

2016

How Healthy is Shasta County?

An Assessment of Our Health





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Acknowledgements

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Introduction and overview

Health "is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1998).

While health is largely influenced by individual choices, the conditions in which we live, work, play and learn are important to people's ability to make healthy choices (Robert Wood Johnson Foundation, September 2011). Factors like availability and access to health care; physical environment such as air quality or neighborhood design; a person's social environment which includes education and income; individual behaviors; and genetics all contribute to a person's health and well-being. Embracing this comprehensive definition of health, members of Shasta County's local public health system set out to understand how they could "move the needle" on important health issues which negatively impact our residents. An integral part of this effort included conducting a Community Health Assessment (CHA) to identify areas of concern and help guide local health system partners on where to focus prevention effort resources.

Vision:

To guide our work, organizational leaders and community stakeholders participated in a process to create the following vision for where they would like to be in 5 years: "Shasta County is a safe and economically vibrant community where children get a great start and there are thriving educational opportunities. All residents have access to healthy, affordable food; superior substance abuse and mental health prevention and treatment options; affordable housing; and a medical home."

Community Health Improvement Framework

In 2015, the Shasta County Health and Human Services Agency's Public Health Branch initiated a comprehensive community health improvement planning process. The Mobilizing for Action through Planning and Partnership (MAPP) model was selected as the strategic planning framework to guide the development of the CHA because of its strong emphasis on community input.

The MAPP process has six phases, each on building on one another. They are:

- Organizing for success and developing partnerships
- Visioning

- Conducting MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action

Early on, the Health and Human Services Agency's Public Health Branch enlisted the expertise of local public health system partners to guide the assessment planning efforts of the CHA to improve Shasta County's health. Representatives of these partner organizations formed a MAPP Steering Committee that included representatives from local hospitals, federally qualified health centers, tribal health, non-profit organizations and community collaboratives. During a 12-month process, MAPP Steering Committee members engaged residents and health system stakeholders to:

- Examine the current health status of Shasta County
- Identify the most pressing health issues
- Determine what resources and opportunities exist to address those issues
- Develop a short list of strategic issues and goals for improving resident's health and well-being

Next Steps

In the coming months, the Public Health Branch will continue to engage community members and stakeholders to develop a Community Health Improvement Plan (CHIP) that identifies goals, strategies, activities and resources to address the strategic issues identified in this report.

Community profile

Nestled in the foothills of the Cascade Mountain Range, Shasta County is situated in the northern Sacramento Valley and is one of California's original counties.

With a total area of 3,837 square miles, it is home to two national protected areas – Whiskeytown National Recreation Area and Shasta-Trinity National Forest and the state's largest water reservoir, Shasta Lake.

There are three incorporated cities within Shasta County - Anderson, Redding and the City of Shasta Lake, which account for 62 percent of the total county population. The remainder of county residents live in outlying rural communities. Shasta County's population has grown by 9.3% between 2000 and 2014. Most (97.7%) of that growth was due to migration into the county. Due to its large land area and the high percent of residents living in rural areas, Shasta County has a population density five times lower than California. Furthermore, the county population is proportionally older and less racially diverse than the state. The county demographics are on a trend to become even older, and the racial makeup of residents is growing in diversity.

Table 1: Change in Shasta County and California Populations, 2000 to 2010-14

	Shasta County	California
Population (2000)	163,256	33,871,648
Population (2010-14)	178,520	38,066,920
Change in Population	15,264	4,195,272
Percent Change	**9.3%**	**12.4%**

Population Density

In 2010-14, Shasta County's average population density was 47.3 people per square mile. On average, Shasta County has only 1/5 the number of people per square mile as California. In 2010, 70.7% (125,321) of Shasta County residents lived in urban areas while the remaining 29.3% (51,902) lived in rural areas. By comparison, 95.0% of Californians lived in urban areas.

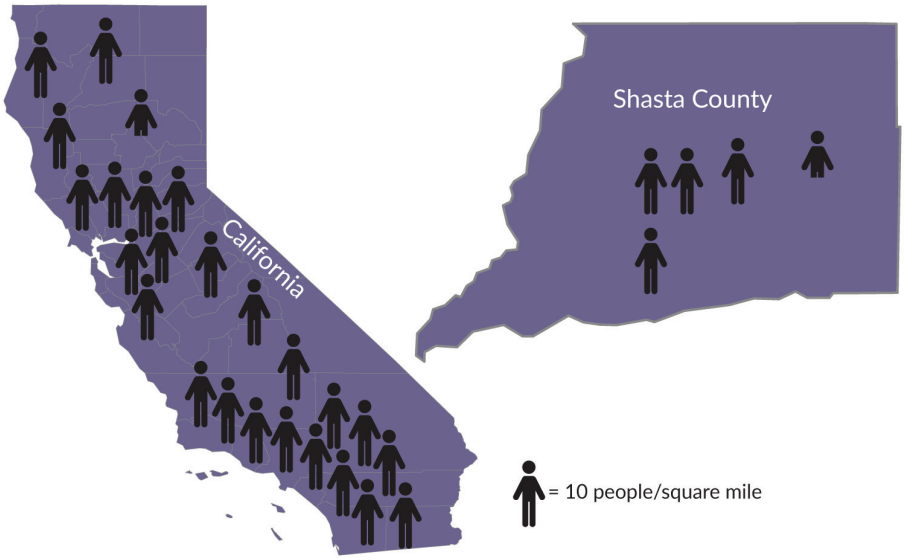


Table 2: Population Density and Rurality, 2010-14

	Shasta County	California
Population	178,520	38,066,920
Land Area in Square Miles	3,775.4	155,779.2
Population Density	47.3	244.4
Urban (2010)	70.7%	95.0%
Rural (2010)	29.3%	5.0%

Age and Sex

Of Shasta County's 178,520 residents, 49.1% are male and 50.9% are female. 46.8% of Shasta County residents are adults over the age of 45 compared to 37.2% of statewide, making Shasta County's population older than that of California overall. Further, 18.1% of Shasta County residents are seniors over 65 compared to 12.1% statewide.

Table 3: Shasta County population by age and gender compared to California, 2010-14

Age Group	Shasta County						California		
	Number			Percentage			Percentage		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
<5	5,223	5,065	10,288	6.0%	5.6%	5.8%	6.8%	6.4%	6.6%
5 – 14	11,182	10,503	21,685	12.8%	11.6%	12.1%	13.7%	13.0%	13.4%
15 – 24	11,790	11,053	22,843	13.5%	12.2%	12.8%	15.3%	14.1%	14.7%
25 – 44	20,079	20,118	40,197	22.9%	22.1%	22.5%	28.7%	27.5%	28.1%
45 – 64	24,646	26,542	51,188	28.1%	29.2%	28.7%	24.8%	25.4%	25.1%
65 – 74	8,865	9,550	18,415	10.1%	10.5%	10.3%	6.3%	7.1%	6.7%
75+	5,858	8,046	13,903	6.7%	8.9%	7.8%	4.4%	6.4%	5.4%
Total	87,643	90,877	178,520						

From 2000 to 2010-14, Shasta County experienced a decrease in the proportion of children (age 5-14) and an increase in the percentage of seniors (age 65+). The proportion of other age groups changed only slightly during this time period.

Table 4: Shasta County population by age, 2000 and 2010-14

Age Group	Shasta County, 2000		Shasta County, 2010-14		Trend
	Number	Percentage	Number	Percentage	
Total Population	163,256		178,520		↑
Young Children (Under 5)	9,643	5.9%	10,288	5.8%	↓
Children (5 – 14)	24,887	15.2%	21,685	12.1%	↓
Teens and Youth (15 – 24)	21,470	13.2%	22,843	12.8%	↓
Adults (25-64)	82,395	50.5%	91,386	51.2%	↑
Seniors (65+)	24,861	15.2%	32,318	18.1%	↑

Race and Ethnicity

White residents make up a larger proportion of the Shasta County population (81.5%) compared to 39.2% of Californians. American Indians/Alaskan Natives are the only racial or ethnic minority group which have a higher proportion of the population in Shasta County than in the state.

Table 5: Shasta County population by race, 2000 and 2010-14

Race	Shasta County, 2000		Shasta County, 2010-14		Trend
	Number	Percentage	Number	Percentage	
Total Population	163,256		178,520		↑
White	145,826	89.3%	155,559	87.1%	↓
Black	1,225	0.8%	1,759	1.0%	↑
American Indian or Alaskan Native	4,528	2.8%	4,214	2.4%	↓
Asian	3,048	1.9%	4,462	2.5%	↑
Native Hawaiian or Pacific Islander	178	0.1%	326	0.2%	↑
Other Race	2,790	1.7%	4,025	2.3%	↑
Two or More Races	5,661	3.5%	8,175	4.6%	↑

Table 6: Shasta County population by Hispanic or Latino ethnicity, 2000 and 2010-14

Race and Ethnicity	Shasta County, 2000		Shasta County, 2014		Trend
	Number	Percent	Number	Percent	
Total Population	163,256		178,520		↑
Hispanic or Latino	8,998	5.5%	15,908	8.9%	↑
White (Non-Hispanic)	141,097	86.4%	145,485	81.5%	↓
Other (Non-Hispanic)	13,161	8.1%	17,127	9.6%	↑

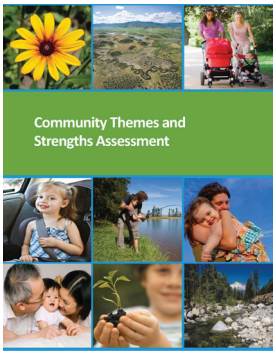
The proportion of Shasta County residents who are Black, Asian, Native Hawaiian/Pacific Islander, "Some Other Race," or "Two or More Races" increased between 2000 and 2010-14. The only race that reduced in numbers was American Indian/Alaskan Native, having decreased their total population by 314 people. The fastest growing races and ethnicities were Hispanic (76.8% growth) and Asian (46.4% growth).

Table 7: Shasta County population by race and ethnicity, compared to California, 2010-14

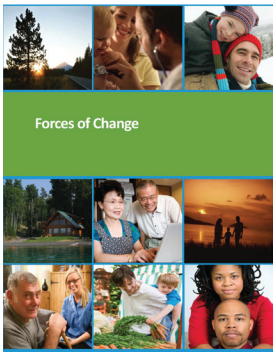
Race and Ethnicity	Shasta County		California
	Number	Percentage	Percentage
White	145,485	81.5%	39.2%
Hispanic (of any race)	15,908	8.9%	38.2%
Multi-racial	6,855	3.8%	2.7%
Asian	4,397	2.5%	13.3%
American Indian or Alaskan Native	3,650	2.0%	0.4%
Other Race	216	0.1%	0.2%
Black	1,692	0.9%	5.7%
Native Hawaiian or Pacific Islander	317	0.2%	0.4%
Total Population	**178,520**		

Assessments

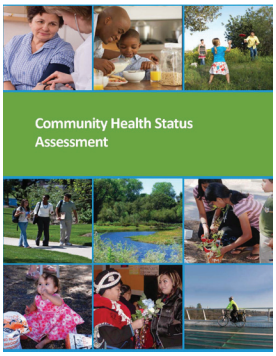
This document includes three main components, each of which measures or analyzes health in Shasta County in a number of different ways.



The Community Themes and Strengths Assessment is intended to gather the thoughts, opinions and perceptions of local residents about health and quality of life in Shasta County.



The Forces of Change Assessment is intended to identify both positive and negative forces that are likely to affect the health of our community.



The Community Health Status Assessment collects, analyzes and compares public health data in order to describe population health.



Community Themes and Strengths Assessment






Introduction

The Community Themes and Strengths Assessment (CTSA) is intended to gather the thoughts, opinions and perceptions of local residents about health and quality of life in Shasta County.

Conducting this assessment answers the questions:

- What's important to our community?
- How is quality of life perceived in our community?
- What assets do we have that can be used to improve community health?

In this report:

Methodology
Results

The information collected provides a deeper understanding of the issues that Shasta County residents feel are important to their families, neighborhoods and communities. This data, combined with results from the Community Health Status Assessment and Forces of Change Assessment, will help identify strategic issues and priorities to drive community action.

Methodology

In an effort to reach a broad cross-section of Shasta County's population, two methods of data collection were used for the Community Themes and Strengths Assessment – a community health survey and focus groups.

The Community Health Survey was distributed widely during February 2016, both electronically and on paper, and was available in English, Spanish and large-print type (see Appendix 1 for text).

Focus groups, led by a facilitator from the National Association of County and City Health Officials (NACCHO), were held in four geographic regions of Shasta County. Shasta County Health and Human Services Agency Community Organizers helped recruit participants to ensure diverse representation from each region. A special effort was made to engage underrepresented populations, including low-income people and ethnic and racial minorities. A copy of the facilitator's guide can be found in Appendix 2: Community Themes and Strengths Focus Group Guide. On average, each focus group included 10 participants and took two hours to complete. Participants completed a community health survey. The facilitator then guided groups through an in-depth discussion based on the survey questions while Public Health Branch staff recorded the discussion. Content of the conversations were then analyzed by a Public Health Program and Policy Analyst to find common themes and differences among the regions.

It's important to note that this survey was not intended to capture a representative sample of Shasta County. Extra effort was made to reach a geographically and demographically diverse group of participants, and in some cases this may have resulted in oversampling. While we tried to reach a more rural, lower-income, less-educated higher proportion of racial and ethnic minorities, we had mixed success with this. See Appendix 3 for a detailed description of the methodology and demographic analysis used in this assessment.

Results

Results of the Community Health Survey and focus group responses were analyzed by examining overall responses to the five main questions.

Where do you go most often in Shasta County to have fun?

Outdoor recreation opportunities are clearly valued by many who were surveyed. All four focus groups agreed that trails and local lakes and rivers were among the top spots for recreation. Focus group participants expressed the importance of having fun, connecting with nature and spending time with family and friends as a way to relieve stress and maintain a work/life balance. All four focus groups also included cultural, community, school and church events as a fun way to connect in their communities. Both survey respondents and focus group participants frequently mentioned accessibility to nature and outdoor activities:

- *"The parks are kept really nice here and are always being improved."*
- *We love going camping…makes the kids disconnect from technology and we get to spend time together."*
- *"At the end of the day, that walk is like 'Calgon, take me away.'"*

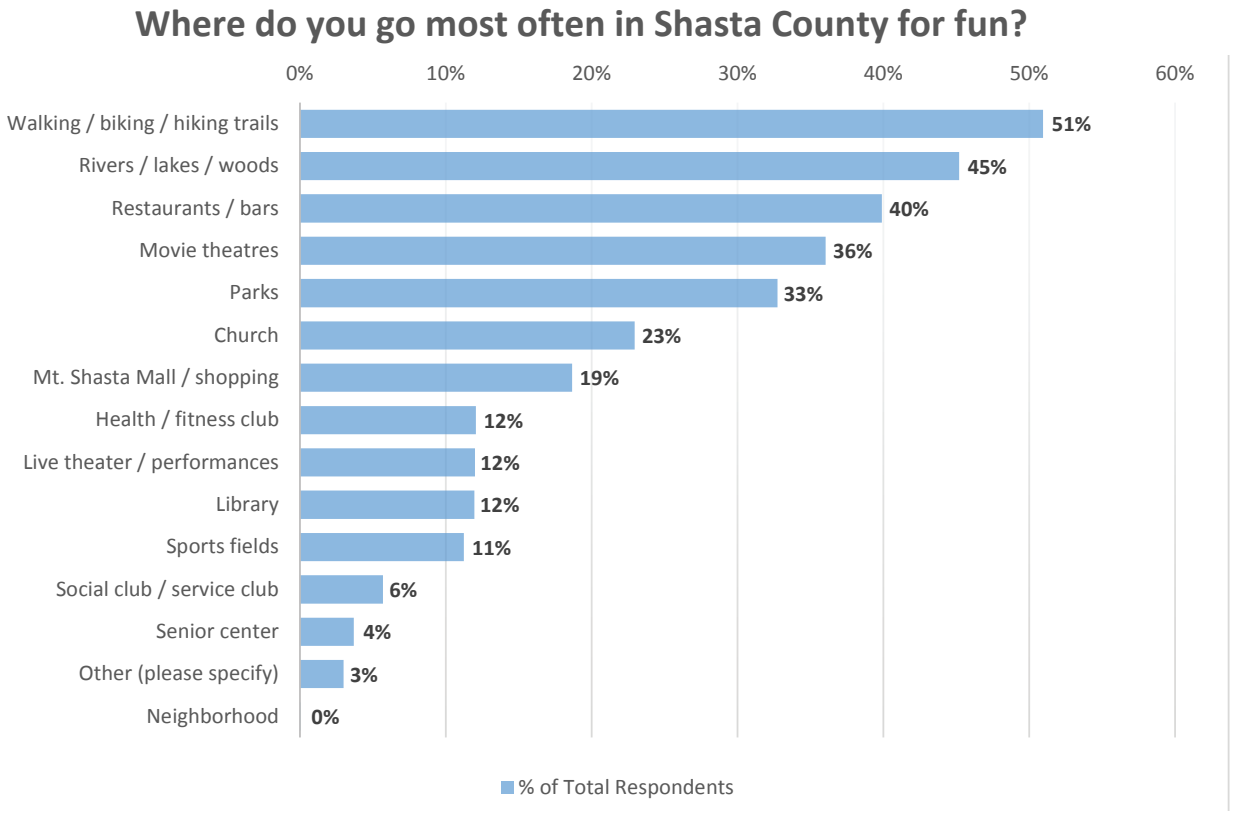
Burney focus group

Of those who wrote in other responses, two-thirds (65%) stated that they enjoy spending time in their own homes, or the homes of family and friends. Other respondents mentioned outdoor activities like golfing, horseback riding, target shooting and disc golfing. Others visited places such as Turtle Bay Exploration Park, Win-River Casino, bowling alleys, Oasis Fun Center and Waterworks Park.

The chart and graph on the following page illustrate where survey respondents go most frequently in Shasta County to have fun.

Asset	Number of respondents	Percent of total respondents
Walking/biking/hiking trails	1,452	51%
Rivers/lakes/woods	1,288	45%
Restaurants/bars	1,137	40%
Movie theatres	1,027	36%
Parks	933	33%
Church	654	23%
Mt. Shasta Mall/shopping	532	19%
Health/fitness club	344	12%
Live theater/performances	342	12%
Library	341	12%
Sports fields	320	11%
Social club/service club	162	6%
Senior center	105	4%
Other (please specify)	92	3%
Neighborhood	1	0%

Total number of respondents was 2,850. Respondents were instructed to choose up to 3. If people chose more, all responses were included.



What do you think are the most important things that make Shasta County a good place to live?

In considering what makes Shasta County a good place to live, the majority of respondents, both in the survey and in focus groups, identified the area's "outdoor recreation opportunities" as one of its most important assets. The result corresponds positively to the answers given to the previous question. Respondents said Shasta County's rural setting and good schools are also positive assets.

Close community connections were an asset identified by Shasta Lake, Anderson and Burney focus group participants, as was the small size of their schools, which contributes to the individual attention and excellent learning environment that students enjoy. Redding focus group participants also listed public transportation as a strength in their community.

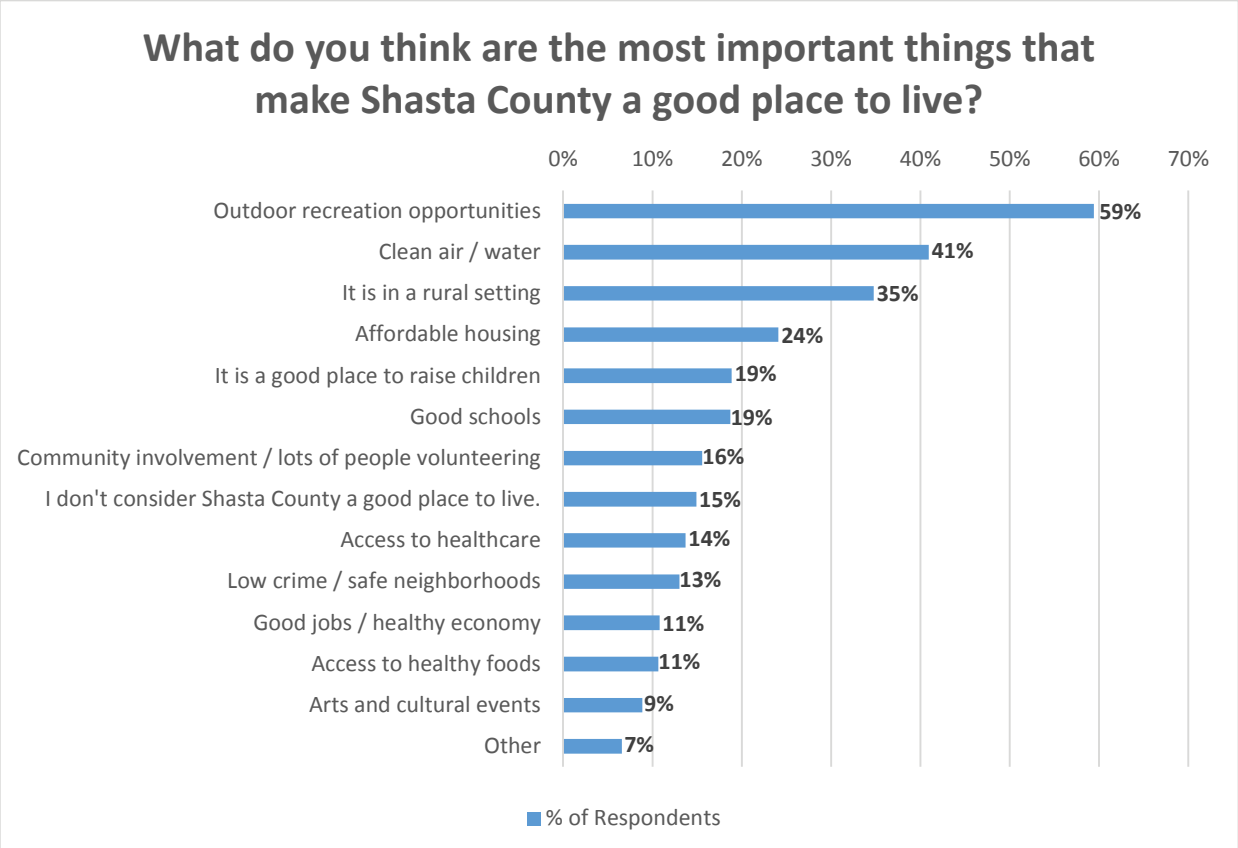
- *"I'm a single mom and when I first moved to Anderson, my neighbors showed up with food to welcome me. I almost cried. I've made friends I will have for life.*
- *"Schools are a hub in our community. They invite in lots of different organizations like Scouts and 4H {and provide} lots of layers for making connections."*
- *"There's a sense of community here. People help each other out. We have less crime here because people look out for each other and the police communicate."*

It is notable, however, that 15% of those survey respondents felt that Shasta County is <u>not</u> a good place to live. Of the 187 individuals who wrote a comment in response to this question, 82 (44%) mentioned crime and drug use as negatively impacting the quality of life here.

The table and graph on the following page illustrate what survey respondents think are the most important things that make Shasta County a good place to live.

Asset	Number of respondents	Percent of total respondents
Outdoor recreation opportunities	1,693	59%
Clean air/water	1,167	41%
It is in a rural setting	991	35%
Affordable housing	687	24%
It is a good place to raise children	538	19%
Good schools	534	19%
Community involvement/lots of people volunteering	444	16%
I don't consider Shasta County a good place to live	425	15%
Access to healthcare	391	14%
Low crime/safe neighborhoods	371	13%
Good jobs/healthy economy	308	11%
Access to healthy foods	304	11%
Arts and cultural events	253	9%
Other	187	7%

Total number of respondents was 2,850. Respondents were instructed to choose up to 3, if people chose more all responses were included.



What are the most important issues that impact *your family*?

Survey respondents most often identified affordable housing, unemployment/ underemployment and aging problems as the top three issues affecting their family. Although not explicitly stated, it is implied by the options given, that it is a *lack of* affordable housing that impacts some Shasta County families.

- *"Good paying job. Have to commute to the Bay Area to find sufficient pay."*
- *"Nowhere for my son to meet other kids locally. We have to live in a 35-foot 5th wheel because housing is so expensive."*
- *"Barriers to care for aging parents. Lack of specialists."*

Focus groups in Anderson, Redding and Shasta Lake, on the other hand, reported lack of mental health resources and lack of medical providers as important issues that impact their families the most. Participants in Burney and Shasta Lake noted both inadequate public transportation and unsafe road conditions for bicyclists and pedestrians as existing issues in their communities.

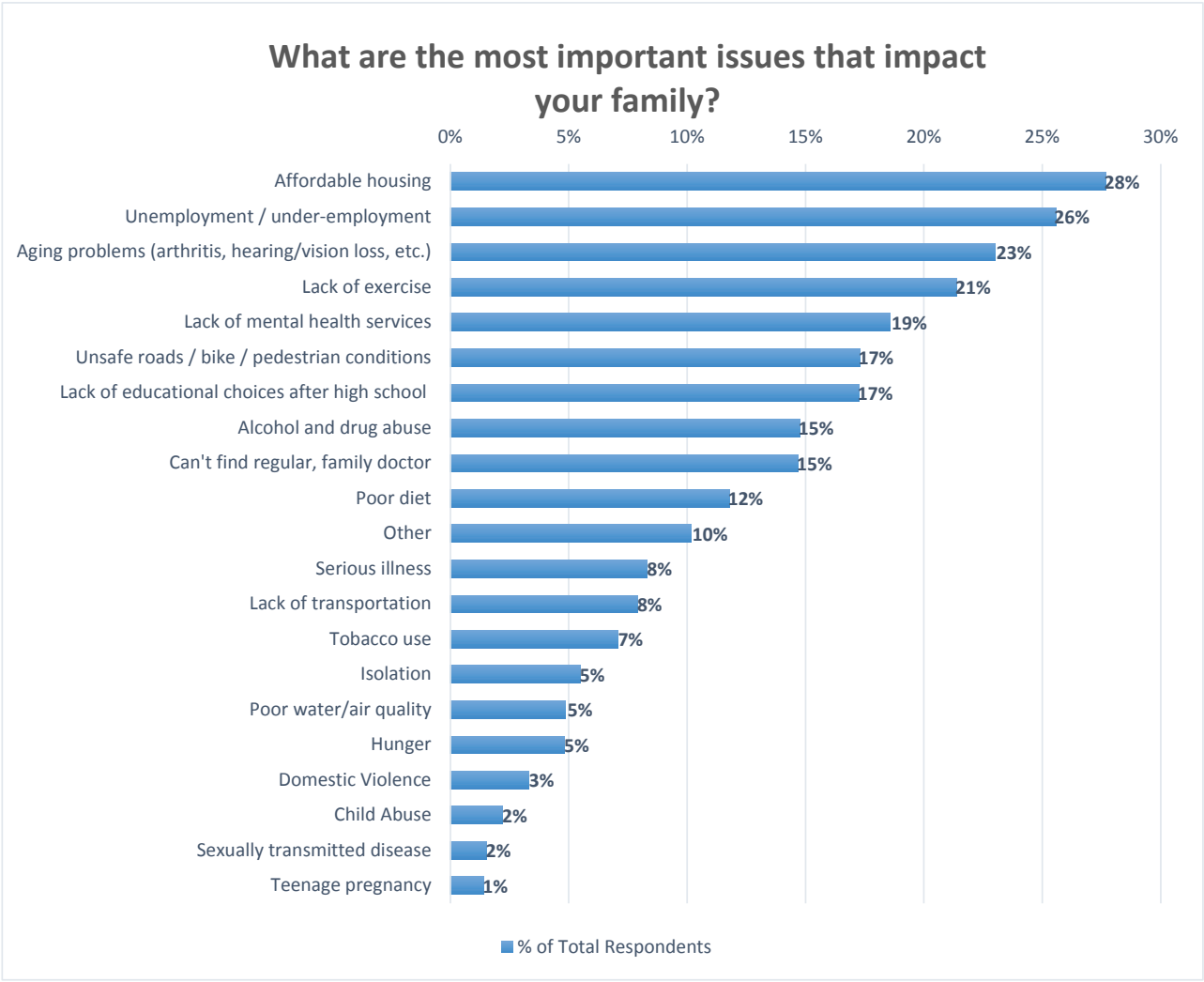
- *"Mental health impacts my family. It's a real problem and people try and put it under the rug. It's real and our community has it."*
- *"Lack of sidewalks and shoulders on roads keep people from walking, getting out and being healthy."*
- *"Many doctors aren't accepting Medi-Cal or Covered California."*
- *"Can't find a local doctor or dentist…not even a walk-in clinic."*

The choices given for answers to this question imply that the survey was asking for issues that negatively impact the respondent's family. Indeed, a number of individuals (290) noted other issues that adversely affect their family. Crime was mentioned most often (30%), along with "the homeless", lack of medical specialists, drug use in the community, the cost of health insurance and medical care, and lack of good-paying jobs. Also mentioned were limited public transportation within the county, poor access to air travel, and insufficient availability of healthy food options.

The table and the graph on the following pages illustrate what issues impact Shasta County families the most as identified by survey respondents.

Issue	Number of respondents	Percent of total respondents
Affordable housing	789	28%
Unemployment/underemployment	729	26%
Aging problems (arthritis, hearing/vision loss, etc.)	656	23%
Lack of exercise	610	21%
Lack of mental health services	530	19%
Unsafe roads/bike/pedestrian conditions	493	17%
Lack of educational choices after high school (college or vocational)	492	17%
Alcohol and drug abuse	421	15%
Can't find regular, family doctor	419	15%
Poor diet	336	12%
Other	290	10%
Serious illness	237	8%
Lack of transportation	225	8%
Tobacco use	202	7%
Isolation	156	5%
Poor water/air quality	138	5%
Hunger	137	5%
Domestic violence	95	3%
Child abuse	63	2%
Sexually transmitted disease	43	2%
Teenage pregnancy	40	1%

Total number of respondents was 2,850. Respondents were instructed to choose up to 3. If people chose more, all responses were included.



Anderson focus group

What are the most important issues that impact the *overall community health* in Shasta County?

When asked to consider which issues most impact the health of the community, nearly two-thirds of Shasta County residents surveyed listed alcohol and drug abuse as a top concern. Almost half of respondents indicated the lack of mental health services and unemployment/ underemployment hurt the health of the community. Affordable housing was viewed as an issue by more than one in four people completing the survey. Ten percent of those surveyed specified other issues as contributors to the health of the community. Of the 10% in the "Other" category, crime (35%) and the size of the homeless population (37%) were mentioned most often.

- *"Heroin abuse in our young adults."*
- *"Lack of mental health facilities."*

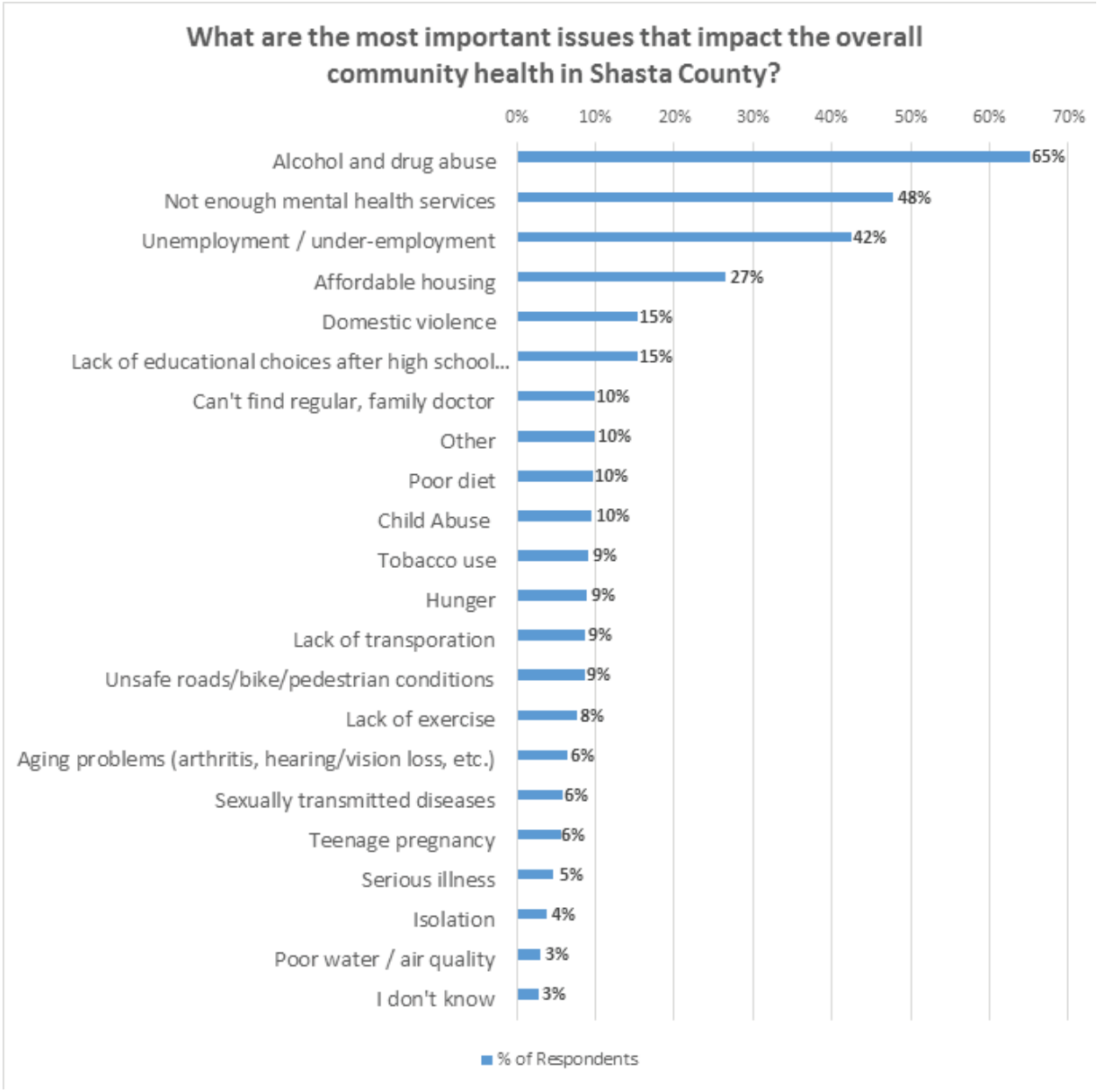
Similarly, focus group participants reported that alcohol and drug abuse and the lack of good-paying jobs are two of the most important issues that negatively impact the overall health of their community. Participants from Burney and Shasta Lake included inadequate public transportation and unsafe sidewalks and roads as major issues in their regions. Although the lack of medical providers was discussed as an important issue in all four focus groups, only Redding included it as an important issue impacting their community.

- *"Families here are underemployed. My wife has an MBA and can't find a job. People are in survival mode, just getting by."*
- *"Lack of transportation makes it hard to get medical care or to appointments."*
- *"Drug and alcohol abuse, addiction and homelessness are all linked to increase in crime."*

The table and graph on the following pages illustrate the issues that impact the overall community health in Shasta County as identified by survey respondents.

Issue	Number of respondents	Percent of total respondents
Alcohol and drug abuse	1,859	65%
Not enough mental health services	1,358	48%
Unemployment/underemployment	1,211	42%
Affordable housing	758	27%
Domestic violence	440	15%
Lack of educational choices after high school (college or vocational)	437	15%
Can't find regular, family doctor	282	10%
Other	281	10%
Poor diet	275	10%
Child abuse	271	10%
Tobacco use	259	9%
Hunger	254	9%
Lack of transportation	249	9%
Unsafe roads/bike/pedestrian conditions	246	9%
Lack of exercise	219	8%
Aging problems (arthritis, hearing/vision loss, etc.)	182	6%
Sexually transmitted diseases	167	6%
Teenage pregnancy	161	6%
Serious illness	135	5%
Isolation	110	4%
Poor water/air quality	86	3%
I don't know	83	3%

Total number of respondents was 2,850. Respondents were instructed to choose up to 3, if people chose more all responses were included.


What are the most important issues that impact the overall community health in Shasta County?
0%
10%
20%
30%
40%
50%
60%
70%
Alcohol and drug abuse
65%
Not enough mental health services
48%
Unemployment / under-employment
42%
Affordable housing
27%
Domestic violence
15%
Lack of educational choices after high school...
15%
Can't find regular, family doctor
10%
Other
10%
Poor diet
10%
Child Abuse
10%
Tobacco use
9%
Hunger
9%
Lack of transporation
9%
Unsafe roads/bike/pedestrian conditions
9%
Lack of exercise
8%
Aging problems (arthritis, hearing/vision loss, etc.)
6%
Sexually transmitted diseases
6%
Teenage pregnancy
6%
Serious illness
5%
Isolation
4%
Poor water / air quality
3%
I don't know
3%
% of Respondents

I think Shasta County is a _____ place to live.

Those taking the survey were asked to complete the statement "I think Shasta County is a _____ place to live." Two-thirds believe Shasta County is either a *healthy or very healthy* place to live. On the other hand, 29.5% of those surveyed feel that the county is an *unhealthy* or *very unhealthy* place to live.

I think Shasta County is...	Number of respondents	Percent of total respondents
Very healthy	125	4%
Healthy	1,801	63%
Unhealthy	668	23%
Very unhealthy	128	4%
Did not answer	128	4%

In closing each focus group discussion, participants were asked to give one word that describes the best thing about their community. Below is a visual compilation of those observations.



Forces of Change






Introduction

Conducting the Forces of Change Assessment answers the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?

- What specific threats or opportunities are generated by these occurrences?

In this report:

Methodology
Results

Information gathered during this assessment helps to identify both positive and negative forces that are likely to affect the health of our community. Forces of change are broad, all-encompassing categories that include:

- Trends: patterns over time, such as migration in and out of a community or a growing interest in non-motorized transportation.

- Factors: discrete elements, such as a large ethnic population or rural setting, etc.

- Events: one-time occurrences, such as a natural disaster, passage of new legislation, etc.

These forces of change, like healthcare reform legislation or an aging population, are for the most part beyond anyone's control. However, being aware of their existence will ensure that strategic issues identified later in the community health improvement planning process are relevant to our community and are responsive to the potential threats and opportunities that come with them.

Methodology

The Forces of Change Assessment was conducted on December 11, 2015 during a day-long workshop with local organizational leaders and the MAPP Steering Committee members.

Twenty-one participants representing a cross-section of the local public health system attended the workshop and provided input based on their considerable knowledge, experience and awareness of the issues facing residents in Shasta County. See Appendix 4: Invitation to Visioning and Forces of Change Workshop. Attendees included representatives from local hospitals, federally qualified healthcare centers, Native American tribes, collaboratives and non-profit organizations. See Appendix 5 for a full list of participants. A NACCHO facilitator guided the group through the following process:

1. Reviewed purpose and components of the Forces of Change Assessment.
2. Divided participants into small groups to respond to five Forces of Change questions. (See Appendix 6: Forces of Change Assessment Questions)
3. Each small group brainstormed and recorded their answers on flipcharts. Groups rotated and contributed answers to each question.
4. Participants then chose four forces or trends that interested them the most and completed the Forces of Change Threats and Opportunities Worksheet. (See Appendix 7: Forces of Changes Threats and Opportunities worksheet)
5. Worksheets and flipcharts were collected for future data analysis.

Participants were also asked to suggest names of any additional people or organizations who

should provide input into the Forces of Change Assessment to make the community assessment more valuable. Based on their recommendations, nine additional stakeholder interviews were conducted with some elected officials and local leaders from the media, education, non-profit organizations and tribal healthcare organizations.

A large number of forces were generated through the brainstorming process and stakeholder interviews. The forces were sorted and grouped by topic by a Public Health Program and Policy Analyst, and participants then identified additional threats and opportunities associated with each force. As a group, they worked through three forces: Changing Demographics, Health Care and Substance Abuse. For the remaining forces, MAPP Steering Committee members were asked to complete the Threats and Opportunities worksheet and encouraged to get input from their organizational leaders. Six people provided feedback which was combined with the original data.

During the analysis of threats and opportunities, similar ideas were combined, statements that identified solutions were eliminated or identified as community assets, and any forces which did not generate threats or opportunities were removed from the final assessment.

Results

The Forces of Change Assessment provided an overview of key trends, events or factors that participants identified as currently or potentially affecting the quality of overall health and wellness of Shasta County. The following is a summary of those forces and the challenges and opportunities for each.

In this section:

Changing demographics

Health care

Adverse Childhood Experiences

Mental health

Housing/homelessness

Crime and safety

Economy

Environment/community design

Transportation

Funding

Leadership

Technology

Changing demographics

Shasta County is experiencing an aging population. We have a growing number of residents 65 years of age and older.

Challenges:

- Increased health care needs may not balance with resources.
- Large home or agency caregiver need may exceed available resources.
- Increased burden on hospitals and rehabilitation centers to provide care for elderly patients, limited resources for appropriate discharge.
- Increased need for geriatric specialists.
- Higher risk of elder abuse, especially financial, stealing of medication and so on.
- More Alzheimer's and other dementia.
- Potentially fewer people in the workforce.
- Caring for elderly in small communities could become problematic (e.g. Hat Creek and other remote locations with a high senior population).

Opportunities:

- More life experience/wisdom to dedicate to solving community problems.
- Potential source of time and money donations for community improvement.
- Possible additional funding for best practices focusing on the older adult population.
- ASSET: Golden Umbrella is an excellent community resource and potential partner to reach the aging population.

We are seeing fewer children, especially in small communities.

Challenges:

- Fewer people care (and vote) for programs and services that benefit children, especially the 0-2 year old category which is critical to brain development.
- With fewer resources devoted to children during critical periods of development, they become more at risk for ACE's and potentially less independent and productive as adults.
- Possible school closures, which could lead to higher rates of unemployment.
- Kids get bused out of community for school.
- Early childhood programs disappear.
- Affects workforce – more difficult to attract families to area.

Opportunities:

- More childless adults could mean more foster families being available.

There is a declining population in Eastern Shasta County.

Challenges:

- Potential for less sense of community and mutual aid.
- Fewer resources go to outlying communities, seniors are concentrated in Redding and along the I-5 corridor. As population declines in these areas, even fewer resources may be available.
- Smaller communities have fewer assets, less transportation.

Opportunities:

- Able to provide services efficiently, more networked delivery system.
- More natural resources or areas that could be developed for industry, recreation, or creative business (tourist areas, 5-star restaurants, local artist shops, culturally diverse shopping centers) that could boost the economy and attract people.
- Potential to preserve and/or restore ecosystem.

We are seeing an increase in racial/ethnic diversity.

Challenges:

- Potential isolation/segregation if we don't embrace the opportunity.
- Potential backlash to increased diversity by a small percent of the population.

Opportunities:

- Cross cultural dynamism, new small business opportunities, attractive to younger adults, jobs, some retirees to move here with their resources.
- Opportunities to celebrate cultural diversity in schools, theater/arts and the community. May attract tourism or highly skilled people that want to stay and contribute to our community.
- Racially/ethnically more diverse communities tend to have higher birth rates than predominantly white communities.
- Enhance cultural competency awareness, more targeted funding.
- Opportunities for education around prejudice and tolerance.
- Increase in teen mixed races provides an opportunity to increase cultural awareness and promote tolerance.

College-going youth are moving away and not returning.

Challenges:

- Level of educational attainment impacts long-term health. Lack of education is a strong determinant of poor health outcomes.
- Could cause a lack of educated and community-minded workers for professional and leadership positions in our community.
- Less skilled workforce.

Opportunities:

- New opportunities to recruit specialists from different areas.
- May inspire companies to make a better effort to hire spouses when recruiting.
- Opportunity for employers to re-think business model, consider developing employee-friendly policies like those which promote a work/life balance.

Thriving spiritual community spurring in-migration of young adults and entrepreneurs from around the world.

Challenges:

- High percentage more wary of vaccination than some other groups, coupled with higher exposure to vaccine-preventable disease, thus potentially more risk to communicable disease outbreaks.
- Could result in a shift of Redding's image, changing the population that Redding is appealing to.
- Increased number of renters make it difficult to find reasonably priced housing.

Opportunities:

- Entrepreneurship, more youth friendly activities and groups. Attracts medical professionals that settle in our community.
- Boosts the economy and real estate industry during the school year and conference times.
- Increase in the number of highly educated people who want to stay in the community.
- Positive impact on housing - good renters
- Bring a culture of volunteerism, come with a heart to serve.
- Introduce new, different perspectives from all over the world, promote education and diversity.

Health care

The Affordable Care Act (ACA) has had a significant impact on Shasta County.

Challenges:

- The number of medical professionals did not increase proportionately with the number of insured. There aren't enough providers to see the patients now seeking services.
- There is limited availability of dental services for adults and children.
- Ongoing legal battles are under way around the validity and further expansion of the Affordable Care Act.

Opportunities:

- Significantly increased the number of residents who have health insurance.
- Undocumented children are newly eligible.
- Increased funding to collaborate on prevention of illness and promotion of health.
- Opportunity to improve insurance coverage for dental/oral health.

Many doctors are retiring or moving away. Decreased funding for health care education and California law that prohibits hospitals from employing physicians are both factors in the shortage of medical providers.

Challenges:

- Decreased access to urgent care increasing the load on emergency rooms.
- Harder to see a doctor and get necessary prescriptions.
- Increased cost of healthcare when frontline medical providers are not available.

Opportunities:

- Open positions for professionals that are excellent in their fields to be recruited from other states that could bring positive impact and possible change / improvements to our medical systems.
- Potential opportunities for medical facilities to get funding.
- ASSET: Partnership Health Plan has been investing in provider recruitment.
- ASSET: County Medical Services Program is going to invest in workforce development through loan forgiveness partnership with California's Office of Statewide Health Planning and Development.
- ASSET: Foundation model, currently in our community, is an asset which is appealing to new doctors.
- ASSET: Fellowship program at Shasta Community Health Center is an asset which is being expanded.
- ASSET: A Health Care Access subcommittee is already in place and working on this issue.

Reimbursement rates for medical services have decreased.

Challenges:

- Declining reimbursement rates has led to fewer medical providers and contributes to reduced access to care.

Opportunities:

- With less money dedicated to health services, there may be opportunities to meet needs through a blend of health and human services like housing, case management, etc.
- Potential to recruit and retain quality mid-level practitioners (e.g. nurse practitioners, physician's assistants, etc.) in addition to primary care providers.
- May increase interest in population based primary prevention efforts which have a good return on investment.
- Currently there is good availability through federally qualified health centers. They are less vulnerable to rate changes in Medi-Cal and Medicare.

Pay-for-performance healthcare is being introduced into our community through Medi-Cal Managed Care.

Challenges:

- Possible health equity issues if providers avoid taking on clients that are likely to negatively impact their performance measures.

Opportunities:

- Higher emphasis on quality care and positive outcomes in patient health.
- Opportunity for funding advances in health care technology, like the health information exchange program.
- Opportunity for expanded use of technology, outreach and patient engagement.
- Opportunity to do more preventative care - outside of hospitals or doctor's offices. (e.g. No RX Abuse coalition).
- Potential to streamline cost structures.

Education

K-12 education system in Shasta County is good with better than average high school graduation rates.

Challenges:

- Some funding formulas in the future may rely on tools for identifying disadvantaged communities based in part on low high school graduation rates. Less likely to get priority funding due to high graduation rates, even though our overall adult educational attainment is not high.
- Shasta County high school graduates are much less likely to have completed A-G requirements than their statewide peers, making them ineligible to enter a four-year public college (either CSU or UC systems) right out of high school.

Opportunities:

- Have a solid base to improve our low rate of adults with a college degree.
- Recruiting/retention opportunity for professionals with school-age children.
- Can be used as the foundation to market the value of education.

Not enough Shasta County children are going to pre-school.

Challenges:

- May begin kindergarten behind and stay behind, making it very difficult to close the education gap.
- May not have the same socialization skills when starting kindergarten as those who attended pre-school.

Opportunities:

- None noted by respondents.

K-12 schools are facing a serious teacher shortage.

Challenges:

- Large classroom size can mean a lower quality education for kids.

Opportunities:

- Job opportunities for education professionals, who may encourage young people to go into teaching profession, showing them there is a future in education.

Current focus (and funding) on childhood is on literacy and school readiness.

Challenges:

- Current educational systems may not be prepared to implement funding well.
- May not support the science on the critical importance of 0-2 years old.

Opportunities:

- Critical review of evidence-based programs improving all 0-2 year olds lives.
- Job opportunities.
- ASSET: Reach Higher Shasta working on improving early literacy through Gates Foundation grant.

Post-secondary educational opportunities are expanding.

Challenges:

- None noted by respondents.

Opportunities:

- Easier to recruit and retain students educated in the community.
- More collaborative opportunities for local students.
- More access to education and career training is a determining factor for future economic stability.

There is a growing emphasis on community colleges as opposed to four-year institutions.

Challenges:

- The rate of students who attend the community college and go onto obtain a four-year degree is low, approximately 9% of students attending local community college transfer to a four-year institution.
- Many students still have to leave the area to get a four-year degree and may not return to area after graduation. Locally we have difficulty recruiting for positions that require four-year degrees.
- Tuition will also go outside the county if we don't have better access to public four-year degrees locally.

Opportunities:

- Does allow students to obtain a degree or certification in an affordable and timely manner.
- Opportunity for job specific training.
- ASSET: Strong leadership and grant programs enhancing workforce development at Shasta College.

More online learning and blended programs available to meet educational needs.

Challenges:

- Tuition is spent out of the area.
- Quality of online education programs needs to be evaluated.

Opportunities:

- Anyone with computer access can embrace DIY U - type education, an online open learning concept that is self-paced and has multiple paths to degrees.
- These options offer flexibility, accommodating the ability to obtain degrees or certifications while working.
- Could be more affordable for some residents.
- Potentially a more educated population.

Increased collaboration around educational attainment (e.g. Reach Higher Shasta).

Challenges:

- None noted by respondents.

Opportunities:

- Provides a solid foundation to increase education status of our population and thus impact health outcomes.
- Further aligns high school graduation requirements with A-G requirements needed to apply to a CSU or UC institution.
- ASSET: Career Connections, as an initiative of Reach Higher Shasta, is working with Shasta College and local businesses to develop opportunities to address local workforce needs.

Adverse Childhood Experiences

The prevalence of child neglect and maltreatment and Adverse Childhood Experiences (ACEs) is high in Shasta County.

Challenges:

- Schools are challenged by how to meet the needs of foster children.
- ACEs have a cascading effect and can lead to self-medication, poor school performance and decreased job opportunities for the individual.
- ACEs lead to increased risk of chronic disease.
- ACEs create most challenging employment barriers.

Opportunities:

- There is an increasing community knowledge of and awareness of ACEs.
- ASSET: Partnership Health Plan is funding ACE screening programs.
- ASSET: Strengthening Families Collaborative - launching community awareness campaign in early 2017.

Substance abuse

Shasta County has high rates of substance abuse and they're increasing.

Challenges:

- Impacts the number of substance-exposed babies.
- One of the Adverse Childhood Experiences (ACEs) and a large barrier to health for many children in Shasta County.
- Contributes to the increasing number of unsheltered homeless in the county.
- Increase in Emergency Room traffic.
- Becoming more of a norm for youth.
- Stresses on/destruction of families.
- Impact on foster care system; more youth in foster care.
- Impact on courts and law enforcement.
- Increase in crime.
- Increased health care costs,
- Increases prevalence of mental illnesses caused by chronic substance abuse.
- Leads to a bad reputation and makes Shasta County a less desirable place to live, impacts the ability to recruit professionals to the area.

Opportunities:

- Increase funding and evidence-based programs for substance abuse prevention.
- Proven need for funding for substance abuse treatment.
- Increased understanding of the struggles related to addiction and substance abuse leads to compassion and empathy for people.
- City is interested in funding a sobering center, which could increase people getting into treatment.

Substance abuse trends in Shasta County show that prescription opiate and heroin use is increasing.

Challenges:

- Changes in federal guidelines are narrowing the acceptable use of opiates for chronic pain patients, making access for legitimate use an issue.

Opportunities:

- Widespread federal/state/media attention on opiate abuse as a public health issue.
- Increased funding available to address prescription opiate abuse.
- ASSET: California Healthcare Foundation grant for NoRXAbuse.
- ASSET: Good local collaborative energy around increasing the awareness of prescription opiate abuse and preventing illegitimate access to prescription opiates.

There is a local law enforcement focus on marijuana.

Challenges:

- Diverts resources away from other issues.

Opportunities:

- Helps to contain criminal activity/violence associated with marijuana growing and distributing.
- Helps prevent youth access to marijuana.

Approval of California's Drug Medi-Cal organized delivery system waiver.

Challenges:

- Higher demand on resources without immediate increase in the resources.

Opportunities:

- Expands what drug and alcohol treatment services are covered.
- Created political openness to methadone treatment.
- Provides a full continuum of care for Medi-Cal patients, coordinates with other systems of care.
- ASSET: Working with Partnership Health Plan of California on a regional model for Drug Medi-Cal Organized Delivery System.

There is a high level of stigma associated with substance abuse addiction.

Challenges:

- Produces shame for those addicted to substances, decreasing the likelihood that they will seek treatment.
- Resistance to developing drug rehabilitation centers or recruiting substance abuse counselors / workers.

Opportunities:

- People feel more pressure to say no to drugs or ask for help to stop using drugs.

Mental health

Mental health problems in our community appear to be growing.

Challenges:

- Contributes to the increasing number of unsheltered homeless in the county.
- Insufficient staff/facilities to provide services.

Opportunities:

- Highlights the importance of addressing mental health as a community issue.
- Increased awareness of the value of early childhood mental health.
- Growing interest in mental health by elected officials.
- ASSET: The Mental Health Services Act is continuing to add new programs and services.
- ASSET: Locally, there is an increased awareness of trauma-informed care and efforts to educate providers on early life interventions.
- ASSET: Home visiting programs like Nurse Family Partnership (NFP) or Parent Partners.

Although there have been improvements, mental health services and resources are underfunded.

Challenges:

- Emergency rooms are impacted, which increases staffing costs and may impact overall cost of health care.
- Categorical funding decreases flexibility in developing treatment options.

Opportunities:

- November 2016 City of Redding ballot measure for sales tax includes $1 million a year for 10 years for a crisis stabilization unit. to add new programs and services.

Community awareness and acceptance of mental illness is improving but there is still a stigma associated with having a mental illness and it is still not seen universally as a medical condition.

Challenges:

- People who need mental health treatment do not seek services.

Opportunities:

- ASSET: The Stand Against Stigma and Brave Faces campaigns are fighting the stigma surrounding mental illness.

Housing/homelessness

Single family home prices are rising.

Challenges:

- Causes some to relocate out of the area in order to buy first home.
- Prevents some from moving to our area.
- Could cause an increase in the proportion of home renters as compared to home owners and home owners usually take better care of their home than renters, thus improving the neighborhood.
- Increasing housing prices could deteriorate the conditions of our neighborhoods. (see above)
- Less available housing for residents that want an opportunity to own their home and stop renting.
- Loss of redevelopment funding makes low income housing harder to develop. Creates a need for more and newer affordable housing options.

Opportunities:

- This is a reflection of an improving economy.
- This improves the value of homes for current home owners.
- Home owners who move to Redding may have financial resources and interest in contributing to our community.
- ASSET: The Woodlands; eastern Shasta County housing project.
- ASSET: Redding Area Homeless Coalition Project.

With the elimination of redevelopment agencies, the City of Redding has fewer resources to help with affordable housing. Very little affordable housing is available in Redding. More is available in outlying areas like Burney.

Challenges:

- Lower home prices cause many people to live in outlying areas where there aren't as many job opportunities.
- People are not living close to where they work, which results in longer commutes and more pollution.
- Low-income housing needs exceed capacity.

Opportunities:

- Creative ideas can lead to renovation of old buildings, which could provide more affordable housing.
- Housing authorities are open to project based vouchers. With these, issued through public housing agencies, the home owner agrees to either rehabilitate or construct the units, or to set aside a portion of the units in an existing development.

The number of homeless people in Shasta County is growing.

Challenges:

- Homelessness creates stress on individuals and families, impacting their health and safety.
- Contributes to a poor image of Shasta County and makes it hard to recruit professionals (doctors, teachers, etc.)
- Creates increasing challenges for schools to meet the needs of the growing numbers of homeless children.
- Homelessness is an issue that polarizes communities.

Opportunities:

- Opportunity to pilot and test programs to end homelessness. Capacity to be a blue print for other communities.
- ASSET: The Redding Area Homeless Coalition Project is an advocacy organization working to end homelessness.
- ASSET: There is proposal afoot to reform the Continuum of Care Council.
- ASSET: The Homeless Management Information System provides more information about the homeless population.
- ASSET: Whole Person Care Pilot provides an opportunity for a new approach.

Housing is beginning to be seen as a component of health as seen in the State's inclusion of housing in the Medicaid 1115 waiver proposal.

Challenges:

- Creates more demand for affordable housing than can be supplied.

Opportunities:

- Hope for funding for housing for our homeless population.
- ASSET: Housing is part of Shasta County's Whole Person Care pilot proposal to the California Department of Health Care Services.

Crime and safety

Shasta County is experiencing increasing crime rates.

Challenges:

- Global feelings of safety are decreasing.

Opportunities:

- ASSET: Blueprint for Public Safety – (a comprehensive strategic plan to reduce crime and enhance public safety in the greater Redding area) has shaped a public conversation around crime.

Anti-government sentiment exists in our rural areas, where there is high gun ownership.

Challenges:

- Possible polarization of government and citizens.

Opportunities:

- Highlights the need for strategic planning to build trust and collaboration in our community.
- Recognize violence is a public health issue.

Rates of family violence are high in Shasta County.

Challenges:

- One of the identified Adverse Childhood Experiences (ACEs) leading to poor health outcomes is children experiencing family violence when they are young. Exposure to ACEs increases the risk of poor health outcomes.

Opportunities:

- ASSET: One SAFE Place is a local domestic violence shelter that offers combined services for victims of domestic violence.

New laws like AB109 and Prop. 47 are changing the system of dealing with low level criminal offenders.

Challenges:

- Shifting the cost of mental health care from state to county.
- Shifting responsibilities of preventing and mitigating crime to county, away from state prisons.
- More people with a criminal history in and around the county without ability to get stable housing, jobs, mental health care, etc.

Opportunities:

- Fewer people sent to state prison system where criminal behavior can be intensified.

Economy

Shasta County has a longstanding high unemployment rate.

Challenges:

- Increases crime and homelessness.
- Forces individuals to move out of the area.
- Difficult to recruit when spouse cannot find work.
- There is a high rate of poverty, including generational poverty, in Shasta County.

Opportunities:

- ASSET: New Venture Hub incubator.
- ASSET: Prosperity Initiative and Reach Higher Shasta's Career Connections initiative are both community-wide efforts to improve employment opportunities.

The local economy is based on low-paying jobs and seasonal employment.

Challenges:

- Makes finding affordable housing harder for a larger portion of our population when the housing prices increase.
- Hard to recruit professionals in some areas because no jobs for spouses.

Opportunities:

- Residents without degrees are competitive for local jobs.
- ASSET: New Redding Chamber of Commerce and Shasta Economic Development Corporation Directors will potentially bring fresh perspective and solutions to local challenges.

There is a threat of another recession.

Challenges:

- Higher unemployment, more people homeless or at risk of homelessness, higher stress means more mental health triggers, family violence, etc.

Opportunities:

- Cyclical nature of recession creates urgency to collaborate on creative economy boosters and job development.

Environment and community design

Water resources are depleted. This was the first substantial rainy season in many years.

Challenges:

- Groundwater reductions.
- Increased fire danger and risk of longer, more severe wildfire season.
- Burden on tourism industry.
- Could potentially affect people's access to healthy, affordable food.

Opportunities:

- Forcing us to re-evaluate our water usage and look for ways to conserve.
- Could help with connecting the Northern and Southern parts of the state due to collaboration on creative ideas to conserve water.

Shasta County has hot summers and an abundance of sun.

Challenges:

- More melanoma, a life threatening skin cancer.
- Increase in heat wave-related deaths or hospitalizations when conditions are extreme.
- Causes people to leave the area. Stops people from relocating to Shasta County.

Opportunities:

- Create "green" opportunities like solar energy technology and jobs.
- Promotes outdoor activities, promotes tourism.

Shasta County is a rural location with natural beauty.

Challenges:

- It's easy to take for granted, and without policies or systems to preserve that beauty, it is vulnerable to urban growth.
- Too much land development could destroy natural resources, risking our unique quality.

Opportunities:

- Makes Shasta County a desirable place to be.
- Makes area marketable.

Shasta County is home to the state's largest water reservoir.

Challenges:

- No control over much of the water rights.

Opportunities:

- Creates jobs and promotes tourism.

Our local general plans include elements of health.

Challenges:

- It can be difficult to implement health elements of the general plan into specific plans or projects.

Opportunities:

- Base from which to strengthen these elements over time.
- Walking and cycling are considered when planning infrastructure.
- Opportunity to be a blueprint or resource for other communities.
- ASSET: Healthy Shasta - great partnerships with Redding/Anderson - growing Shasta Lake partnerships.

Transportation

Redding has good access to transportation, but outlying areas are isolated and transportation barriers impact access services.

Challenges:

- Transportation barriers create inequitable opportunities for low income, vulnerable populations.

Opportunities:

- Jobs for transportation workers.

We are experiencing an increased use of non-motorized transportation.

Challenges:

- Increased risk of pedestrian and cyclist injuries

Opportunities:

- Promotes physical activity, less diabetes and better population mental well-being.
- Keeps people healthier, physically and mentally.
- Lowers the cost of living.
- Better for the environment. Less pollution.

There are continued improvements to our local trail systems.

Challenges:

- The pace is slow as infrastructure costs can be large; hard to compete politically with other priorities like crime.

Opportunities:

- Outdoor and ecotourism, better physical and mental well-being.
- Attracts young professionals.
- Increases opportunities for exercise. Promotes physical activity.
- Helps keep people in Redding. Improves lifestyle
- Market to outsiders for tourism.
- Household savings on gas when people use trails to commute.
- ASSET: Healthy Shasta Collaborative, City of Redding, Bureau of Land Management are very supportive agencies.

Shasta County has limited air travel access. There are very few flights in and out of the local airport

Challenges:

- Decreases economic growth opportunities; moves dollars spent on such travel out of county, e.g. to Sacramento or Bay Area.
- Limits recruitment and retention opportunities.

Opportunities:

- Development has a chance to be more measured and planned.

There is no traffic here like in large metropolitan/urban areas.

Challenges:

- People drive more, negatively affecting their health.
- Many roads have too high speed limits and are unsafe for biking or walking.

Opportunities:

- Attracts people to the area.
- Less pollution.

Funding

Community needs are increasing and resources are stagnant or decreasing.

Challenges:

- Mismatch of health needs and local resources as economic cycle turns.

Opportunities:

- Quality improvement, efficiency, cost-effectiveness, leadership and evidence-based program opportunities.
- ASSET: Inter-Governmental Transfer (IGT) for a few more years; realignment revenues have rebounded.

Local funding is affected by state and federal funding/policy decisions.

Challenges:

- Policy changes could occur that make it more difficult to protect and improve our community.
- Lack of flexibility in funding streams that are prescriptive about how money is spent make it difficult to meet community needs and collaborate.
- Reactionary funding shifts focus from prevention and quality of life to crisis.

Opportunities:

- Opportunity to be aware of government changes and take advantage of opportunities to request funding / grants for our community.
- Funding once designated for an emergency may become available for other things.
- Opportunity to talk about national threats to safety (terrorism, gun violence) as a public health issue.

The area has generous philanthropic organizations.

Challenges:

- None noted by respondents.

Opportunities:

- Drives the economy by improving local conditions.
- It is a reflection of our general population and local culture.
- Provides opportunities for generosity in our community. Possible resources to ask for help with community projects.
- ASSET: McConnell Foundation meets local needs and will be doing a new strategic plan in 2017.

There is a failure to prioritize early childhood years and young families as evidenced by funding decisions (e.g. Medi-Cal). Children don't have a voice or a vote.

Challenges:

- Huge long-term threat to local population health and economy.

Opportunities:

- Improve understanding of critical importance of 0-5 year old brain development beyond early childhood advocates to other sectors.
- Tobacco tax measure on 2016 ballot would replenish decreasing funds to First 5 commissions.
- ASSET: Strong leadership at First Five Shasta organization.

Legislative/Political

School immunization law (SB277) was recently passed, reducing the opportunity for exemption from immunization requirements on various school entry points.

Challenges:

- Might encourage more children to be home schooled, reducing funding for local schools.
- Could polarize government and citizens due to citizens not feeling empowered to make informed decisions for their child's health care.

Opportunities:

- Increased immunization rates will mean less communicable disease, more healthy children and community.
- Heightened opportunity to partner with schools and influence decisions of parents who don't feel strongly for or against vaccinations.

Leadership

There is a growing involvement of Catalyst – Redding Young Professionals Group.

Challenges:

- None noted by respondents.

Opportunities:

- Young, fresh ideas.
- Promotes leadership in the younger population, keeps them engaged.
- Opportunity to create mentoring programs for our youth, homeless, or jobless to learn from professional volunteers that are willing to teach their trade.
- Can use membership for focus groups in solution development.

County Boards of Supervisors are more receptive and aware of community health issues.

Challenges:

- None noted by respondents.

Opportunities:

- Opportunity for creative ideas to be heard and executed that could improve healthcare.
- Opportunity for criminal justice reforms and more emphasis on mental health services.
- Changing conversations and social norms. Build support for community health promotion and prevention of health problems.

We have strong, innovative leaders who trust and respect one another.

Challenges:

- Too many competing issues for leaders to tackle.

Opportunities:

- Opportunity for collaboration and creative problem solving.
- Collective impact potential.

Large number of local leaders reaching retirement age.

Challenges:

- Loss of institutional knowledge and many years of experience.

Opportunities:

- Fresh perspective and energy brought to problems.

Technology

24/7 social media and the ability to be connected is changing how the community interacts.

Challenges:

- In order to be able to keep up with community education and communication, need to be able to change quickly and adapt.
- Hard for large bureaucracies to keep up with the fast changes in how people communicate and get their information.

Opportunities:

- None noted by respondents.

Technology is improving.

Challenges:

- Cost of keeping up with new technology.

Opportunities:

- Might offer a solution to community transportation needs, such as Uber.
- Health Information Exchange will assist with patient information sharing between providers resulting in improved patient care.
- Telecommuting opportunities can bring in new businesses and reduce carbon footprint and pollution.



Community Health Status Assessment






Purpose

The purpose of the Community Health Status Assessment (CHSA) is to collect, analyze and compare public health data to describe population health.

It answers the questions "How healthy are our residents?" and "What does the health status of our community look like?"

In this report:

Methodology
Results

The data represented in this Community Health Status Assessment is a snapshot of the most recent data available as of April 2016. This data was used by community groups to set priorities for a community health improvement plan. Certain indicators, including health insurance coverage and syphilis incidence rates, have undergone substantial changes since the time this report was developed. For the most current data available, please visit www.co.shasta.ca.us/index/hhsa_index/Health_and_Safety/Community_health_data.aspx.

Methodology

The MAPP Steering Committee chosethe indicators included in this list.

Based on the National Association of City and County Health Officials (NACCHO) core set of health indicators, OPE staff developed a preliminary list of indicators for review by the MAPP Steering Committee. This list was based on available data.

In January 2016, MAPP Steering Committee members completed a survey giving their input about which of key health indicators they wanted to see in the Community Health Status Assessment. Full results of the CHSA Indicator Feedback Survey can be found in Appendix 8. Based on the results of the survey and a discussion at the February 2016 MAPP Steering Committee meeting, indicators in eight categories were selected for inclusion in the CHSA. These categories include:

- Socioeconomics
- Health Resource Availability
- Health Behavior Risk Factors
- Social and Mental Health
- Maternal and Child Health
- Death, Illness and Injury
- Preventable Diseases
- Communicable Diseases

From January to April 2016, the OPE team gathered and analyzed local and comparable state and national data to create Shasta County's 2016/2017 Community Health Status Assessment. Data was then reviewed by the MAPP Steering Commitee members using the Community Health Status Assessment Worksheet - Appendix 9. This worksheet was used to decide which data was included in the CHSA summary, found in the conclusion.

Table of Contents

Socioeconomics

The experiences of Shasta County residents can be very different depending on their income, education level, race, gender, ethnic background or where they live.

An individual or group's economic status affects social behavior, opportunity, and equitable access. These factors, in part, set a path toward health outcomes. Understanding how different populations are influenced by these factors, often called "social determinants of health," is key to eliminating health inequities and meeting the basic needs of all residents.

In 2010-14, the median household income for Shasta County was $44,556, and the average per capita income was $23,763. These rates are lower than the state at $61,489 and $29,906, respectively. These incomes are also lower than what Shasta County residents were making in 2000 when inflation is taken into account. The median household income of $34,355 in 2000 would be equivalent to $47,239 in 2016[1].

In this section:

	Median Household Income	Per Capita Income
Shasta County	$44,556	$23,763
California	$61,489	$29,906

Table 1: Median household income and per capita income for California and Shasta County, 2010-14

Cost of Living

A living wage is defined as how much income is required to provide a minimum standard of living, covering costs of food, child care, health insurance, housing, transportation, and other necessities. This amount varies not only by the family size, ages of children, and number of income providers, but also because of regional differences in costs and standards of living.

The 2016 living wage in Shasta County is estimated to be $23,576 for a single adult, $54,666 for a single parent of two children, and $60,406 for a family of two working adults with two children[2]. This means that a single adult making the average per capita income ($23,763) in the county is making just enough to provide for their basic needs, but most households are not making enough to support a family with two children. The following table states the percent of single mothers and married couples with two children who were earning less than the living wage in 2010.

Table 2: Married couples and single mothers earning less than a living wage, 2010

	Shasta County	California
Married Couples with 2 Children Earning Below Living Wage	21.8%	25.0%
Single Mothers with 2 Children Earning Below Living Wage	84.3%	77.1%

Poverty

In 2010-14, 18.0% of all residents and 23.9% of residents under 18 years old in Shasta County were living below the federal poverty level[3]. This is an increase from 2000 by 2.6% and 2.4%, respectively. Among Shasta County residents, only those age 65 years and older have significantly lower rates (7.9%) of poverty than the state rate. Adults age 18-64, women, white non-Hispanics, black, Asian, Hispanics, multiracial, and residents of "other races", all have significantly higher rates of poverty than their statewide counterparts. Hispanic, black, multiracial, and residents of "other races" also have significantly higher rates of poverty than the county average.

In 2010-14, the poverty rate for Shasta County families with children under 18 was 21.3%. This rate was lower for married couples with children and higher for single female-headed households.

Table 3: Percent of persons living below the poverty level, 2010-14

	Population in Poverty		Children in Poverty	
	Count	Percent	Count	Percent
Shasta County	31,616	18.0%	9,130	23.9%
California	6,115,244	16.4%	2,059,262	22.7%

Table 4: Poverty status of Shasta County children and families, 2010-14

	Total Count	Percent below Poverty Level
Families	44,541	11.5%
Families with related children under 18	18,401	**21.3%**
Married Couple Families	32,830	6.4%
Married Couple Families with Children under 18	11,086	11.0%
Female Householder, No Husband Present	8,511	30.6%
Female Householder, No Husband Present with Children Under 18	5,337	**43.2%**

Bold: Significantly higher than California

Employment

In 2010-14, the percent of Shasta County's labor force who were unemployed (12.2%) was significantly higher than California's (11.0%). Neither Shasta County nor California's unemployment rates have recovered to where they were in 2000 (8.7% and 7.0%, respectively).

Unemployment rates
Shasta County: 12.2%
California: 11.0%

Source: U.S. Census Bureau. American Factfinder

Homelessness

Homeless people made up 0.33% of the total population in Shasta County in 2015, which is slightly more than 0.30% in California. The number of homeless has grown by 49.4% between 2010-12 and 2013-15. The largest growth was among homeless in "transitional housing," which provides housing and supportive services to facilitate movement to independent living within 24 months[4].

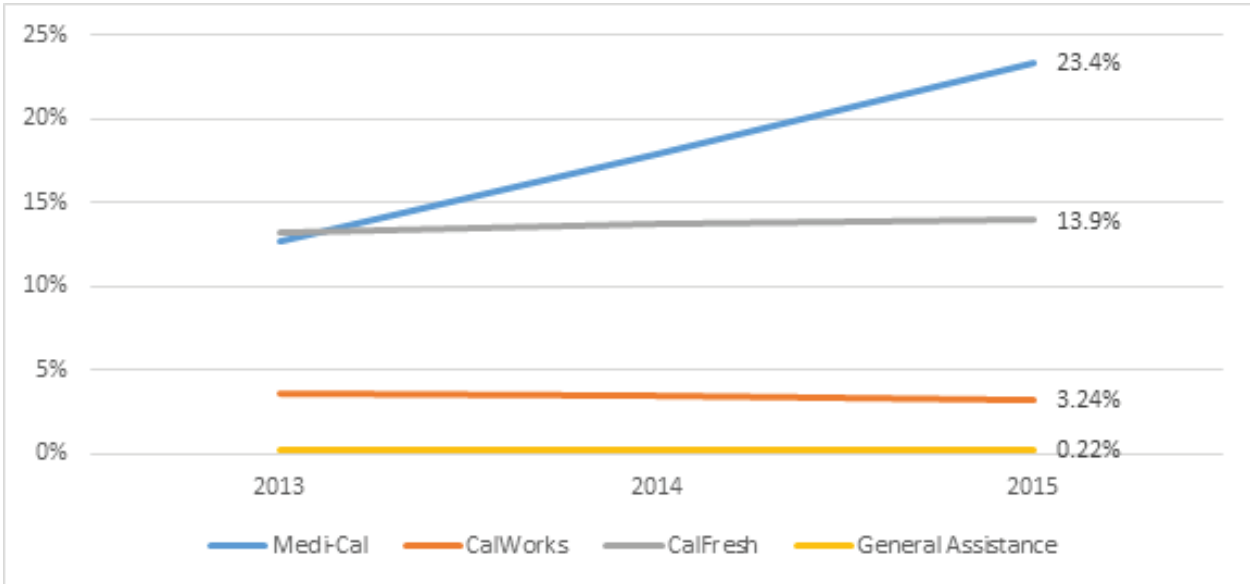
Table 5: Shasta County homelessness by sheltered status

	2013-15 Average	Percent increase since 2010-12
Emergency Shelter	205	5.3%
Transitional Housing	227	107.0%
Unsheltered	259	63.7%
Total	691	49.4%

Public Assistance

While the number of individuals participating in CalWORKs, CalFresh, and General Assistance has remained steady, the number with Medi-Cal health insurance has grown in the last 3 years to include 1 out of every 4 individuals. The percent of children enrolled in Medi-Cal has grown by 15.7%. This growth is due to the changes made by the Affordable Care Act to Medicaid's income requirements, effective January 1, 2014, that expanded access to those making up to 138% of poverty. This expansion helped reduce the number of uninsured in Shasta County by 1,913 from 16.3% of the population in 2012 down to 15.1% in 2014. CalFresh helped an average of 25,086 (nearly 1 in every 7) Shasta County individuals per month buy food in 2015. CalWORKs is a welfare program helping families afford housing, food, and other necessities. Shasta County's General Assistance program provides temporary and longer-term assistance for those awaiting Supplemental Security Income approval.

Figure 1: Average Monthly Percent of Residents on Shasta County Public Assistance by Program, 2013-15



Education

Of the 2,176 Shasta County students in the 2012-13 high school cohort, 88.5% graduated on time. This was higher than the California rate of 80.4%. Black and socioeconomically disadvantaged students and those in special education programs had significantly lower graduation rates than the county average.

Although Shasta County residents have higher rates of high school graduation, they have lower rates that complete a Bachelor's degree when compared with California. While nearly one-third of California residents have a Bachelor's degree or higher, less than 1 in 5 Shasta County residents have earned these degrees.

Table 6: High school graduation rates, 2012-13

Race/Ethnicity	High School Graduation Rate
American Indian or Alaska Native	81.3%
Asian	90.8%
Hispanic or Latino	87.9%
Black or African American	**60.6%**
White	89.8%
Two or More Races	86.1%
Program	
English Learners	78.3%
Special Education	**74.2%**
Socioeconomically Disadvantaged*	**83.2%**
All Students	**88.5%**

Bold: Significantly lower than Shasta County average rate
*Students eligible for free or reduced lunch

Table 7: Educational attainment for residents age 25 and over, 2010-14

Educational Attainment	Shasta County	California
Less Than High School Graduate	**11.3%**	18.5%
High School Graduate (Includes Equivalency)	**25.8%**	20.7%
Some College or Associate's Degree	**43.7%**	29.8%
Bachelor's Degree or Higher	**19.1%**	31.0%

Bold: Significantly different than California

Child Care

A common financial burden and barrier for low-income parents trying to enter the workforce or obtain higher education is accessing affordable childcare. This burden is often highest for low-income families during the first 2 years after giving birth, when their child is too young to attend school.

Table 8: Child care needs and capacity, 2013

	Infants (0-2)	Preschool (3-5)	School Age (6-12)	Total (0-12)
Total Children in Shasta County	6,102	6,211	15,149	27,462
Children in Households at or below 70% of State Median Income	3,368	3,428	8,362	15,158
Countywide Capacity to Serve Income-Eligible Children*	1,310	3,440	10,126	14,876

**Income eligibility set at a family income of 70% state median income*

Primary Language

The predominant primary language in Shasta County is English, with 91.6% of residents speaking only English. Of the 1 in 12 Shasta County residents who predominantly speak another language at home, only 2.8% speak English less than "very well."[5]

Table 9: Primary language spoken at home for residents age 5 and over, 2010-14

	Shasta County	California
Speak only English	91.6%	56.2%
Spanish or Spanish Creole	4.6%	28.7%
Other Indo-European languages *	1.6%	4.4%
Asian and Pacific Island languages ‡	1.9%	9.7%
Other languages §	0.2%	0.9%

* For example: French, German, Italian, Portuguese, Russian, Persian, and Hindi.
‡ For example: Chinese, Japanese, Hmong, Korean, and Thai.
§ For example: Arabic, Hungarian, Native American languages, and African languages.

Household Composition

64.6% of Shasta County households are families with 2 or more related individuals. The average size of Shasta County family households is 3.09 people.

Figure 2: Shasta County household composition, 2010-14

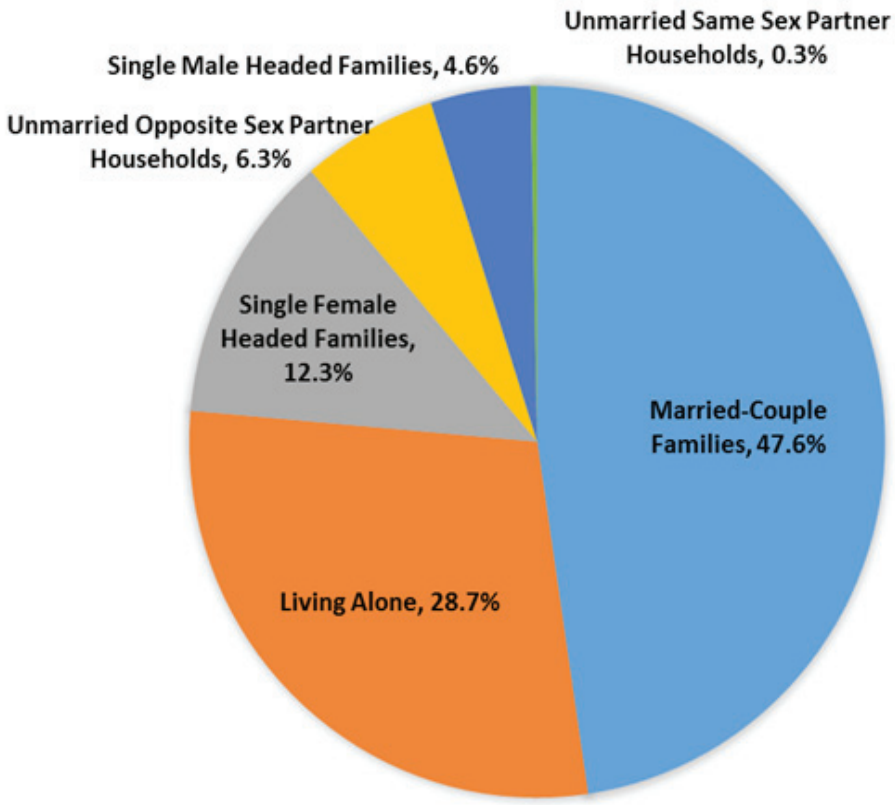


Table 10: Shasta County family household composition, 2010-14

Families	Count	Percent with Own Children	Average Family Size
Married-Couple Family	32,830	31.5%	3.06
Single Female Headed Household	8,511	52.3%	3.21
Single Male Headed Household	3,200	55.8%	3.05
Total Families	44,541	24.0%	3.09

Health Resource Availability

In Shasta County, more residents have health insurance than residents of California, on average. The expansion of Medi-Cal has allowed more low-income residents to become insured.

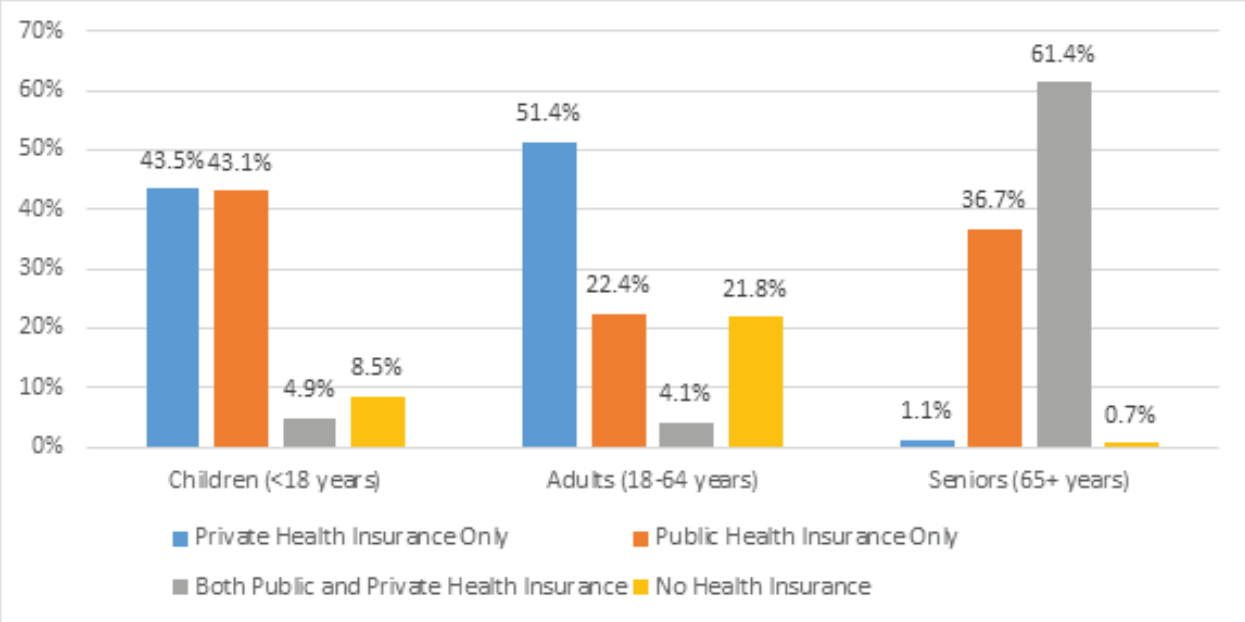
However, residents still experience challenges accessing healthcare. This is partly due to shortages in healthcare professionals serving low income and rural residents. Higher rates of uninsurance among minority residents exemplify the inequities in access to healthcare that exist between racial and ethnic groups. Overcoming the barriers that prevent all residents from accessing Shasta County's health resources is essential to improving the health of the community.

In this section:

Health Insurance Coverage

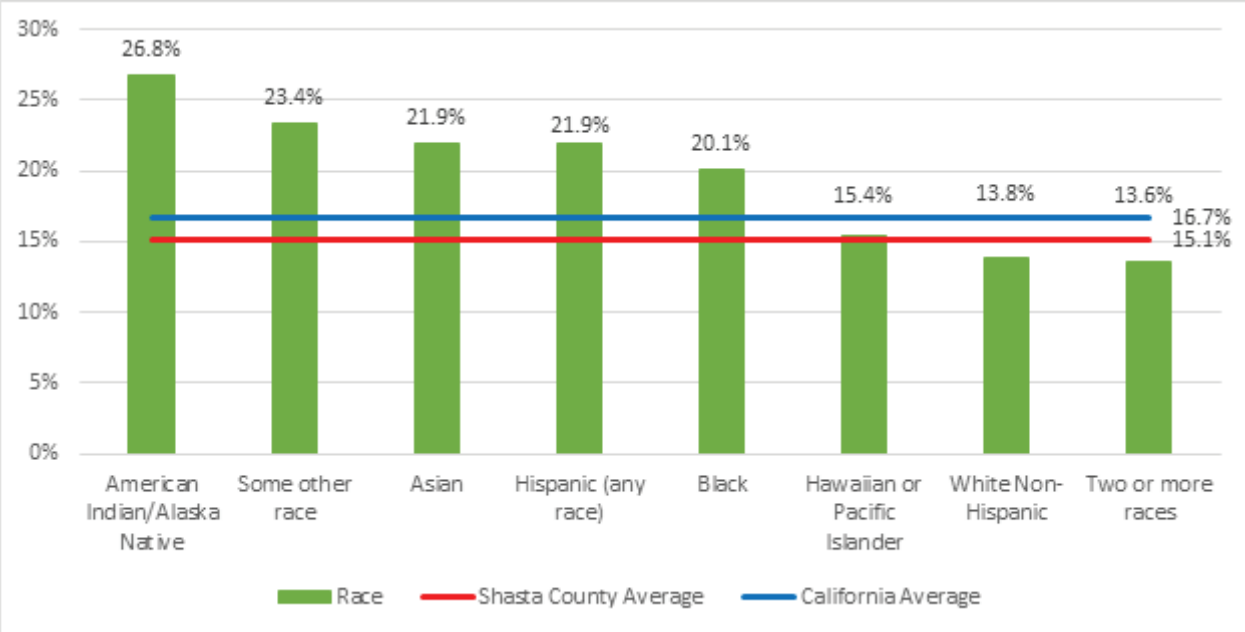
In 2010-14, 15.1% (26,728) of Shasta County residents lacked healthcare insurance. This was lower than the state average of 16.7%. A larger percent of Shasta County residents under the age of 65 had only public health insurance compared to statewide rates.

Figure 1: Percent of Shasta County Residents by Type of Health Insurance and Age Group, 2010-14



Significant differences exist among racial and ethnic groups without health insurance. American Indian/Alaskan Native, Asian, Hispanic, and residents of "Some other race" had significantly lower levels of health insurance than the county average; and White non-Hispanic residents had a significantly higher percent with health insurance.

Figure 2: Percent of Shasta County Residents without Health Insurance by Race, 2010-14



Healthcare System Efficiency

Per capita spending is used for comparison purposes. Lower spending per capita may signal a more efficient health system[1]. In 2014, Shasta County spent 13.9% less per Medicare beneficiary than the California average.

Per Capita Medicare Spending:
Shasta County: $7,401
California: $8,598

Source: CMS Office of Enterprise Data and Analytics

Primary Care Availability

Population to Primary Care Physician Ratio:
Shasta County: 1,220:1
California: 1,270:1
National Benchmark*: 1,040:1

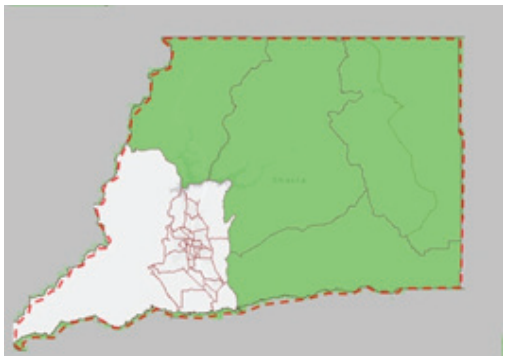
*County Health Rankings, 90th Percentile
Source: University of Wisconsin Population Health Institute

In order for people to access health care, adequate resources need to be available in the community. Shasta County and California have similar ratios of residents to primary care physicians, but neither meets the national benchmark. Regular use of primary care prevents chronic diseases from going untreated and becoming emergencies. It can also improve disease detection and early treatment. Finally, primary care can reduce the cost of healthcare for a community by reducing preventable emergency room visits and hospitalizations.

Health Professional Shortage Areas (Primary Care)

The U.S. Health Resources and Services Administration (HRSA) has designated six Shasta County clinics as having shortages of primary healthcare professionals (1 practitioner for more than 3,500 population served). These clinics include the comprehensive health centers of Hill Country Health and Wellness Center, Shasta Community Health Center, and Shingletown Medical Center; Pit River Health Services and Redding Rancheria Health Clinic which serve Native American tribal populations; and Lassen Medical Group-Cottonwood, which serves as a rural health clinic. The HRSA has also designated 6 Shasta County census tracts as having shortages of primary health care professionals to serve their populations (see map).

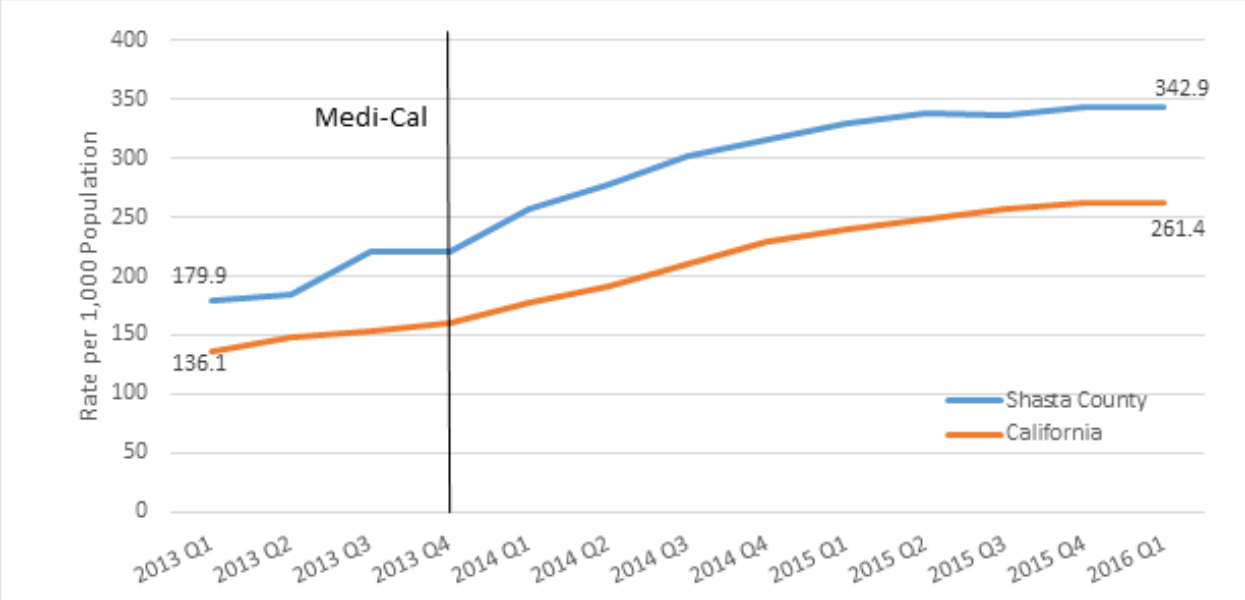
Figure 3: Census Tracts with Primary Care Health Professional Shortage Areas (Green)



Medi-Cal Enrollment and Physician Supply

Medi-Cal is the California Medicaid health insurance program for low-income people and some people with disabilities. Effective January 2014, California expanded the population eligible to enroll in Medi-Cal to those with incomes of less than 138% of the Federal Poverty Limit. For a household of one, this means $16,038 per year, plus $5,589 for each additional person. Since January of 2014, when 45,324 residents were enrolled in Medi-Cal managed care plans, enrollment has climbed by 37.2% to 62,200 residents in January of 2016. This means nearly 17,000 more Shasta County low-income residents have access to health insurance than two years ago through Medi-Cal. However, local primary care physician supply has not increased correspondingly.

Figure 4: Shasta County and California Medi-Cal Managed Care Quarterly Rate of Beneficiaries per 1,000 Population, 2013-16



Note: Does not include Medi-Cal Fee-For-Service

During the first quarter of 2016, there were 787 residents enrolled in Medi-Cal managed care for every 1 primary care physician accepting Medi-Cal managed care health insurance.

Table 1: Managed Care Medi-Cal eligible patients to participating physicians 2016 Q1

	Primary Care Physicians	Primary Care and Specialist Physicians
Shasta County	787:1	286:1

HOPE Van

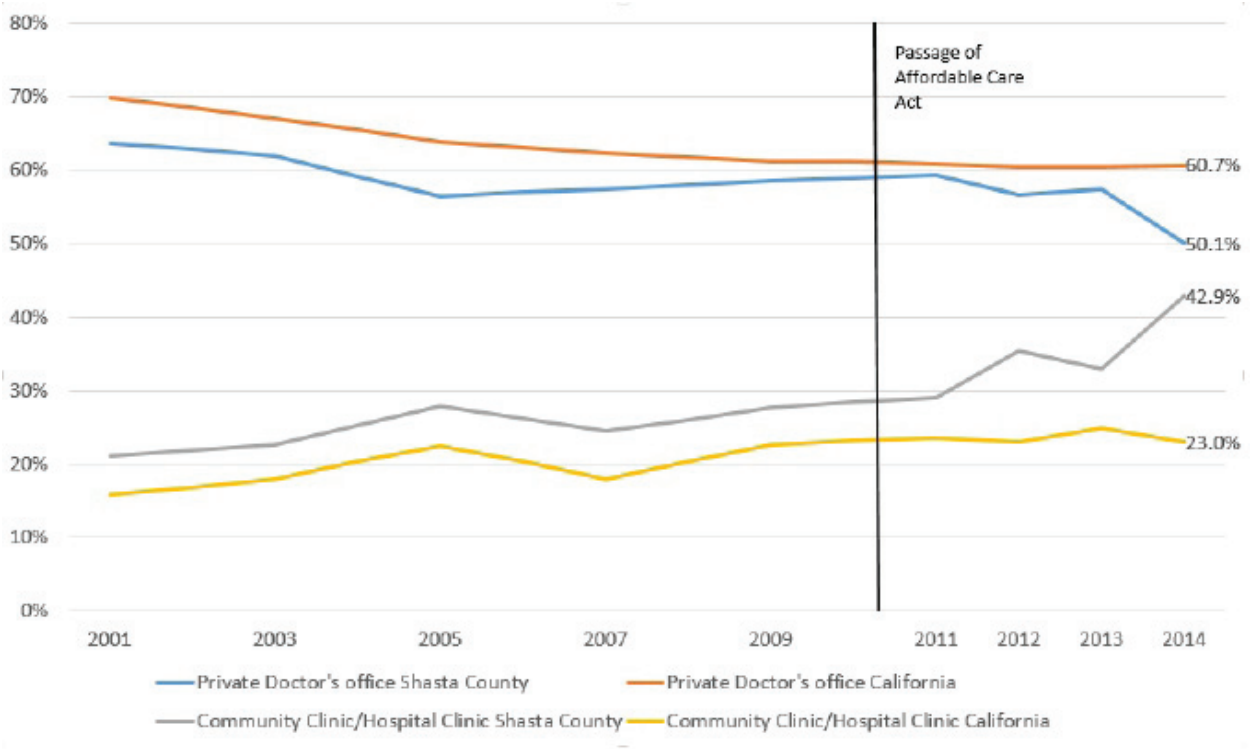
Healthcare use

As Shasta County's population grows and the number of residents with Medi-Cal increases, finding primary care doctors who accept new patients becomes harder. This barrier to accessing care may be reflected in the 1 in 6 Shasta County residents who delayed getting needed medical care[2]. Community health centers serve a large percentage of poor, uninsured, and publicly-insured residents, and expanding the reach of providers like them will be key to meeting increased demand for primary healthcare in Shasta County.[3]

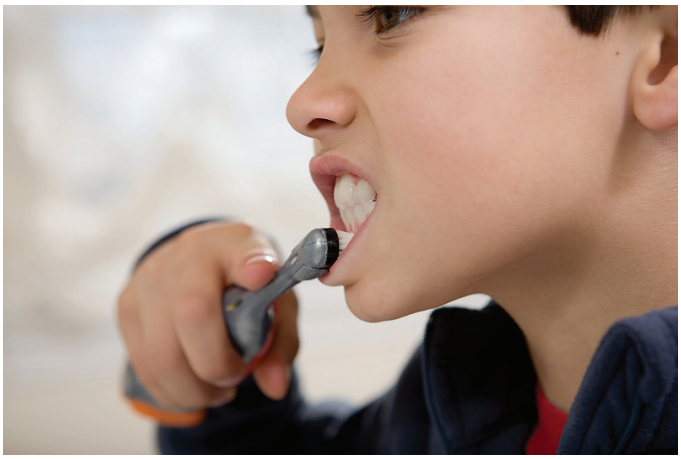
Residents who have a regular doctor:
Shasta County: 91.8%
California: 86.2%

Source: UCLA Center for Health Policy Research.

Figure 5: Usual Source of Health Care

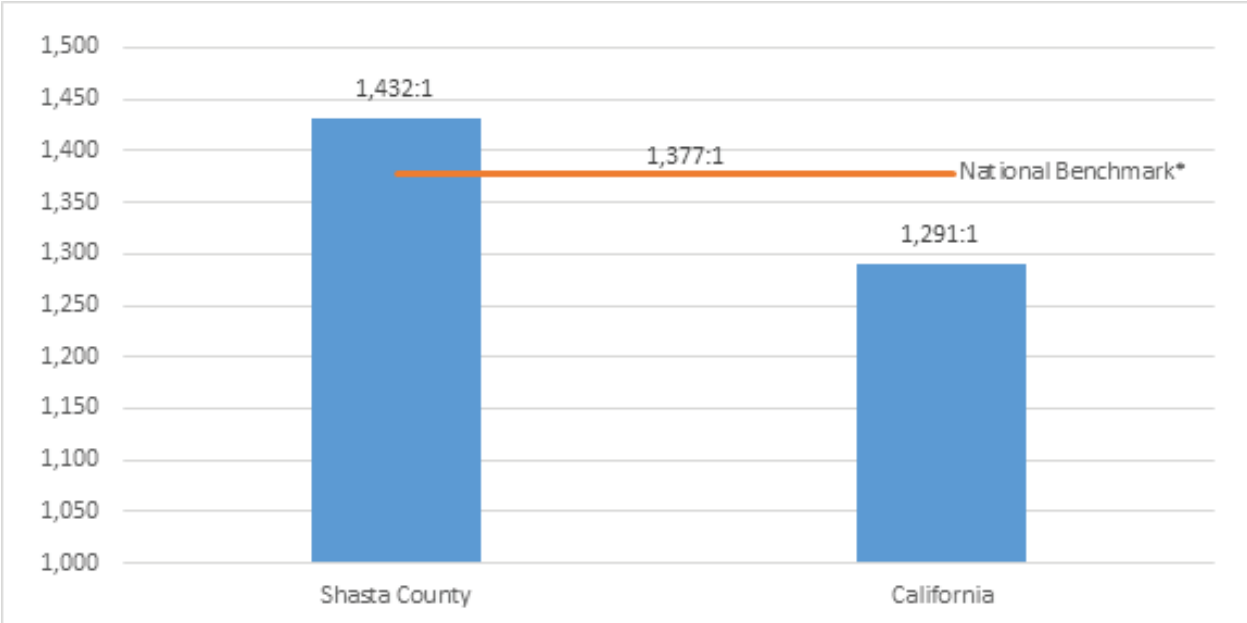


Oral and Dental Care



In 2013, there were 1,432 residents for every 1 dentist in Shasta County. This ratio is worse than the California average and limits residents' access to dental care. Furthermore, nearly half of Shasta County adults lacked dental insurance in the last reported year.[2] Among low income residents with Medi-Cal's dental insurance (Denti-Cal), there were 3,237 residents for every 1 dentist accepting this insurance. These barriers to oral health services may have contributed to 1 in 4 Shasta County residents not having been to a dentist in more than two years.[2]

Figure 6: Ratio of Residents per Dentist, 2013

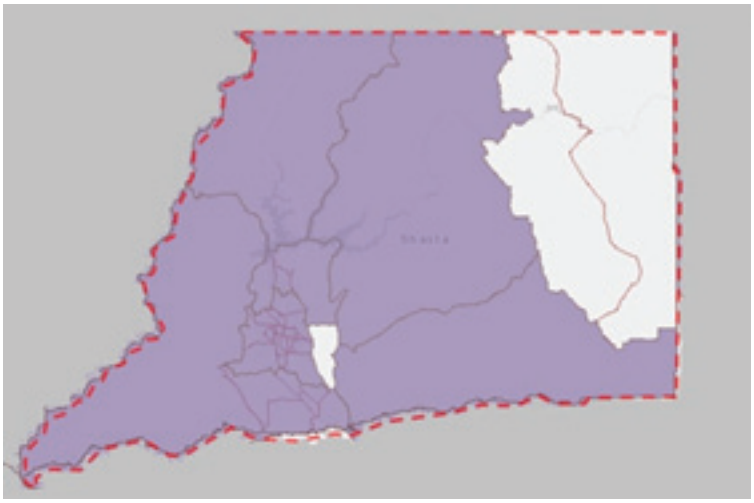


*County Health Rankings, 90th Percentile

Healthcare Professional Shortage Areas (Dental Care)

The U.S. Health Resources and Services Administration (HRSA) has designated five Shasta County clinics as having shortages of dental healthcare professionals (one practitioner for more than 5,000 population served). The same five clinics are listed as primary care health professional shortage areas. Additionally, eight census tracts have low income/migrant farmworker/homeless populations, 35 census tracts with low income populations, and two additional census tracts designated as dental care health professional shortage areas.

Figure 7: Census Tracts with Health Professional Shortage Areas for Dental Care (Purple)



Health Behavior Risk Factors

Higher rates of poor health behaviors like smoking put residents at higher risk of developing diseases, disabilities, and early death.

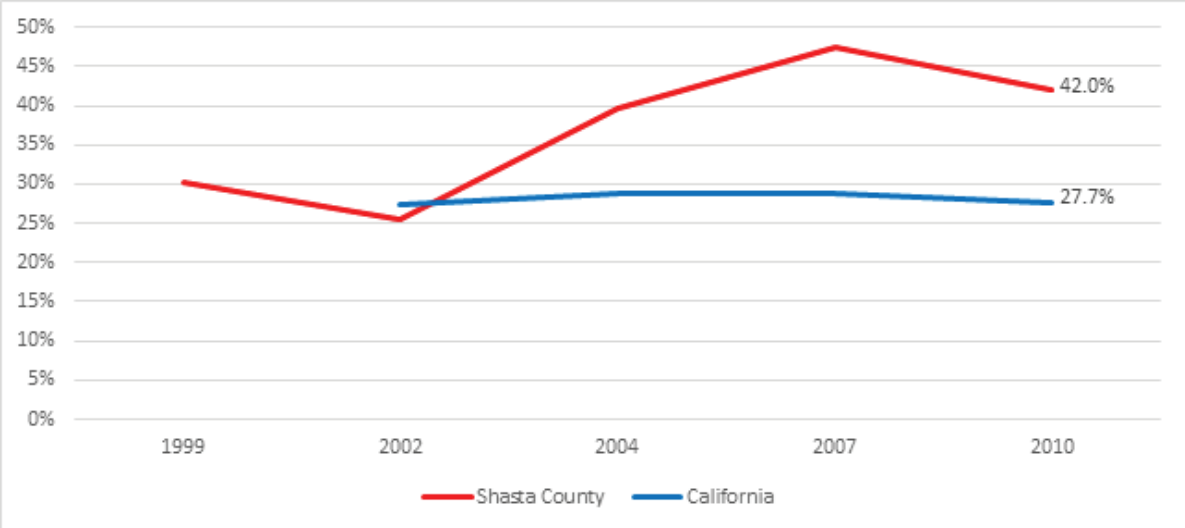
As the rate of residents who participate in regular exercise has declined, the percent of obesity has gone up. Inequities in health outcomes between residents with less education and lower income and residents with higher education and income are measured in deaths and disabilities. However, inequities are caused in part by environments that create barriers to practicing healthy behaviors. While tobacco use among Shasta County residents with higher income and educational attainment are closer to statewide rates, smoking among those with lower income and education are nearly double California averages. Furthermore, more than half of residents with incomes of 200% of poverty or higher meet CDC recommendations for exercise but only 1 in 3 with income below 200% of poverty meet these recommendations. The higher percentage of low-income residents who don't use their leisure time for physical activity may suggest financial barriers to accessing parks and gyms. The statistics underscore our responsibility to ensure that all residents have access to resources to live healthy in Shasta County.

In this section:

Nutrition

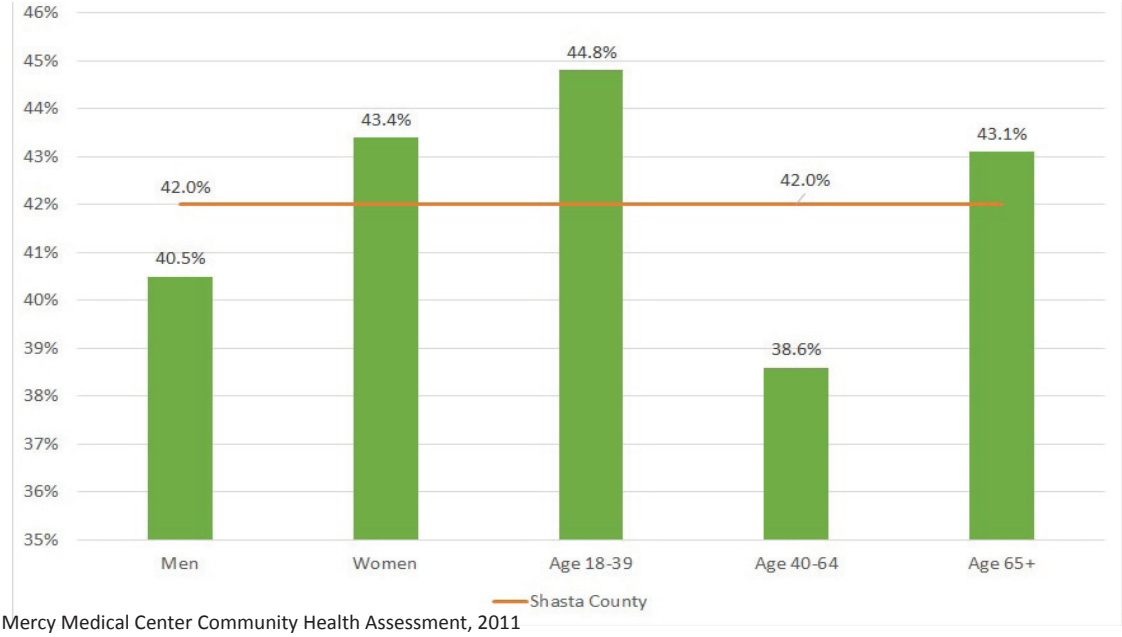
Eating more fruits and vegetables adds nutrients and fiber to diets, reduces the risk for heart disease, stroke, and some cancers, and helps manage body weight when consumed in place of more energy-dense foods[1]. About 2 in every 5 Shasta County residents consumed the recommended 5 or more servings of fruits and vegetables in 2010.

Figure 1: Percent Consume 5 or More Fruits and Vegetable Servings per Day



Note: 2005 & 2009 BRFSS data used for 2004 & 2010 California and USA, respectively, USA: States & DC

Figure 2: Percent Consume 5 or More Fruits and Vegetable Servings per Day, 2010

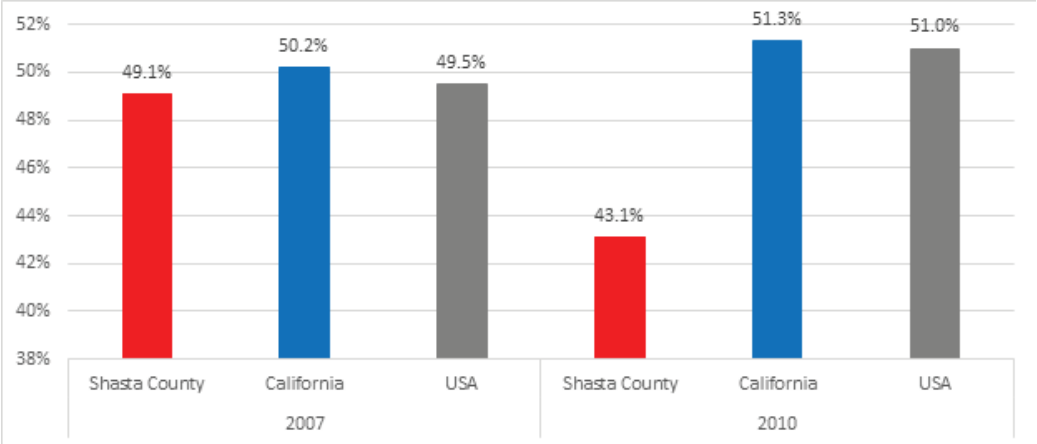


Mercy Medical Center Community Health Assessment, 2011

Physical Activity

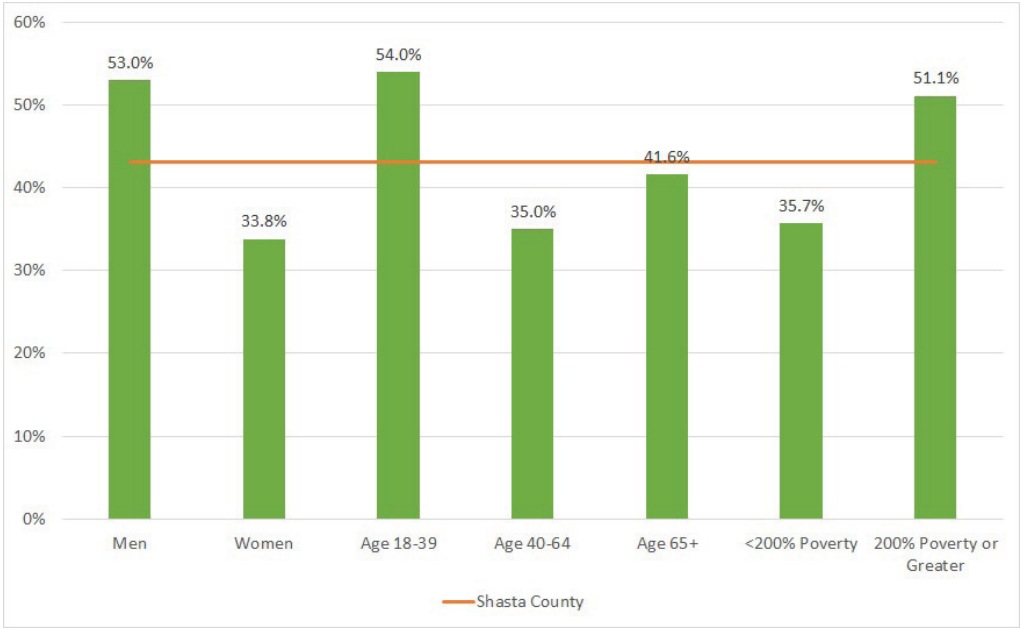
Physical activity can improve health. People who are physically active live longer and have lower risks for heart disease, stroke, type 2 diabetes, depression, and some cancers[2]. Shasta County adults have lower rates of regular exercise than residents statewide.

Figure 3: Percent Meeting Physical Activity Recommendations



Note: 2009 BRFSS data used for 2010 California and USA data, respectively, USA: States and DC

Figure 4: Percent Meeting Physical Activity Recommendations by Subgroup, 2010



Obesity

Body Mass Index (BMI) is based on height and weight and can be used to estimate body fat. Obesity is defined as having a BMI of 30 or higher. Obese people have higher risk of many health conditions, including hypertension, high cholesterol, Type 2 diabetes, heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, some cancers, some mental illnesses, and death[3].

Figure 5: Obese Adults Age 18 and Older (BMI>29.9)

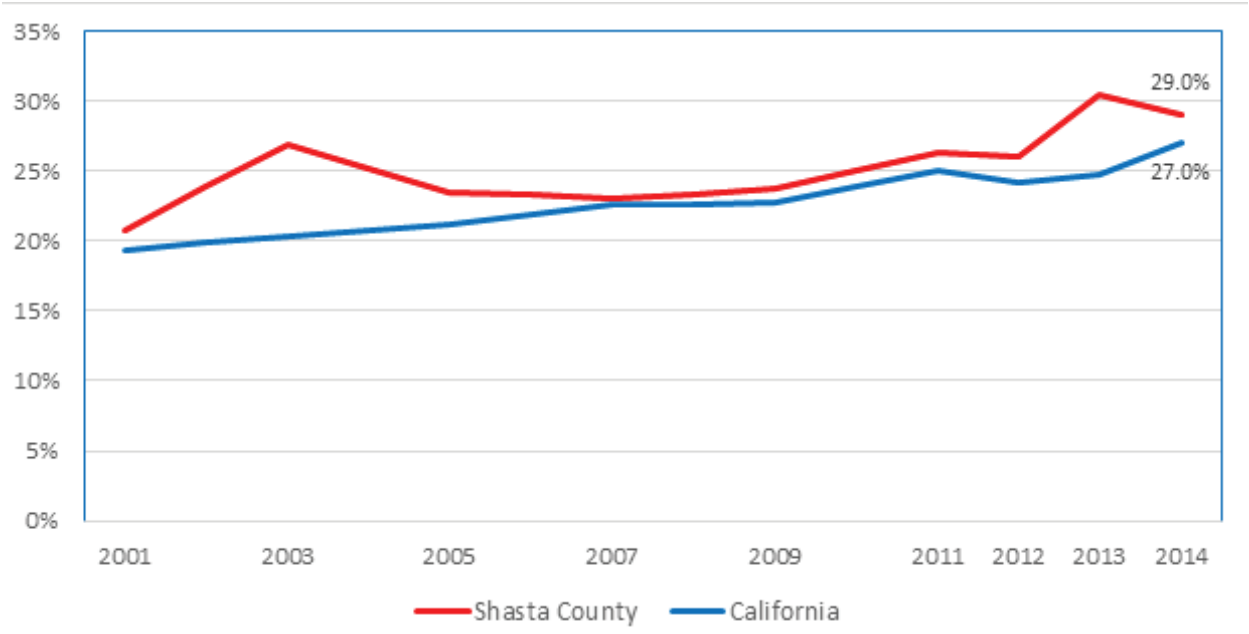


Table 1: Obesity among Shasta County and California adults (18+), 2013-14

	Shasta County	California
Total Obesity (BMI>29.9)	29.8%	25.9%
Rates by Age		
Adult (18-64)	30.4%	26.3%
Senior (65+)	25.7%	23.5%
Rates by Educational Attainment		
High School Graduate or Less	39.0%	30.9%
Some College, Vocational School, or Associate's Degree	34.7%	28.1%
Bachelor's Degree or Higher	12.5%*	18.4%
Rates by Race/Ethnicity		
White (Non-Hispanic)	29.8%	22.8%
Non-White (Including Hispanics)	30.2%	28.2%
Rates by Income Level		
Less than 200% Federal Poverty Level	37.5%	29.8%
Greater than 200% Federal Poverty Level	25.8%	23.6%

* statistically unstable: has not met criteria for a minimum number of respondents or exceeded acceptable value for coefficient of variance
(UCLA Center for Health Policy Research, 2003-14)

Working Together: Healthy Shasta

Healthy Shasta is a local partnership to promote healthy and active living. More than 20 partner organizations joined forces more than 10 years ago out of concern over increasing rates of childhood obesity and chronic diseases. Its vision is a community where "the healthy choice is the easy choice."

Its initiative areas include:

- Fruits and Vegetables
- Sugary Beverages
- Walking and Biking
- Fitness and Play

HEALTHY SHASTA
Better choices. Healthy changes.

Learn more at www.healthyshasta.org.

Tobacco Use

Shasta County has one of the highest rates of tobacco use in California. In 2011-14, 21.4% of Shasta County adults currently smoked. People most likely to smoke were those with a high school education or less (35.5%) and those with incomes of 200% of poverty or less (32.8%)[4]. The proportion of annual household expenditures spent on cigarettes in Shasta County was the third highest of any California county in 2014[5]. Smoking increases risk of disease in nearly every organ of the body, and is the leading cause of preventable death in the United States (480,000 deaths per year). Smoking is linked to cancers in the lung, liver, colon, rectum, bladder, stomach, kidney, pancreas, trachea, and other organs. It also increases risk for stroke, diabetes, Chronic Obstructive Pulmonary Disease (COPD), ectopic pregnancy, male sexual dysfunction, rheumatoid arthritis, reduced fertility in women, coronary heart disease, pneumonia, vascular diseases, and others[6].

Figure 6: Current Smoking Status - Adults Age 18 and Older

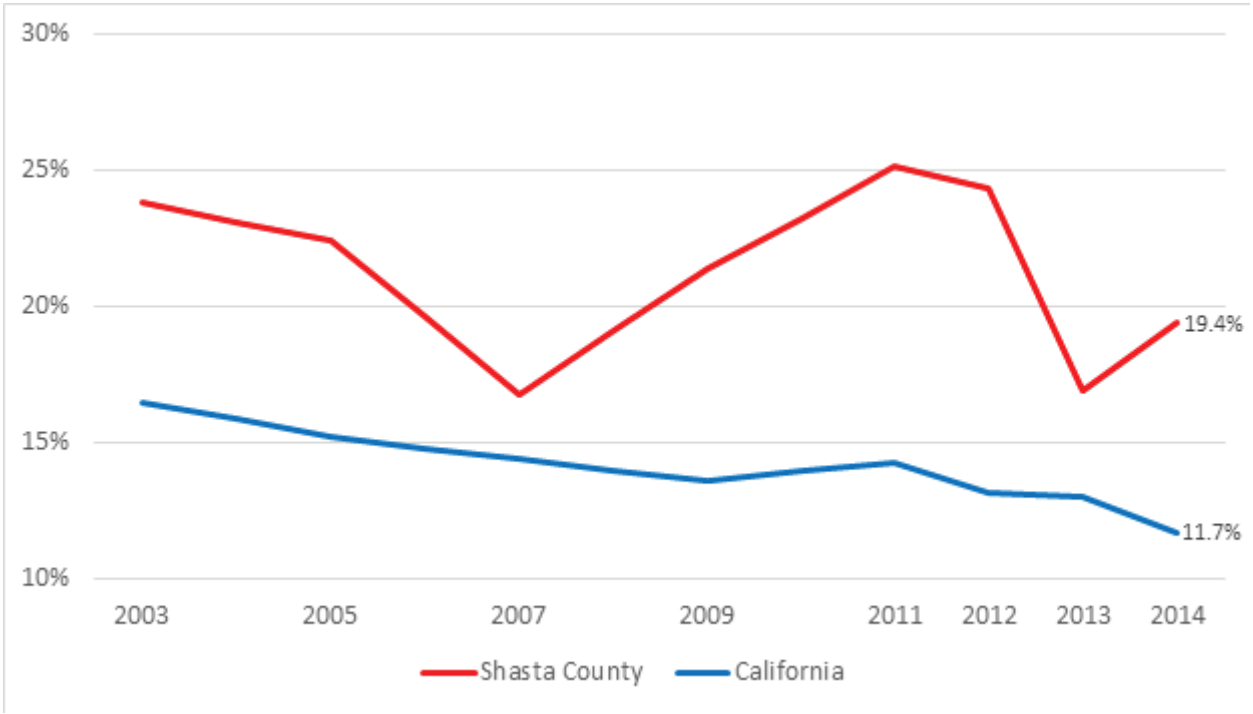


Table 2: Tobacco use in Shasta County and California adults (18+), 2011-14

	Shasta County	California
Total Current Smokers	**21.4%**	13.1%
Rates by Age		
Adult (18-64)	**24.1%**	14.3%
Senior (65+)	**12.5%**	6.4%
Rates by Educational Attainment		
High School Graduate or Less	**35.5%**	16.6%
Some College, Vocational School, or Associate's Degree	13.4%	15.6%
Bachelor's Degree or Higher	8.6% *	7.2%
Rates by Race/Ethnicity		
White (Non-Hispanic)	**20.5%**	14.2%
Non-White (Including Hispanics)	**26.4%**	12.2%
Rates by Income Level		
Less than 200% Federal Poverty Level	**32.8%**	16.6%
Greater than 200% Federal Poverty Level	14.7%	11.1%

BOLD= Statistically different that California rate. *statistically unstable: has not met criteria for a minimum number of respondents or exceeded acceptable value for coefficient of variance (UCLA Center for Health Policy Research, 2003-14)

Working Together: Tobacco Education Coalition

The Shasta County Tobacco Education Coalition collaborates around the common goal of tobacco prevention and health promotion. It advocates for systems and policies that regulate tobacco in Shasta County, collaborating with neighboring cities, business communities, public health agencies, churches, schools, and community-based organizations. It's an advisory body to the Shasta County Health and Human Services Agency's Tobacco Education Program, and it helps with program development and the implementation and evaluation of the local tobacco control plan throughout Shasta County.

Learn more at www.tobaccofreeshasta.org.

Social and Mental Health

Social and mental health are closely linked, with shared causes and experiences. Social health involves interpersonal relationships; mental health involves one's own wellbeing.

What impacts one often has an impact on the other. For example, 22.1% of Shasta County residents who died by suicide in 2008-13 had a known mental health problem[1]. Exposure to Adverse Childhood Experiences (ACEs) have a profound and long-lasting effect on a person's health and well-being into adulthood. These experiences include physical, sexual or emotional abuse, alcohol or other substance abuse by a family member, mental illness of a family member, divorce or separation, domestic violence or incarceration of a household member.The more of these that a person experiences in childhood, the more likely he or she is to experience risky health behaviors, chronic health conditions and early death.[2]

In this section:

Overall Mental Health

Mental Health is not just the absence of mental illness, but rather, "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[3] In 2013-14, about one in eight Shasta County adults under 70 said that their emotions interfered with their performance at work in the past year, and about one in seven adults said their emotions interfered with their relationships with friends and family. Moreover, one in 11 said they had likely experienced a serious psychological distress in the past year.[4]

The graphic below describes survey responses to the question, "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Shasta County residents averaged
4.1 poor mental health days in the last month

California residents averaged
3.6 poor mental health days in the last month

Average number of mentally unhealthy days in the past 30 days, 2006-12. Age-adjusted. CDC, BRFSS, via County Health Rankings, 2015.

Child Abuse

Verbal, physical, and sexual abuse are among several Adverse Childhood Experiences (ACEs) that have been linked to known risk factors for chronic disease and other adverse mental and physical health outcomes into adulthood. The full measure of how these traumatic experiences harm children is hard to relate, but aside from direct physical harms, they can also create, "social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality."[5]

Child maltreatment cases include children who have experienced sexual, physical, or emotional abuse, neglect, exploitation, caretaker absence or incapacity, and those at risk because a sibling was abused. In 2010-14, there was an average of 699 substantiated cases of reported maltreatment for children under 18 years old. This is a 5-year average rate of 18.0 per 1,000 Shasta County children. During these 5 years, this rate decreased by 31%. Nevertheless, by 2014 the rate was still higher than the California average rate and the Healthy People 2020 target of 8.5 survivors/victims per 1,000 children under 18.[6] Furthermore, in 2014 the rate of child maltreatment for children under the age of 1 was more than double the state rate and equates to almost 1 in every 20 Shasta County infants.

Figure 1: Substantiated Cases of Reported Child Maltreatment

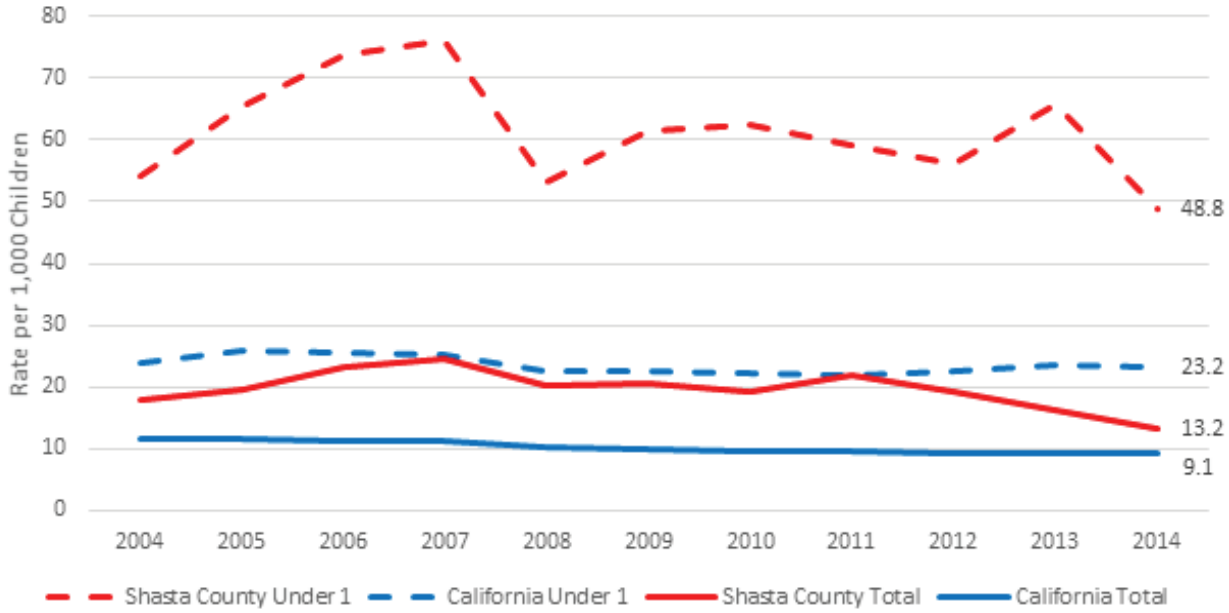


Table 1: Substantiated Reported Child Maltreatment Cases per 1,000 Children, 2014

		Shasta County	California
Total		**13.2**	9.1
Gender	Female	**14.3**	9.4
	Male	**12.2**	8.8
Age Group	Under 1	**48.8**	23.2
	Age 1-2	**20.4**	11.2
	Age 3-5	**16.0**	10.2
	Age 6-10	**11.5**	8.7
	Age 11-15	7.7	6.7
	Age 16-17	*	5.1
Race	Black	*	24.4
	White	**11.1**	7.5
	Latino	9.4	9.8
	Asian/ Pacific Islander	*	2.5
	American Indian/ Alaska Native	23.4	23.8

*Suppressed due to fewer than 20 cases. BOLD: Significantly higher than California rate.

Working Together: Strengthening Families

More than 30 agencies in Shasta County have joined forces to address Adverse Childhood Experiences (ACEs) in a systematic, focused and collaborative way. This group works to build "protective factors" which improve the health and well-being of children and families. They help parents find resources and support, and build coping strategies that allow them to parent effectively, even under stress. Protective factors include parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children.

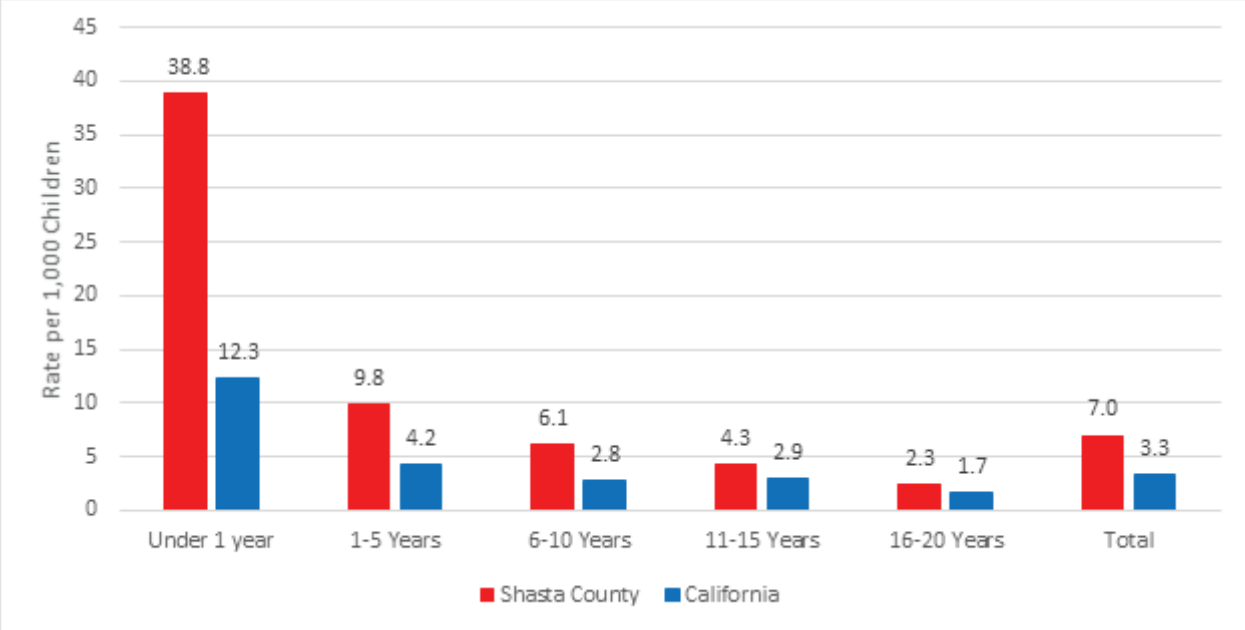
Learn more at www.shastastrongfamilies.org.

Foster Care

There are several reasons children may enter foster care. Physical or sexual abuse, neglect, abandonment, and incarceration or death of a parent may lead to children being placed in foster care. Children may also be placed into foster care by law enforcement if they are juvenile offenders and issues at home make parents unable to manage the child's behavior.

The rate of entries into foster care in Shasta County is significantly higher than the California average. There are more than 3 times as many entries among infants (under 1 year old) into foster care in Shasta County compared to statewide.

Figure 2: Entries into Foster Care by Age, 2012-14

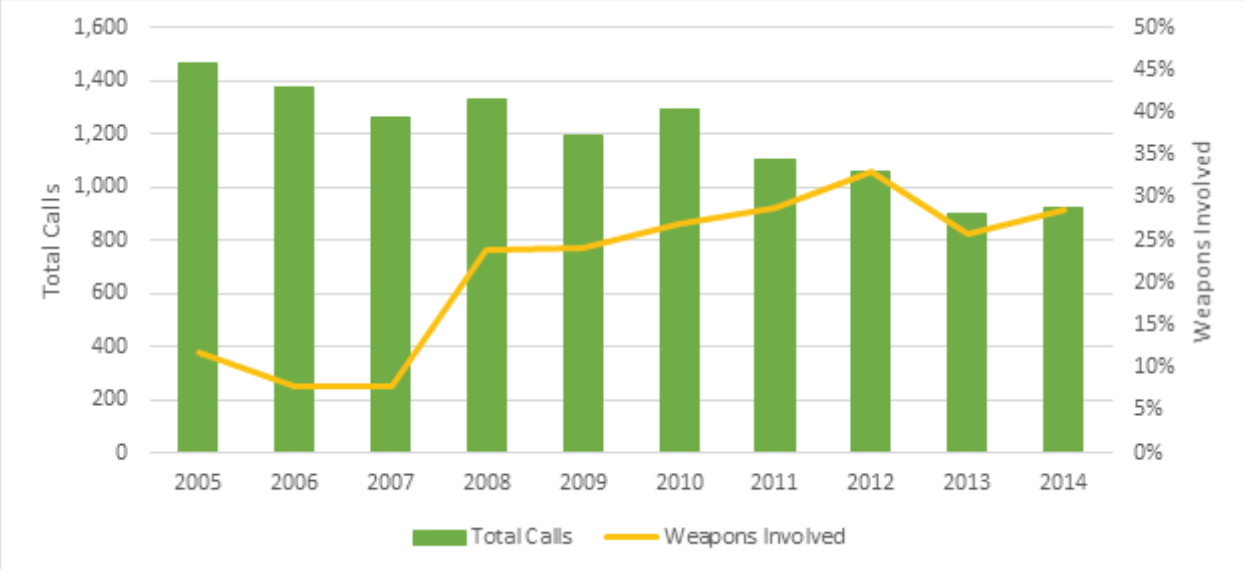


Domestic Abuse

Domestic abuse (intimate partner violence) is physical, sexual, or psychological abuse by a current or former partner. More than a third of American women have experienced physical violence, rape, and/or stalking by an intimate partner in their lifetime. Health consequences may include mental health problems, unintended pregnancy, sexually transmitted infections, and other physical health problems. Of people who experienced intimate partner violence, 81% of women and 35% of men reported at least one health-related or other impact.[7]

In 2012-14, Shasta County's rate of 536.6 domestic abuse calls per 100,000 residents was significantly higher than the California rate of 405.5. While efforts around child and domestic abuse generally focus on prevention, protection, and law enforcement, growing attention is paid to the role of resilience in the recovery process. "The ability to thrive, mature, and increase competence in the face of adverse circumstances" can be rooted in personal traits such as "easy temperament, secure attachment, basic trust, problem solving abilities, an internal locus of control, an active coping style, enlisting people to help, making friends, acquiring language and reading well, realistic self-esteem, a sense of harmony, a desire to contribute to others, and faith that one's life matters."[8]

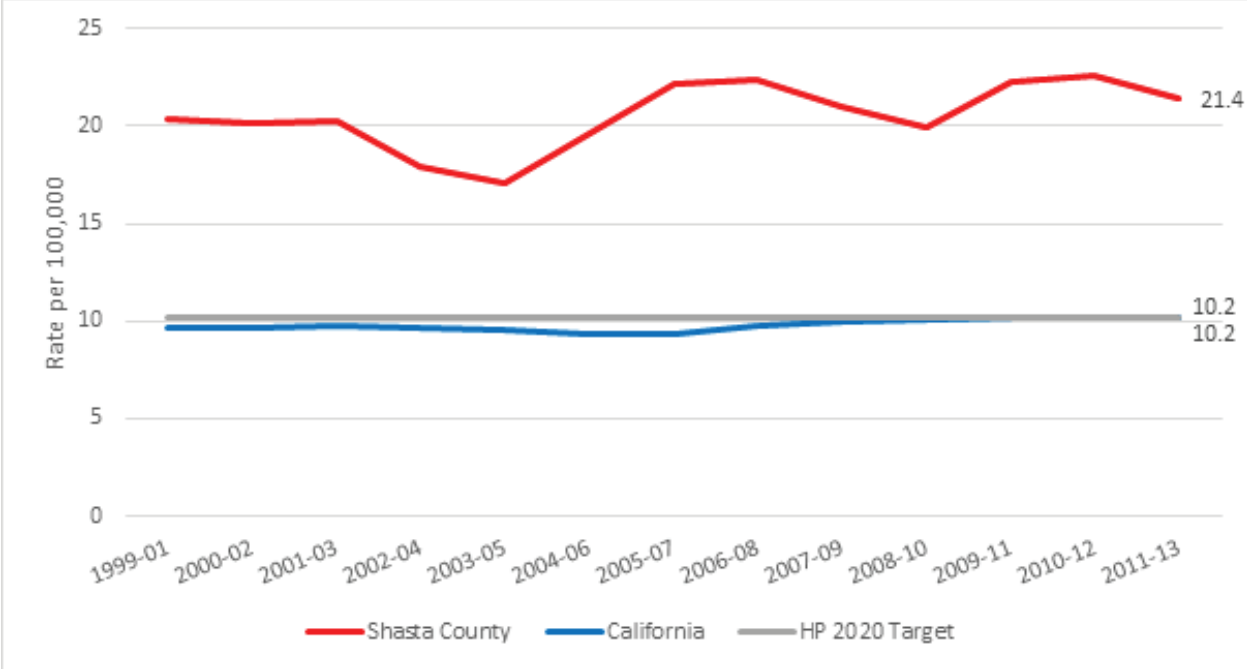
Figure 3: Domestic violence calls to police in Shasta County by year



Suicide

In 2011-13, Shasta County had the 12th highest average annual age-adjusted suicide death rate (21.4 per 100,000) of California counties. The Healthy People 2020 goal for suicide is to reduce the rate to 10.2 per 100,000.[9]

Figure 4: Age-Adjusted Death Rate from Suicide/Intentional Self-Harm (3-Year Average Annual Rates/100,000), 1999-2013



237 Shasta County residents died by suicide in 2008-13; 4 of 5 were men and 2 of 3 were age 45 or older. 58.4% were in a depressed mood at the time of suicide. 22.1% had a known mental health problem and of those, 28.6% had depression. However, less than half of those with a current mental health problem had ever received treatment.

Veterans made up nearly 1 in 4 Shasta County suicides, which was a larger percent than in California or nationally. Firearms were used in more than half of Shasta County suicides, much higher than the state average. It is important to recognize the warning signs of suicide, since only 1 in 4 disclosed an intent to take their own lives.[1]

Homicide

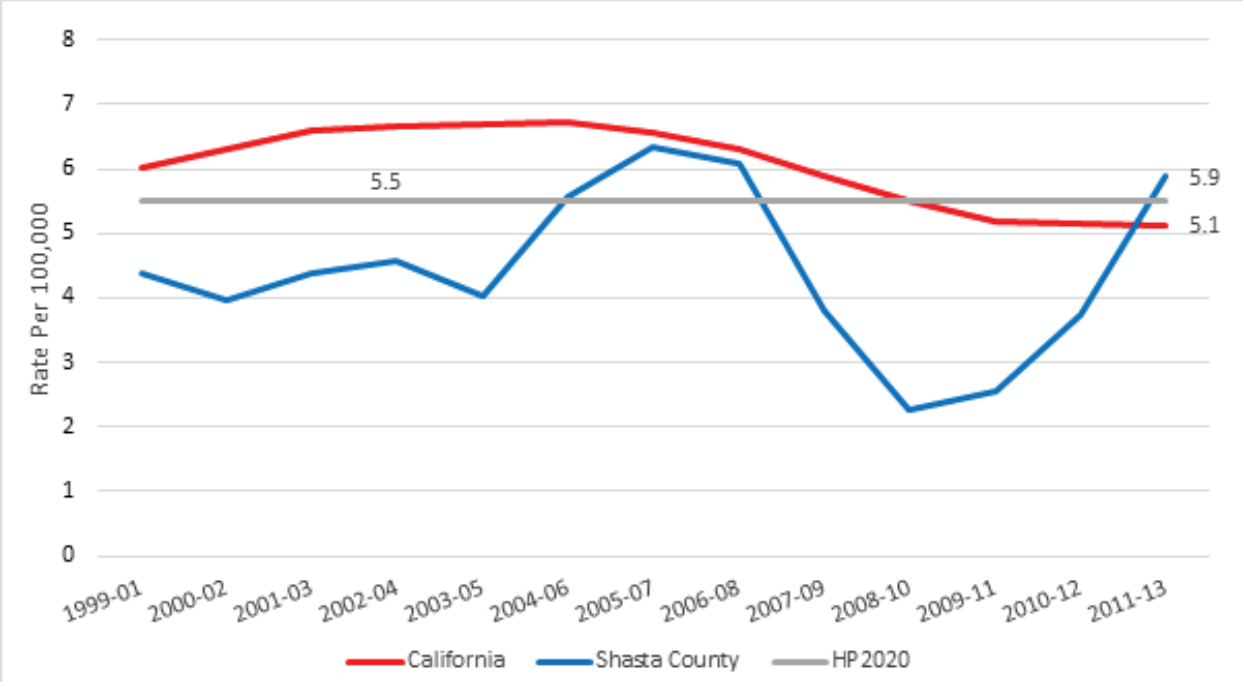
In 2011-13, there was an average of 9.7 annual deaths by homicide in Shasta County. Significant predictors of violent behavior include experiencing divorce/separation, unemployment, or victimization in the past year as well as substance abuse, history of violence, juvenile detention, or parental criminal history.[10]

Table 2: Age-adjusted homicide death rates per 100,000, 2011-13

	Shasta County	California	HP2020 Target
Homicide	5.9*	5.1	5.5

*Rate unstable due to fewer than 20 cases per year

Figure 5: Age-adjusted homicide deaths per 100,000 (3-Year Average Annual Rates/100,000), 1999-2013

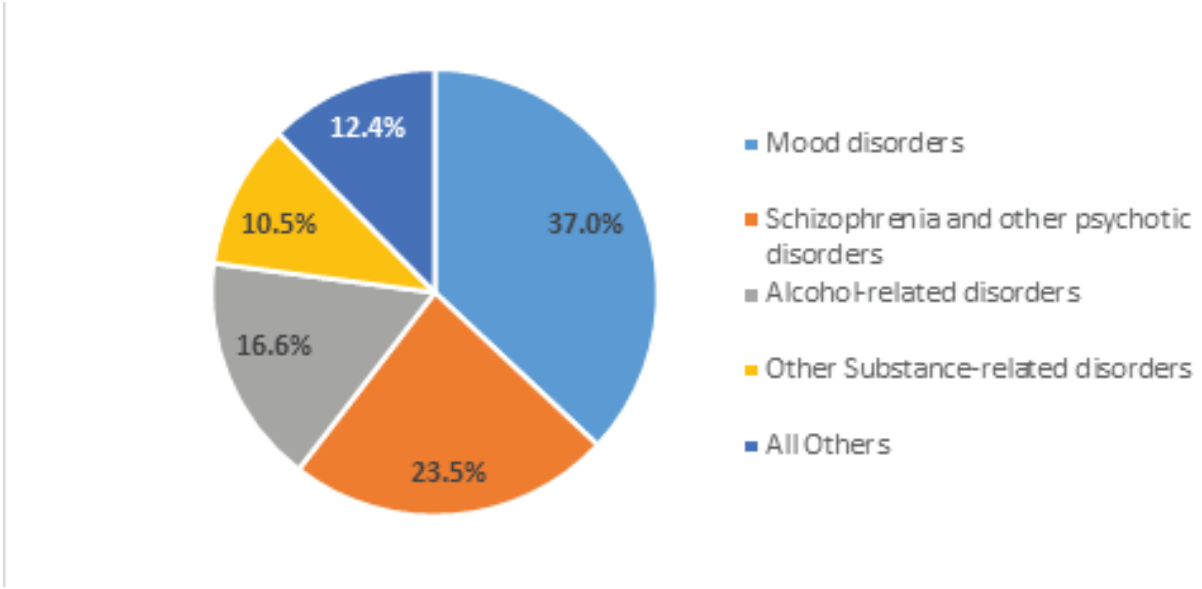


Mental Health-Related Hospital Admissions

Almost 1 in 4 U.S. adults currently have a mental illness and nearly half will have one during their lifetime. Individuals with mental illnesses have worse outcomes for other health conditions because, as a group, they are less likely to seek and adhere to medical treatments. Moreover, their rates of intentional and unintentional injuries are higher than the overall population. Risky health behaviors, such as alcohol abuse and tobacco use, are also associated with mental illness.[11]

In 2009, 5.3% of Shasta County adults and 4.3% of adults statewide had a severe mental illness. Severe mental illnesses are a wide range of diagnoses (e.g. major depression, severe anxiety, schizophrenia, bipolar disorder, attention deficit hyperactivity disorder, and post-traumatic stress disorder) that substantially impair major life activities. It is essential for these residents to be able to access psychiatric care in the management of their mental illnesses. Yet in 2012, there were an average of 19 psychiatrists per 100,000 people in California and only 8 per 100,000 in Shasta County.[12] "Limited access to mental health care increases patient and family suffering. Unmet mental health needs have a negative effect on poverty reduction initiatives and economic development. Untreated mental conditions contribute to economic loss because

Figure 6: Hospitalizations of Shasta County residents due to mental illness (n=5,020), 2010-14



they increase school and work absenteeism and dropout rates, healthcare expenditure, and unemployment."[13]

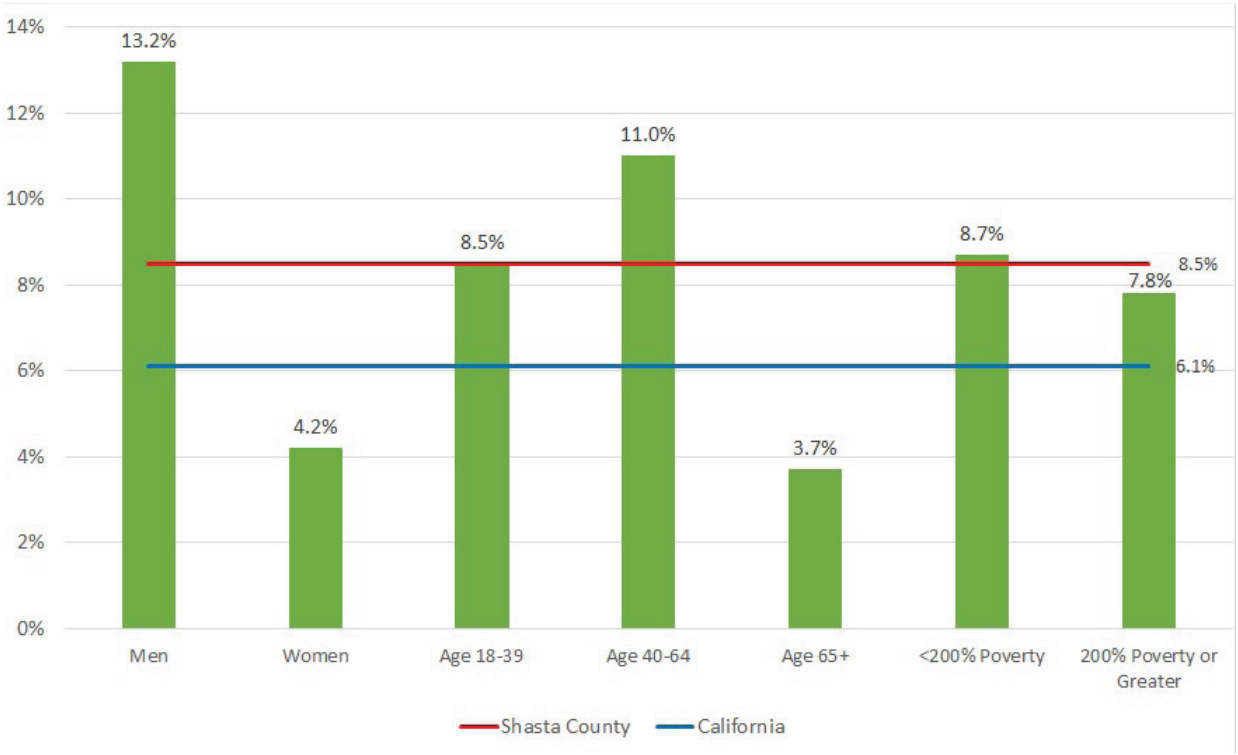
There was an average of 1,004 hospitalizations of Shasta County residents per year due to mental illnesses in 2010-14. Mood disorders, such as Major Depression and Bipolar Disorder, were the most common diagnosis. Diagnoses of mental illnesses made up 4.4% of all hospital discharges in Shasta County. More than 1 in 4 mental health hospitalizations were due to alcohol and substance abuse related disorders. These do not include poisonings and physical illnesses related to drug and alcohol abuse which are addressed in the following sections. Rather these include mental disorders such as drug-induced psychosis, withdrawal, hallucinations, dementia, and mood disorders.

Alcohol and Other Substance Abuse

Chronic Drinking

Chronic drinkers are defined here as adults who consume two or more drinks of alcohol per day in the past month. Shasta County rate (8.5%) of chronic drinkers is similar to California (6.1%) but nearly double the national proportion (4.5%).[14] The proportion of annual household expenditures that Shasta County spent on alcohol was the 10th highest of any California county in 2014.[15]

Figure 7: Chronic Drinking among Shasta County Adults, 2010



Binge Drinking

Binge drinking is defined as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams per deciliter or above. This typically happens when men consume 5 or more drinks, and when women consume 4 or more drinks, in about 2 hours. Binge drinking is associated with: unintentional and intentional injuries, alcohol poisoning, sexually transmitted disease, children born with Fetal Alcohol Spectrum Disorders, cardiovascular diseases, liver disease, neurological damage, sexual dysfunction, as well as societal costs from lost productivity, healthcare, and crime.

Figure 8: Binge Drinking in Past Year - Adults Age 18 and Older

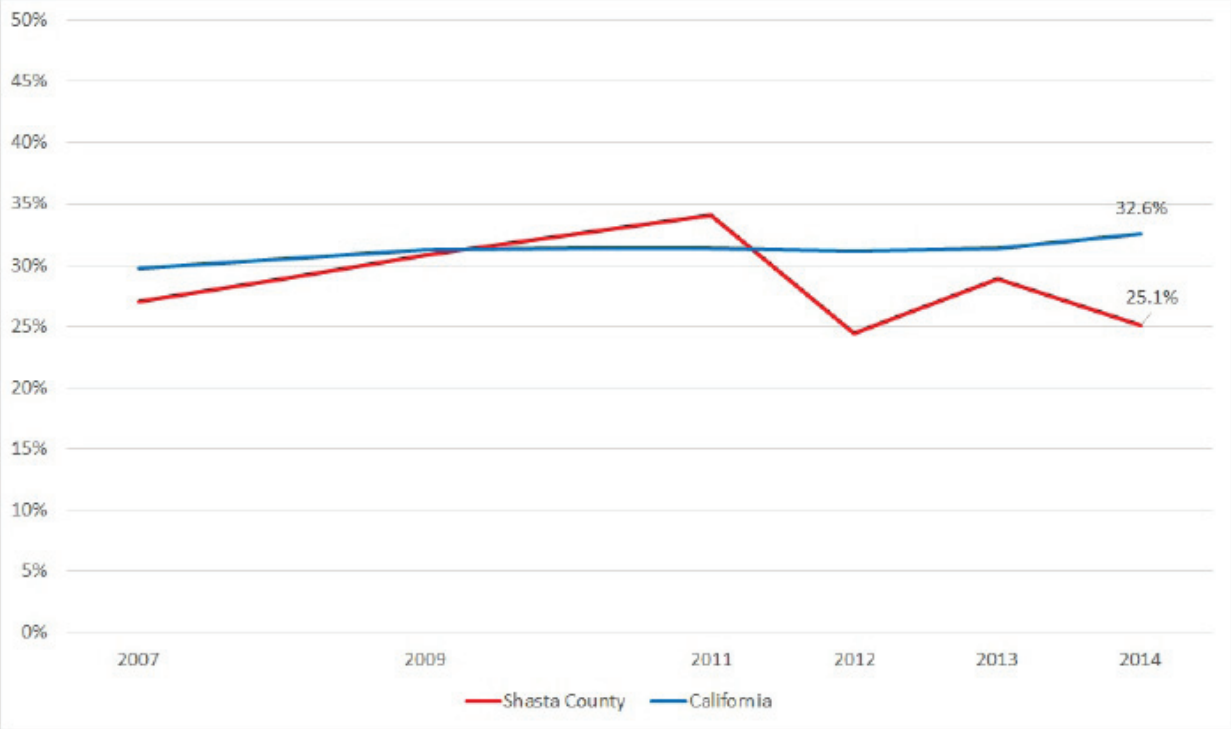


Table 3: Binge drinking in Shasta County and California adults (18+), 2013-14

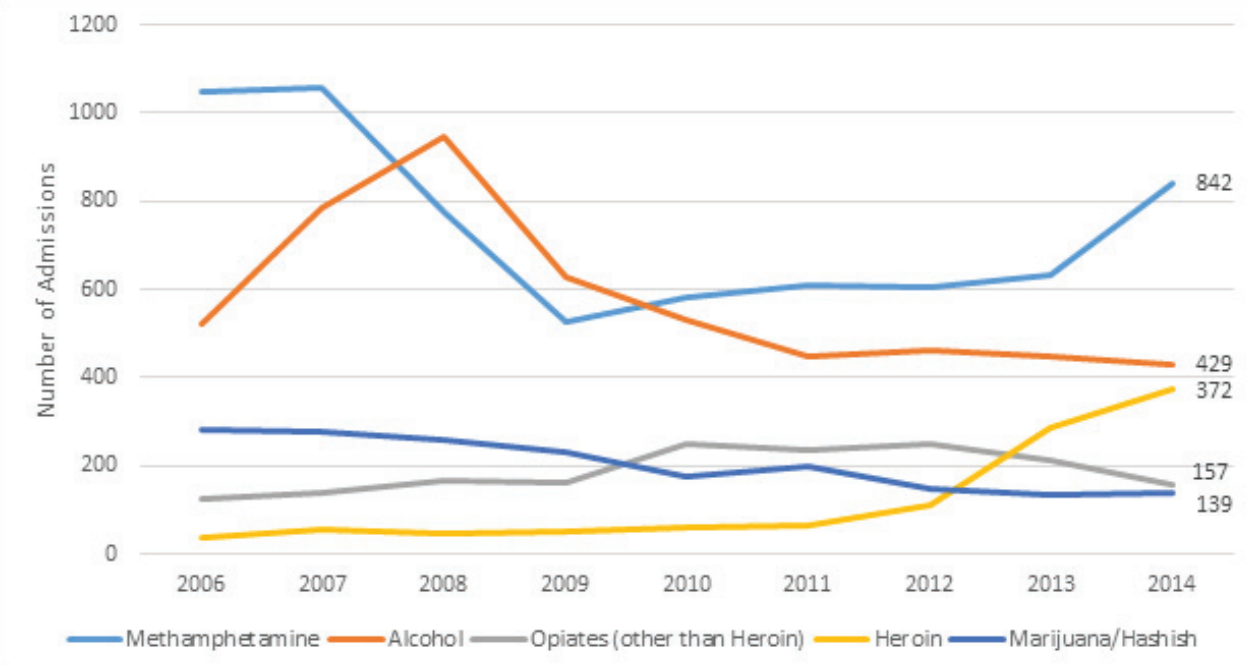
	Shasta County	California
Total Binge Drinking in Past Year	27.0%	32.0%
Rates by Age		
Adult (18-64)	33.6%	36.7%
Senior (65+)	7.1% *	8.8%
Rates by Educational Attainment		
High School Graduate or Less	22.3%	30.2%
Some College, Vocational School, or Associate's Degree	38.3%	35.5%
Bachelor's Degree or Higher	**18.8%**	31.6%
Rates by Race/Ethnicity		
White (Non-Hispanic)	27.2%	34.7%
Non-White (Including Hispanics)	26.3% *	30.1%
Rates by Income Level		
Less than 200% Federal Poverty Level	37.5%	28.6%
Greater than 200% Federal Poverty Level	**20.7%**	34.0%

BOLD= Statistically different than California rate. *statistically unstable: has not met criteria for a minimum number of respondents or exceeded acceptable value for coefficient of variance.

Alcohol and Other Substance Abuse Treatment

In 2010-14, 8,481 people were treated by alcohol and other drug treatment providers in Shasta County for substance abuse. Nearly 2 in every 5 who sought treatment reported methamphetamine as their primary drug of choice. The number of people admitted to substance abuse treatment who reported heroin as their primary drug of choice rose from less than 1 in 20 in 2010 to nearly 1 in every 5 admissions in 2014.

Figure 9: Primary Drug of Choice for Shasta County Alcohol and Drug Treatment Admissions, 2006-14



Alcohol and Other Substance Abuse Health Consequences

Alcohol-Attributable Death, Illnesses, and Injuries

Table 4: Average Annual Shasta County Alcohol-Attributable Fatal and Non-Fatal, Illnesses, Injuries, and Crimes

Average Annual Alcohol-Attributable	Non-Fatal*	Fatal
Digestive Diseases	276	40
Neuro-Psychiatric Conditions	822	13
Cardio-Vascular Diseases	38	4
Pregnancy-Related Conditions	5	0
Malignant Neoplasms	0	0
Illness Total	**1,141**	**57**
Traffic Injuries	180	10
Poisonings (Non-Alcohol)	161	13
Suicide	113	10
Falls	2,073	8
Occupational and Machine Injuries	620	0
Alcohol Poisoning	44	2
Other	522	3
Injury Total	**3,824**	**46**
Homicide	N/A	3
Burglary	54	N/A
Larceny	298	N/A
Motor Theft	17	N/A
Assault	213	N/A
Rape	20	N/A
Robbery	25	N/A
Child Maltreatment	123	N/A
Crime Total	**750**	**3**
Total Alcohol Attributable	**5,715**	**106**

*Non-fatal: hospitalizations, ER visits, crimes, and child abuse cases
Note: Digestive Diseases include cirrhosis of the liver, alcoholic liver disease, alcoholic gastritis, and pancreatitis; Neuro-psychiatric conditions include alcohol abuse, alcohol dependence syndrome, alcoholic polyneuropathy, and alcoholic psychosis

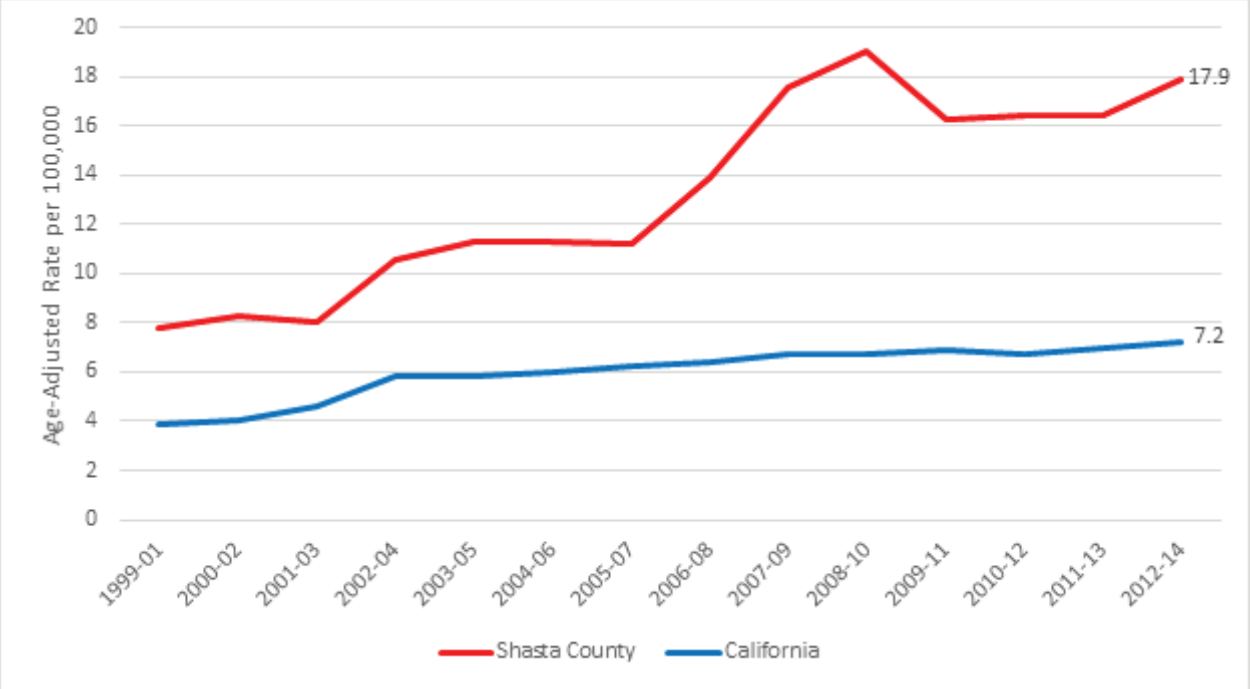
Alcohol and Drug-Affected Newborns

In 2010-14, 800 babies born to Shasta County residents were diagnosed with having been affected by drugs or alcohol. Seventy-seven newborns were diagnosed with withdrawal from drugs that they became addicted to from maternal substance abuse while in utero.[15]

Drug-Induced Deaths

Shasta County's age-adjusted rate of death from drugs has grown to 17.9 per 100,000 residents in 2012-14. This is more than double the rate of California. In 2012-14, there was an average of 31 deaths per year from drug-induced deaths.

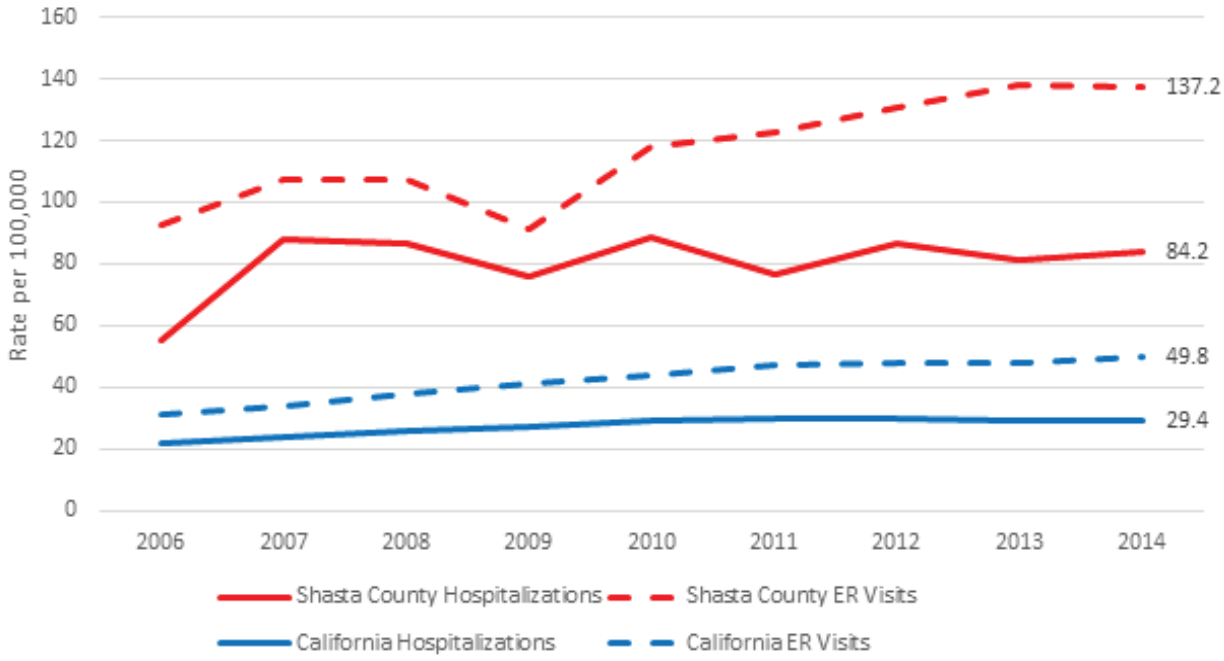
Figure 10: Age-Adjusted Rate of Drug-Induced Deaths per 100,000 Residents (3-Year Average Annual Rates/100,000), 1999-2014



Drug-Related Injuries

The rate of non-fatal drug poisonings has increased in Shasta County and statewide. The rate of emergency department visits in Shasta County due to drug poisonings has increased by 16.6% over the last 5 years. In addition to poisonings, health consequences from drug use can also include mental disorders and physical diseases such as liver disease, pancreatitis, and some neuropathies. Furthermore, intravenous drug use is a risk factor for several infectious diseases such as Hepatitis B and C and HIV.

Figure 11: Rate of Hospitalizations and Emergency Room Visits due to Non-Fatal Drug Poisoning Injuries, 2006-14



Maternal and Child Health

It is important to monitor health factors surrounding pregnancy, birth, and infancy. Some pregnancy risk factors, like poverty and exposure to pollution, can be largely out of a mother's control.

However, many adverse health consequences are preventable with proper prenatal care, changes to environments and behaviors. Promotion of practices like exclusive breastfeeding through at least the first six months and family planning to space births apart can also improve the health of mother and baby.

In this section:

Perinatal Health

Infant and Child Mortality

Breastfeeding

Perinatal Health

In 2011-13, there was an average of 2,090 births per year in Shasta County. 79.5% of Shasta County mothers were white, 60.5% were age 20-29 years old, and 2 of every 3 began prenatal care in the first trimester. Shasta County mothers gave birth at younger ages than women statewide and were less likely to start prenatal care during the first 3 months of pregnancy.

Shasta County and California both met the Healthy People 2020 target of reducing low birth weight (less than 2,500 grams [5.5 pounds]) and very low birth weight (less than 1,500 grams [3.3 pounds]) to 7.8% and 1.4% of all live births, respectively. However, while California met the Healthy People 2020 goal of increasing the proportion of pregnant women who receive prenatal care in the first trimester to 77.9%, only 66.6% of Shasta County women receive this recommended care.[1]

Table 1: Births and birth outcomes, 2011-13

	Shasta County		California
Race/Ethnicity of Mother	**Annual Average Births**	**Percent**	**Percent**
Asian	65.3	**3.1%**	13.2%
Black	19.0	**0.9%**	5.3%
Hispanic/Latina	205.7	**9.8%**	48.8%
White	1,661.0	**79.5%**	29.7%
American Indian/Alaska Native	70.7	**3.4%**	0.4%
Pacific Islander	6.3	0.3%	0.4%
Two or More Races	62.3	**3.0%**	2.2%
Age of Mother			
Under 17	44.0	2.1%	2.1%
18-19	117.7	**5.6%**	4.9%
20-29	1,265.3	**60.5%**	46.6%
30-34	446.7	**21.4%**	27.2%
Over 34	216.3	**10.3%**	19.2%
Infant Birth Weight			
Under 1500g (Very Low Birth Weight)	18.7	0.9%	1.1%
1500-2499g (Low Birth Weight)	113.3	5.4%	5.6%
2500g or More	1,958.3	93.7%	93.2%
Prenatal Care Started			
First Trimester	1,391.7	**66.6%**	81.9%

Note: BOLD are significantly different than California percent

Infant and Child Mortality

In 2009-13, Shasta County and California met the Healthy People 2020 goal of reducing infant mortality (deaths in the first year) to 6.0 per 1,000 live births and neonatal mortality (deaths in the first 28 days) to 4.1 per 1,000 live births. Shasta County's mortality rates are not significantly different than California's.

Table 2: Infant and Child Mortality, 2009-13

Indicator	Age	Description	Shasta County	California	HP2020
Neonatal Mortality	Less than 28 Days	Rate per 1,000 live births	3.2	3.3‡	4.1
Infant Mortality	Less than 1 Year	Rate per 1,000 live births	5.5	4.7	6.0
Child and Adolescent Mortality	1-14 Years	Rate per 100,000 age 1-14	20.4	13.8	NA

‡2009-11 data only

Smoking during pregnancy increases the risk of health problems, including premature birth, low birth weight, certain birth defects, miscarriage, and infant death. Smoking during and after pregnancy is a risk factor for Sudden Infant Death Syndrome (SIDS).[2] "The risks of smoking during pregnancy extend beyond pregnancy-related complications. Children born to mothers who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity."[3]

Healthy People 2020 also set targets for reducing infant deaths from birth defects to 1.3 per 1,000 live births and infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed) to 0.84 per 1,000 live births. In 2009-13, Shasta County's rates were slightly higher than these targets. 1.7 infants per 1,000 live births died from birth defects and 1.2 per 1,000 died from sudden unexpected causes.[4]

Table 3: Smoking during pregnancy and rates of associated health outcomes per 1,000 live births, 2009-13

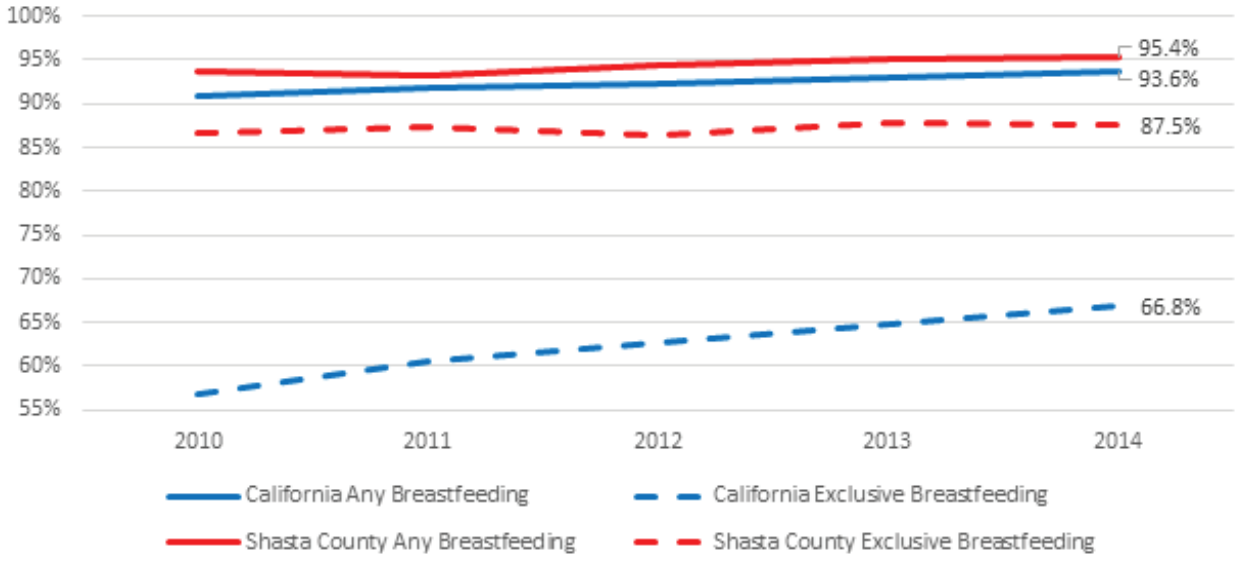
	Shasta County	Healthy People 2020 Goal
Mothers who smoked during pregnancy	16.7%	14.6%
Infant mortality	5.5	6.0
Deaths from birth defects	1.7	1.3
Deaths from sudden unexpected causes	1.2	0.8

Breastfeeding

"Both babies and mothers gain many benefits from breastfeeding. Breast milk is easy to digest and contains antibodies that can protect infants from bacterial and viral infections. A baby's risk of becoming an overweight child goes down with each month of breastfeeding. Also, women who breastfeed may have lower rates of ovarian cancer and certain types of breast cancer."[5]

Healthy People 2020 set a target of reducing the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life to 14.2%. Only 7.9% of breastfed newborns in Shasta County received supplementation in 2014, which meets the Healthy People target and is better than the California rate.[1]

Figure 1: Breastfeeding in hospital for first 24-48 hours after birth



Healthy People 2020 also set targets to increase the proportion of infants who are being breastfed at 6 months to 60.6%. In 2011, 60% of Shasta County mothers reported that they were either currently breastfeeding their children older than 6 months or their child stopped breastfeeding after 6 months.[6] Nationwide in 2011, only 49.4% of mothers breastfed at or longer than 6 months.[7]

Death, Illness and Injury

Shasta County residents have significantly higher rates of death and certain kinds of injuries and illnesses than statewide averages.

Premature deaths before age 75 have robbed Shasta County residents of over 15,000 years of life each year in 2012-14. The county ranks among the 10 worst rates of death for 11 different cancers, and the 4th worst rate of death for all cancers combined among California counties. Shasta County has significantly higher rates of deaths from unintentional injuries, and 2 out of 5 of these were poisonings, mostly drug poisonings. Many of the causes of death, injury, and illnesses in Shasta County could be reduced by improving access to population health services and preventative healthcare, reducing risky health behaviors and addressing social determinants of health.

In this section:

Overall Health Status

In 2014, 52.0% of Shasta County adult (18+ years) residents reported their health status as excellent or very good, while 20.5% reported their health as fair or poor. These rates are similar to the state rates of 48.4% and 20.7%, respectively.[1] Similarly, when asked about the number of poor physical health days in the last month, Shasta County and California residents reported 3.9 and 3.8 days, respectively, which is more than the U.S. benchmark of 2.9 days.

Table 1: Average number of poor health days in the past month among adults, 2014

	Shasta County	California	National Benchmark*
Poor Physical Health Days	3.9	3.8	2.9
Poor Mental Health Days	4.0	3.6	2.8

* 90th percentile of U.S. counties

Top Causes of Death

Shasta County had a significantly higher age-adjusted death rate than California in 2012-14. Moreover, 8 of the top 10 causes of Shasta County deaths occurred at rates significantly higher than state rates.

Diseases of the heart (23.0% of deaths) and malignant cancers (21.8% of deaths) were responsible for more than 2 in every 5 Shasta County deaths in 2012-14. Although only 5.5% of deaths in Shasta County were under the age of 45, 1 in 3 unintentional injury deaths and 1 in 4 completed suicides were in this age group. The younger age at death for these injuries results in a greater number of years of potential life lost (YPLL).

Table 2: Average Annual Deaths, YPLL, and AADR for Shasta County's Top 10 Causes of Death, 2012-14

	Shasta County			California
	Average Annual Deaths‡	Years of Potential Life Lost*‡	Age-Adjusted Death Rate per 100,000‡	
All Causes	2,132.0	15,337.0	**871.7**	621.8
Diseases of heart	490.7	2,279.2	**194.3**	149.0
Malignant neoplasms	464.0	2,968.3	**182.8**	147.2
Chronic lower respiratory diseases (CLRD)	188.3	739.2	**73.2**	33.9
Unintentional injuries	117.7	2,636.7	**61.4**	28.8
Alzheimer's disease	110.7	119.2	**42.9**	30.3
Cerebrovascular diseases	110.0	478.3	**44.0**	34.7
Diabetes mellitus	46.7	278.3	19.0	20.5
Chronic liver disease and cirrhosis	44.3	623.3	**18.4**	11.8
Intentional self-harm (suicide)	43.0	959.2	**21.8**	10.3
Essential hypertension and hypertensive renal disease	35.3	177.5	13.7	11.5

Rates in bold are significantly different than California.
‡Deaths, Years of Potential Life Lost, and Age-Adjusted Death Rates, represent 3 year annual averages.
*YPLL calculated from death data and represent years of life before age 75 lost. 2014 deaths exclude those occurring outside of California.

Unintentional Injuries

Unintentional injuries were the 4th most common cause of death in Shasta County and accounted for the second highest number of years of potential life lost (2,636.7).

In 2009-13, there were 857 injury deaths among Shasta County residents. 70.0% of all injury deaths were unintentional, 23.6% were self-inflicted/suicides, 4.0% were assault/homicides, and the remaining had undetermined intent. The most common cause of unintentional death was poisoning, and 96.7% of those were drug or alcohol poisonings. 1 in 5 unintentional deaths were motor vehicle traffic accidents and another 1 in 5 were from falls.

Figure 1: Shasta County Unintentional Injury Deaths, 2009-13, N=600

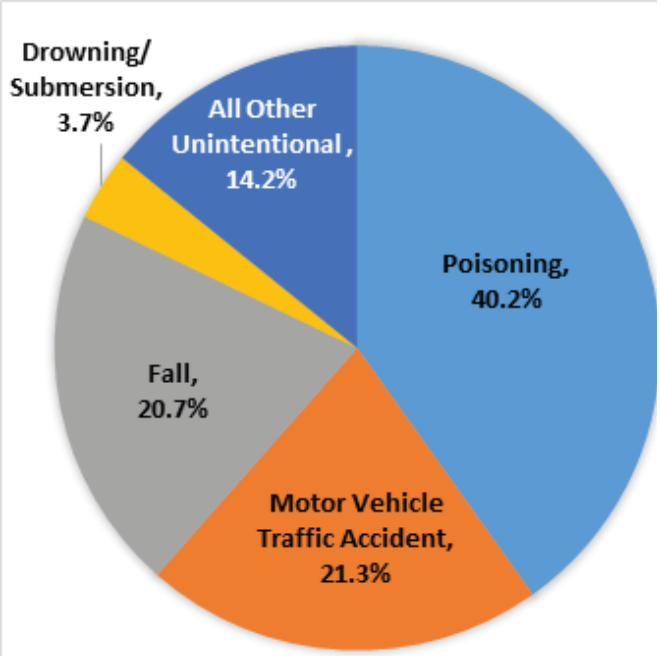
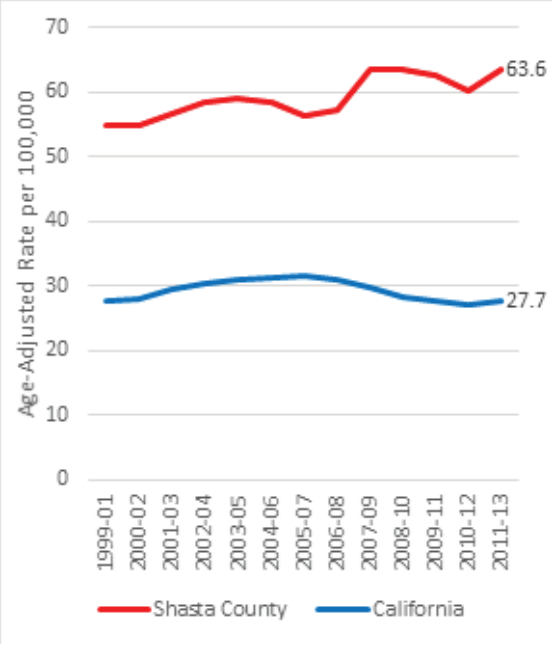


Figure 2: Unintentional Injury 3-Year Death Rates



Motor Vehicle Collisions

In 2012-14, there was an average of 1,842.3 motor vehicle collisions per year in Shasta County. The primary reason for more than 1 in 3 collisions was driving at unsafe speed or improper turning. 1 in 10 collisions involved being under the influence of alcohol or drugs as the primary factor. However, when victims were severely injured or killed, driving under the influence was the most commonly identified factor. Driving under the influence was identified as the primary collision factor causing 22.5% of the 271 severely injured victims in 2012-14. 1 in 4 fatal collisions were due to driving under the influence of alcohol or drugs.[2]

Working Together: Injury Prevention Coalition

The Injury Prevention Coalition of Shasta County was formed in 1978 to prevent unintentional injuries through education. Members include law enforcement, nonprofits, hospitals and numerous other organizations.

For more information, call (530) 225-5468.

Cancer Mortality

In 2008-12, Shasta County ranked fourth out of 58 California counties for cancer death rates. Shasta County ranked among the top 10 highest rates of cancer death for 11 of the 18 cancer sites listed below. The county had significantly higher age-adjusted death rates per 100,000 residents from cancers of the lung, melanoma of the skin, kidney, and esophagus than California.[3] Rates of death from these cancers could be reduced by avoiding behaviors linked to them. Lung and some kidney cancers are caused by smoking, melanoma is caused by sun exposure, and esophageal cancers are most common among those who drink heavily and smoke.

Table 3: Age-Adjusted Death Rate of Cancers by Site per 100,000 Population, 2008-12

Cancer Site	Rank among 58 counties*	Shasta County	California
All Sites	4	**191.0**	155.1
Lung and Bronchus	7	**50.8**	36.2
Prostate	7	25.7	21.1
Female Breast	20	21.6	21.2
Colon and Rectum	6	16.6	14.2
Pancreas	6	11.9	10.4
Leukemia	4	8.1	6.6
Ovary	17	7.7	7.7
Non-Hodgkin Lymphoma	5	7.2	5.8
Liver and Bile Duct	38	**5.4**	7.2
Melanoma of Skin	1	**5.3**	2.6
Kidney and Renal Pelvis	4	**5.2**	3.5
Esophagus	5	**4.9**	3.5
Brain & Other Central Nervous System	13	4.8	4.3
Bladder	12	4.6	3.9
Uterus	30	3.8	4.3
Oral Cavity & Pharynx	2	3.5	2.5
Cervix	3	2.9	2.2
Stomach	36	**2.4**	4.3

Rates in **bold** are significantly different than California rates.
*Rank of 1 has the highest age-adjusted death rate among California counties

Cardiovascular Disease

In 2010-14, 14.2% of all hospitalizations in Shasta County were for diseases of the circulatory system. Nearly 2 in every 3 of those were for diseases of the heart. In 2012-14, diseases of the heart were the leading cause of death among Shasta County residents and killed an average of 491 Shasta County residents per year. About 1 in 5 hospitalizations for cardiovascular diseases were for strokes (Cerebrovascular Disease). 110 Shasta County residents die from strokes each year. Although hypertension makes up only 3.1% of hospitalizations for cardiovascular diseases, it is also among the top 10 killers of Shasta County residents. Put together, heart disease, stroke, and hypertension result in 3 out of every 10 Shasta County deaths.[4,5]

Figure 3: Cardiovascular Disease Hospitalizations of Shasta County Residents, 2010-14, N=16,612

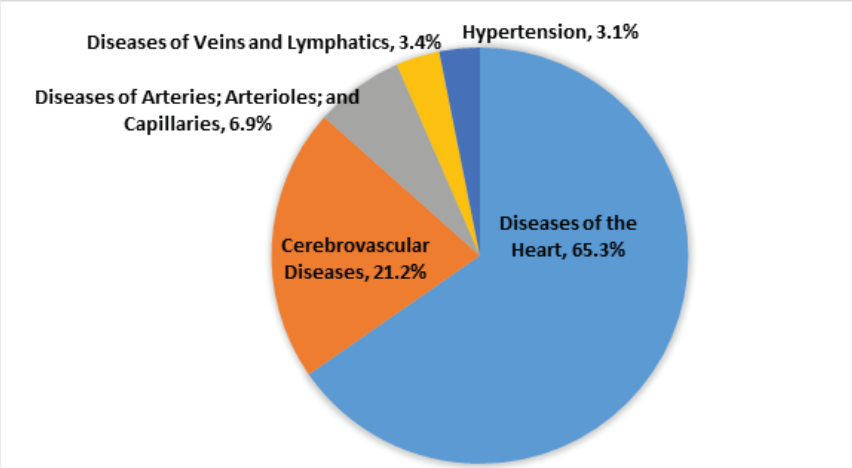
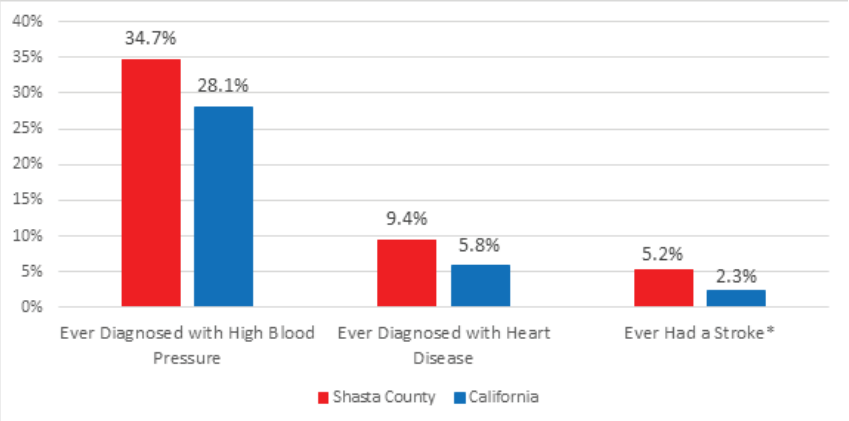


Figure 4: Reported Diagnoses of Cardiovascular Disease, 2013-14

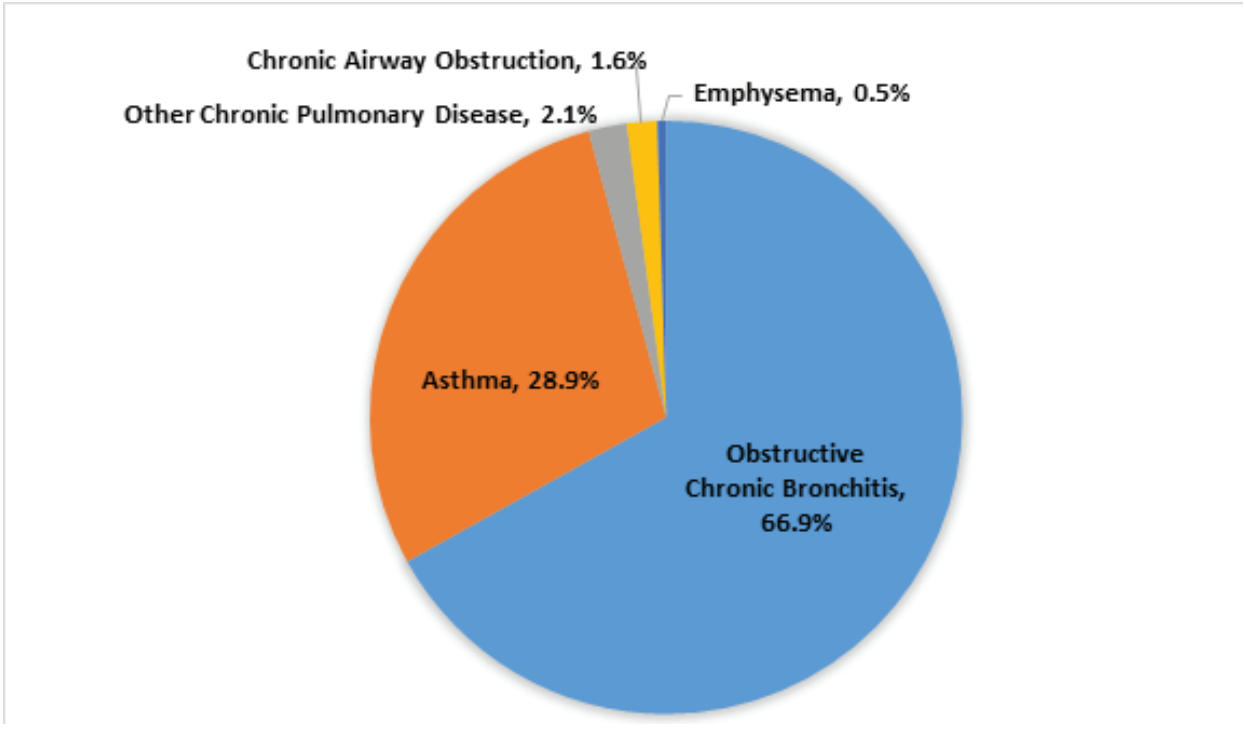


*Stroke data from 2011-12

Chronic Lower Respiratory Diseases

After heart disease and cancer, more Shasta County residents die of chronic lower respiratory diseases (CLRD) than any other condition. CLRD made up 2.0% of all hospitalizations of Shasta County residents in 2010-14 and nearly 1 in 10 deaths in 2012-14. 2 out of every 3 CLRD hospitalizations were for obstructive chronic bronchitis and most of the rest were (28.9%) were for asthma. Obstructive chronic bronchitis, emphysema, and bronchiectasis are grouped into a condition known as chronic obstructive pulmonary disease (COPD). 8 out of 10 COPD related deaths are due to smoking. Smoking in childhood and teenage years slows lung development and can increase the risk of developing COPD in adulthood.[6]

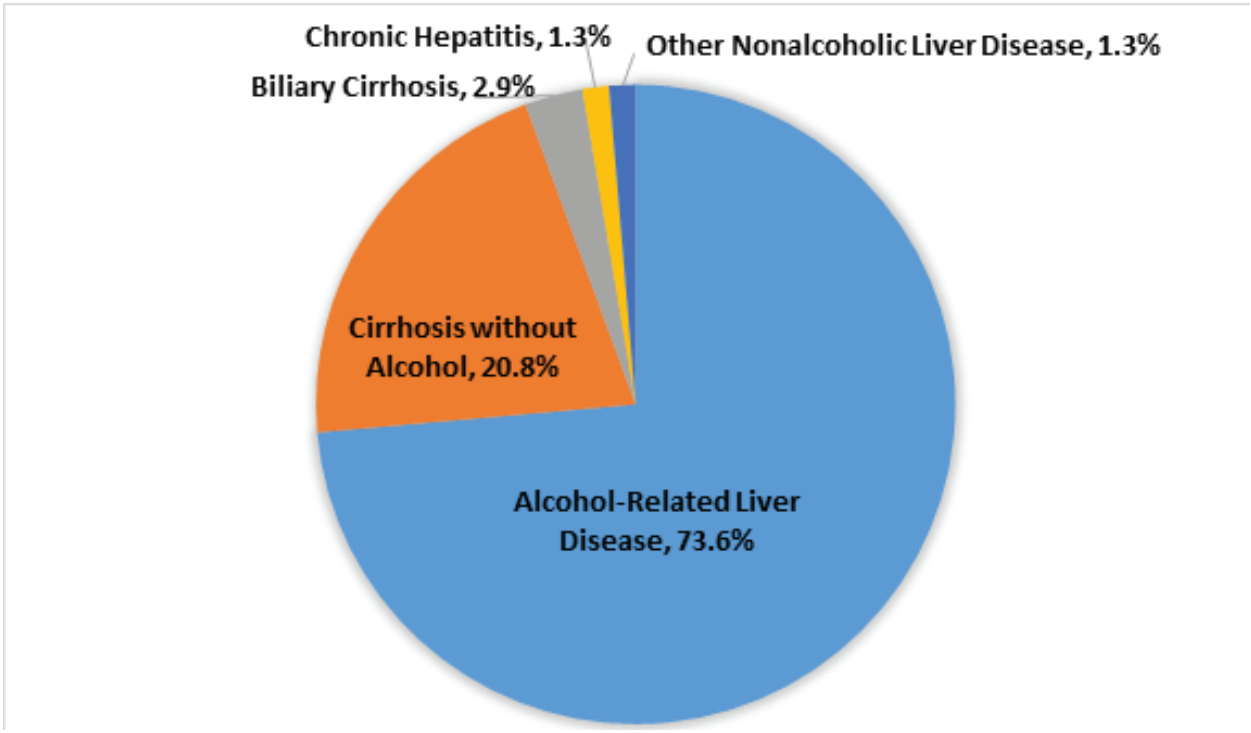
Figure 5: Chronic Lower Respiratory Disease Hospitalizations of Shasta County Residents, 2010-14, N=2,304



Chronic Liver Disease and Cirrhosis

Chronic liver disease and cirrhosis was the 8th most common cause of death in Shasta County in 2012-14. In 2010-14, nearly 3 out of 4 hospitalizations for these diseases were alcohol-related. Alcoholic liver damage can include acute hepatitis leading to alcohol-induced cirrhosis and fatty liver disease. The toxic effects of alcohol on the liver reduce its ability to metabolize lipids, result in fibrous bands which causes portal hypertension, and can result in testicular atrophy and impotence. Once the cirrhosis stage is reached regardless of cause, damage is irreversible, life expectancy is reduced, and patients are susceptible to complications.[7]

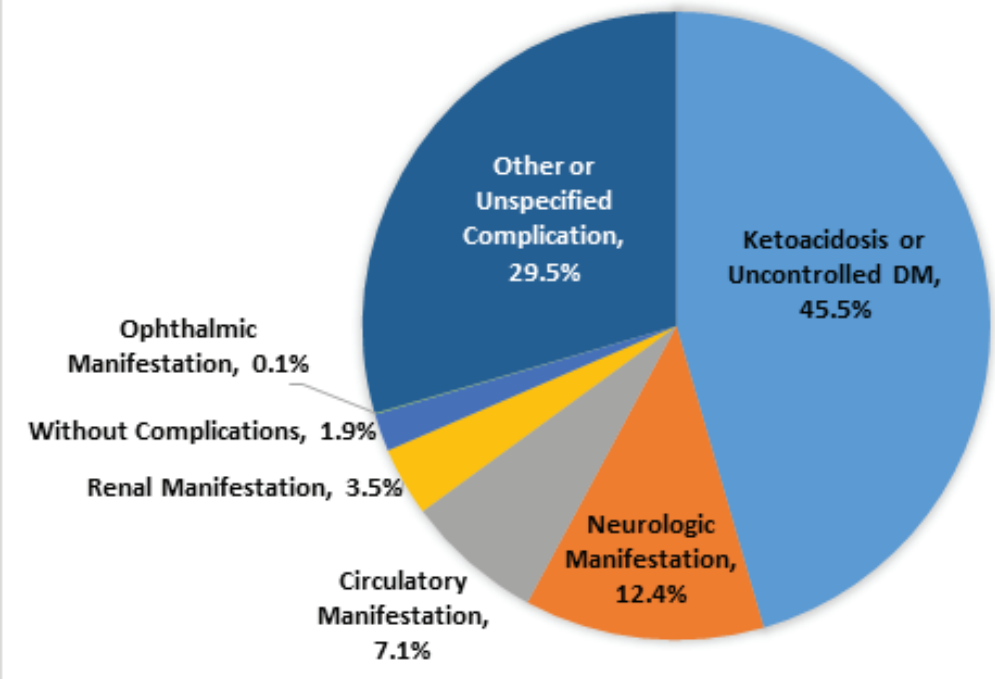
Figure 6: Chronic Liver Disease and Cirrhosis Hospitalizations, 2010-14, N=375



Diabetes Mellitus

More than 60 percent of people in Shasta County have diabetes mellitus or pre-diabetes, according to a UCLA study, and in 2012-14, diabetes was the 7th most common cause of death among Shasta County residents.[5] In 2010-14, nearly half of all hospitalizations for diabetes mellitus were for uncontrolled diabetes or ketoacidosis.[4] Ketoacidosis is a condition in which the body is unable to compensate for poor diabetic control and suffers acidosis, dehydration, clouding of consciousness or even coma. It is preventable through regular insulin control.[8] The 2nd most common complication that led Shasta County residents with diabetes to be hospitalized was neurologic complications. Long-term diabetes can damage nerve cells leading to decrease feeling and weakness in extremities. A common sign of this is ulcers on the feet. Other complications from diabetes mellitus that residents were hospitalized for include damage to the kidneys (including dialysis and chronic kidney diseases), eyes (including blindness and cataracts), and blood vessels (ischemic foot ulcers and gangrene, often requiring amputation). Diabetes itself is a risk factor for heart disease and stroke. Type II diabetes mellitus is much more common in obese people and obesity, smoking, high blood pressure, and high cholesterol are also risk factors for heart disease.[9]

Figure 7: Diabetes Mellitus Hospitalizations by Complication, 2010-14, N=1,747

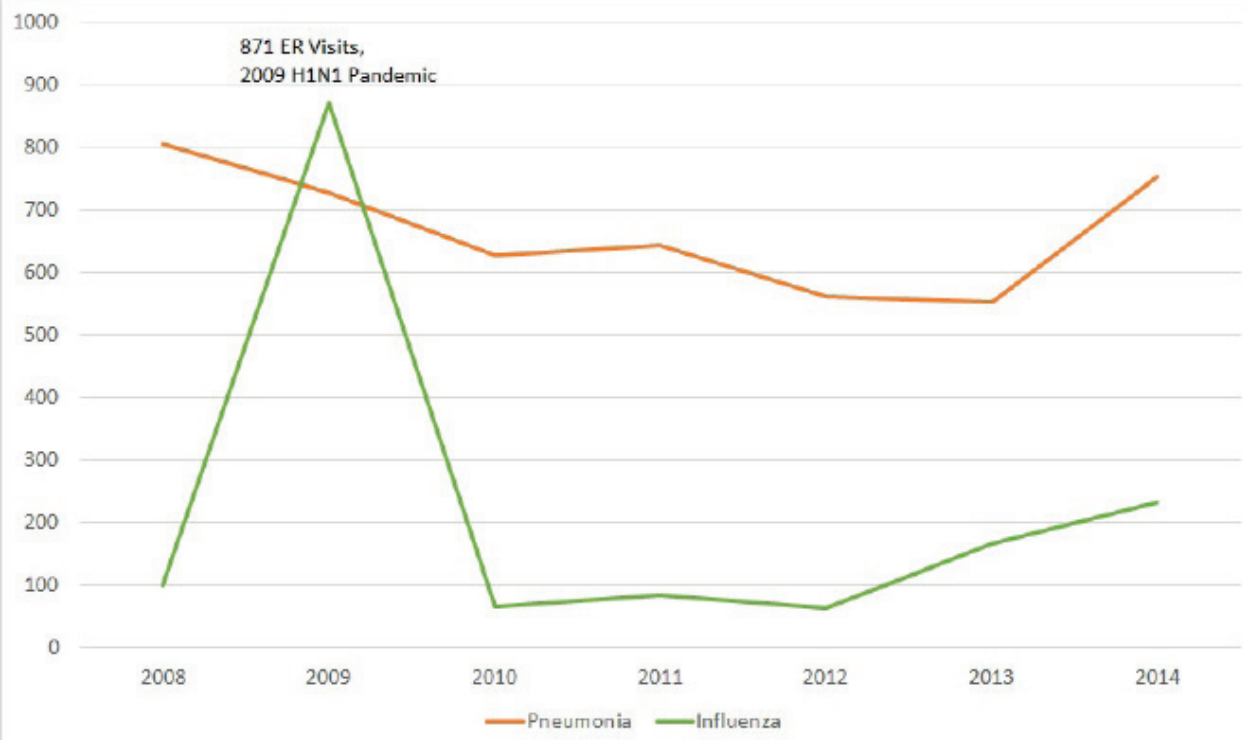


Pneumonia and Influenza

Pneumonia and Influenza combined were the 11th most common cause of death among Shasta County residents in 2012-14. Pneumonia is a broad category of infections of the lungs by bacteria, viruses, fungi or parasites. Because of the large number of possible infectious agents, pneumonias are often treated on the basis of possible exposures, age of patients, and clinical features like whether it was acquired in a hospital, or has a typical presentation of rapid onset of chills, fever and cough.[10]

Influenza is a viral infection characterized by headache, fever, cough, myalgia (muscle pain), and malaise (discomfort). Yearly vaccinations are recommended to help combat the spread of the most common strains of influenza A and B. Since these strains change every year, some years the vaccine doesn't match the most common circulating strains and higher numbers of cases are reported, as seen during the 2009 pandemic in the graph below. Pneumococcal vaccine, both in children and adults, especially seniors, and any age with certain medical conditions can prevent the most common cause of community acquired bacterial pneumonia.

Figure 8: Shasta County Pneumonia and Influenza Emergency Department Visits by Year, 2008-14



Preventable Diseases

While many infectious diseases can be prevented by vaccinations and hygiene, chronic disease prevention involves improving lifestyle choices and environmental conditions, including social determinants of health.

These include employment, housing, educational attainment, and eliminating discrimination. Regular screenings to detect health conditions early may reduce their damage and improve treatment outcomes. Shasta County residents have higher rates of preventable hospitalizations and deaths from preventable diseases. Lower rates of screening often result in cancers going untreated until they have spread. Turning these statistics around will require changes in behaviors, improved rates of screenings, investments in the primary healthcare system, and elimination of the barriers that produce inequities among vulnerable low-income, rural, and minority residents.

In this section:

Preventable Hospitalizations

In 2005-13, Shasta County had significantly higher rates of hospital admissions for preventable conditions than the State of California or the 2012 National Benchmarks. These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention and lifestyle changes can prevent complications or more severe disease. All age groups (except 75 years and older), males and females were all significantly higher than California rates.

Table 1: Adult Hospitalizations for Preventable Conditions, 2005-13*

	Shasta County		California	2012 National Benchmark
	Yearly Average	Crude Rate	Crude Rate	Crude Rate
Overall	2,333.8	**1,694.8**	1,203.6	1,457.5
Females	1,296.0	**1,825.2**	1,307.9	1,591.4
Males	1,037.8	**1,556.1**	1,096.3	1,316.0
18-39 years	230.2	**508.7**	237.1	313.7
40-64 years	739.7	**1,171.0**	917.0	1,102.6
65-74 years	455.4	**2,863.8**	2,747.8	2,861.2
75+ years	908.4	**6,794.7**	6,992.7	7,034.6

Bold are significantly different than California rates; Crude rates per 100,000 residents
*Agency for Healthcare Research and Quality's Prevention Quality Indicators include admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.

Late-Stage Diagnosed Cancers

Screenings are an essential part of preventing deaths from cancers. As cancers grow and spread, the likelihood of survival decreases. A localized cancer has not spread farther than the organ in which it started. The regional stage of cancers is broadly defined as those that have spread beyond the boundary of the organ it started in. There is a potential for cancers at this stage to spread through the lymphatic system or in the blood. At the distant stage, cells from the tumor called metastases have broken off and travelled to new locations in the body and begun to grow.[1]

In 2009-13 Shasta County residents had significantly higher rates of death from cancers of the prostate, colon/rectum, esophagus, and lung/bronchus than residents statewide. While the rates of death for lung cancer were significantly higher among both Shasta County men and women, the higher rates of colorectal and esophageal cancer deaths were due to significantly elevated rates among male residents.

Table 2: Shasta County Age-Adjusted rates per 100,000, 2009-13

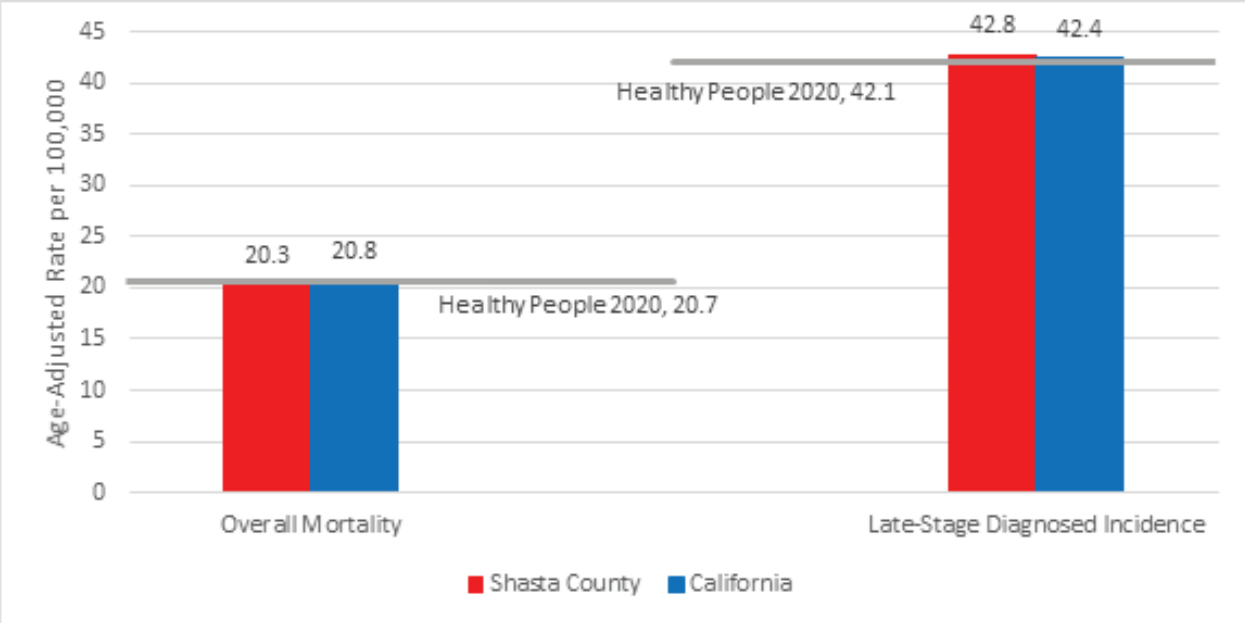
Cancer Type	Overall Mortality Rate	Percent Late-Stage When Diagnosed	Late-Stage Diagnosed Cancer Incidence Rate
Lung/Bronchus	**47.5**	80.2%	**47.6**
Prostate	**26.5**	16.5%	23.5
Female Breast	20.3	34.5%	42.8
Colon/Rectum	**16.9**	52.5%	18.4
Pancreas	11.6	72.4%	8.7
Ovarian	8.3	87.7%	11.6
Liver	5.3	49.6%	3.5
Esophagus	**4.8**	65.1%	3.1
Cervical	2.6	52.8%	3.9

BOLD Shasta County rates are significantly higher than California rates.
~ too small to calculate
Late stage defined by Summary Staging: Distant and Regional, 5-year survival based on 2004-13 data

Late-Stage Female Breast Cancer

Healthy People 2020 set targets of reducing deaths from female breast cancer to 20.7 per 100,000 women and reducing the rate of late-stage diagnosed female breast cancer to 42.1 per 100,000 women.[2] While Shasta County's mortality rate now meets this target, its rate of late-stage diagnosed cancers is still slightly above the target.

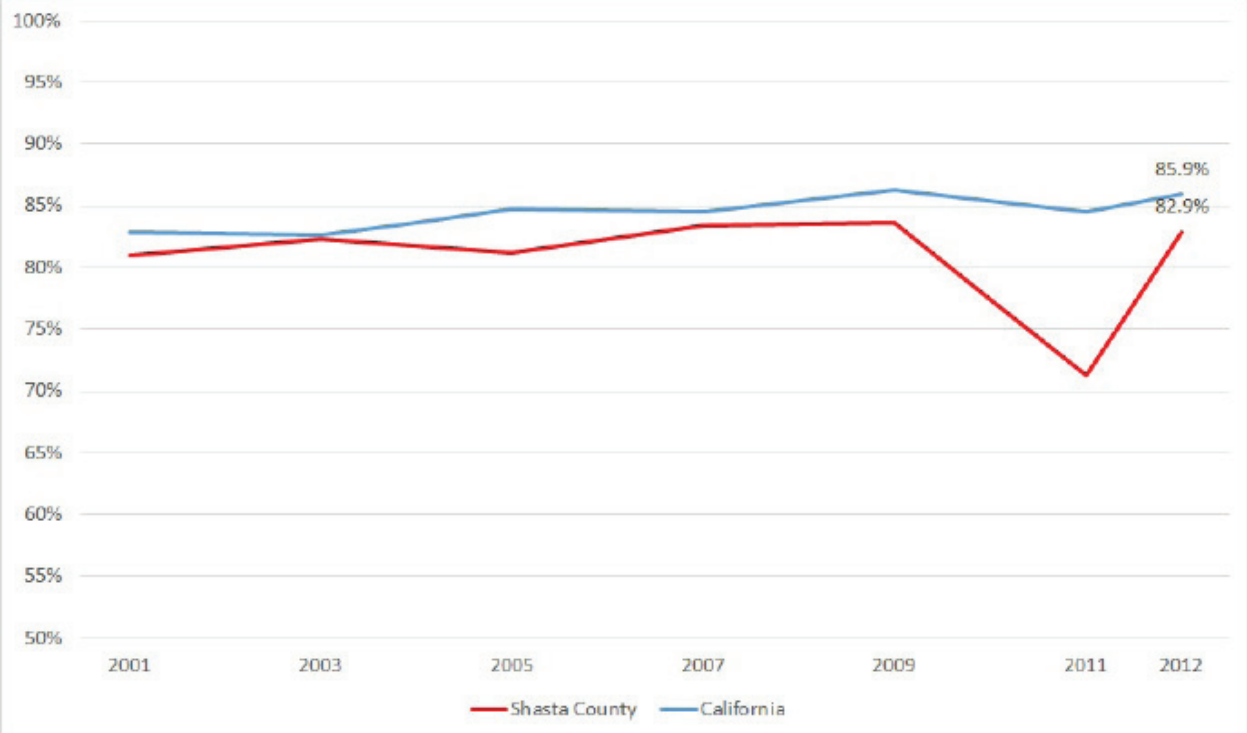
Figure 1: Age-Adjusted Rates of Death from Female Breast Cancer and Incidence of Late Stage Diagnosed, 2009-13



Breast Cancer Screening

The U.S. Preventive Services Task Force recommends screening mammography for women aged 50-74 every 2 years. However, women with a parent, sibling, or child with a history of breast cancer are at higher risk for breast cancer and may benefit from beginning screening in their 40s.[3] The Healthy People 2020 target is for 81.1% of women age 50-74 to receive these screenings every 2 years.[2]

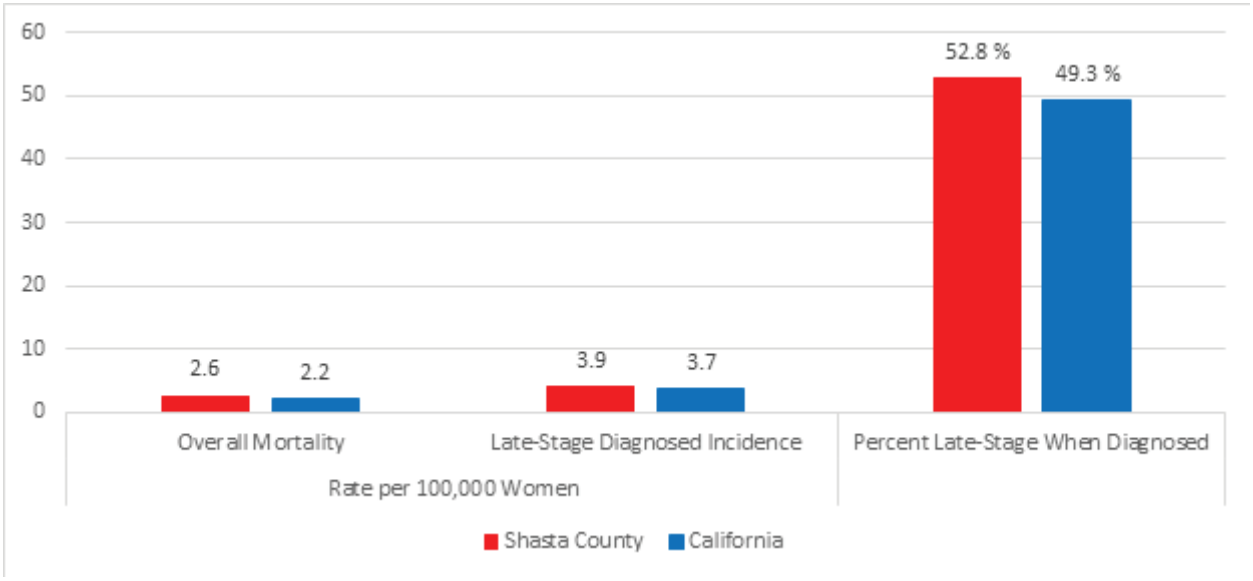
Figure 2: Women aged 50-74 who received a mammogram in the past 2 years, 2001-12



Late-Stage Cervical Cancer

Healthy People 2020 set targets of reducing deaths from cervical cancer to 2.2 per 100,000 women.[2] California's mortality rate now meets this target, but Shasta County's is still slightly above this target. One contributing factor may be that more than half of women diagnosed with cervical cancer in Shasta County are not diagnosed until the cancer has reached regional or distal spread.

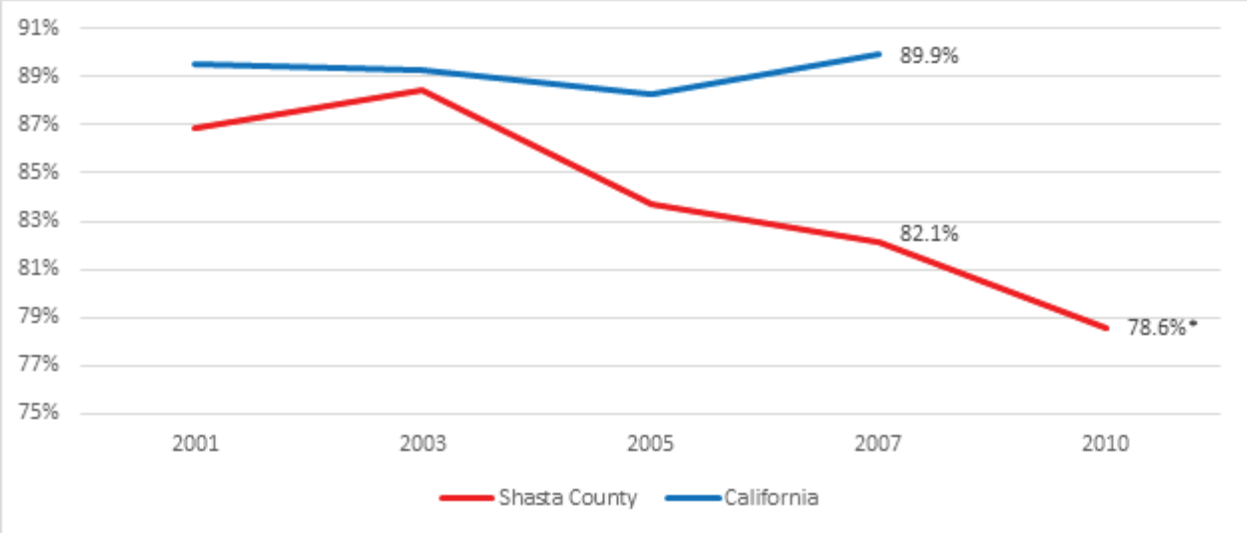
Figure 3: Age-Adjusted Rates of Death and Late Stage Diagnosed Cervical Cancer, 2009-13



Cervical Cancer Screening

The U.S. Preventive Services Task Force recommends that women aged 21-65 receive screening for cervical cancer with a Pap smear every 3 years. Women aged 30-65 may lengthen the time between screenings by receiving a combination Pap smear and human papillomavirus (HPV) test every 5 years.[4] Healthy People 2020 set a target of increasing the percent of women aged 21-65 who receive cervical cancer screenings to 93.0%.[2]

Figure 4: Women aged 21-65 who have had a Pap smear in the past 3 years, 2001-10

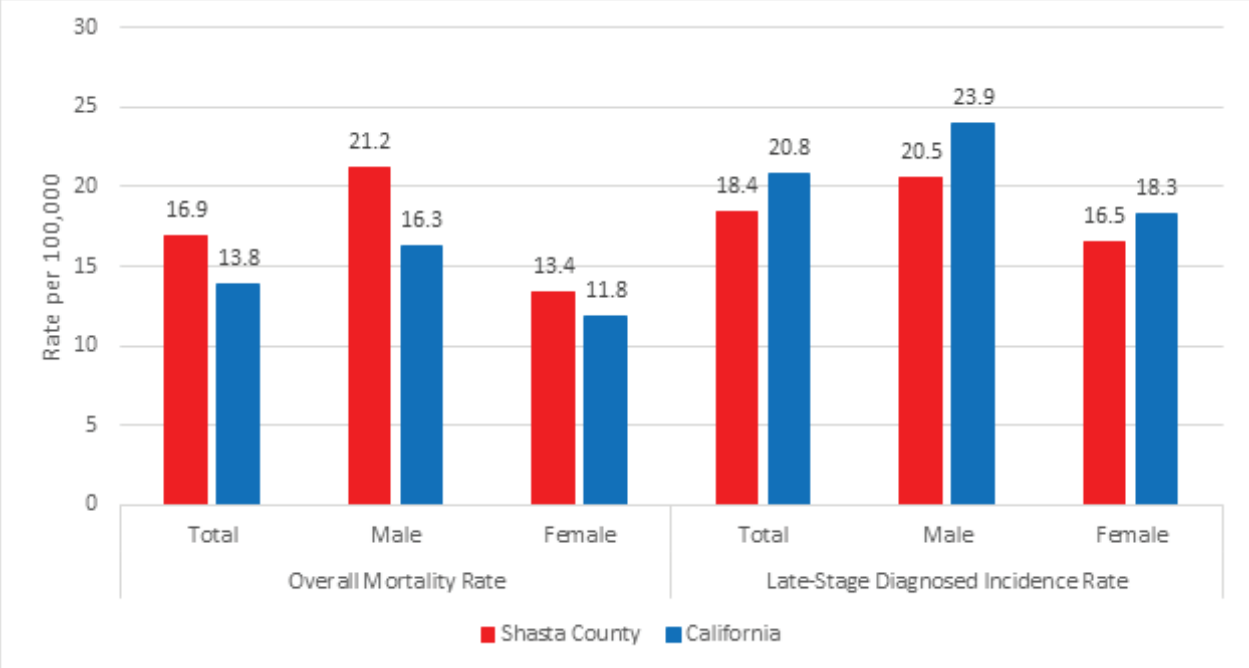


*2010 Shasta County data from separate source than 2001-2007

Late-Stage Colorectal Cancer

Healthy People 2020 set a target of reducing colorectal cancer death rates to 14.5 per 100,000.[2] (2) While California has met this goal, Shasta County's rate is 16.9. Over half of all colorectal cancers in Shasta County are diagnosed after reaching a regional or distal stage where the 5-year survival rate sharply decreases from 83.8% if discovered with only local spread to only 14.4% when discovered in the distal stage.

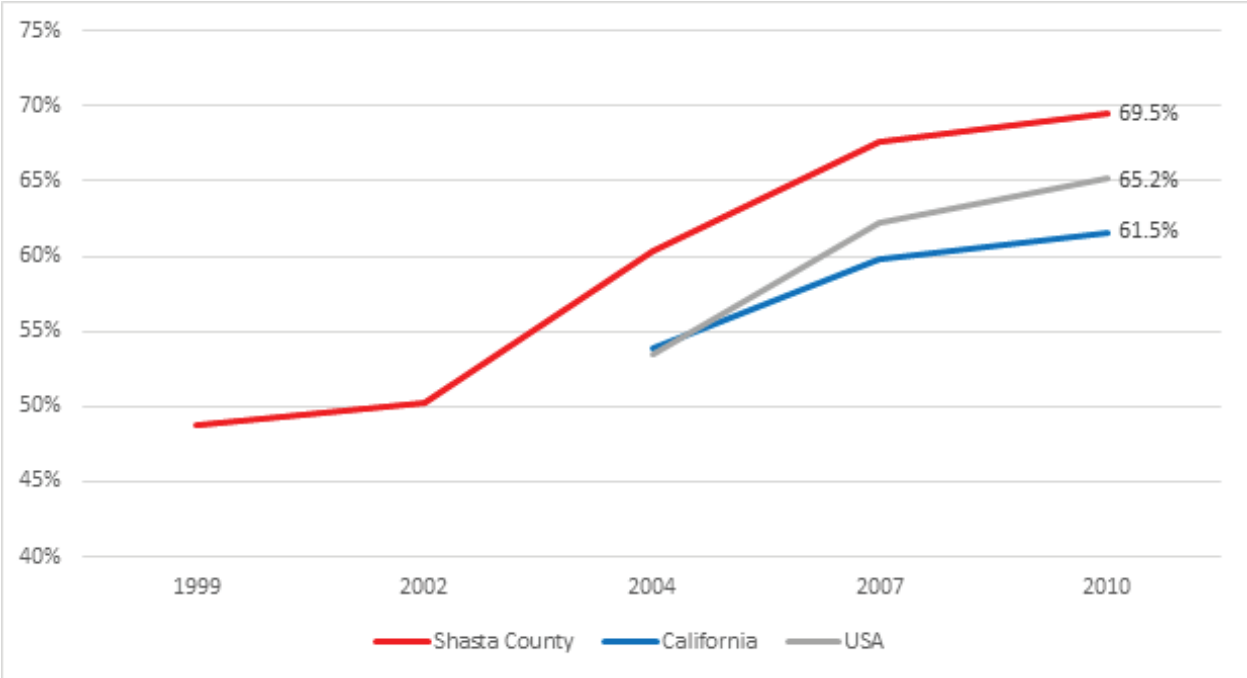
Figure 5: Age-Adjusted Rates of Death and Late Stage Diagnosed Colorectal Cancer, 2009-13



Colorectal Cancer Screening

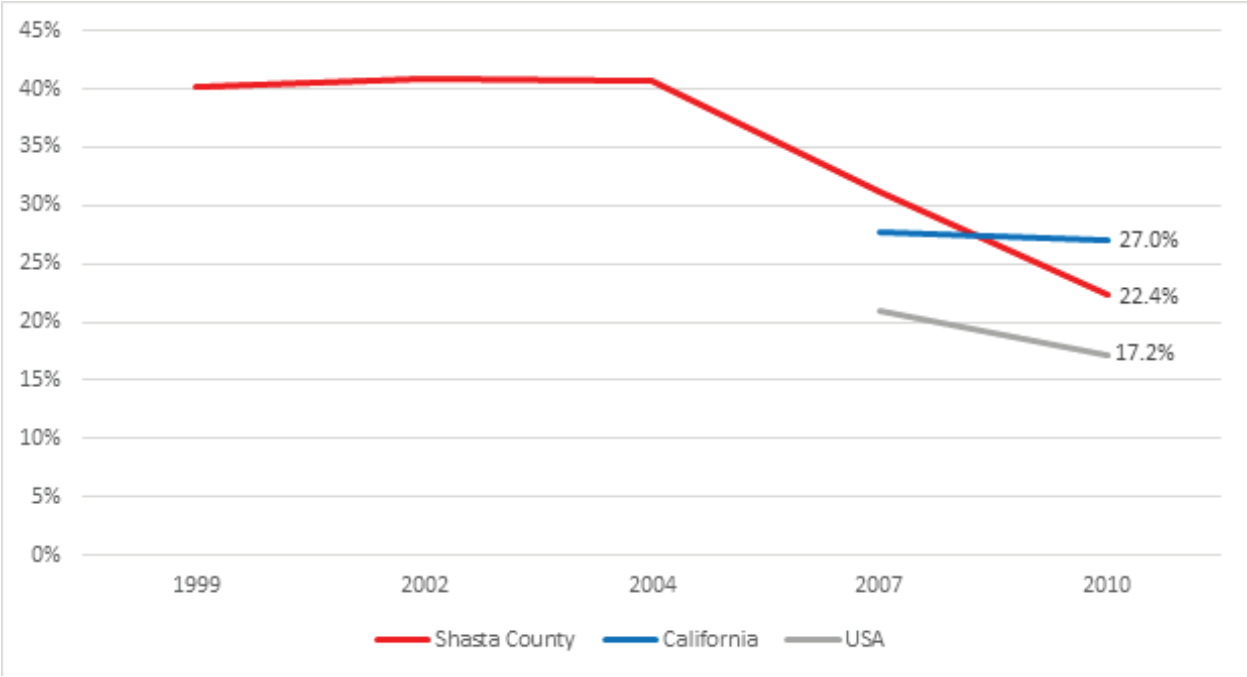
The American Cancer Society and the U.S. Preventative Services Task Force guidelines for people over 50 years of age recommend a fecal occult blood test annually, flexible sigmoidoscopy every 5 years, a double-contrast barium enema every 5 years, or colonoscopy every 10 years.[5] In 2010, 69.5% of Shasta County's over-50 population reported that they had received a sigmoidoscopy or colonoscopy in the past and 22.4% had received a fecal occult blood test in the past 2 years. Healthy People 2020 set a target of increasing the proportion of adults aged 50-75 who receive colorectal cancer screenings to 70.5%.[2]

Figure 6: Adults aged 50+ who have ever had a sigmoidoscopy or colonoscopy, 1999-2010



Note: 2008 BRFSS data used for 2007 California and USA; USA: States & DC

Figure 7: Adults aged 50+ who have had a fecal occult blood test within the past two years, 1999-2010



Note: 2008 BRFSS data used for 2007 California and USA; USA: States & DC

Late-Stage Lung/Bronchus and Esophageal Cancers

Healthy People 2020 set a target of reducing lung cancer death rates to 45.5 per 100,000.[2] While California has met this goal, Shasta County continues to have slightly higher rates. Shasta County also has significantly higher rates of death from esophageal cancer than California. People who smoke are at increased risk of both lung and esophageal cancer. With over 1 in 5 adults as current smokers, Shasta County has among the highest tobacco use rates in California.[6] Alcohol consumption is also a major risk factor for esophageal cancer.[7] Behavioral changes like quitting smoking, decreasing alcohol abuse, changing diets, and increasing exercise can also help prevent diseases.

Figure 8: Age-Adjusted Rates of Death and Late Stage Diagnosed Lung Cancer, 2009-13

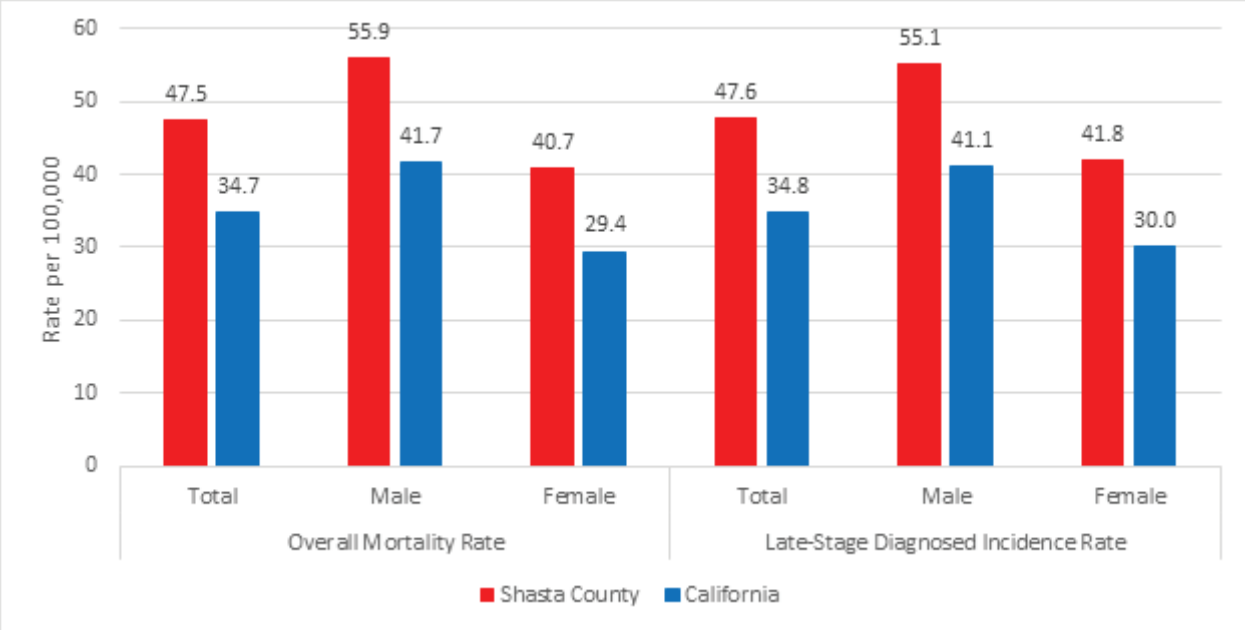
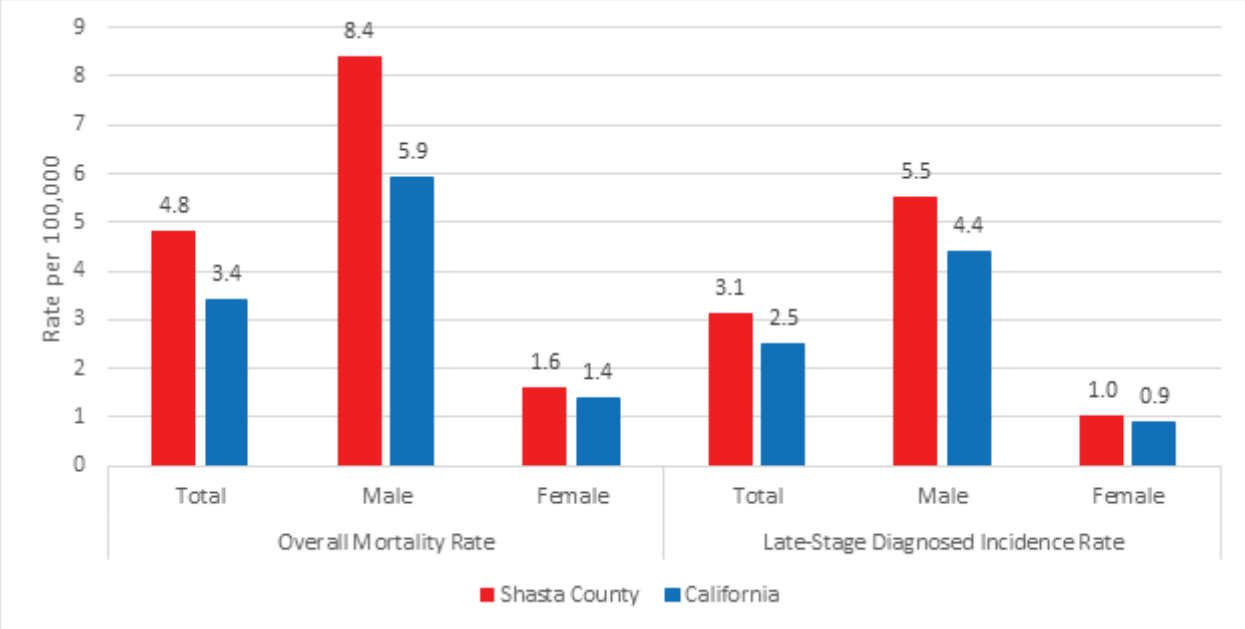


Figure 9: Age-Adjusted Rates of Death and Late Stage Diagnosed Esophageal Cancer, 2009-13



Communicable Diseases

Many reportable diseases can be prevented through vaccination of vulnerable populations, or through the use of protective measures, such as condoms for the prevention of sexually-transmitted diseases.

This information is critical for monitoring disease in the community, for ensuring appropriate treatments and monitoring of cases, and identifying people who may have been exposed. Health care providers are required by California law to report certain communicable diseases to the local health department.

In this section:

Vaccine Preventable Disease

Vaccine-preventable diseases include meningococcal disease, human papillomavirus, chickenpox, diphtheria, Haemophilus influenzae Type B, Hepatitis A and B, influenza, measles, mumps, pertussis, polio, pneumococcal, rotavirus, rubella, tetanus, and influenza.[1]

Table 1: Select vaccine preventable disease average annual reported incidence rates per 100,000 population, 2012-14

	Shasta County	California
Pertussis	5.79	9.03
Mumps	0	0.09
Measles	0.19	0.09
*Tetanus	0	0.01
Rubella	0	0.003

*In 2010, Council of State and Territorial Epidemiologists removed the "confirmed" classification and defined all clinically compatible cases as probable cases.

The CDC states that for every year's group of children that are vaccinated, approximately 42,000 deaths and 20 million cases of disease are prevented, saving $14 billion in direct costs and $69 billion in societal costs.[2] Though many young children receive all immunizations, many under-immunized children live in our county, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well.[3] Shasta County has a slightly lower incidence rate of many vaccine-preventable diseases compared to California as a whole.

Working Together: ShastaShots.com

Vaccine-preventable diseases are still a very real threat to our children, and immunizing them is the best way to keep them safe and healthy. The Shasta Flu Shots website is a one-stop shop for parents to find reliable, useful information about the vaccines that their children need.

Learn more at www.shastashots.com.

Bacterial Meningitis

Bacterial meningitis is usually severe and can cause brain damage, hearing loss, learning disabilities, or death. There are several pathogens that can cause bacterial meningitis. Some of the leading causes of bacterial meningitis in the United States include *Neisseria meningitidis*, *Streptococcus pneumoniae*, group B Streptococcus, *Listeria monocytogenes*, and *Haemophilus influenzae* (most often caused by type b, Hib).[4]

Meningococcal disease refers to any illness that is caused by the bacteria Neisseria meningitidis. The bacteria that cause meningococcal disease are spread through the exchange of respiratory and throat secretions. This can occur when people live or sleep in close contact or through other contact such as kissing. Teens and young adults are at a higher risk for meningococcal disease.[5] Meningococcal disease can be treated with antibiotics, but immediate medical attention is essential. Appropriate vaccination is a good defense against meningococcal disease.[6]

A vaccine against four types of the meningococcal bacteria is recommended routinely for 11-12 year olds, adolescents entering high school or 15 years of age, college freshmen living in dorms, and other high-risk people. Teens need a booster shot when they are 16, especially if they are going to move into a college dorm or go into the military. Other people at high-risk for meningococcal disease, including children and adults with certain medical conditions, may also need to get vaccinated and should talk to their doctor.

From 2012-14, Shasta County had an average annual incidence rate of 0.37 cases per 100,000 population for invasive meningococcal disease. This was slightly higher than California's average annual incidence of 0.22 cases of invasive meningococcal disease per 100,000 population.

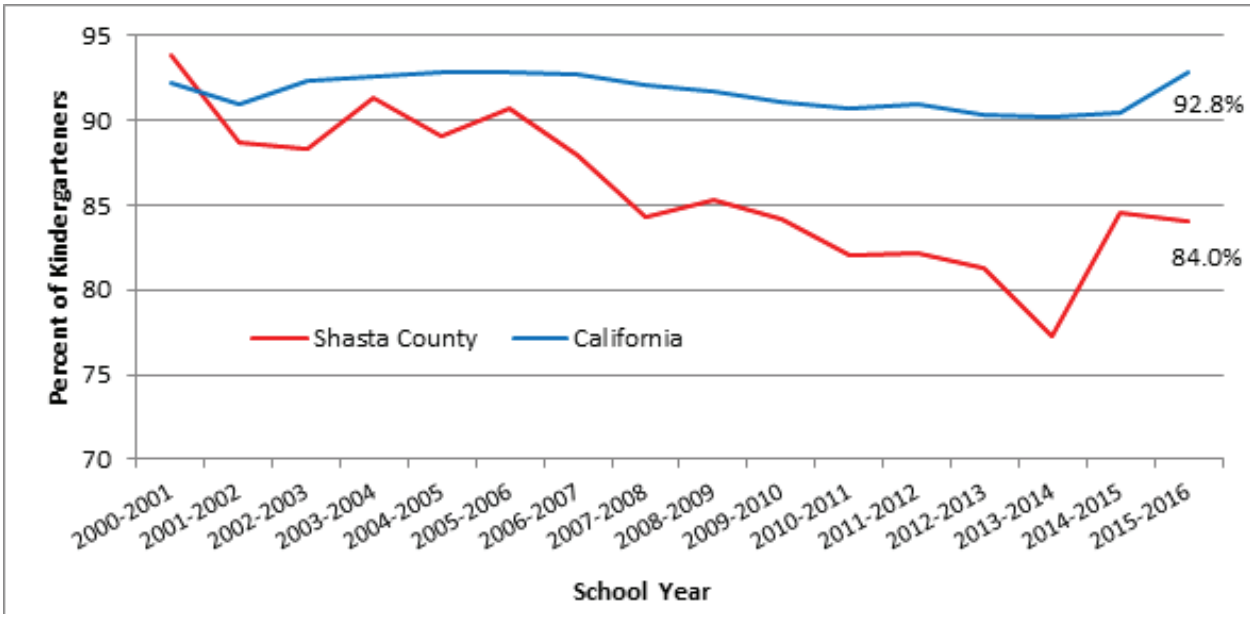
Immunizations

Childhood Immunizations

California law requires children to receive a series of immunizations before entry to schools, child care centers, and family child care homes and is used to maintain high vaccination coverage and protect school children and others from vaccine-preventable diseases.

Since the 2001-2002 school season, Shasta County immunization rates for Kindergarten students have been consistently and significantly lower than the overall California immunization rates. To create "community immunity" and slow the spread of diseases, such as measles or whooping cough, an immunization rate greater than 90-95% is necessary.[7]

Figure 1: Kindergarten students up-to-date on immunizations by school year, 2000-15*



*Up-to-date: 4 or more doses of Diphtheria, Tetanus, Pertussis (4+ DTP), 3+ Polio, 2+ MMR (Measles, Mumps, Rubella), 3+ Hep B (Hepatitis B), and 1+ Var (Varicella) or physician-documented varicella disease.

Influenza Immunizations

When healthy adults and children are vaccinated against influenza, it helps to protect those who are most vulnerable, particularly babies too young to be immunized, older adults who may not be developing as strong an immune response, and anyone with a compromised immune system. Influenza vaccination is recommended for all individuals over 6 months old, including pregnant women, to protect those vaccinated and those they come in contact with. 90% of influenza-related deaths occur in people 65 years of age and older.[8]

Rates of influenza vaccination for those under the age of 18 and those who are 18-64 in Shasta County are similar to the California rate.

Table 2: Vaccination rates for Influenza in the past 12 months by age, 2014

	Under 18	18-64	65 and older
Shasta County	49.6%	39.4%	61.0%
California	53.7%	37.4%	72.7%

Sexually Transmitted Diseases

Chlamydia, gonorrhea, and syphilis are the most common notifiable sexually transmitted diseases in the United States. Nationally, the CDC estimates that there are 20 million new STD infections each year which leads to almost $16 billion in health care costs. Half of all sexually transmitted infections occur in people age 15-24 years old.[9]

Table 3: Average annual reported incidence rates per 100,000 population for selected sexually transmitted diseases in Shasta County, 2012-14

STD	Shasta County	California
Gonorrhea	149.3	102.2
Chlamydia	345.7	447.0
Syphilis (Primary and Secondary)	0.7	9.0

Both young men and young women are affected by chlamydia and gonorrhea in Shasta County — but young women face the most serious long-term health consequences. It is estimated that undiagnosed cases of chlamydia and gonorrhea cause more than 20,000 women to become infertile each year in the United States.[9]

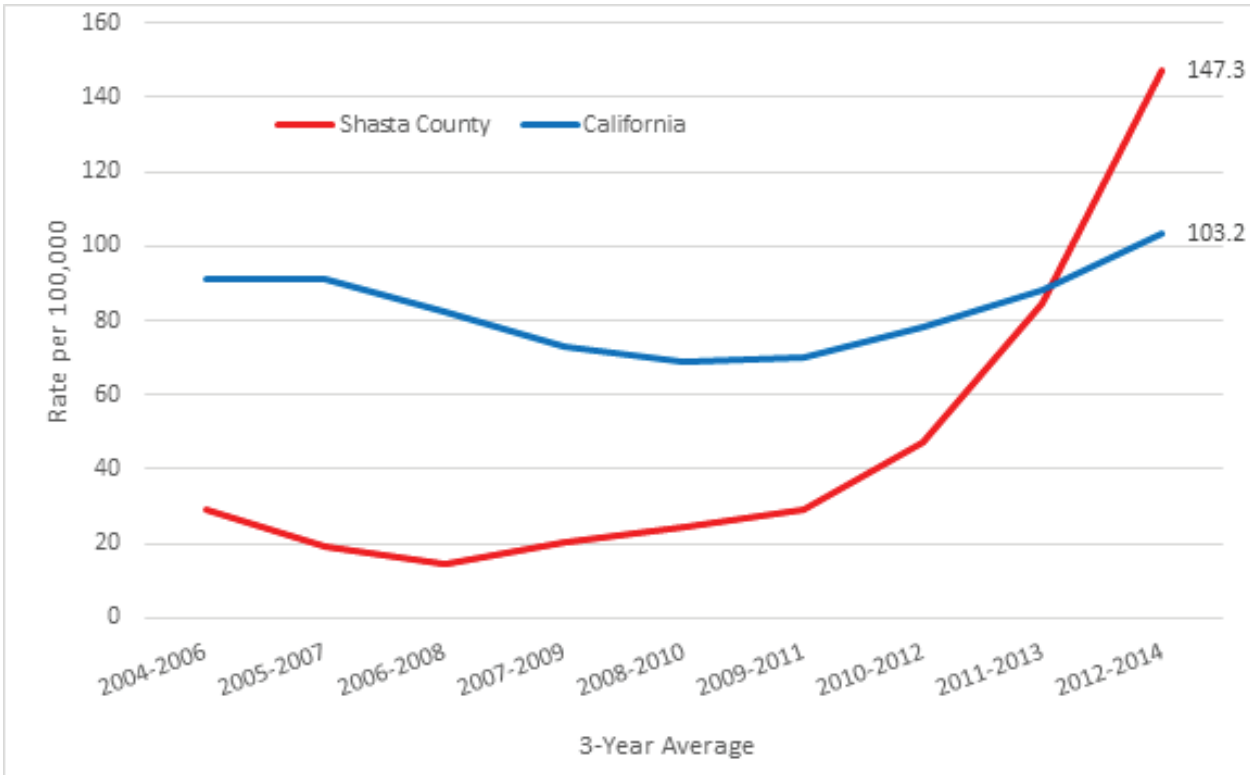
Table 4: Selected STD average annual reported incidence rates per 100,000 population by age in Shasta County, 2012-14

	Gonorrhea	Chlamydia	Syphilis (Primary & Secondary)
0-14 Years	2.1	11.6	0.0
15-19 Years	304.7	1,831.3	0.0
20-24 Years	570.5	1,733.4	0.0
25-29 Years	542.9	975.3	0.0
30-34 Years	441.8	402.8	0.0
35+ Years	55.8	37.2	1.3

Gonorrhea

Between 2012 and 2014, the rate of gonorrhea in Shasta County has seen a significant increase, surpassing the California rate in 2012. In Shasta County, gonorrhea rates are similar between men and women and are highest among 20 to 29 year olds. These rates are second only to San Francisco in California, creating an epidemic situation.

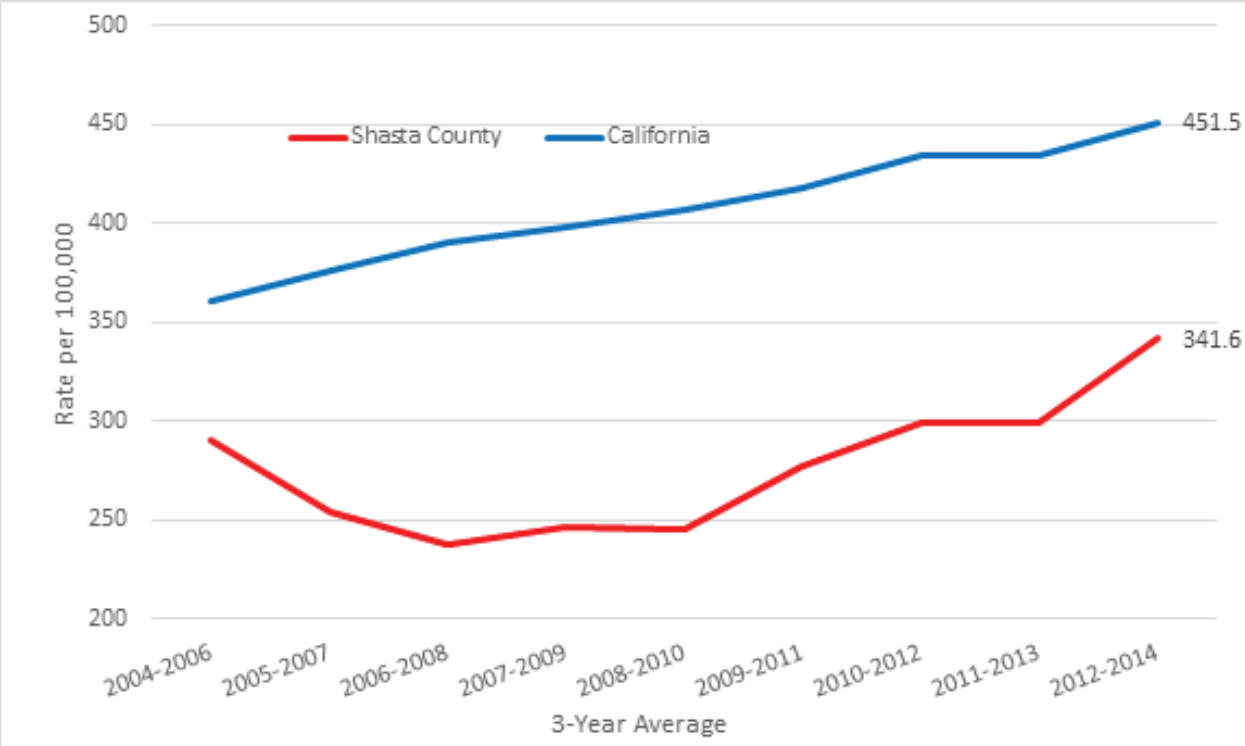
Figure 2: Gonorrhea average annual incidence rates per 100,000 population in Shasta County and California, 2004-14



Chlamydia

Chlamydia is the most common reportable sexually transmitted disease in Shasta County and throughout all of California. Between 2008 and 2014, there has been a steady increase in the rate of chlamydia in Shasta County though rates are lower than California as a whole. In Shasta County, chlamydia rates are highest among women. Similar to the national statistics, 15-24 year olds in Shasta County have a higher rate of chlamydia when compared to other age groups.

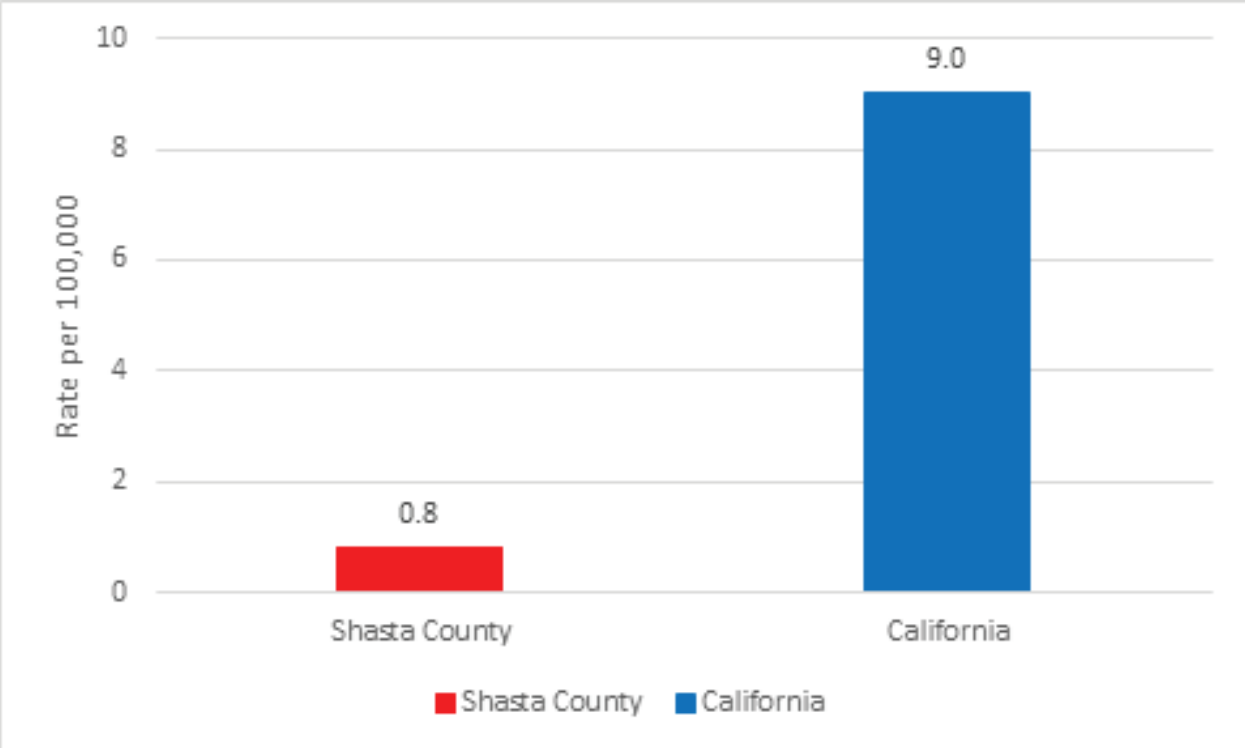
Figure 3: Chlamydia average annual incidence rates per 100,000 population in Shasta County and California, 2004-14



Syphilis

The reported incidence of Primary and Secondary Syphilis in Shasta County was considerably lower than statewide in 2012-14. Rates among both women and men have increased locally and statewide in recent years, which is an emerging concern, especially since syphilis can pass unknowingly from a pregnant woman to her baby.

Figure 4: Primary and Secondary Syphilis average annual incidence rate per 100,000 population in Shasta County and California, 2012-14



HIV/AIDS

Human immunodeficiency virus (HIV) is a virus that attacks the body's immune system. Acquired Immune Deficiency Syndrome (AIDS) refers to the most advanced stages of HIV infection. Nationwide, Blacks and Hispanics, men who have sex with men, and young people (age 13-24) are disproportionately affected.[10] Prevalence of both reported HIV and AIDS in Shasta County is much lower than statewide rates.

Identification and treatment of HIV is associated with slowing the progression to AIDS and reduced HIV transmission.

Table 5: HIV and AIDS reported prevalence rate per 100,000, 2013

	Shasta County	California
HIV	27.4	121.9
AIDS	40.9	191.9

Table 6: Percent ever tested for HIV, 2013-14

At-Risk Groups	Shasta County	California
Adults with 2 or more sexual partners in past 12 months	8.7%	11.3%
Gay or Bisexual Adult Men	2.8%*	4.5%
18-70 year-olds ever tested for HIV‡	83.9%*	74.2%

*Statistically Unstable
‡Asked of adults under 70 with at least 2 sexual partners in the last year and all self-identified gay or bisexual men

Viral Hepatitis

Hepatitis is liver inflammation most commonly caused by viral infection. The most common types of viral hepatitis are Hepatitis A, Hepatitis B, and Hepatitis C. Vaccines are available for Hepatitis A and Hepatitis B. Hepatitis B and C are capable of developing into chronic long-term infections and are the leading cause of liver cancer and liver transplant in the United States. Nationally, 3 in 4 people with Hepatitis C were born from 1945-1965.[11]

The average annual incidence rate of acute Hepatitis infections in Shasta County are similar to the statewide rate.

Table 7: Average annual reported incidence rates per 100,000 for acute viral hepatitis infections in Shasta County, 2012-14

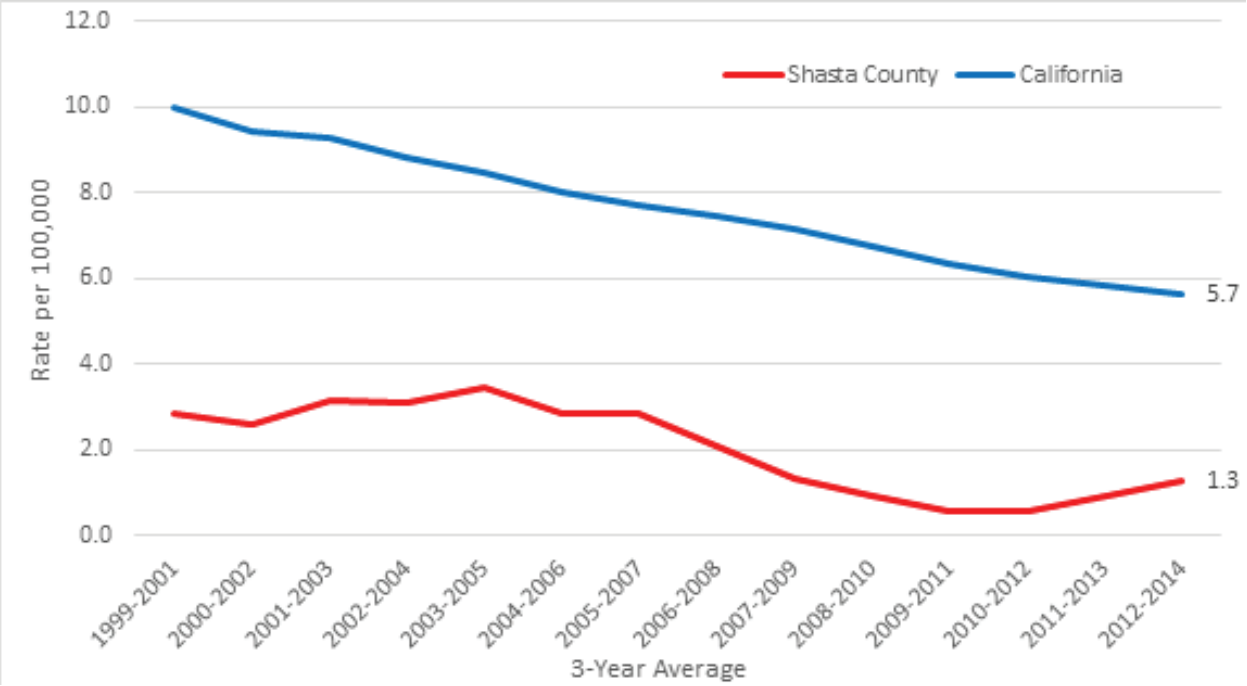
	Shasta County	California
Hepatitis A	0.93	0.53
Hepatitis B, acute	0.37	0.34
Hepatitis C, acute	0.37	0.19

Tuberculosis

Tuberculosis (TB) is a communicable disease caused by the bacterium *Mycobacterium tuberculosis* which usually attacks the lungs but can attack any part of the body. TB can remain dormant for many years after a person has been exposed and can develop into active disease later in life. If left untreated or not treated properly, it can cause death. Tuberculosis has a 10 percent mortality.

TB rates statewide and in Shasta County have decreased over the last 15 years and the rate of infection in Shasta County is low compared to the statewide rate. Those at high risk for TB include some foreign-born residents, alcoholics and the homeless. Chronic illnesses that can weaken the immune system like HIV and diabetes are also a risk for TB.[12]

Figure 5: Reported tuberculosis average annual incidence rates per 100,000 population in Shasta County and California, 1999-2014



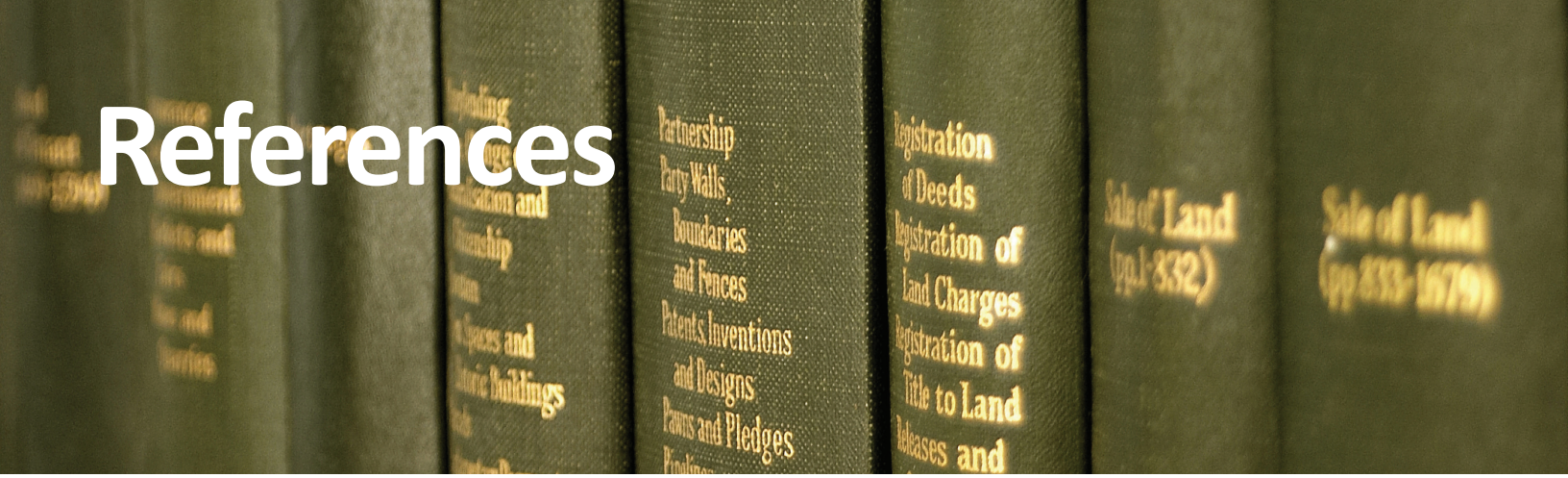


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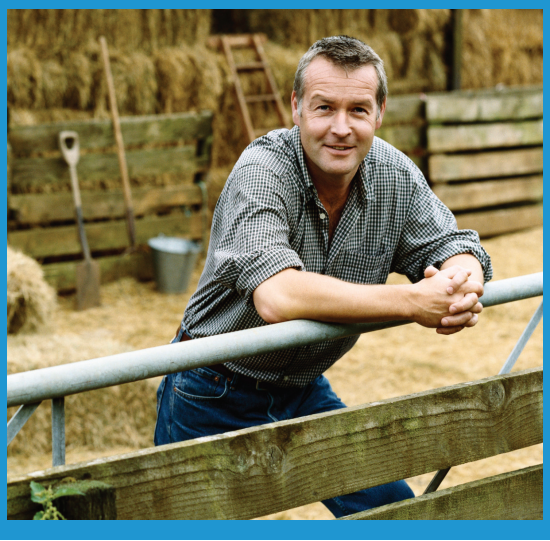
Figure 5: Tuberculosis Control Branch. Tuberculosis Disease Data. California Department of Public Health. [Online] October 29, 2015. https://www.cdph.ca.gov/data/statistics/Pages/TuberculosisDiseaseData.aspx



Conclusion




The development of this Community Health Assessment has provided an opportunity for Shasta County residents, local health system partners and Health and Human Services Agency - Public Health Branch staff to work collaboratively in assessing the health of our community.

Using the voice of the community and supporting data, findings from this report will be used to develop a five-year Community Health Improvement Plan that supports improvement in the mental, physical and social health of Shasta County residents.

MAPP ASSESSMENT SUMMARIES

Community Themes and Strengths Assessment

Overall, people who responded to the Community Health Survey or participated in a focus group feel like Shasta County is a healthy or very healthy place to live. Our community strengths include plentiful outdoor recreation opportunities, access to nature and parks, and a rural setting. Many also included good schools and affordable housing as advantages of living in Shasta County. Survey respondents were asked to select the three most important issues which impact overall community health and their family. The community health issues that were important to at least one quarter (25%) of survey takers were:

- Alcohol and drug abuse. Of the 2,850 survey respondents, 1,856 (65%) chose alcohol and drug abuse as issues affecting the community. On the other hand, only 419 (15%) indicated that these were issues that impacted their family.
- Lack of mental health services was selected by 1,358 (48%) survey respondents as the second most import issue impacting community health and was also among the top five issues affecting their family with 530 votes (19%).
- Unemployment or underemployment was ranked as the third biggest issues impacting the community by 1,211 (42%) of survey respondents. This issues ranked as the 2nd biggest issue impacting their family by 792 (28%) of respondents.
- Affordable housing. The lack of affordable housing was selected by 758 (27%) survey respondents as impacting overall community health. It ranked as the number one issue impacting their family, with 789 or (28%) selecting this issue.

Forces of Change Assessment

Assessment participants identified a number of trends, factors and events that are likely to influence community health and wellbeing. Many of the forces reflect what is happening at the national level – a slow economic recovery, health care reform and ongoing climate change. Other forces noted by community partners were specific to our region including an aging population, limited public transportation in outlying areas and above average rates of child maltreatment and neglect.

Each of the identified Forces of Change has both inherent challenges that could threaten health and opportunities and resources to support better health for the community. Understanding these forces will help with both strategic planning and decision making throughout the community health improvement planning process.

Community Health Status Assessment

Through a review of primary and secondary quantitative data, this assessment provided a snapshot of the overall health status of Shasta County residents. This information will be used to ensure that community health priorities are strategic and data-driven. After examining more than 140 indicators across eight broad-based categories related to health and wellbeing, it's evident that Shasta County residents experience poorer health outcomes in many areas compared to the state. In some categories, like suicide and child abuse and maltreatment, they are significantly higher, even double. Below is a summary of key findings from the assessment:

Socioeconomic

- The number of homeless people in Shasta County has grown by nearly 50% in the last 6 years.
- Shasta County consistently has a higher unemployment rate than California (12.2%, 11.0%).
- Shasta County has a higher percentage of people living below the federal poverty level than California (23.9%, 22.7%). Households with children under 18 years headed by single females experience even higher rates of poverty (43.2%).
- A lower percentage of Shasta County adults (19.1%) have a bachelor's degree or higher than in the rest of California (31.0%).

Health Resource Availability

- Shasta County does not meet the national benchmark ratio of people to primary care physicians. There are not enough physicians to serve the population, especially people on Medi-Cal.
- Access to psychiatry resources and services is inadequate.
- 8.5% of Shasta County children are still uninsured.
- Shasta County does not meet the national benchmark for the number of dentists per resident.
- Among low-income residents with Medi-Cal's dental insurance, there are twice as many people for every dentist accepting this insurance.

Health Behavior Risk Factors

- Shasta County consistently has almost twice the rate of adult smoking rates when compared to the rest of California.
- One in three Shasta County adults is obese, slightly higher than the state. People living below 200% of the federal poverty level are more likely to be obese.
- A lower percentage of Shasta County adults meet physical activity recommendations than in California and the rest of the United States.

Social and Mental Health

- Child abuse and foster care rates are higher in Shasta County than in California, especially among infants (less than one year old).
- Prenatal substance abuse is a problem in Shasta County. From 2010-2014, there were 800 babies born affected by drugs.
- Shasta County has higher rates of chronic drinking among adults than California, but not higher binge drinking rates.
- Drug related deaths and non-fatal emergency department visits and hospitalizations have increased in Shasta County in recent years and has been consistently higher than the state.
- The number of alcohol and drug treatment admissions where heroin is the primary drug of choice has increased.
- Mental illness made up 4.4% of all hospital discharges, an average of more than 1,000 per year.
- Domestic violence calls for assistance are much more common per capita in Shasta County than in California.

- The suicide rate is consistently twice as high in Shasta County than in California.
- While Shasta County has consistently had a lower homicide rate than the state, in the most recent year of data, Shasta County's homicide rate surpassed California.

Maternal and Child Health

- Shasta County women are less likely to get prenatal care during their first trimester than pregnant women in the rest of California. (66.6%, 81.9%)
- Shasta County has a high rate of child and adolescent mortality (20.4 deaths per 100,000 people compared to 13.8 in California).

Death, Injury, and Illness

- More than 60% of people in Shasta County have diabetes or pre-diabetes and it was the 7th most common cause of death.
- Shasta County has a high rate of death due to heart disease.
- High incidence of lung, bronchial, esophageal cancer with mortality rates that are higher than California for lung, bronchus, esophagus, liver, bile duct and melanoma cancer.

Preventable Disease

- Shasta County has rates of preventable hospitalizations that are higher than California among all adults, females, males, and all age groups, indicating a need for addressing social determinants of health, lifestyle changes, more screenings, early interventions and good outpatient care.
- The percentage of women aged 21-65 years who have had a Pap smear in the past 3 years declined in the last four years of data available from almost 89% to almost 79%.
- Shasta County has high late-stage diagnosed incidence rates of lung and esophageal cancer, especially among men.

Communicable Disease

- Rates of reported cases of gonorrhea has dramatically increased and the rates of syphilis reported in recent years has also increased, making it an emerging concern.
- Shasta County has low childhood immunization rates compared to California.

IDENTIFYING STRATEGIC COMMUNITY HEALTH ISSUES

Upon completion of the three assessments, MAPP Steering Committee members reviewed and summarized the data in order to identify cross-cutting themes. They used a worksheet to reflect on data by answering the following questions:

1. Did you find any contradictions or differences with the data among the three assessment categories?
2. Given the data you have read, what are key gaps between Shasta County's current status, as indicated by the assessment data, and its vision?
3. Please list three themes that emerged across at least two data assessments. For each theme, please provide a short description and 5-6 data points.

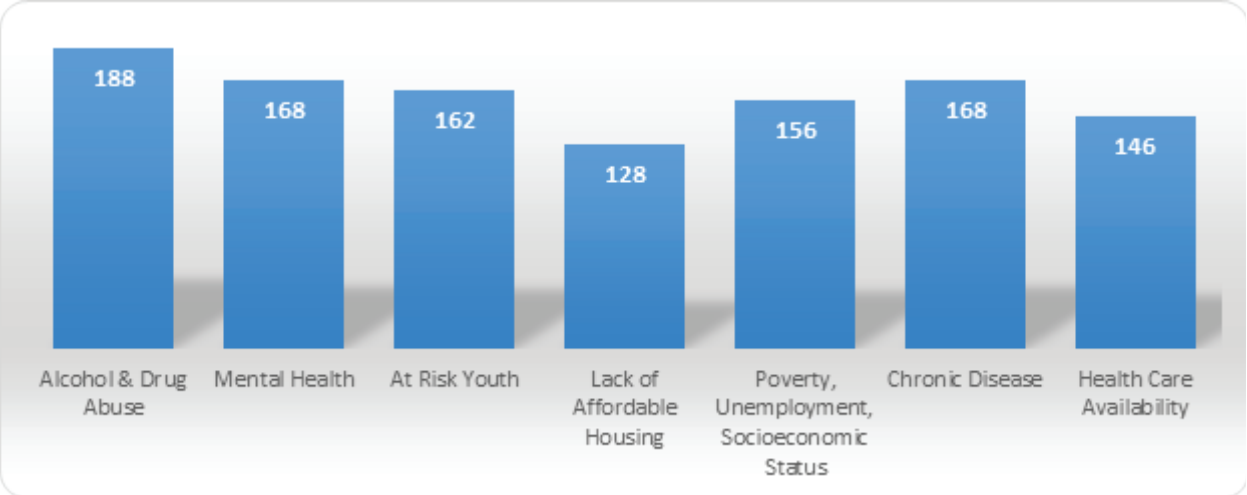
Public Health Branch staff compiled data from individual worksheets and found the following community health issues were referenced most frequently:

- Alcohol and Drug Abuse
- Mental Health
- At Risk Youth
- Lack of Affordable Housing
- Poverty, Unemployment and Socioeconomic Status
- Chronic Disease
- Health Care Availability

These became the Strategic Community Health Issues that were presented to MAPP Steering Committee members and organizational leaders on September 16, 2016 at the Choosing Strategic Priorities Workshop. See Appendix 10 for workshop participant list.

The day began with a brief overview of how the MAPP Steering Committee developed cross-cutting themes from the three MAPP assessments followed by brief presentations on each Community Health Issue and its supporting data points (Appendix 11: Community Health Issues). Afterwards, participants broke into small World-Café style discussion groups to learn more about three issues of their choosing. To determine the strategic nature of each issue, participants were asked to apply a five-question weighted scoring tool. See Appendix 12: Strategic Issues Scoring Tool. After completing it individually, participants joined other members from their own organization and completed just one scoring sheet per organization.

The three Community Health Issues which received the highest scores are the issues which will be included in the Community Health Improvement Plan. Scores for each issue were tallied and the results were as follows:



The three Community Health Issues which received the most votes and will be priorities for our collaborative work going forward are:

1. Alcohol and Drug Abuse
2. Mental Health
3. Chronic Disease

In the coming months, we will continue to work with our partners to develop a Community Health Improvement Plan (CHIP). The CHIP will include specific goals, strategies and commitments to address the community health priorities identified by partners.

Most importantly, we will work closely with community members and local organizations to ensure that this effort builds on existing collaborations, leverages community assets and emphasizes prevention in a manner that benefits all who live and work in Shasta County.



Appendices






Index of appendices

Appendix 1: Community Health Survey

Shasta County **Community Health Survey**

Thank you for taking the time to complete the survey below. **The purpose of this survey is to get information about your experience living in Shasta County.** The results will be used to improve health in our community.

Your opinion is important! Please read the questions carefully and answer to the best of your ability. *Your answers will be kept confidential.* If you have already completed a survey, thank you. Please do not fill out another one. The deadline to complete this survey is February 29th, 2016.

1. Do you live in Shasta County?
   ☐ Yes ☐ No

   If you do not live in Shasta County, thank you but we are only gathering information from Shasta County residents.

2. What is the zip code where you live?

3. Where do you go most often in Shasta County to have fun?
   Below is a list of examples. Check **UP TO 3** from the list below or write in responses using the "other" box.

   ☐ Parks
   ☐ Walking / biking / hiking trails
   ☐ Rivers / lakes / woods
   ☐ Movie theatres
   ☐ Mt. Shasta Mall / shopping
   ☐ Sports fields
   ☐ Restaurants / bars
   ☐ Health / fitness club
   ☐ Senior center
   ☐ Library
   ☐ Live theater / performances
   ☐ Church
   ☐ Social club / service club
   ☐ Other (please specify)

Page **1** of **4**

4. What do you think are the most important things that make Shasta County a good place to live?
Below is a list of examples. Check **UP TO 3** from the list below or write in responses using the "other "box.

- □ Clean air / water
- □ Affordable housing
- □ Good schools
- □ Low crime/safe neighborhoods
- □ Outdoor recreation opportunities
- □ Access to healthcare
- □ Good jobs / healthy economy
- □ It's a good place to raise children
- □ Arts and cultural events
- □ Access to healthy foods
- □ Community involvement / lots of people volunteering
- □ It is in a rural setting
- □ I don't consider Shasta County a good place to live
- □ Other (please specify)

The next two questions are about what impacts health. Number 5 is about *your* family and number 6 is about the *whole community*. It might be that things that impact the health of your family are different than what you think impacts the rest of the community.

5. What are the *most important issues* that impact **YOUR FAMILY***?*
Below is a list of examples. Check **UP TO 3** from the list below or write in responses using the "other box.

- □ Affordable housing
- □ Tobacco use
- □ Alcohol and drug abuse
- □ Serious illness
- □ Hunger
- □ Poor diet
- □ Lack of exercise
- □ Aging problems (arthritis, hearing/vision loss, etc.)
- □ Poor water/air quality
- □ Isolation
- □ Lack of mental health services
- □ Unemployment / under-employment
- □ Domestic violence
- □ Sexually transmitted diseases
- □ Teenage pregnancy
- □ Child abuse
- □ Lack of educational choices after high school (college or vocational)
- □ Can't find regular, family doctor
- □ Unsafe roads / bike / pedestrian conditions
- □ Lack of transportation
- □ Other (please specify)

6. What are the *most important issues* that impact the **overall community health** in Shasta County?
Below is a list of examples. Check **UP TO 3** from the list below or write in responses using the "other" box.

- □ Affordable housing
- □ Tobacco use
- □ Alcohol and drug abuse
- □ Serious illness
- □ Hunger
- □ Poor diet
- □ Lack of exercise
- □ Aging problems (arthritis, hearing/vision loss, etc.)
- □ Poor water/air quality
- □ Isolation
- □ Other (please specify)
- □ Lack of mental health services
- □ Unemployment / under-employment
- □ Domestic violence
- □ Sexually transmitted diseases
- □ Teenage pregnancy
- □ Child abuse
- □ Lack of educational choices after high school (college or vocational)
- □ Can't find regular, family doctor
- □ Unsafe roads / bike / pedestrian conditions
- □ Lack of transportation
- □ I don't know

7. I think Shasta County is a _____ place to live.
Check an answer to fill in the blank.

□ Very healthy □ Healthy □ Unhealthy □ Very unhealthy

Please answer the following questions so we can make sure we are hearing from a diverse group of Shasta County residents. *This section is optional.*

8. Your gender:

- □ Male
- □ Female
- □ Self identify

9. Your age:

- □ Under 18 years
- □ 18 - 25
- □ 26 - 39
- □ 40 - 54
- □ 55 - 64
- □ 65 - 80
- □ 81 and over

10. What is the ethnic group you most identify with?
Check **all** that apply.

- □ African American/Black
- □ Asian / Pacific Islander
- □ Other (please specify)
- □ Hispanic / Latino
- □ Native American
- □ White / Caucasian

11. What is the highest level of education you have completed?

- □ Less than a high school diploma
- □ High School diploma
- □ Other (please specify)
- □ General Equivalency Diploma (GED)
- □ Some college
- □ College degree
- □ Graduate or professional degree

12. How many people, including yourself, live in your household?

Children 0 to 5 years old
Children 6 to 17 years old
Adults 18 years old or older

13. How much total combined money did all members of your HOUSEHOLD earn last year?
(If you are not sure, please guess the best you can.)

- □ $0 - $9,999
- □ $10,000 - $24,999
- □ $25,000 - $49,999
- □ $50,000 - $74,999
- □ $75,000 - $99,999
- □ $100,000 - $124,999
- □ $125,000 - $149,999
- □ $150,000 - $174,999
- □ $175,000 - $199,999
- □ $200,000 and up
- □ prefer not to answer

Thank you for your time! If you have questions about this survey, please call Anna at Shasta County Public Health at (530) 225-5271.

This survey is sponsored by the Shasta County MAPP Collaborative. Members include: First 5 Shasta, Healthy Shasta Collaborative, Hill County Health & Wellness, McConnell Foundation, Mercy Medical Center, Partnership Health Plan of CA, Public Health Advisory Board (PHAB), Reach Higher Shasta Collaborative, City of Redding, Redding Rancheria, Shasta Community Health Center, Shasta County Public Health, Shasta Health Assessment and Redesign Collaborative (SHARC), Strengthening Families Collaborative and Shasta Regional Medical Center.

Appendix 2: Community Themes and Strengths Assessment Focus Group Guide

Shasta County Community Health Improvement Process

NOTE TAKING TEMPLATE
February 23 - 26, 2016 12:00 pm – 2:00 pm

4 Regional Sessions: Eastern, Southern, Redding, North

Location: *Date:* *Number of participants:*

Note Taker: *Focus Group Facilitator:*

TOPIC	DESCRIPTION
Welcome and introduction:	**Roundtable introduction**: Name, where they live and how long they have lived there, what health means to them.
Focus Group question 1	**CTSA Survey Question 3:** Where do you go most often in Shasta County for fun? Potential probe questions: • What does fun mean to you? • What is fun about these places? • Why are they fun? • Who do you go there with?
Focus Group question 2:	**CTSA Survey Question 4:** What do you think are the most important things that make Shasta County a good place to live? Below is a list of examples. Potential probe questions: • What makes something a good place to live? • Why do the things you selected make Shasta a good place to live? • What is important to you about the things you selected? • When you answered this question, who were you thinking of?
Focus Group question 3:	**CTSA Survey Question 5:** What are the most important issues that impact your family? Potential Probe Questions: • How do these things impact your family? • What are the ways the availability or unavailability of those things impact your family's health? • What makes the things you selected valuable to your family's health?
Focus Group question 4:	**CTSA Survey Question 6:** What are the most important issues that impact the overall community health in Shasta County? Potential Probe Questions: • What does community mean to you? • Is a healthy community important to you? Why or why not?

	• How does living in a healthy or unhealthy community impact your life?
Focus Group question 5:	**CTSA Survey Question 7:** I think Shasta County is a _____ place to live. Check an answer to fill in the blank. □ Very healthy □ Healthy □ Unhealthy □ Very unhealthy Potential Probe Questions: • How did you answer this question? • What are the reasons for the answer you gave? • What would be different about your life if you answered "very healthy?"
Closing:	Close with one word that describes the best about their community.

Appendix 3: Community Themes and Strengths Assessment Methodology

Community Health Survey: The Shasta County Community Health Survey was developed based on a review of surveys conducted in other communities. The Community Health Survey was customized for Shasta County and consisted of five health-related questions with an opportunity for open-ended comments and seven optional demographic questions. The five health-related questions asked participants to choose their three top selections from an extensive list of quality-of-life factors and health-related issues.

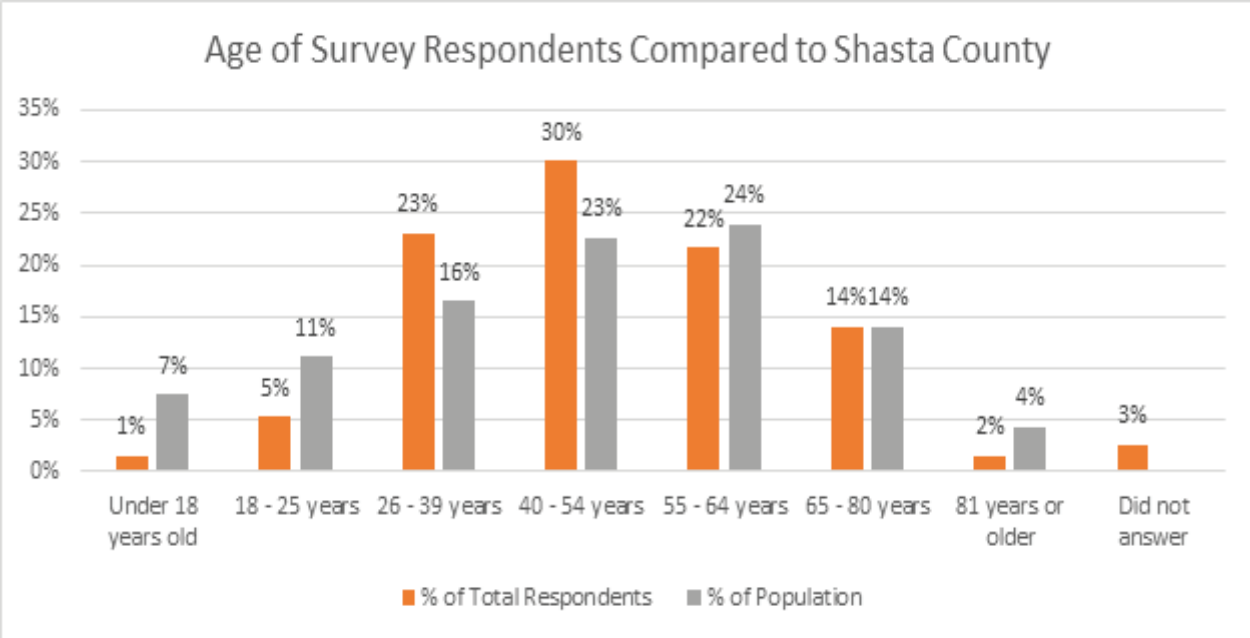
The survey was vetted with members of the Shasta County Mobilizing for Action through Planning and Partnership (MAPP) Steering Committee, and was focus tested with members of the community for readability and comprehension. Prior to its distribution, a communication plan was created to ensure that the survey reached specific groups and geographic areas that might otherwise be underrepresented. Through this plan, the subcommittee was able to identify more than 60 community events, meetings and locations to promote the Community Health Survey.

The anonymous survey was available online from February 1-29, 2016. Many community members posted links to the survey on organization webpages, shared it broadly through email contacts and distributed postcards with the web address. Paper copies of the survey, promotional posters and drop boxes were provided to community partners for expanded distribution to residents who might not have access to email or who were more likely to complete a hard copy. Through the collective efforts of MAPP Steering Committee members, partner organizations and volunteers, 2,850 surveys were completed – 1,210 paper surveys were received and 1,640 were completed online.

Demographics/limitations: The seven demographic questions include home ZIP code, gender, age, ethnicity/race, education level, household size and income. The language (English or Spanish) in which the survey was taken was also recorded.

It's important to note that this survey was not intended to capture a representative sample of Shasta County. Extra effort was made to reach a geographically and demographically diverse group of participants, but in some cases, this may have resulted in oversampling. See below for a comparison of our survey respondents' demographic characteristics to those of the general population of Shasta County. While we tried to reach a more rural, lower income, less educated, higher proportion of racial and ethnic minorities, we had mixed success.

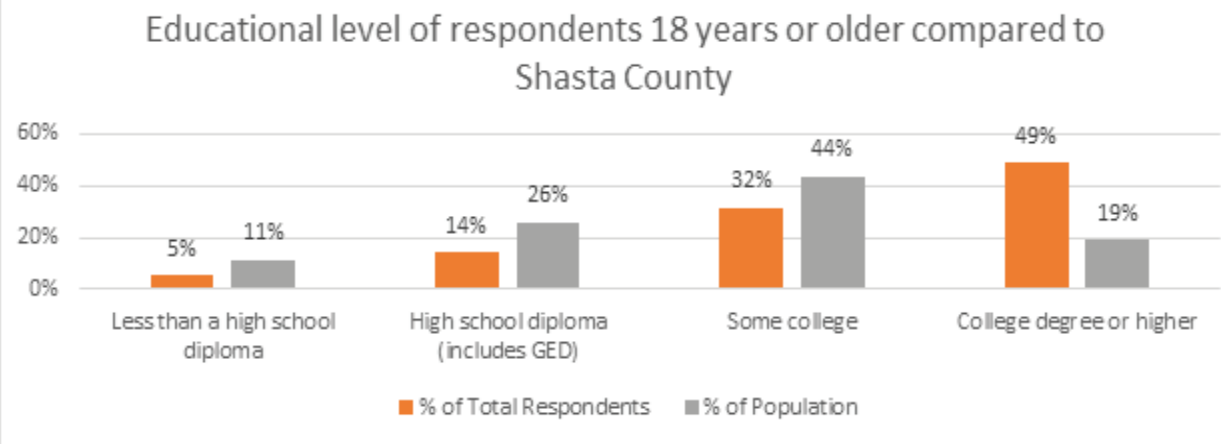
Age: A higher percentage of our survey respondents were 26-54 years old than the general population. We had the same percent of survey respondents aged 65 years old to 80 years old as the Shasta County population, and the survey sample had an underrepresentation of people 81 years of age and older and of 18-25 year olds. A small percentage (1.5%) of survey respondents were under 18 years old and 7.5% of our general population is under 18 years, but there weren't large-scale efforts aimed to reach teens with this survey.



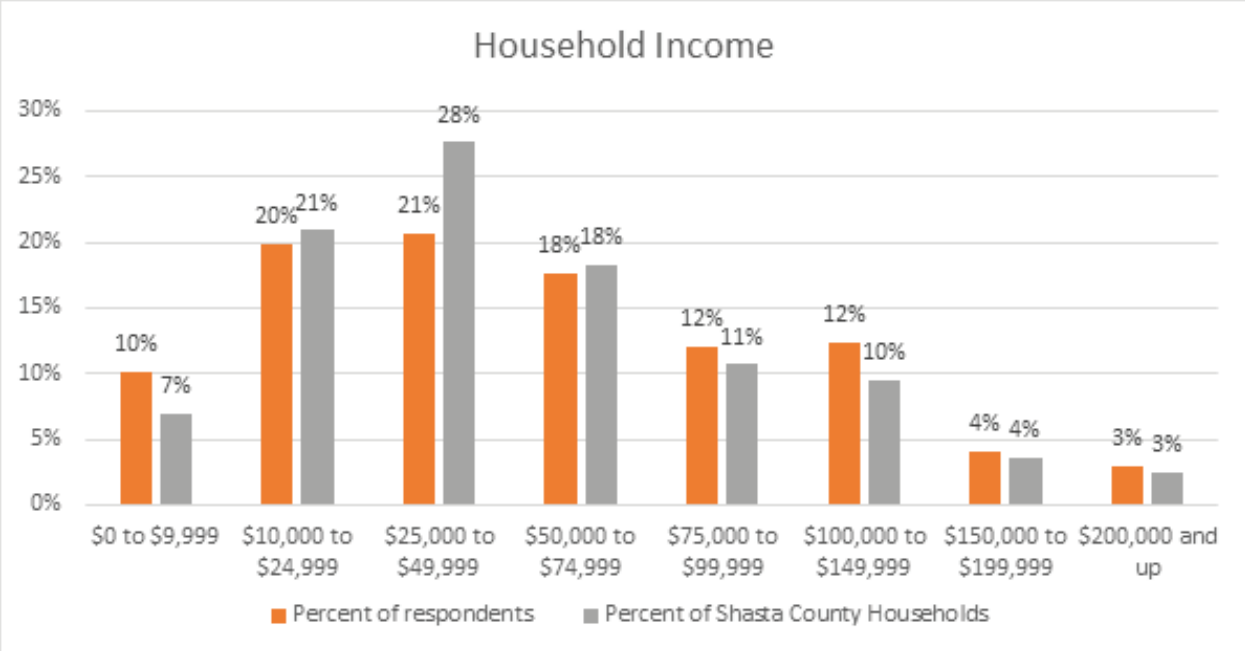
Have Children: A higher proportion of the survey respondents (42%) had children less than 18 years living in their household than households in Shasta County (35%). Twenty-one percent of survey respondents had at least one child under the age of 6 years living in their household.

Gender: Our survey respondents were much more likely to be female than you would find in the county in general (76% of survey respondents compared to 51% of the Shasta County population). Similarly, only 24% of our respondents were male, as compared to 49% in the general population.

Education: Our survey respondents were more than twice as likely to have a college degree or higher education as the adult population of Shasta County. We had an under-representation of people with a high school degree or less and an underrepresentation of those with some college.

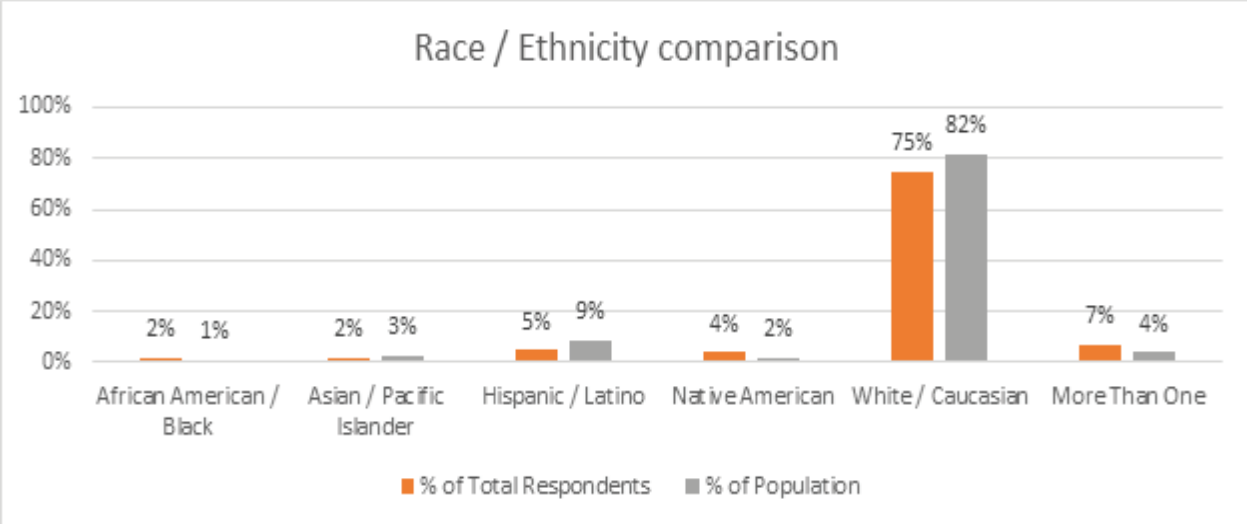


Income: Our survey respondents were more likely to have a household income of $75,000 or more than Shasta County in general. Conversely, they were less likely to be in a household with an annual income of less than $75,000. There is one exception to this generality. Our respondents were more likely to be in a household with an annual income less than $10,000 than one would find in the Shasta County population in general (10% compared to 7%).



Race/Ethnicity: Our survey respondents were more likely to be non-white than the general population of Shasta County.

Our survey had a higher percentage of multi-racial people (6.9% compared to 3.8% in the general population), Native American (3.9% compared to 2.0%) and African American (1.75% compared to 1%) respondents than the population of Shasta County. However, our survey respondents were less likely to be Hispanic than the general population of Shasta County (almost 5% compared to almost 9% in the general population).



Geography: We had oversampling in the following communities: Anderson, Cottonwood, Burney, McArthur, Montgomery Creek, Round Mountain and Redding. We have an undersampling in Shasta Lake, Bella Vista, Happy Valley/Igo area, Oak Run, Shasta, Millville, and Whitmore.

Focus Groups: While the Community Health Survey collected data from a larger number of Shasta County residents, focus groups provided an opportunity to get more in-depth information from community members about the issues most important to them. Community Organizers from the Shasta County Health and Human Services Agency - Public Health Branch helped recruit focus group participants from diverse backgrounds who were familiar with their communities. Special effort was made to engage underrepresented populations like low-income families and ethnic minorities. A NACCHO facilitator worked with two Public Health Branch staff to facilitate focus groups in four geographical regions of Shasta County – City of Shasta Lake (north), Anderson (south), Burney (east) and Redding (central). On average, each focus group included 10 participants and took two hours to complete. Participants completed a community health survey. The facilitator then guided groups through an in-depth discussion based on the survey questions while Public Health Branch staff recorded the discussion. Content of the conversations were then analyzed by a Public Health Program and Policy Analyst to find common themes and differences among the regions.

Appendix 4: Community Themes and Strengths Assessment Methodology

Community Health Visioning and Forces of Change Workshop

Friday, December 11, 2015

Noon to 5 p.m. at Shasta Regional Medical Center's Liberty Room #2.

Lunch will be available at 11:45 a.m.

Hello,

I want to thank you all once again for partnering to develop a plan for improving the health of our community.

We look forward to seeing you at next week's workshop, the first of two sessions where your input will directly guide this effort. Friday's session will start promptly at noon, so we encourage you to arrive by 11:45 to get your lunch, and we promise to end by 5 p.m.

The focus of this workshop will be to set a 5-year vision for Community Health here in Shasta, and to identify local forces that may impact that vision. The results of this session will provide valuable data for the Community Health Assessment (CHA).

Below is some information and questions to consider before Friday. This preparatory work will help us accomplish our goals in a compact timeframe, being respectful of your busy schedules.

Visioning will help us identify where we, as a community, want to be in the future. It may help to think about your organization's existing vision or reflect on a visioning process that you participated in. Typical visioning questions include:

- What are important characteristics of a healthy community for all who work, learn, live, and play here?
- Five years from now, what would we want the local newspaper to say about the health of our community?

The **Forces of Change Assessment** identifies the forces and associated threats and opportunities that can affect, either now or in the future, a community's health. Forces can be trends, factors or events.

Trends are patterns over time, such as an aging population or migration in and out of a community.

Factors are discrete elements, such as a community's ethnic population, a rural setting, or a jurisdiction's proximity to a major interstate.

Events are one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

When considering Forces of Change ask:

- What has occurred recently that may affect our local health system or the community at large? What may occur in the future?
- What characteristics of our county may pose an opportunity or threat?

Your perspective in this process is invaluable as we look for ways to collaboratively improve current and prevent future health conditions. See you all Friday and feel free to contact me if you have questions.

Terri Fields Hosler, Public Health Director

Shasta County Health and Human Services Agency, Public Health Branch

Appendix 5: Participant list for Visioning and Forces of Change Assessment

Participant	Organization
*Kim Niemer	City of Redding
* Joy Garcia	First 5 Shasta
Liz Poole	First 5 Shasta
Barbara Jackson	Healthy Shasta Collaborative
Lynn Dorroh	Hill Country Health & Wellness
Amy McCune	Hill Country Health & Wellness
*Marta McKenzie	Kemper Consulting Group
Brian Sindt	McConnell Foundation
Shannon Phillips	McConnell Foundation
Alexis Ross	Mercy Medical Center
Jordan Wright	Mercy Medical Center
*Bruce Ross	Office of Assemblyman Brian Dahle
Margaret Kisliuk	Partnership Health Plan of Northern California
Dr. Richard Yoder	Public Health Advisory Board
Elizabeth Hester	Redding Rancheria
*Glen Hayward	Redding Rancheria
*Silas Lyons	Redding Record Searchlight
Tina Cable	Shasta Community Health Center
Robin Glasco	Shasta Community Health Center
Dean Germano	Shasta Community Health Center
Harold Carlson	Shasta Community Health Center
Brandy Isola	Shasta County Heath and Human Services Agency, Public Health Branch
Terri Fields Hosler	Shasta County Heath and Human Services Agency, Public Health Branch
Dr. Andrew Deckert	Shasta County Heath and Human Services Agency, Public Health Branch
Donnell Ewert	Shasta County Heath and Human Services Agency
*Tom Armelino	Shasta County Office of Education
Patrick Moriarty	Shasta Health Assessment and Redesign Collaborative
Leslie Woodson	Shasta Regional Medical Center
Carla Clark	Strengthening Families Collaborative
*Cindy Dodds	Tri-County Community Network

*Denotes individual interview conducted

Appendix 6: Forces of Change Assessment Questions

Shasta County Vision for Community Health (original text) developed 12-11-2015

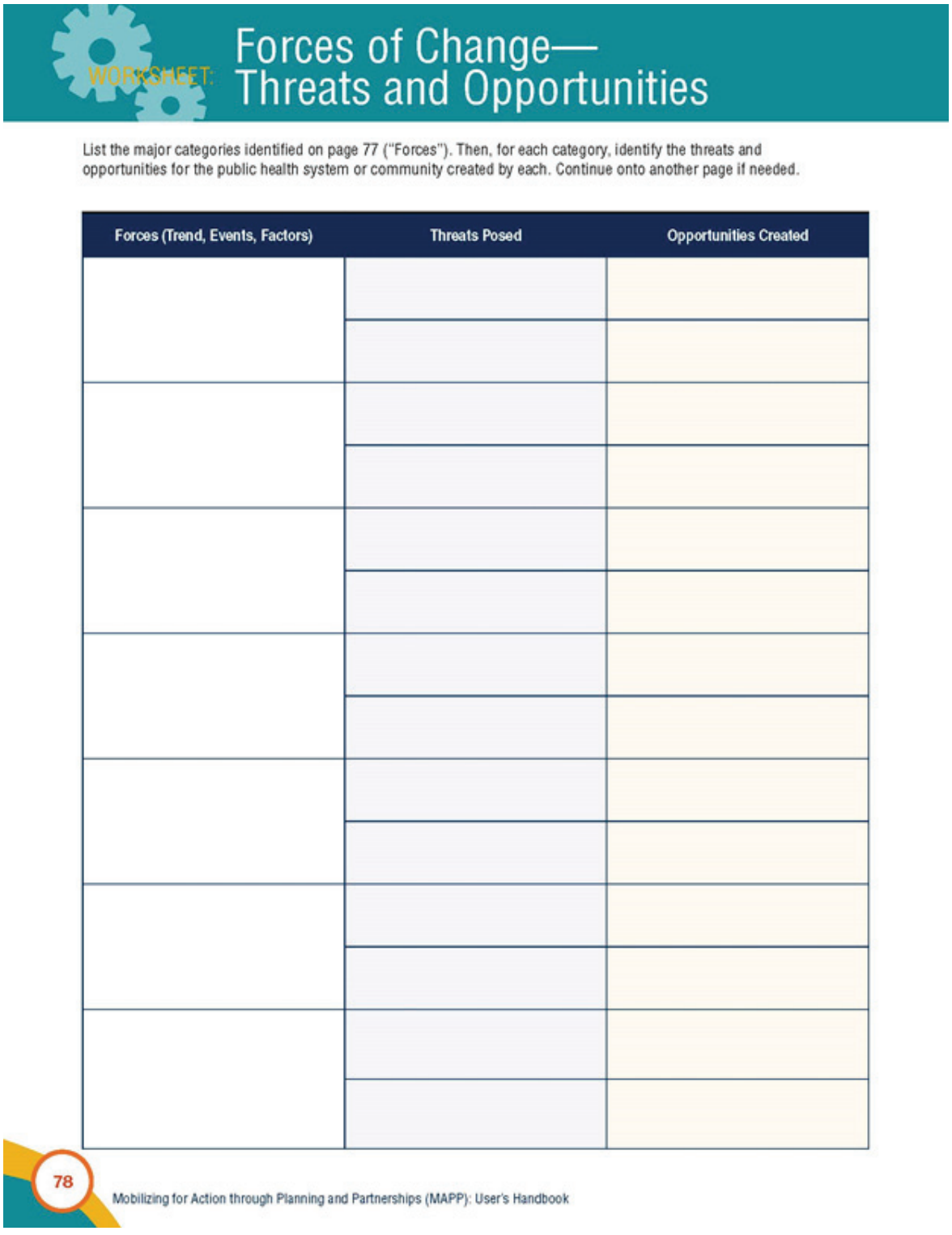
Shasta County has a medical home for every patient; healthy, affordable food; vibrant economic opportunities for all; superior mental health prevention and treatment; housing for all; robust substance abuse treatment and prevention; and supportive, thriving educational opportunities.

In Shasta County, people feel safe, our kids get a great early start and it's a great place to belong.

Forces of Change questions:

1. Are there any trends occurring that will have an impact on our community?
2. What are forces that are occurring that will have an impact on our community? Locally? Regionally? Nationally? Globally?
3. What patterns of decision, policies, investments, rules and laws affect the health of our community?
4. What may occur or has occurred that may pose a barrier to our shared vision?
5. What characteristics of our county may pose an opportunity or threat?

Appendix 7: Forces of Change Assessment – Threats and Opportunities worksheet



WORKSHEET:

Forces of Change— Threats and Opportunities

List the major categories identified on page 77 ("Forces"). Then, for each category, identify the threats and opportunities for the public health system or community created by each. Continue onto another page if needed.

Forces (Trend, Events, Factors)	Threats Posed	Opportunities Created

78

Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

Appendix 8: Health Status Assessment Indicator Feedback Survey

Community Health Status Assessment Indicator Feedback Survey

1. Please fill out the following information about you and the organization or collaborative that you represent

Answer Options	Response Percent	Response Count
Organization or Collaborative you represent on the	100.0%	16
Your first Your first and last name	100.0%	16
ed question	*answered question*	*16* 16
ed question	*skipped question*	*0* 0

Number	Response Date	Organization or Collaborative you represent on the MAPP Steering Committee	Your first and last name
1	Jan 8, 2016 12:06 AM	PHAB	Richard Yoder
2	Jan 6, 2016 11:57 PM	Shasta Community Health Center	Tina Cable
3	Jan 6, 2016 11:34 PM	Shasta Community Health Center	Tina Cable
4	Jan 5, 2016 9:06 PM	City of Redding	Kim Niemer
5	Jan 5, 2016 7:32 PM	First 5 Shasta	Liz Poole
6	Jan 5, 2016 6:54 PM	Mercy Medical Center Redding	Alexis Ross
7	Dec 31, 2015 6:55 PM	Shasta HHSA--PH	A Deckert
8	Dec 23, 2015 5:17 PM	Redding Rancheria	Elizabeth Hester
9	Dec 22, 2015 5:57 PM	The McConnell Foundation	Brian Sindt
10	Dec 21, 2015 11:12 PM	Healthy Shasta	Barbara Jackson
11	Dec 20, 2015 10:31 PM	Partnership HealthPlan of California	Margaret Kisliuk
12	Dec 17, 2015 5:36 AM	Hill Country Health and Wellness Center- n	Lynn Dorroh
13	Dec 16, 2015 12:52 AM	Strengthening Families	Carla Clark
14	Dec 15, 2015 11:09 PM	Reach Higher Shasta	Robert Adams
15	Dec 15, 2015 8:10 PM	Shasta Health Assessment and Re-design	Patrick Moriarty
16	Dec 15, 2015 8:03 PM	Shasta Regional Medical Center	Leslie Woodson

Socioeconomic Characteristics

2. Please rate your interest in the following indicators being included in the Community Health Status Assessment.

Answer Options	Not Important	Somewhat important	Very Important	Must be included	Rating Average	Response Count
Employment - Percent unemployed	0	0	9	7	3.44	16
Percent of people living below the poverty level	0	0	8	8	3.50	16
Percent of children living below the poverty level	0	1	9	6	3.31	16
Percent of families living below the poverty level	0	2	9	5	3.19	16
Median household income	1	2	9	2	2.86	14
High School graduation rate	0	2	9	4	3.13	15
Migrant person (number, proportion of total population,	1	9	3	2	2.40	15
Homeless persons (number, proportion of total	0	2	8	5	3.20	15
Persons aged 25 and older with less than a high school	0	3	7	5	3.13	15
Persons without health insurance	1	2	7	5	3.07	15
Single parent families	0	6	7	2	2.73	15
					answered question	16
					skipped question	0

Health Resource Availability

3. Please rate your interest in including the following indicators in the Community Health Status Assessment.

Answer Options	Not Important	Somewhat important	Very Important	Must be included	Rating Average	Response Count
Ratio of Medi-Cal eligible people to participating	0	3	6	6	3.20	15
Licensed dentists: rate per total population	1	7	4	3	2.60	15
Licensed primary care physicians (general practice,	0	2	9	4	3.13	15
Licensed hospital beds: total, acute, specialty beds; rate	1	8	4	2	2.47	15
Proportion of population without a regular source of	0	0	10	5	3.33	15
Per capita health care spending for Medicare	0	4	9	2	2.87	15
				answered question		15
				skipped question		1

Quality of Life

4. Please rate your interest in including the following indicators in the Community Health Status Assessment.

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Number of openings in child care facilities for low income	0	3	11	1	2.87	15
Percent of registered voters who vote	1	12	1	1	2.13	15
					answered question	15
					skipped question	1

Behavioral Risk Factors - Substance Use and Abuse

5. Please rate your interest in including the following indicators in the Community Health Status Assessment.Substance Use and Abuse

Answer Options	Not Important	Somewhat important	Very Important	Must be included	Rating Average	Response Count
Tobacco use	0	0	7	8	3.53	15
Binge drinking	0	2	6	7	3.33	15
					answered question	15
					skipped question	1

Behavioral Risk Factors - Lifestyle

6. Please rate your interest in including the following indicators in the Community Health Status Assessment.Lifestyle

Answer Options	Not Important	Somewhat important	Very Important	Must be included	Rating Average	Response Count
Nutrition (eg consumption of fruits and vegetables,	0	3	8	4	3.07	15
Exercise	0	2	9	4	3.13	15
Sedentary lifestyle	0	2	9	4	3.13	15
Obesity	0	0	8	7	3.47	15
					answered question	15
					skipped question	1

Behavioral Risk Factors - Screening

7. Please rate your interest in including the following indicators in the Community Health Status Assessment.Screening

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Pap smear (percent of age-specific female population	0	10	5	0	2.33	15
Mammography (percent of age-specific female	0	11	4	0	2.27	15
				answered question		15
				skipped question		1

Environmental Health Indicators

8. Please rate your interest in including the indicators listed below in the Community Health Status Assessment

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Air quality (e.g. number and type of US Environmental	0	7	6	2	2.67	15
Indoor clean air - percent of public facilities designated	0	7	8	0	2.53	15
Food safety - rates of reported foodborne disease	0	10	4	1	2.40	15
Lead exposure - Percent of children under 5 years of age	0	6	7	2	2.73	15
Waterborne disease: rate per total population	0	8	5	2	2.60	15
Fluoridated water - percent total population with	1	8	5	1	2.40	15
Rabies in animals	4	8	3	0	1.93	15
					answered question	15
					skipped question	1

Social and Mental Health

9. Please rate your interest in including the indicators listed below in the Community Health Status Assessment

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
During the past 30 days, average number of days for	0	2	9	4	3.13	15
Number and rate of confirmed cases of child abuse and	0	1	5	9	3.53	15
Homicide rate	0	1	9	5	3.27	15
Suicide rate	0	0	7	8	3.53	15
Domestic violence	0	0	6	8	3.57	14
Psychiatric admissions	0	0	10	5	3.33	15
Alcohol related motor vehicle injuries/mortality	0	1	6	8	3.47	15
Drug related mortality	0	0	6	9	3.60	15
				answered question		15
				skipped question		1

Maternal and Child Health

10. Please rate your interest in including the indicators listed below in the Community Health Status Assessment

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Infant mortality (death within 1st year)	0	1	7	7	3.40	15
Entrance into prenatal care in 1st trimester	0	2	8	5	3.20	15
Births to adolescents (ages 10-17) as a proportion of	0	2	8	5	3.20	15
Very low birthweight (less than 1,500 grams): Percent	0	1	11	3	3.13	15
Child mortality: rate per population age 1-14 years	0	2	8	5	3.20	15
Neonatal mortality: rate per live births	0	3	8	4	3.07	15
Post Neonatal mortality: rate per live births	0	3	8	4	3.07	15
				answered question		15
				skipped question		1

Death, Illness, and Injury

11. Please rate your interest in including the indicators listed below in the Community Health Status Assessment.Each indicator may be measured in mortality and/or morbidity. Mortality is measured via the death certificates and morbidity may either be measured through hospitalizationd

Answer Options	Not Important	Somewhat important	Very Important	Must be included	Rating Average	Response Count
General health status (percent of respondents reporting	1	3	6	5	3.00	15
Average number of sick days within the past month (self	1	9	4	1	2.33	15
All cause mortality	0	3	7	5	3.13	15
All cancer mortality	0	1	9	5	3.27	15
Unintentional injury mortality	0	3	9	3	3.00	15
Breast cancer	0	2	8	4	3.14	14
Lung cancer	0	1	8	6	3.33	15
Cardiovascular disease	0	1	7	7	3.40	15
Motor vehicle crash	0	2	6	6	3.29	14
Cervical cancer	0	3	7	5	3.13	15
Chronic obstructive lung disease	0	2	8	5	3.20	15
Chronic liver disease and cirrhosis	0	1	8	6	3.33	15
Diabetes Mellitus	0	1	6	8	3.47	15
Pneumonia/influenza	0	2	9	4	3.13	15
Stroke (cardiovascular disease)	0	1	9	5	3.27	15
				answered question	15	
				skipped question	1	

Preventable Disease with Appropriate and Timely Medical Care

12. Please rate your interest in including the indicators listed below in the Community Health Status Assessment.Preventable disease with appropriate and timely medical care

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Percent of cervical cancer with late stage diagnosis	0	3	8	4	3.07	15
Percent of breast cancer with a late stage diagnosis	0	3	8	4	3.07	15
				answered question	15	
				skipped question	1	

Communicable Disease

13. Please rate your interest in including the indicators listed below in the Community Health Status Assessment.

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Percent of appropriately immunized children/population	0	4	5	6	3.13	15
Proportion of adults aged 65 and older who have ever	0	5	7	2	2.79	14
Syphilis (primary and secondary) cases:	0	6	4	5	2.93	15
Gonorrhea	0	5	5	5	3.00	15
Chlamydia	0	5	6	4	2.93	15
Tuberculosis	0	6	4	5	2.93	15
AIDS	0	4	6	5	3.07	15
Bacterial meningitis	0	3	8	4	3.07	15
Hepatitis A	0	4	8	3	2.93	15
Hepatitis B	0	4	9	2	2.87	15
				answered question	15	
				skipped question	1	

14. Please rate your interest in including the indicators listed below in the Community Health Status Assessment.Vaccine Preventable Disease

Answer Options	Not Important	Somewhat Important	Very Important	Must be Included	Rating Average	Response Count
Measles	0	6	4	5	2.93	15
Mumps	0	7	3	5	2.87	15
Rubella	0	7	3	5	2.87	15
Pertussis	0	4	5	6	3.13	15
Tetanus	0	6	4	5	2.93	15
				answered question	15	
				skipped question	1	

15. If there is an indicator missing from this list that you would rank as a "must have" that we should consider adding, please list it below. (There is more space	
Answer Options	Response Count
	3
answered question	3
skipped question	13

Number	Response Date	Response Text
1	Jan 5, 2016 7:02 PM	Considering all of the work that is being done around Rethink your Drink it might be worth adding questions/information regarding daily/monthly consumption of sugar sweetened beverages.
2	Dec 31, 2015 7:33 PM	i would pick some of the county-level available currently community health indicators from the CDPH Community Health Indicators core list which are not already covered by the surveymonkey indicator options...if need be, i would eliminate some of the indicators on the surveymonkey, including if need be very important or even must have ones, to make room for some of these CDPH community health indicators for lots of reasons, and would be happy to share the reasons and also recommendations of which ones to let go of in order to include some of the below...see http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx#DataIndAv...specifically i would include *Access to healthy foods: retail food environment index *Annual VMT per capita *Prevalence of smoking in adults (could let go of one of the smoking related mortality ones if include this one) *Living Wage for Couple with two children *Number of Violent Crimes per 1,000 Population (maybe) Thank you for your consideration
3	Dec 15, 2015 8:21 PM	Data from Substance Abuse treatment programs - Visions of the Cross, Empire, Wright Education, RightRoad etc.

Appendix 9: Community Health Status Assessment Worksheet

Community Health Status Assessment Worksheet

Shasta County MAPP Steering Committee – 2016

When going through the Shasta County CHSA, take note of one or two challenges or opportunities per section, roughly adding up to 15 total that you think should be highlighted in the summary. **You can use the following pages to collect your thoughts.**

When doing that, consider the following questions.

- **Does this health problem affect large numbers of people, have serious consequences, show evidence of wide inequity between groups or increasing trends, and is it susceptible to proven interventions?**
- **Does the issue have broad implications over the long term for potential health improvements?**
- **By addressing this issue, is there potential for a major breakthrough in approaching community health improvement?**
- **Is this issue one that has been persistent, nagging, and seemingly unsolvable?**
- **Does this issue identify a particular strength that can be replicated throughout the community?**
- **Is ongoing monitoring of this issue possible?**

Community Health Status Assessment Worksheet

Shasta County MAPP Steering Committee – 2016

Socioeconomics

_____
_____
_____
_____

Health Resource Availability

_____
_____
_____
_____

Health Behavior Risk Factors

_____
_____
_____
_____

Social and Mental Health

_____
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_____

Community Health Status Assessment Worksheet

Shasta County MAPP Steering Committee – 2016

Maternal and Child Health

_____
_____
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_____

Death, Illness and Injury

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Preventable Diseases

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_____

Communicable Diseases

_____
_____
_____
_____

Appendix 10: Shasta County MAPP - Choosing Strategic Priorities Workshop, Attendee List

Name	Organization	Role
Rob Adams	Reach Higher Shasta	Steering Committee member
Tina Cable	Shasta Community Health Center	Steering Committee member
Carla Clark	Strengthening Families Collaborative	Steering Committee member
Lynn Dorroh	Hill Country Health and Wellness	Steering Committee member
Brandy Isola	Shasta County Health and Human Services Agency, Public Health Branch	Steering Committee member
Barbara Jackson	Healthy Shasta Collaborative	Steering Committee member
Margaret Kisliuk	Partnership HealthPlan of Northern California	Steering Committee member
Patrick Moriarty	Shasta Health Assessment & Redesign Collaborative	Steering Committee member
Liz Poole	First 5 Shasta	Steering Committee member
Alexis Ross	Mercy Medical Center, Redding	Steering Committee member
Leslie Woodson	Shasta Regional Medical Center	Steering Committee member
Dr. Richard Yoder	Public Health Advisory Board representative	Steering Committee member
Terri Fields Hosler	Shasta County Health and Human Services Agency, Public Health Branch	Organizational Leader
Dr. Andrew Deckert	Shasta County Health and Human Services Agency, Public Health Branch	Organizational Leader
Donnell Ewert	Shasta County Health and Human Services Agency	Organizational Leader
Dean Germano	Shasta Community Health Center	Organizational Leader
Robin Glasco	Shasta Community Health Center	Organizational Leader
Wendy Dickens	First 5 Shasta	Organizational Leader
Jordan Wright	Mercy Medical Center, Redding	Organizational Leader
Anna Champe	Shasta County Health and Human Services Agency, Public Health Branch	Staff
Amanda Harris	Shasta County Health and Human Services Agency, Public Health Branch	Staff
Robin Schurig	Shasta County Health and Human Services Agency, Public Health Branch	Table host
Charlene Ramont	Shasta County Health and Human Services Agency, Public Health Branch	Table host
Ruth Atkins	Shasta County Health and Human Services Agency, Public Health Branch	Table host

Appendix 11: Community Health Issues Data Sheets

Alcohol and Drug Abuse

High rates of alcohol and drug abuse are impacting the health of Shasta County adults, and when suffered by a parent, impact the chances for children to have long, healthy and high-quality lives.

SUPPORTING DATA POINTS:

Community Health Status Assessment (CHSA)

- Shasta County's age-adjusted drug-related death rate has grown to 17.9 per 100,000 residents in 2012 to 2014, more than double the rate for California.
- Drug-related deaths and non-fatal ER visits and hospitalization rates have increased in Shasta County in recent years and are consistently higher than the state.
- From 2010 - 2014, 800 babies born to Shasta County residents were diagnosed with having been affected by drugs or alcohol.
- Alcohol and drug abuse also leads to domestic violence. In 2012 - 2014, Shasta County's rate of 527 domestic abuse calls per 100,000 residents was significantly higher than the California rate of 405.5.
- More than 1 in 4 mental health hospitalizations were due to drug and alcohol abuse disorders.
- Nearly 2 in every 5 people who were admitted for substance abuse treatment reported methamphetamine as their primary drug of choice. The number of people who reported heroin as their primary drug of choice rose from less than 1 in 20 in 2010 to nearly 1 in every 5 in 2014.
- Shasta County's rate of chronic drinking (8.5%) is slightly higher than California (6.1%) but nearly double the national rate (4.5%).

Community Themes and Strengths Assessment (CTSA)

- Alcohol and drug abuse was chosen by 65% of survey respondents, making it the most commonly chosen issue that impacts overall community health in Shasta County.
- 15% of survey respondents said alcohol and drug abuse is an issue that impacts their family, making it the eighth most commonly chosen issue that impacts families.

Forces of Change Assessment (FOCA)

- Substance abuse among parents is one of the Adverse Childhood Experiences (ACEs) that has been shown to contribute to an increased risk of chronic disease, mental illness, addiction, etc.
- Alcohol and drug abuse contributes to an increased risk of homelessness.
- Alcohol and drug abuse contributes to an increased risk of children entering the foster care system.
- Alcohol and drug abuse increases health care costs.
- There has been an increase in crime related to drug use.
- Substance abuse trends in Shasta County show that opiate and heroin use is increasing.
- Shasta County has high rates of alcohol and drug abuse.

Many Shasta County residents are living with a mental health illness and do not have access to consistent and appropriate services and treatment.

SUPPORTING DATA POINTS

Community Health Status Assessment (CHSA)

- More than 1 in 4 mental health hospitalizations in 2010 - 2014 were due to drug and alcohol abuse disorders.
- In 2012, there was an average of 19 psychiatrists per 100,000 in California and only 8 psychiatrists per 100,000 people in Shasta County.
- Access to psychiatry resources and services is inadequate.
- Mental illness made up 4.4% of all hospital discharges, an average of more than 1,000 per year.
- The suicide rate in Shasta County is consistently double that of California.
- In 2011-2013, Shasta County had the 12th highest average annual age-adjusted suicide death rate (21.4 per 100,000) of California counties.
- Residents of Shasta County have a 20% higher incidence of mental illness than the state as a whole.

Community Themes and Strengths Assessment (CTSA)

- Almost half (48%) of all survey respondents selected lack of mental health services as an important issue that impacts community health, making it the second most frequently selected community health issue.
- Almost 1 in 5 (19%) chose it as an issue that impacts their family.

Forces of Change Assessment (FOCA)

- Although there have been improvements, mental health services and resources are under-funded.
- Shasta County has high rates of mental illness and very few treatment options.
- The mental health situation in our community is getting worse.
- Untreated mental illness contributes to the increasing number of unsheltered homeless in the county.
- There is stigma around seeking help for mental health needs.
- Shasta County is experiencing a rise in crime rates.

Children in Shasta County are at a greater risk than other California kids of experiencing events that will negatively impact lifelong health and opportunities.

SUPPORTING DATA POINTS

Community Health Status Assessment (CHSA)

- Shasta County has high rates of child and adolescent (1-14 years) mortality compared to the state (20.4, 13.8).
- Shasta County has high rates of child abuse. In 2010 -2014, there was an average of 699 substantiated cases of reported maltreatment of children under 18 years old. This is a 5-year average rate of 18.0 per 1,000 Shasta County children compared to the state average of 9.1. For children under the age of 1, the rate is more than double the state rate and equates to almost 1 in every 20 Shasta County infants.
- In 2012 - 2014, Shasta County's rate of 527 domestic abuse calls per 100,000 residents was significantly higher than the California rate of 405.5. Almost all domestic violence calls to police in Shasta County involve weapons.
- In 2010 - 2014, 800 babies born to Shasta County residents were diagnosed with having been affected by drugs or alcohol.
- 8.5% of Shasta County children are still uninsured.
- There are almost twice as many infants from low-income families than there is capacity to serve them in subsidized child care.

Community Themes and Strengths Assessment (CTSA)

- 10% of Community Health Survey respondents chose child abuse as an important issue that impacts overall community health making it the 10th most commonly chosen issue.
- 15% of survey respondents selected domestic violence is an important issue that impacts overall community health in Shasta County.
- 19% of respondents think Shasta County is a good place to raise children.

Forces of Change Assessment (FOCA)

- The prevalence of Adverse Childhood Experiences (ACEs) and child neglect and maltreatment are high in Shasta County.
- Rates of family violence are high in Shasta County.
- Shasta County has high rates of substance abuse.
- Fewer Shasta County children are going pre-school.

FINAL—9/13/2016

Adequate, affordable housing options are a critical factor to health.

SUPPORTING DATA POINTS:

Community Health Status Assessment (CHSA)

- The number of homeless people in Shasta County has grown nearly 50% in the last 6 years.

Community Themes & Strength Assessment (CTSA)

- Affordable housing (28%) and unemployment/underemployment (26%) were the two most commonly chosen health issues selected by survey respondents as important issues that impact their family.
- Unemployment/underemployment and affordable housing were chosen by 42% and 27% of survey respondents respectively, making them the 3rd and 4th most commonly chosen health issues impacting overall community health.
- Inadequate transportation options in outlying areas limit people who might be able to find and afford housing outside of central Redding area.

Forces of Change Assessment (FOCA)

- Single family home prices are rising.
- Very little affordable housing is available in the city of Redding where the majority of the jobs are.
- Shasta County has limited local resources for affordable housing.
- Housing is gaining credibility as an important factor for health. Housing is beginning to be seen as a component of health as seen in the state's inclusion of housing in the Medicaid 1115 waiver proposal.
- Substance abuse contributes to increased number of unsheltered homeless in the county.
- Homelessness causes stress, impacts health and safety, and contributes to a poor community image.
- Local schools are challenged to meet the unique needs of children experiencing homelessness.

Poverty, Unemployment, and Socioeconomic Status

A shortage of living wage jobs, lack of industry and low educational attainment keep many Shasta County residents from providing for their families' basic needs. People who live in outlying communities face even greater challenges finding good jobs and accessing services.

SUPPORTING DATA POINTS

Community Health Status Assessment (CHSA)

- Between 2010 - 2014, the median household income for Shasta County was $44,556 and the average per capita income was $23,763. These income levels were lower than California's at $61,489 and $29,906 respectively.
- Shasta County has a higher percentage of people living below the federal poverty level than California (18%, 16.4%)
- Households with children under 18 years headed by single females experience even higher rates of poverty (43.2%) .
- In 2010-2014, the percent of Shasta County's labor force who were unemployed (12.2%) was substantially higher than California's (11%).
- A lower percentage of Shasta County adults (19.1%) have a Bachelor's Degree or higher than in the rest of California (31%).

Community Themes and Strengths Assessment (CTSA)

- Unemployment/underemployment was chosen by 42% of survey respondents, the third most commonly chosen issue impacting overall community health. It was the 2nd most frequently chosen issue (26%) impacting their family.

Forces of Change Assessment (FOCA)

- Shasta County's local economy is based on low-paying jobs and seasonal employment.
- Shasta County has a longstanding high unemployment rate.
- Many young Shasta County adults move away to go to school and do not return.
- High unemployment rates are related to increased rates of child abuse, domestic violence and substance abuse.
- There are challenges recruiting professionals to this area because of lack of jobs for spouses.

FINAL—9/13/2016

Chronic Disease

Despite Shasta County's abundant outdoor recreational opportunities, residents report lower rates of physical exercise and experience higher rates of chronic disease than California residents statewide.

SUPPORTING DATA POINTS

Community Health Status Assessment (CHSA)

- More than 60% of people in Shasta County have diabetes or pre-diabetes, and in 2012-2014, diabetes was the 7th most common cause of death among Shasta County residents.
- Shasta County adults age 18 and older have higher rates of overweight and obesity than other California residents (29.8%, 25.9%).
- Shasta County adults with low incomes and/or have no post-secondary education are more likely to be obese. In 2013-2014, 37.5% of Shasta County residents with incomes <200% Federal Poverty Level (FPL) had a BMI greater than 29.9 and 39% of adults with a high school diploma or less fell into the obese category.
- In 2010, Shasta County adults reported having lower rates of regular exercise than residents statewide (43.1%, 51.3%).
- About 2 in every 5 Shasta County residents consumed the recommended 5 or more servings of fruits and vegetables in 2010.
- Shasta County has almost twice the rate of adult smoking rates when compared to the rest of California.

Community Themes and Strengths Assessment (CTSA)

- 23% of survey respondents chose aging problems (arthritis, hearing/vision loss, etc.) as an important issue that impacts their family. Only 6%, however, chose it as an important issue that impacts overall community health in Shasta County.
- One in five (21%) Community Health Survey respondents chose lack of exercise as an important issue affecting their family's health.
- Unsafe roads, bike and pedestrian conditions were chosen by 17% of survey respondents as having an impact on their family, 9% chose it as an important issue that impacts overall community health.
- 12% of survey respondents chose poor diet as an important issue that impacts their family.
- 59% of Community Health Survey respondents chose outdoor recreational opportunities as one of the things that makes Shasta County a great place to live; 35% chose the rural setting as one of the things that make this area a great place to live.

Forces of Change Assessment (FOCA)

- People who live in this area are at much greater risk of developing melanoma, a life-threatening skin cancer and, when conditions are extreme, have a greater chance of heat-related illness, hospitalization or death.
- Many roads have speed limits that are too high and make it unsafe for biking or walking.

FINAL—9/13/2016

Health Care Availability

Many Shasta County residents experience barriers when trying to access the primary care services necessary for health promotion and early intervention of disease.

SUPPORTING DATA POINTS:

Community Health Status Assessment (CHSA)

- Shasta County does not meet the national benchmark for the number of doctors per resident.
- Shasta County does not meet the national benchmark for the number of dentists per resident.
- 8.5% of Shasta County children are still uninsured.
- Pregnant women are less likely to get early prenatal care than women in the rest of California.
- The number of women in Shasta County getting Pap smears is decreasing.
- Shasta County has high rates of preventable disease and hospitalizations.

Community Themes and Strengths Assessment (CTSA)

- 15% of survey respondents chose the inability to find a regular family doctor as an issue that impacts their family, tied with alcohol and drug abuse as the 8th most commonly chosen issue.
- 10% of survey respondents said the inability to find a regular family doctor is an issue impacting the overall health of Shasta County.
- Focus group participants noted that inadequate public transportation makes it difficult to access health care.

Forces of Change Assessment (FOCA)

- The passage of the Affordable Care Act (ACA) made it possible for more Shasta County residents to obtain medical insurance. The number of medical professionals, however, did not increase proportionately.
- Shasta County does not meet the national benchmark for primary care physicians. There are not enough physicians to serve our current population, especially the Medi-Cal population.
- Declining reimbursement rates has led to fewer medical providers.
- Doctors are retiring and moving away. Current recruitment efforts are not effective.
- There is limited access to dentistry under the Affordable Care Act.
- The growing number of residents 65 or older will increase the demand for medical services.

Appendix 12: Strategic Issues Scoring Tool

Strategic Scoring Tool

Directions:

1. Score each of the themes below by giving the question 0, 2 or 4 points as indicated in the question.
2. Work through all of the questions on each theme before moving on to the next theme. Top to bottom.
3. Tally the points in the bottom row.

	Alcohol and Drug Abuse	Mental Health	At Risk Youth	Lack of Affordable Housing	Poverty, Unemployment and Socioeconomic Status	Chronic Disease	Health Care Availability
Is this issue related to our group vision? No = 0 Yes = 2							
Does this issue impact everyone in Shasta County? Only a small group = 0 Some but not a large number of people in Shasta County = 2 A large number, if not all people in Shasta County = 4							
Is this issue of concern to Shasta County residents? No = 0 To some but not a large majority = 2 To a large majority or almost all = 4							
Does a substantial improvement on the issue require the involvement of more than one organization? No = 0 Yes = 2							
Do you see a way for your organization to have a positive impact on this issue? No = 0 Maybe = 2 Yes, definitely = 4							
TOTAL SCORE							

How Healthy is Shasta County? An Assessment of Our Health

Produced by the Shasta County Health and Human Services Agency

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We appreciate any questions or comments that you may have about this report and welcome recommendations for improving subsequent reports. If you have any comments to share, please contact us at:

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