Teen pregnancy... lack of recreational centers in rural areas and safe places to congregate.
Avoidable Hospitalization	<u>Hospital</u> Lower than the SJV (9%) and CA (12%) <u>Mortality</u> NA	<u>Hospital</u> Reduction for SJV (24%). Better reduction than CA (16%) <u>Mortality</u> NA	<u>Hospital</u> 29% higher for Latinos. 28% Lower for African Americans. <u>Mortality</u> NA	Self management Primary care Preventative services

COMMUNITY BENEFIT PLAN AND RESULTS

The Community Benefit Planning Committee used the information from the Community Needs Assessment to identify the following objectives and tactics for 2011, basing priorities on both quantitative and qualitative data. Results are listed below each objective.

Objective 1

Increase awareness and education to a large indigent population on diabetes, nutrition and childhood obesity.

Tactics:

- Increase outreach activities and education.
- Use education tools to attract interest and facilitate learning at events.
- Increase education through mass communications and website.
- Increase the number of blood pressure, blood glucose and blood cholesterol checks.

Evaluation Method

- Track the numbers of outreach activities and participants.
- Track the numbers of blood pressure and blood glucose checks performed at outreach activities.
- Track responses to mass communication efforts.
- Track visits to website.
- Track community health.

Results

- Participated in and organized a total of 208 various outreach activities that resulted in 30,269 encounters across the Valley.
- Educated over 300 individuals at 21 Diabetes Support Group meetings in Sanger, Selma and Reedley
- Mentored about 150 Doctors Academy students from Selma and Caruthers High School at Selma Community and Community Care clinics, as part of the University of California, San Francisco-Fresno, Latino Center for Medical Education and Research Program.
- There were 9,503 unique visits to the Website in 2011, a 22.5% increase from 2010.

Objective 2

Increase the availability of primary care, specialty, mental health and physical therapy services in the Valley by recruiting more health care professionals and communicating their availability; by opening clinics in underserved areas; and by increasing specialty services.

Tactics:

- Increase the number of physicians serving our community.
- Increase internal and external communications about new physicians.
- Add physicians to online directories.
- Open clinics and expand hours at other clinics.
- Expand services for Physical Therapy and other service lines and communicate those services.

Results

- Took over operations of Sierra Kings District Hospital and its rural health clinics in Dinuba, Orange Cove, Parlier and Reedley to preserve critical health care services for the rural region.
- Recruited 11 physicians to the Consolidated Medical Staff.
- Graduated total of five new doctors from the Hanford and Selma family medicine residency programs.

Objective 3

Implement our newly adopted vision to become the health care system of choice by providing the highest quality care to the community.

Evaluation Method

Track improvements made in 2011.

Results

- Four network employees earned a Bronze award at the California Team Excellence Award competition highlighting their efforts in the Adventist Health / Community Care Medication Inventory Control Project processes and findings.
- Hosted a team of Swiss health care leaders who visited the network to learn more about Rapid Medical Evaluation (RME), a process used in our Emergency Departments to reduce wait times and improve patient satisfaction.
- Increased core measure composite process scores from 2010 in the following areas - AMI rose by 6 percentage points to 98%, pneumonia rose by 3 points to 96%, heart failure rose by 7 points to 97% and surgical (SCIP) rose by 5 points to 96%.

COMMUNITY BENEFIT REPORT FORM – 2011

Return to Community Benefit Coordinator

Hospital _____ Date _____

Service/Program _____ Target Population _____

The service is provided primarily for The Poor Special Needs Group Broader Community

Coordinating Department _____

Contact Person _____ Phone/Ext _____

Brief Description of Service/Program _____

Caseload _____ Persons Served or _____ Encounters

<i>Names of Hospital Staff Involved</i>	<i>Hospital Paid Hours</i>	<i>Unpaid Hours</i>	<i>Total Hours</i>
Total Hours			

1. Total value of donated hours (multiply total hours above by \$41.01) _____

2. Other direct costs _____

Supplies _____

Travel Expense _____

Other _____

Hospital Facilities Used _____ hours @ \$ _____/hour _____

3. Value of other in-kind goods and services donated from hospital resources _____

Goods and services donated by the facility (describe): _____

4. Goods and services donated by others (describe): _____

5. Indirect costs (hospital average allocation _____%) _____

Total Value of All Costs (add items in 1-5) _____

6. Funding Sources _____

Fundraising/Foundations _____

Governmental Support _____

Total Funding Sources (add items in 6) (_____)

Net Quantifiable Community Benefit _____

(Subtract "Total Funding Sources" from "Total Value of All Costs") _____

PLEASE USE OTHER SIDE TO REPORT NON-QUANTIFIABLE COMMUNITY BENEFITS AND HUMAN INTEREST STORIES

NON-QUANTIFIABLE COMMUNITY BENEFIT AND HUMAN INTEREST STORIES

Please fill in the date and complete the lines above the table on other side of worksheet

Who: _____

What: _____

When: _____

Where: _____

How: _____

Additional information may be obtained by contacting:

Phone: _____ Fax: _____ Email: _____

PLEASE USE OTHER SIDE TO REPORT QUANTIFIABLE COMMUNITY BENEFITS



Facility

System-wide Corporate Policy

Standard Policy

Model Policy

Policy No.

AD-04-002-S

Page

1 of 1

Department:

Administrative Services

Category/Section:

Planning

Manual:

Policy/Procedure Manual

POLICY: COMMUNITY BENEFIT COORDINATION

POLICY SUMMARY/INTENT:

The following community benefit coordination plan was approved by the Adventist Health Corporate President's Council on November 1, 1996, to clarify community benefit management roles, to standardize planning and reporting procedures, and to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals.

POLICY: COMPLIANCE – KEY ELEMENTS

1. The Adventist Health *OSHPD Community Benefit Planning & Reporting Guidelines* will be the standard for community needs assessment and community benefit plans in all Adventist Health hospitals.
2. Adventist Health hospitals in California will comply with OSHPD requirements in their community benefit planning and reporting. Other Adventist Health hospitals will provide the same data by engaging in the process identified in the Adventist Health *OSHPD Community Benefit Planning & Reporting Guidelines*.
3. The Adventist Health Government Relations Department will monitor hospital progress on community needs assessment, community benefit plan development, and community benefit reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals' community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.
4. The Adventist Health Budget & Reimbursement Department will monitor community benefit data gathering and reporting in Adventist Health hospitals.
5. California Adventist Health hospitals' finalized community benefit reports will be consolidated and sent to OSHPD by the Government Relations Department.
6. The corporate office will be a resource to provide needed help to the hospitals in meeting both the corporate and California OSHPD requirements relating to community benefit planning and reporting.

AUTHOR: Administration
APPROVED: AH Board, SLT
EFFECTIVE DATE: 6-12-95
DISTRIBUTION: AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Directors
REVISION: 3-27-01, 2-21-08
REVIEWED: 9-6-01; 7-8-03

COMMUNITY BENEFIT SUMMARY

Adventist Medical Center - Hanford
 (Includes Adventist Medical Center - Selma)
Community Benefit Summary
December 31, 2011

	CASELOAD				TOTAL COMMUNITY BENEFIT COSTS		DIRECT CB REIMBURSEMENT	UNSPONSORED COMMUNITY BENEFIT COSTS	
	NUMBER OF PROGRAMS	PERSONS SERVED	UNITS OF SERVICE		TOTAL CB EXPENSE	% OF TOTAL COSTS	OFFSETTING REVENUE	NET CB EXPENSE	% OF TOTAL COSTS
			NUMBER	MEASURE					
*BENEFITS FOR THE POOR									
Traditional charity care	1		245 / 10,377	Pt. Days / Visits	4,787,105	3.09%	0	4,787,105	3.09%
Public programs - Medicaid	1		11,075 / 62,164	Pt. Days / Visits	43,596,430	28.11%	41,203,462	2,392,969	1.54%
Other means-tested government programs					-	0.00%	-	-	0.00%
Community health improvement services	1	28	28	ENCOUNTERS	780	0.00%	-	780	0.00%
***Non-billed and subsidized health services					-	0.00%	-	-	0.00%
Cash and in-kind contributions for community benefit			500	DOLLARS	500	0.00%	-	500	0.00%
Community building activities					-	0.00%	-	-	0.00%
TOTAL BENEFITS FOR THE POOR					48,384,815	31.20%	41,203,462	7,181,354	4.63%
**BENEFITS FOR THE BROADER COMMUNITY									
Medicare	1		/	Pt. Days / Visits	49,137,687	31.69%	46,747,510	2,390,177	1.54%
Community health improvement services	7	3,480	3,446	ENCOUNTERS	67,074	0.04%	-	67,074	0.04%
Health professions education	2	2	2	STUDENTS	105,820	0.07%	-	105,820	0.07%
***Non-billed and subsidized health services					-	0.00%	-	-	0.00%
Generalizable Research					-	0.00%	-	-	0.00%
Cash and in-kind contributions for community benefit	24		13,966	DOLLARS	13,966	0.01%	-	13,966	0.01%
Community building activities	1	1			717,278	0.46%	-	717,278	0.46%
All other community benefits					-	0.00%	-	-	0.00%
TOTAL BENEFITS FOR THE BROADER COMMUNITY					50,041,825	32.27%	46,747,510	3,294,315	2.12%
TOTAL COMMUNITY BENEFIT					98,426,641	63.47%	87,950,972	10,475,669	6.76%

*Persons living in poverty per hospital's charity eligibility guidelines

**Community at large - available to anyone

***AKA low or negative margin services