

COMMUNITY BENEFITS REPORT 2011



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EXECUTIVE SUMMARY

Adventist Medical Center – Hanford (AMC-H) and Central Valley General Hospital (CVGH) are 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 nonprofit community hospitals, AMC-H and CVGH are committed to offering care to those in need without regard to their financial status or level of insurance. This is especially important since Kings County does not have a county hospital to provide services to low-income families. Our hospitals provide comprehensive care to the poorest congressional district in the nation.

AMC-H and CVGH provide a comprehensive range of services, centers and programs:

Adventist Medical Center – Hanford

142-bed acute-care hospital with 120 private medical / surgical beds, 22 ICU beds, six surgical suites, 26 private emergency beds, outpatient cardiopulmonary services, outpatient laboratory services.

Adjacent Hanford Medical Pavilion with Outpatient Lab and Imaging Center, Cardiopulmonary Services and Breast Care Center.

Central Valley General Hospital

49-bed birthing hospital with all private rooms:

14 labor and delivery

15 mother and baby

6 ante-partum rooms

2 surgical suites

Lab and imaging services

18 rural health clinics in 17 Valley communities, including two family medicine residency programs

3 JobCare occupational medicine locations

Sleep Apnea Center

The hospitals have the combined numbers in their work force:

2,768 employees

484 physicians

167 volunteers

Their community partners include:

Links for Life

Chambers of Commerce of Hanford, Lemoore, Corcoran, Coalinga and Kettleman City

Kings County Diabetes Coalition

Kings County Asthma Coalition

Kings County Public Health Department

Kings Community Action Organization

Kings Partnership for Prevention

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

CVGH and AMC-H have a long history of caring for our communities.

CVGH was first established in 1915 as Sacred Heart by an order of Dominican Nuns and then enlarged in 1959. In the 1990s, the small 49-bed hospital went in and out of management company hands and private owners until 1998, when Adventist Health purchased the hospital and CVGH was developed.

AMC-H was first incorporated into the community in March 1908. It occupied a three-story frame residence at the corner of Irwin and Ivy streets and was called the Hanford Sanitarium. In 1956, the name was changed to Hanford Community Hospital (HCH) when it changed from a proprietary hospital to a nonprofit facility through purchase of stock from private interests.

In 1962, HCH directors entered into an agreement with the Seventh-day Adventist Church to assume ownership and build a new hospital facility. The hospital was subsequently relocated in 1965 to 450 Greenfield Avenue. The name was changed to Hanford Community Medical Center (HCMC) in the late 1980s, and a three-story Kerr Outpatient Center was built just north of the hospital in 1993 to provide space for outpatient surgery and lab services as well as physician offices.

HCMC became AMC-H when the new hospital opened and commenced operation at 115 Mall Drive in Hanford on Sunday, December 5, 2010. The hospital features 142 private beds, including 120 medical/surgical beds and 22 intensive care units. It also offers 26 private emergency rooms, including four trauma rooms. In addition, GetWellNetwork, an interactive television program, provides patient education and entertainment in each patient room.

The Lab and Imaging Center at the Hanford Medical Pavilion adjacent to Adventist Medical Center - Hanford began operation in November 2010. The imaging center features a 64-slice CT scanner, the first in Kings County.

In addition to providing hospital services, AMC-H and CVGH have a history of proactive community engagement and collaboration. In 1992, AHCVN opened its first rural health clinic, the Douty Clinic, in Hanford. Since then, the Hanford hospitals along with Adventist Medical Center – Selma (AMCS) and Adventist Medical Center – Reedley (AMC-R) in southern Fresno County have opened 22 additional clinics in 18 rural Valley communities ranging in population from 1,500 to 54,000 people.

As the only community hospitals in Hanford, CVGH and AMC-H have 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	Robert Hansen	Gloria Pierson, RN
Ramiro Cano	George Johnson	Nicholas Reiber, MD
Dawn Bickner	Larry M. Jorge	Daniel Schlund, MD
David (Bud) Dickerson	Mary Ann Landis	Ashok Verma, MD
Richard K. Ellsworth, DO	Adam Mackey	J. Darrick Wells, MD
Wayne Ferch	Grant Mitchell, JD	Annie Wong, MD
Kenneth Gibb		

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 define 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/ 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 San Joaquin Valley (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 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 grade 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 Hanford Health Service Area Compared to the San Joaquin Valley and California

Table 8 compares hospitalization rates per 100,000 for the Hanford service area to the San Joaquin Valley and California for 2006/2007. Overall, the Hanford service area had lower rates of hospitalizations than the Valley and slightly similar to the state for all conditions. There was a 0.13% difference in hospitalization rates for the Hanford service area (9,753.4 per 100,000) compared to the San Joaquin Valley (11,237.5 per 100,000) and a 0.08 difference in hospitalization rates for the Hanford service area compared to the state (10,612.8). The Hanford service area had slightly lower hospitalization rates than the Valley and the state for all cancer (0.17 and 0.2), COPD (0.26 and 0.34), mental retardation (0.29 and 0.48), diabetes all ages (0.13 and 0.09), injuries and poisonings (0.19 and 0.19), urinary tract infection (0.15 and 0.39), osteoarthritis (0.03 and 0.05), avoidable hospitalization (0.16 and 0.19) and for appendicitis at 0.22. Birth and pregnancy-related hospitalizations were more than twice the rate in the Hanford service area (3,414.9) than the state at 1,565 per 100,000.

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

Table 9 displays the hospitalization rates per 100,000 for the Hanford service area from 1999/2000 to 2006/2007 and compares to California for the same period of time. Among all hospitalizations, there was a slight (0.04) increase in the rates over the six-year period for Hanford and 10% for California. Hanford service area hospitalization rates showed slight increases for all cancer (0.03), all cardiovascular (0.04), diabetes all ages (0.04), birth and pregnancy-related hospitalization (0.05) and injury and poisoning (0.04). A relatively higher increase for the Hanford service area showed in acute renal failure (0.26), appendicitis (0.10), pancreatic disorder (0.32), and osteoarthritis (0.79). There was one notable increase, more than double (2.27), for the state in acute renal failure hospitalization. There was also a notable decrease for the state in pneumonia (0.36), COPD (0.48) and acute bronchitis (0.47) hospitalization for the state.

Hanford Service Area Non-Latinos Compared to Latinos and Whites Compared to African Americans 2006/2007

Table 10 compares hospitalization rates per 100,000 by race/ethnicity for the Hanford 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 Hanford service area. The high/low proportions are a calculation of the highest hospitalization rate divided by the lowest hospitalization rate within the Hanford service area. Overall, Latinos face much higher rates of hospitalization than Non-Latinos. Latinos are hospitalized at a higher rate for breast cancer, coronary atherosclerosis, pediatric asthma, acute bronchitis, all mental disorders including mental retardation and alcohol-related mental disorder, diabetes for all ages, birth and pregnancy-related hospitalization and appendicitis. However, Latinos had lower rates for avoidable hospitalization than non-Latinos.

While African Americans and Whites have similar overall hospitalization rates (African Americans 0.15 higher), there are some noteworthy differences, with African Americans experiencing hospitalization rates that are close to four times higher than those for Whites for osteoarthritis, appendicitis and younger than 19 years of age diabetes . African Americans also face more than double the rate of Whites for acute bronchitis. As with Latinos, African Americans had lower rates for avoidable hospitalization than Whites.

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

Hospitalization Rates per 100K <i>(06/07 Hanford Area Compared to the San Joaquin Valley and California)</i>					
CONDITION	06/07 Hospitalization Rate Hanford Area	06/07 Hospitalization Rate SJV	06/07 Hospitalization Rate Hanford Area vs. SJV (CI 95%)	06/07 Hospitalization Rate on Rate Calif.	06/07 Hospitalization Hanford Area County vs. Calif. (CI 95%)
All Cancer	373.49	447.77	0.83 (0.79-0.88)	465.18	0.80 (0.78-0.83)
Lung Cancer	22.41	27.96	0.80 (0.64-0.99)	30.56	0.73 (0.64-0.84)
Breast Cancer	23.23	24.67	0.94 (0.75-1.16)	28.13	0.83 (0.72-0.95)
Colon, Rectum, Anal Cancer	24.85	33.08	0.75 (0.61-0.92)	38.61	0.64 (0.57-0.73)
All Cardiovascular	1253.88	1310.57	0.96 (0.93-0.98)	1230.73	1.02 (1.00-1.04)
Acute Myocardial Infarction	130.98	152.87	0.86 (0.78-0.94)	146.59	0.89 (0.85-0.94)
Heart Failure	172.84	252.54	0.68(0.63-0.74)	229.24	0.75 (0.72-0.79)
Coronary Atherosclerosis	364.04	259.45	1.40 (1.33-1.48)	196.09	1.86 (1.79-1.93)
Hypertension	21.06	17.23	1.22 (0.97-1.53)	26.46	0.80 (0.68-0.93)
All Respiratory	712.95	850.60	0.84 (0.81-0.87)	661.44	1.08 (1.05-1.10)
Asthma All Age	76.16	101.32	0.75 (0.67-0.84)	85.72	0.89 (0.83-0.95)
Pediatric Asthma	65.53	90.16	0.73 (0.57-0.91)	ND	
Pneumonia	329.74	340.55	0.97 (0.91-1.02)	257.79	1.28 (1.23-1.33)
COPD	66.43	89.48	0.74 (0.65-0.84)	100.02	0.66 (0.61-0.72)
Acute Bronchitis	48.88	62.13	0.79 (0.68-0.91)	35.83	1.36 (1.25-1.49)
All Mental Disorders	273.30	388.27	0.70 (0.66-0.75)		ND
Mental Retardation	209.84	294.90	0.71 (0.66-0.76)	402.56	0.52 (0.50-0.55)
Alcohol Related Mental	63.46	93.38	0.68 (0.60-0.77)		ND
Diabetes All Age	126.12	144.53	0.87 (0.80-0.96)	137.97	0.91 (0.87-0.96)
Diabetes 0-19	18.11	21.01	0.86 (0.53-1.32)		
Birth & Pregnancy Related	3414.89	3919.66	0.87 (0.86-0.89)	1565.0	2.18 (2.16-2.20)

Injury & Poisoning	636.26	783.56	0.81 (0.78-0.85)	788.88	0.81 (0.79-0.83)
Other Conditions					
Urinary Tract Infection	82.37	96.40	0.85 (0.76-0.96)	134.98	0.61 (0.57-0.65)
Acute Renal Failure	86.96	98.06	0.89 (0.79-0.99)	82.76	1.05 (0.98-1.13)
Appendicitis	92.90	119.67	0.78 (0.70-0.86)	94.21	0.99 (0.93-1.05)
Pancreatic Disorders	91.55	93.77	0.98 (0.88-1.09)	80.53	1.14 (1.06-1.22)
Osteoarthritis	171.22	176.62	0.97 (0.90-1.05)	181.02	0.95 (0.90-1.00)
Ambulatory Care Sensitive Admissions	837.99	995.64	0.84 (0.81-0.87)	1040.26	0.81 (0.79-0.82)
All Hospitalizations	9753.44	11237.46	0.87 (0.86-0.88)	10612.83	0.92 (0.91-0.92)

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

Table 9 - Hanford Health Service Area Hospitalization Rate Per 100K vs. California Comparison by Year 99/00 to 06/07

Hospitalization Rates per 100K (Hanford Health Service Area vs. California Comparison by Year 99/00 to 06/07)						
CONDITION	99/00 Hanford Area	06/07 Rate Hanford Area	Hanford Area 06/07 vs. 99/00 (CI 95%)	99/00 California	06/07 California	California 06/07 vs. 99/00 (CI - 95%)
All Cancer	363.1	373.5	1.03 (0.98-1.08)	481.2	465.2	0.97 (0.96-0.97)
Lung Cancer	24.9	22.4	0.90 (.72-1.12)	41.2	30.6	0.74 (0.73-0.76)
Breast Cancer	29.5	23.2	0.79 (0.63-0.97)	34.6	28.1	0.81 (0.80-0.83)
Colon, Rectum, Anal Cancer	26.1	24.8	0.95 (0.77-1.17)	46.8	38.6	0.83 (0.81-0.84)
All Cardiovascular	1205.0	1253.9	1.04 (1.01-1.07)	1399.3	1230.7	0.88 (0.88-0.88)
Acute Myocardial Infarction	213.2	131.0	0.61 (0.56-0.67)	194.1	146.6	0.76 (0.75-0.76)
Heart Failure	192.9	172.8	0.90 (0.83-0.97)	254.0	229.2	0.90 (0.90-0.91)
Coronary Atherosclerosis	319.8	364.0	1.14 (1.08-1.20)	281.0	196.1	0.70 (0.69-0.70)
Hypertension	16.9	21.1	1.25 (0.99-1.56)	13.4	26.5	1.98 (1.94-2.02)
All Respiratory	791.9	713.0	0.90 (0.87-0.94)	946.9	661.4	0.70 (0.70-0.70)
Asthma All Age	121.6	76.2	0.63 (0.56-0.70)	121.5	85.7	0.71 (0.70-0.71)
Pediatric Asthma	161.3	65.5	0.41 (0.32-0.51)	ND	ND	ND
Pneumonia	299.8	329.7	1.10 (1.04-1.16)	403.4	257.8	0.64 (0.64-0.64)
COPD	95.2	66.4	0.70 (0.61-0.79)	193.9	100.0	0.52 (0.51-0.52)
Acute Bronchitis	92.5	48.9	0.53 (0.45-0.61)	67.5	35.8	0.53 (0.52-0.54)
All Mental Disorders	296.1	273.3	0.92 (0.87-0.98)			
Mental Retardation	222.4	209.8	0.94 (0.88-1.01)	429.3	402.6	0.94 (0.93-0.94)
Alcohol Related Mental	73.7	63.5	0.86 (0.75-0.98)			
Diabetes All Age	121.0	126.1	1.04 (0.95-1.14)	134.7	138.0	1.02 (1.02-1.03)
Diabetes 0-19	24.4	18.1	0.74 (0.46-1.14)			
Birth & Pregnancy Related	3237.9	3414.9	1.05 (1.04-1.07)	1469.5	1565.0	1.07 (1.06-1.07)
Injury & Poisoning	611.3	636.3	1.04 (1.00-1.08)	856.3	788.9	0.92 (0.92-0.92)
Other Conditions						
Urinary Tract Infection	82.0	82.4	1.00 (0.89-1.12)	131.5	135.0	1.03 (1.02-1.04)
Acute Renal Failure	69.1	87.0	1.26 (1.12-1.40)	36.5	82.8	2.27 (2.24-2.29)
Appendicitis	84.8	92.9	1.10 (0.98-1.22)	98.2	94.2	0.96 (0.95-0.97)
Pancreatic Disorders	69.4	91.5	1.32 (1.18-1.47)	71.1	80.5	1.13 (1.12-1.15)
Osteoarthritis	95.8	171.2	1.79 (1.65-1.93)	133.9	181.0	1.35 (1.34-1.36)
Ambulatory Care Sensitive Admissions	1093.2	838.0	0.77 (0.74-0.79)	1238.0	1040.3	0.84 (0.84-0.84)
All Hospitalizations	9405.2	9753.4	1.04 (1.03-1.05)	9631.7	10612.8	1.10 (1.10-1.10)

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

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

Hospitalizations per 100K Population <i>(06/07 Hospitalization Rates Race Comparison)</i>				
CONDITION	Raw Count Non Hispanic Hanford Area	06/07 Non-Latino vs. Latino (CI - 95%)	Raw Count White Hanford Area	06/07 White vs. Blacks (CI - 95%)
All Cancer	366	0.36 (0.33-0.40)	858	0.52 (0.49-0.56)
Lung Cancer	8	0.18 (0.08-0.35)	54	0.82 (0.62-1.07)
Breast Cancer	42	1.19 (0.86-1.61)	61	1.05 (0.80-1.34)
Colon, Rectum, Anal Cancer	38	0.92 (0.65-1.27)	70	1.48 (1.15-1.87)
All Cardiovascular	1926	1.02 (0.97-1.06)	3077	0.91 (0.88-0.95)
Acute Myocardial Infarction	193	0.86 (0.75-0.99)	325	1.09 (0.97-1.21)
Heart Failure	256	0.76 (0.67-0.86)	436	0.48 (0.43-0.53)
Coronary Atherosclerosis	544	1.19 (1.09-1.29)	867	1.65 (1.54-1.76)
Hypertension	20	0.69 (0.42-1.07)	56	0.59 (0.45-0.77)
All Respiratory	1242	1.24 (1.18-1.31)	1791	0.94 (0.90-0.99)
Asthma All Age	145	1.32 (1.12-1.56)	160	0.39 (0.33-0.45)
Pediatric Asthma	45	2.59 (1.89-3.46)	53	0.45 (0.33-0.58)
Pneumonia	571	1.34 (1.23-1.45)	818	1.17 (1.09-1.25)
COPD	35	0.24 (0.17-0.34)	210	0.90 (0.78-1.03)
Acute Bronchitis	125	3.64 (3.03-4.33)	129	2.72 (2.27-3.23)
All Mental Disorders	544	1.62 (1.49-1.76)	477	0.69 (0.63-0.75)
Mental Retardation	419	1.62 (1.47-1.78)	342	0.64 (0.57-0.71)
Alcohol Related Mental	125	1.62 (1.35-1.93)	135	0.86 (0.72-1.02)
Diabetes All Age	261	1.70 (1.50-1.92)	288	0.63 (0.56-0.70)
Diabetes 0-19	7	1.71 (0.68-3.52)	15	3.65 (2.04-6.03)
Birth & Pregnancy Related	8345	3.04 (2.98-3.11)	4918	1.27 (1.23-1.30)
Injury & Poisoning	1146	1.31 (1.23-1.39)	1403	1.25 (1.18-1.31)
Other Conditions				
Urinary Tract Infection	94	0.70 (0.57-0.86)	239	1.26 (1.11-1.43)
Acute Renal Failure	152	1.19 (1.01-1.39)	216	0.67 (0.58-0.76)
Appendicitis	250	3.69 (3.25-4.18)	201	3.67 (3.18-4.22)
Pancreatic Disorders	173	1.67 (1.43-1.94)	204	1.12 (0.97-1.28)
Osteoarthritis	233	0.85 (0.74-0.96)	491	3.85 (3.51-4.20)
Ambulatory Care Sensitive Admissions	3455	0.62 (0.60-0.64)	5174	0.72 (0.70-0.74)
All Hospitalizations	19641	1.75 (1.72-1.77)	19805	1.15 (1.14-1.17)

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

Mortality - Age-Adjusted Death Rates

Age-adjusted Death Rates (AADR) - Hanford Health Service Area and California Comparison for 1999/2000 to 2006/2007

Table 11 examines change in age-adjusted death rates per 100,000 between 1999/2000 and 2006/2007 for the Hanford service area ZIP codes and compares the rates to California for the same time period. While overall age-adjusted death rates were a little lower for both the Hanford service area and California, some causes of death showed increases. In the Hanford service area, while rates of AMI and atherosclerotic heart disease went down, rates of heart failure deaths increased. Increased age-adjusted death rates were also notable for homicide, suicide, breast cancer, pneumonia and Alzheimer's disease. Compared to California as a whole, the Hanford service area experienced more decrease in death rate than California overall.

AADR – Hanford 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 Hanford service area ZIP codes to the eight San Joaquin Valley counties and California. Overall, the Hanford services area experiences 0.61 less AADR than the SJV and 53% less than the state. Hanford service area age-adjusted death rates were higher for motor vehicle accidents, heart failure and diabetes than the state as a whole.

AADR – Hanford Service Area Race Comparison

Table 13 examines racial/ethnic and place disparities in age-adjusted death rates. Overall, non-Latinos experienced higher (more than double) death rates than Latinos and notably higher rates for lung and breast cancers, heart failure and suicide. Latinos face higher age-adjusted death rates for motor vehicle accidents, diabetes and homicide. Age-adjusted death rates for African Americans compared to Whites are also shown. Overall, African Americans face slightly higher age-adjusted death rates compared to Whites, mostly linked to higher deaths for motor vehicle accidents.

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

Mortality - Age-adjusted Death Rates (AADR) per 100K Population (AADR Hanford Area and California Comparison by Year 1999/2000 to 2006/2007)						
CONDITION	99/00 Hanford Area	06/07 Hanford Area	Hanford Area 99/00 vs. 06/07 (CI - 95%)	99/00 California	06/07 California	California 99/00 vs. 06/07 (CI - 95%)
All Cancer	124.9	122.6	0.98 (0.89-1.08)	187.1	166.4	0.89 (0.88-0.89)
Lung Cancer	31.2	31.6	1.02 (0.84-1.22)	48.6	40.6	0.84 (0.83-0.85)
Breast Cancer	7.4	8.7	1.19 (0.79-1.70)	14.1	12.2	0.87 (0.85-0.88)
Colon, Rectum, Anal Cancer	9.8	11.3	1.15 (0.82-1.56)	17.8	15.1	0.85 (0.83-0.86)
All Cardiovascular Acute	176.1	147.5	0.84 (0.77-0.91)	227.3	177.6	0.78 (0.78-0.79)
Myocardial Infarction	51.2	35.0	0.68 (0.56-0.82)	56	35.7	0.64 (0.63-0.65)
Heart Failure	12.7	18.2	1.4 (1.13-1.80)	9.9	12.2	1.23 (1.21-1.26)
Atherosclerotic Cardiovascular Disease	12.0	4.4	0.37 (0.18-0.67)	28.8	21.1	0.73 (0.72-0.74)
Injury and Violence						
Homicide	3.6	6.4	1.78 (0.99-2.93)	5.8	6.4	1.10 (1.07-1.14)
Suicide	5.3	6.9	1.30 (0.87-1.87)	9.5	9.3	0.98 (0.96-1.00)
Motor Vehicle Accident	14.5	17.8	1.23 (0.97-1.53)	9.5	11.1	1.17 (1.14-1.19)
All Respiratory	54.1	49.3	0.91 (0.78-1.06)	80.3	66.1	0.82 (0.82-0.83)
Pneumonia	10.0	13.0	1.3 (0.92-1.79)	25.5	19	0.75 (0.73-0.76)
Alzheimer's Disease	6.8	9.3	1.38 (0.92-1.99)	13.1	22.2	1.69 (1.67-1.72)
Diabetes	32.7	25.8	0.79 (0.61-1.00)	21	21.9	1.04 (1.03-1.06)
All Deaths	839.1	311.4	0.37 (0.35-.39)	751.7	664.1	0.88 (0.88-0.89)

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

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

Mortality - Age-adjusted Death Rates (AADR) per 100K Population (06/07 AADR Hanford Area compared to the San Joaquin Valley and California)					
CONDITION	06/07 Hanford Area	06/07 SJV	06/07 Hanford Area vs. SJV (CI- 95%)	06/07 AADR California	06/07 Hanford Area vs. California (CI - 95%)
All Cancer	122.6	176.1	0.70 (0.63-0.77)	166.4	0.74 (0.67-0.81)
Lung Cancer	31.6	46.1	0.68 (0.57-0.82)	40.6	0.78 (0.64-0.94)
Breast Cancer	8.7	12.5	0.70 (0.47-1.00)	12.2	0.72 (0.48-1.03)
Colon, Rectum, Anal Cancer	11.3	15.5	0.73 (0.52-0.99)	15.1	0.75 (0.53-1.02)
All Cardiovascular	147.5	219.8	0.67 (0.61-0.73)	177.6	0.83 (0.76-0.91)
Acute Myocardial Infarction	35.0	43.9	0.80 (0.66-0.96)	35.7	0.98 (0.81-1.18)
Heart Failure	18.2	16.8	1.08 (0.85-1.36)	12.2	1.49 (1.17-1.87)
Atherosclerotic Cardiovascular Disease	4.4	20.0	0.22 (0.11-0.41)	21.1	0.21 (0.10-0.38)
Injury and Violence					
Homicide	6.4	7.1	1.00 (0.51-1.49)	6.4	1.00 (0.56-1.65)
Suicide	6.9	10.0	0.69 (0.46-0.99)	9.3	0.74 (0.50-1.07)
Motor Vehicle Accident	17.8	19.5	0.91 (0.71-1.14)	11.1	1.60 (1.26-2.00)
All Respiratory	49.3	83.7	0.59 (0.50-0.68)	66.1	0.74 (0.64-0.87)
Pneumonia	13.0	20.7	0.63 (0.45-0.86)	19.0	0.69 (0.49-0.94)
Alzheimer's Disease	9.3	22.8	0.41 (0.27-0.59)	22.2	0.42 (0.28-0.61)
Diabetes	25.8	31.8	0.81 (0.63-1.03)	21.9	1.18 (0.92-1.49)
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 – Hanford Service Area Rates (AADR) Race Comparison 2006/2007

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	328	0.83 (0.74-0.92)	392	0.43 (0.39-0.47)
Lung Cancer	103	1.76 (1.43-2.13)	105	0.51 (0.42-0.62)
Breast Cancer	20	1.76 (1.07-2.71)	27	0.29 (0.19-0.42)
Colon, Rectum, Anal Cancer	31	0.91 (0.62-1.29)	38	0.57 (0.40-0.78)
All Cardiovascular	406	1.00 (0.90-1.10)	448	0.32 (0.30-0.36)
Acute Myocardial Infarction	86	0.93 (0.74-1.15)	102	0.37 (0.31-0.45)
Heart Failure	61	1.31 (1.00-1.69)	64	0.29 (0.22-0.37)
Atherosclerotic Cardiovascular Disease	9	0.74 (0.34-1.40)	10	0.27 (0.13-0.49)
Injury and Violence				
Homicide	9	0.36 (0.16-0.68)	12	0.08 (0.04-0.14)
Suicide	21	1.38 (0.85-2.10)	26	0.52 (0.34-0.77)
Motor Vehicle Accident	27	0.30 (0.20-0.44)	73	1.84 (1.44-2.31)
All Respiratory	140	1.08 (0.91-1.27)	157	0.51 (0.43-0.60)
Pneumonia	30	0.54 (0.37-0.77)	35	0.43 (0.30-0.60)
Alzheimer's Disease	24	0.83 (0.53-1.24)	26	0.37 (0.24-0.54)
Diabetes	45	0.33 (0.24-0.44)	62	0.25 (0.19-0.32)
All Deaths	3572	2.36 (2.29-2.44)	4715	0.98 (0.95-1.01)

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

Years of Potential Life Lost

Years of Potential Life Lost (YPLL) Rates - Hanford 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 to 2006/2007 for the Hanford 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 Hanford service area experienced an increase (0.11) in productive years lost (mainly due to a notable increase in heart failure), the state experienced a 0.04 reduction in these early deaths.

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

Table 15 compares YPPLs/10,000 in the Hanford service area to the San Joaquin Valley and California for 2006/2007. The Hanford service area and the San Joaquin Valley experienced similar rates of early deaths, but these are notably higher (0.37) than for California as a whole. Further, the Hanford service area is losing notably more years of life before age 65 than the SJV and California for lung cancer, heart failure, motor vehicle accidents, Alzheimer's disease and respiratory conditions.

YPLL Rates - Hanford Service Area Race Comparison

Table 16 examines inequalities by race/ethnicity and place for YPPLs/10,000 in the Hanford 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 Hanford service area. The high/low proportions are a calculation of the highest YPLL rate divided by the lowest YPLL rate within the Hanford service area. As with age-adjusted death rate, Non-Latinos experienced an overall lower YPLL rate than Latinos. For all cancer, all cardiovascular and all respiratory Non-Latinos have notably higher YPPLs, while Latinos lose more young lives to homicides and motor vehicle accidents. While African Americans have lower rates of YPLL (0.24 lower) compared to Whites, for most causes of death, they are notably higher for homicide and breast cancer. African Americans are at much lower risk of losing lives before age 65 in homicide.

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

Years of Potential Life Lost (YPLL) per 10K Population <i>(YPLL Hanford Area and California Comparison by Year 1999/2000 to 2006/2007)</i>						
Condition	99/00 YPLL Hanford Area	06/07 YPLL Hanford Area	YPLL Hanford 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	120.441	53.2	0.44 (0.42-0.46)	59.5	54.5	0.92 (0.91-0.92)
Lung Cancer	19.5667	9.7	0.50 (0.45-0.55)	9.4	7.3	0.78 (0.78-0.79)
Breast Cancer	9.0615	4.0	0.44 (0.37-0.51)	7.1	6.1	0.86 (0.85-0.87)
Colon, Rectum, Anal Cancer	6.23554	3.8	0.61 (0.52-0.72)	4.3	4.4	1.02 (1.01-1.03)
All Cardiovascular	87.4723	44.3	0.51 (0.48-0.53)	37.2	34.5	0.93 (0.92-0.93)
Acute Myocardial Infarction	23.9592	12.0	0.50 (0.46-0.55)	7.3	5.5	0.75 (0.74-0.76)
Heart Failure	1.56657	3.3	2.14 (1.78-2.55)	0.5	0.9	1.63 (1.59-1.68)
Atherosclerotic Cardiovascular Disease	2.1809	0.8	0.35 (0.23-0.50)	4.7	5.2	1.12 (1.11-1.13)
All Respiratory	32.9823	17.7	0.54 (0.50-0.58)	11.4	9.7	0.85 (0.84-0.85)
Pneumonia	7.89426	5.8	0.74 (0.64-0.84)	3.4	2.7	0.78 (0.77-0.79)
Injury and Violence						
Homicide	36.0873	11.0	0.31 (0.28-0.34)	20.6	22.7	1.10 (1.10-1.11)
Suicide	42.7273	15.2	0.36 (0.33-0.39)	18.0	17.5	0.98 (0.97-0.98)
Motor Vehicle Accident	162.523	62.4	0.38 (0.37-0.40)	24.8	29.7	1.20 (1.19-1.20)
Alzheimer's Disease	0	0.5	ND	0.07	0.1	2.01 (1.89-2.14)
Diabetes	17.0786	5.6	0.33 (0.28-0.38)	5.7	6.2	1.08 (1.07-1.09)
All Deaths	395.761	440.3	1.11 (1.10-1.12)	335.4	320.6	0.96 (0.95-0.96)

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

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

Years of Potential Life Lost (YPLL) per 10K Population <i>(06/07 YPLL Hanford Area compared to the San Joaquin Valley and California)</i>					
CONDITION	06/07 YPLL Hanford Area	06/07 YPLL SJV	06/07 YPLL Hanford Area vs. SJV (CI- 95%)	06/07 YPLL California	06/07 YPLL Hanford Area vs. CA (CI - 95%)
All Cancer	53.2	56.0	0.95 (0.92-0.98)	54.5	0.98 (0.95-1.00)
Lung Cancer	9.7	7.8	1.25 (1.15-1.35)	7.3	1.33 (1.22-1.44)
Breast Cancer	4.0	6.0	0.66 (0.60-0.73)	6.1	0.65 (0.59-0.71)
Colon, Rectum, Anal Cancer	3.8	4.4	0.87 (0.77-0.97)	4.4	0.88 (0.78-0.98)
All Cardiovascular	44.3	39.5	1.12 (1.08-1.16)	34.5	1.29 (1.24-1.33)
Acute Myocardial Infarction	12.0	7.5	1.61 (1.50-1.73)	5.5	2.19 (2.04-2.35)
Heart Failure	3.3	1.3	2.65 (2.30-3.03)	0.9	3.90 (3.39-4.47)
Atherosclerotic Cardiovascular Disease	0.8	5.1	0.15 (0.12-0.18)	5.2	0.14 (0.12-0.17)
All Respiratory	17.7	17.0	1.04 (0.99-1.10)	9.7	1.83 (1.74-1.93)
Pneumonia	5.8	5.2	1.11 (1.02-1.21)	2.7	2.17 (2.00-2.36)
Injury and Violence					
Homicide	11.0	25.8	0.43 (0.41-0.45)	22.7	0.49 (0.47-0.51)
Suicide	15.2	19.5	0.78 (0.74-0.82)	17.5	0.87 (0.82-0.91)
Motor Vehicle Accident	62.4	54.9	1.14 (1.11-1.16)	29.7	2.10 (2.06-2.16)
Alzheimer's Disease	0.5	0.2	2.90 (2.04-4.00)	0.1	3.29 (2.31-4.53)
Diabetes	5.6	8.5	0.66 (0.61-0.71)	6.2	0.91 (0.84-0.97)
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 – Hanford 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	1279.0	1.40 (1.32-1.48)	1572	0.92 (0.88-0.97)
Lung Cancer	337.0	12.85 (11.51-14.30)	302	1.30 (1.15-1.45)
Breast Cancer	107.0	1.42 (1.16-1.72)	114	0.70 (0.57-0.83)
Colon, Rectum, Anal Cancer	98.0	3.35 (2.72-4.08)	136	6.20 (5.21-7.34)
All Cardiovascular	1051.0	2.40 (2.26-2.55)	1338	0.82 (0.78-0.87)
Acute Myocardial Infarction	278.0	2.54 (2.25-2.86)	365	1.22 (1.10-1.35)
Heart Failure	62.0	1.52 (1.17-1.95)	101	ND
Atherosclerotic Cardiovascular Disease	28.0	1.89 (1.26-2.74)	28	0.70 (0.46-1.01)
All Respiratory	309.0	1.15 (1.02-1.28)	634	1.42 (1.31-1.54)
Pneumonia	178.0	2.52 (2.16-2.92)	197	1.35 (1.17-1.55)
Injury and Violence				
Homicide	240.0	0.52 (0.45-0.58)	318	0.17 (0.16-0.19)
Suicide	355.0	1.38 (1.24-1.53)	503	2.19 (2.00-2.38)
Motor Vehicle Accident	711.0	0.41 (0.38-0.44)	2202	7.01 (6.72-7.31)
Alzheimer’s Disease	17.0	ND	17	ND
Diabetes	114.0	0.73 (0.61-0.88)	190	1.58 (1.36-1.82)
All Deaths	8027.9	0.52 (0.51-0.53)	13795	0.77 (0.76-0.78)

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

Avoidable Hospitalization

Table 17 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) 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,” yet they remain a low priority for public financing in health systems, globally as well as in California. 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. 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.

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 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 & Nyandoro.

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 (SEM/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 SED/SMI. 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. Given figures as high as this, it is unlikely that a new BHSC located at Community Medical Centers in Fresno 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 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 three sets of focus groups. One of these involved community residents from the South Fresno communities of Selma, Kingsburg, Fowler, Caruthers, Kerman, Sanger, Parlier, Reedley and Dinuba. The other two involved clinicians and executives. We also conducted one telephone interview with the medical director of a clinic in Selma.

Focus Group General Introductions

Process – The focus group sessions began by around-the-table self-introductions, with each participant providing name, position, affiliation as well as one success, challenge and opportunity they perceive for their community’s health and well-being.

Challenges

Access to Care

- Urgent care – lack of weekend coverage/after hours services
- Transportation – to get to places that are out of their area. Child care/injury... don’t need to drive an hour for care... specialty care needs to be closer to home.

Education

- Focus on prevention – continue to educate people
- Services available to residents and how to access them
- Provide more health promoting foods and activities and emphasizes on home/ families – a battle
- Obesity prevention

Funding/Economics

- Low paying jobs – mostly what exists
- No access to healthy fruits and vegetables – how can we pay for...
- Distribution of resources – Corcoran medical profession is not what it should be...Corcoran Hospital...got less money than needed...instead they are being annexed to another...implications for care – growth, keeping up with demand

Affordable Health Care

- Technology/costs – how can we afford
- Economic capacity – how can we get care that fits – Armona is a poor community
- Equity and Quality – how can we achieve within our resources ... uninsured – how to cover the undocumented/uninsured ... how in the future will we ...

Physician Shortage – Lack of Specialty Care

- Transport to other area where services are available
- No specialty service on kids’ asthma
- No focus for health care for seniors? What will senior care be in the future?
- No counseling services and psychologists/mental health
- No diabetes care specialization

Lack of Services

- Family planning services
- Teen pregnancy
- Alcoholic services for youth
- Children clinic

Successes

Collaboration/partnerships/small, knit community

- Partnering to help provide services for families that don't have health insurance or don't have the money to pay for health care costs
- Working with specific groups and passed policies (e.g. tobacco, smoke free policy at health department)
- Work close with AH – AH is Big help
- Close knit community – everybody knows everybody and who to turn to if there is a need.

Expansion

- New hospital opening ... a major step – new hospital.... Hanford hospital ... important when aging
- Education achievement
- Care provided
- Cardiologist has been brought on and some specialists

Opportunities

- More collaboration with outer-lying agencies. Collaborating with health community to know what is out there (services) to provide to our community.
 - Growing community...pay attention to our real needs and assets – forming partnerships
 - Great opportunities to collaborate
 - Interested in partnering with Selma in doing immunization
 - Hanford hospital engagement can lead to improved services in Corcoran
- More knowledge – How do families access those resources when don't have the means to get to Hanford
- Making sense of growth – using it to our advantage – hospital can attract new activity

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 Kings and Hanford communities that support/inhibit Community Health and Well Being (CHWB) and respective policies needed to sustain/change these efforts.

The group then was 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?

- Urgent care
- Ongoing care management
- Mental and behavioral health – access
- Educating parents
- More collaboration (agencies, non-profits, parents)
- Lack of understanding of indigent care programs
- Breast Cancer Care – and other cancer as well... even Fresno is not enough?
Focus on Prevention Quality of urgent care available
- 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
- 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 – structure
- Focus on prevention
- More collaboration
- Educating parents
- Behavioral health

Strategies

- 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?
- Expanding practice to make it easier access for behavioral health.
- Recognizing 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)

	<p>Identify conditions and opportunities that support community health and well-being (CHWB)</p>	<p>What policies or practices are needed to sustain and grow these</p>
<p>Primary Care/Access to Care</p>	<p>Partnering with: Health care providers such as Family Health Care Network (provides dental care to Head Start children and provide transportation if needed)</p> <p>Health Department (takes mobile clinics out and that helps with transportation issues, immunizations at low cost or free)</p> <p>Schools and primary care physicians for referrals. Then we test children and parents for illnesses (e.g. diabetes)</p> <p>Preconception program for teen parents is expanding out</p> <p>Health Department or insurance providers to make transportation available.</p> <p>Just School farm stand to support healthy eating at the school level--</p> <p>Adventist health clinic — peds and dental clinic helpful.</p> <p>Insurance: Because this is a rural area we probably have more coverage qualification as far as income level</p> <p>Depends on the doctor if they are willing to take Medi-Cal patients... United health accepts Medi-Cal patients.</p> <p>Some insurance are starting to make changes to the adolescents coverage –</p> <p>Implementing the CA School wellness policy–nutrition and Physical activity.</p>	<p>Mandatory meeting for Head Start where they meet with partners and learn about services available for the community</p> <p>A similar meeting can be done to improve Primary Care/Access to Care</p>

<p>Specialty care access/coordination with primary care – all insurance categories</p>	<p>Opened up a mental health service building – we need to attract specialty care to practice in the area.</p> <p>There is coordination between primary care and specialists when referrals are concerned</p> <p>Expansion of specialty care is possible (especially cancer) with the creation of new hospital</p> <p>Building a mental health service building</p>	<p>Need to expand access/availability and reduce stigma around behavioral health care</p>
<p>Uninsured/Indigent/Implementation new national policy/ undocumented etc.</p>	<p>Health Department offer services disregarding immigration and insurance status</p> <p>Expand services</p>	<p>Need expanded access to care and increased resources for advocacy for those with limited English/less educated re care management</p> <p>Expand services</p> <p>Identify resources and make them available to public</p> <p>Rural Clinics</p> <p>Armona clinic—within walking distance of community it serves; prevents from ER visits</p> <p>Home Garden CHC</p> <p>First 5</p> <p>Kings Community Action Organization-- Do a lot of work around education on primary care and prevention services in community</p>
<p>Chronic Disease Management</p>	<p>Tobacco control program</p> <p>Education and follow-up through health department programs</p> <p>Hear lots of prevention messages in community about heart disease, diabetes and asthma</p> <p>No coordination of care; eg... Going to different to ER's, doc's, etc in different towns</p>	<p>Partner with other agencies and parents to educate self and families.</p> <p>Financial – for health campaigns</p> <p>Education, personal responsibility</p> <p>Electronic medical records</p>
<p>Breast Cancer Care</p>	<p>There is huge need for breast cancer care</p>	<p>Women's health services</p>

<p>Prevention (Services, Policies, Environments) clean air and water – specifically access to short-term health education – for example, diet, exercise, health info etc.)</p>	<p>Head Start initiative I'm Moving, I'm Learning. Promote learning of healthy eating through physical activity.</p> <p>Working on adapting student activity with parents as well</p> <p>Teach parents so they can teach their children.</p> <p>Health Department's Obesity Coalition- promotes healthy eating and physical activity</p> <p>Community Resource Center is about to implement programs for children to eat healthier and be active</p> <p>Farmer's market and community garden in Hanford</p> <p>Home Garden waste water improvement</p> <p>Lots of attention on Kettleman City</p> <p>Some great parks – Hidden Valley, Freedom Park, floating on rivers</p> <p>Hanford high schools have banned soda sales...similar restrictions in Corcoran</p> <p>Food link/ KCAO food gardens, food bank....well utilized, not over tapped...</p> <p>Food drive by Salvatio Army... ...Christian aid will be tapped this year....</p> <p>Meals on Wheels...in Hanford...but not in Corcoran</p> <p>Most schools well-maintained facilities....but only 1 school meets state standards...</p> <p>Parents get letters saying under-performing...but there is only one choice that is better...public pays for busing costs.....(the one that is working has older, more experienced teachers)</p> <p>High turnover in schools...hard to motivate kids.</p>	<p>Create a train the trainer opportunity</p> <p>Need a community conversation about our goals and expectations of schools... how to hold schools, teachers and families/kids accountable for achievement</p> <p>Addressing the unresolved issues around language learning and expectations....explore the barriers to motivation</p> <p>Need to expose kids to hygiene training – washing hands etc...improve focus on self-health care in the curriculum</p> <p>Need to create more services options for the working poor....who don't qualify/can't afford</p> <p>School grounds should be available for kids to play</p> <p>No initiatives to support people in eating healthy....</p> <p>Continue various free-lunch programs etc....</p>
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	<p>Too much focus on performance on tests and drilling...</p> <p>Low expectations for all kids</p> <p>People becoming multi-lingual is a positive</p> <p>Strong social services for kids...First 5, Community Action, etc....</p>	
Hospital /Emergency services	<p>Head Start tries to look for those services that families need</p> <p>Corcoran, Adventist and Hanford hospitals have outer line clinics, so that's helpful</p> <p>New hospital, completely smoke free</p> <p>Pretty active in some of our coalitions and community events</p> <p>Work closely with family resource center to be out there and support.</p>	Educate non-profit groups (where the people are), then nonprofits can inform families of the services available.
Public Safety/Behavioral Health	<p>Health Department takes referrals from people in need of behavioral services, then behavioral health does the follow-ups</p> <p>Behavioral Health Department is expanding its services within schools</p> <p>Head Start offers limited behavioral health services to the entire family</p> <p>Kings View near....only service provider....both on site and at community sites...they come to Y as well...important</p> <p>At base, military has services for their population</p> <p>Religious communities/faith based Organizations</p> <p>VA in Fresno Community watch Classes in CPR/Red Cross etc. – includes the Y...now low cost/no cost at Y in Hanford</p> <p>Corcoran – no real plan for community response to a big emergency – train wreck downtown...Could create training opportunities... could bring back “civil defense drill”</p>	<p>More resources for behavioral health services</p> <p>Many resources – such as CPR classes...have been only in Visalia...and many people need the training/cant get</p>

<p>Expectations – for access, services, quality of life – understanding rights, civic engagement (where’s the rage) – visioning</p>	<p>Poverty – prevention is not a priority</p> <p>In the past, there were more activities/events that brought the community together...</p> <p>Same small group of doers...they get too busy....and maybe quality of life goes does....Lack of motivation as other extreme</p>	<p>Family literacy program on how to understand health resources (programs, insurance, etc.)</p> <p>Important to focus on prevention, educate on the importance of prevention, lack of awareness.</p>
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Table 21- Kings, Hanford, and South Fresno Communities Policies and Environments that Inhibit Community Health and Well-being (CHWB)

	<p>Identify conditions and opportunities that inhibit community health and well-being (CHWB)</p>	<p>What policies or practices are needed to change these</p>
<p>Primary Care/Access to Care</p>	<p>Lack of insurance: don’t qualify for public health insurance and don’t make enough to buy private health insurance</p> <p>Continued care</p> <p>Lack of resources or knowledge of resources</p> <p>Access to care in outer line areas, transportation can be an issue. Does new hospital have a helicopter pad? Corcoran has the helicopter pad</p> <p>Transportation – even Fresno is not enough may have to go further.</p> <p>Gaps for different coverage –those in the middle fall through the cracks and use ER</p> <p>2-3 clinics – not all services are offered</p> <p>Access is a challenge because of rurality, we have to drive to other areas for service. Transportation is a huge issue.</p> <p>Low reimbursement rate for practitioners so they are less willing to accept Medi-Cal.</p> <p>Adolescents coverage at a certain age your coverage is gone and not a decent job that offers coverage.</p> <p>Tulare county mental health cut back in mental health</p> <p>Dinuba losing mental health services</p>	<p>Cover the uninsured program</p>

<p>Specialty care access/coordination with primary care – all insurance categories</p>	<p>No coordination between Health Department and specialists</p> <p>Once diagnosed and if uninsured, people do not receive specialty care</p> <p>Not much specialty care</p>	<p>County budget cuts</p>
<p>Uninsured/Indigent/Implementation new national policy/ undocumented etc.</p>	<p>Once diagnosed, where do they receive specialty care?</p>	<p>Funding is needed</p>
<p>Chronic Disease Management</p>	<p>Staff is challenged with how to educate others and especially parents. Knowing what's out there as far as resources.</p> <p>Interplay of psych and physical challenges not addressed well</p> <p>No possible referrals for MH services – so district bears unnecessary costs</p> <p>No counseling available</p>	<p>Need to have stronger collaborations so that all agencies are educated and can come up with policies and procedures.</p>
<p>Breast Cancer Care</p>	<p>Nothing exists</p>	<p>Need women's health service center</p>
<p>Prevention (Services, Policies, Environments) air/water – specifically access to short-term health education – for example, diet, exercise, health info etc.)</p>	<p>Air/water problems are significant</p> <p>Unemployment is very high in</p> <p>Corcoran...emergency aid caseload has tripled</p> <p>A language barrier is a big issue...</p> <p>After school competes with free "Ready" program at schools.....they wanted the Y out....now Y is much better</p>	<p>Need land use plan/reduce growth of subdivisions</p> <p>Storage of bottled water to prepare for emergency</p>
<p>Hospital /Emergency services</p>	<p>People who don't have health insurance have to depend on these services</p> <p>People can't have continued care after diagnosed</p> <p>Not enough outreach to monolingual Spanish population</p> <p>People with special needs/complex problems are scared to use ER</p>	
<p>Public Safety/Behavioral Health</p>	<p>Stigma with mental health....</p> <p>At 50k pop...people afraid of being seen/recognized</p> <p>Smoking</p> <p>Need more police/larger facility or substations</p>	

<p>Expectations – for access, services, quality of life – understanding rights, civic engagement (where’s the rage) – visioning</p>	<p>Lack of affordable dental care</p> <p>Air/water problems are significant</p> <p>Some communities lack places to play – Rec department identified this... Efforts, i.e. flu clinics, duplicated efforts</p> <p>Need improved education....we don’t have the workforce to support industry – why come</p> <p>College graduates don’t come back...if you get an MBA why come back....</p> <p>Growing number of homeless people....more than 300 getting services in Hanford...</p> <p>Can’t speak for first 5...are services being utilized</p>	<p>We need some type of literacy program that helps families understand what they have access to and how that works together.</p> <p>May be planning a new park.....SE Hanford? Needs a new park....</p> <p>Efforts need to focus on prevention. It will be beneficial on the long term.</p> <p>Better communication to industry...they can be a partner if approached</p> <p>Efforts/opportunities to focus on retaining young college graduates.</p>
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**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	<p><u>Hospital</u> Lower than SJV and CA</p> <p><u>Mortality</u> Slightly lower than SJV and similar to CA</p>	<p><u>Hospital</u> Slight reduction (9%). Better than CA (3%)</p> <p><u>Mortality</u> Similar reduction (~8%) to CA</p>	<p><u>Hospital</u> Higher for Latinos and African Americans</p> <p><u>Mortality</u> 46% lower for Latinos Slightly higher for African American</p>	<p>Limited access to cancer care outside central Fresno</p> <p>Difficult access to screening/prevention services for uninsured</p>
Cardiovascular	<p><u>Hospital</u> Slightly lower than SJV Similar to CA</p> <p><u>Mortality</u> 10% lower than SJV 11%) Higher than CA</p>	<p><u>Hospital</u> Slight reduction (4%) Less reduction than CA (12%)</p> <p><u>Mortality</u> Large reduction (~19%) Similar reduction to CA</p>	<p><u>Hospital</u> Much higher for Latinos Lower for African Americans</p> <p><u>Mortality</u> 88% lower for Latinos 26% higher for African Americans</p>	<p>Inadequate supports for healthy eating and physical activity.</p> <p>Rural communities/ communities of color face more barriers.</p> <p>Difficult access to screening/prevention/self-management services for uninsured, rural residents and communities of color</p> <p>Limited access to specialty care – insurance, shortage, transportation as barriers</p>
Diabetes	<p><u>Hospital</u> Slightly higher than SJV (2%) and CA (7%)</p> <p><u>Mortality</u> 15% higher than SJV. 67% higher than CA</p>	<p><u>Hospital</u> 15% increase. Higher increase than CA (2%)</p> <p><u>Mortality</u> Reduction of 16% Very slight increase in CA</p>	<p><u>Hospital</u> Notably higher for Latino and lower for African American</p> <p><u>Mortality</u> Much higher for Latinos and African Americans.</p>	<p>Inadequate supports for healthy eating and physical activity.</p> <p>Rural communities/ communities of color face more barriers.</p>
Respiratory	<p><u>Hospital</u> Lower than the SJV (12%) and higher than CA (13%)</p> <p><u>Mortality</u> Lower than the SJV and slightly higher than CA.</p>	<p><u>Hospital</u> Reduction of 15%. Less than Ca (30%)</p> <p><u>Mortality</u> Similar reduction to CA (~12%)</p>	<p><u>Hospital</u> Much higher for Latinos. Slightly lower for African American</p> <p><u>Mortality</u> Much lower for Latinos and African Americans.</p>	<p>Lack of funding for school nurse.</p> <p>Need to educate parents.</p>

Mental Health	<u>Hospital</u> Lower than the SJV (30%) no comparison data for CA <u>Mortality</u> NA	<u>Hospital</u> Slight reduction. No data for CA <u>Mortality</u> NA	<u>Hospital</u> Much higher for Latinos. Much lower for Africans Americans <u>Mortality</u> NA	Need to work on the stigma. Challenge in ability to serve and manage the numbers. 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 151 individuals at 10 Diabetes Support Group meetings in Hanford.
- Conducted Grief Support Group meetings to help 87 community members cope with loss.
- Provided prepared childbirth classes to 120 expectant mothers and instructed 50 new mothers on how to breastfeed their new infant.
- Staff provided free blood pressure screens, blood-glucose screens and dental exams for 87 people at the events, which drew more than 100 people in need of assistance, and free follow-up visits at clinics and other health care services for those in need of a physician's care.
- Over 250 families participated in our Back to School Health Fair in Hanford. Staff performed over 75 school physicals and immunizations and 125 health screenings for members of the communities.
- Partnered with Main Street Hanford to "Paint Downtown Pink" in recognition of National Breast Cancer Awareness Month. Market Place vendors decorated their booths in pink, and nearly 600 community members and employees wore pink and participated in a contest. To promote physical activity, contest participants signed up to receive a pink pedometer and walk 2,500 steps, or about 1.5 miles, at the Market Place.
- Organized the "First Friday with a Physician" lecture series that meets on the first Fridays of most months at the Adventist Medical Center – Hanford Conference Center. Lectures are free to the public and lunch is provided. Educated 278 people with various health topics at seven lectures.

- Coordinated the “Pink Glove” community video shoot to raise breast cancer awareness. The video shoot attracted participation from over 50 community groups and hospital departments. The video is posted on the network’s YouTube channel.
- Provided health information at the Lemoore Pizza Festival in April to over 500 people who walked over 1,000 steps.
- 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

- Recruited 11 physicians to the Consolidated Medical Staff.
- Graduated total of five new doctors from the Hanford and Selma family medicine residency programs.
- Commenced operations at Adventist Medical Center - Reedley and its five rural health clinics.
- Broke ground on the 7,200-square-foot Adventist Medical Plaza in Dinuba, Calif. The Medical Plaza will provide extended-hour urgent care and imaging, radiology, laboratory and JobCare occupational medicine services for the region.
- Opened a 2,800-square-foot Adventist Health/Breast Care Center in the Hanford Medical Pavilion that offers a full complement of services covering multiple aspects of breast diagnostics and care.
- Opened a 2,000-square-foot comprehensive Adventist Health/Cardiopulmonary Services in the Hanford Medical Pavilion. It has three major treatment rooms and all new equipment to provide cardiopulmonary tests, outpatient peripherally inserted central catheter (PICC) insertions and per-op services for patients who have congestive heart failure, asthma or chronic obstruction pulmonary disease (COPD).
- Partnered with leading outpatient dialysis center, DaVita, to open outpatient kidney and dialysis service in Lemoore for patients with kidney failure and end-stage renal disease.
- Expanded Central Valley General Hospital’s Women’s Services Department into the second floor to provide all private rooms for mothers.
- Opened a Physical Therapy clinic in Kingsburg.

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

- Central Valley General Hospital scored above the 95th percentile in top patient satisfaction ranking in pain management.
- 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.
- Adventist Medical Center – Hanford ranks in the 72nd percentile on “Rate Hospital on a scale from 1-10,” with 73% of our patients scoring us a 9 or 10.
- 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

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

**Central Valley General Hospital
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		74 / 29,866	Pt. Days / Visits	5,072,264	4.46%	56,275	5,015,989	4.41%
Public programs - Medicaid	1		452 / 18,554	Pt. Days / Visits	5,395,104	4.74%	4,385,846	1,009,259	0.89%
Other means-tested government programs					-	0.00%	-	-	0.00%
Community health improvement services	7	903	903	ENCOUNTERS	16,766	0.01%	-	16,766	0.01%
***Non-billed and subsidized health services					-	0.00%	-	-	0.00%
Cash and in-kind contributions for community benefit	1		500	DOLLARS	500	0.00%	-	500	0.00%
Community building activities					-	0.00%	-	-	0.00%
TOTAL BENEFITS FOR THE POOR					10,484,635	9.21%	4,442,121	6,042,514	5.31%
**BENEFITS FOR THE BROADER COMMUNITY									
Medicare	1		3,148 / 61,968	Pt. Days / Visits	17,768,053	15.61%	16,653,946	1,114,106	0.98%
Community health improvement services	64	18,426	18,392	ENCOUNTERS	227,651	0.20%	-	227,651	0.20%
Health professions education	4	15	15	STUDENTS	2,475,580	2.18%	-	2,475,580	2.18%
***Non-billed and subsidized health services					-	0.00%	-	-	0.00%
Generalizable Research					-	0.00%	-	-	0.00%
Cash and in-kind contributions for community benefit	30		52,825	DOLLARS	52,825	0.05%	-	52,825	0.05%
Community building activities	1	1			242,076	0.21%	-	242,076	0.21%
All other community benefits					-	0.00%	-	-	0.00%
TOTAL BENEFITS FOR THE BROADER COMMUNITY					20,766,185	18.25%	16,653,946	4,112,239	3.61%
TOTAL COMMUNITY BENEFIT					31,250,820	27.46%	21,096,067	10,154,753	8.92%

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

**Community at large - available to anyone

***AKA low or negative margin services