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Certificate of Amendment of Articles of Incorporation of
BIGGS-GRIDLEY MEMORIAL HOSPITAL

FILED
Secretary of State
State of California
MAY 22 2015
1 cc

The undersigned certify that:

1. They are the chairman and the secretary, respectively, of BIGGS-GRIDLEY MEMORIAL HOSPITAL, a California corporation.

2. Article I of the Articles of Incorporation of this corporation is amended to read as follows:

The name of said corporation shall be:
ORCHARD HOSPITAL.

3. The foregoing amendment of Articles of Incorporation has been duly approved by the board of directors.

4. The corporation has no members.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

Date: May 21, 2015

John T. Harris
JOHN T. HARRIS, Chairman of the Board

CLARK REDFIELD, Secretary

I hereby certify that the foregoing transcript of 1 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

MAY 26 2015

Date:

ALEX PADILLA, Secretary of State

A0691273

State of California
Secretary of State

I, DEBRA BOWEN, Secretary of State of the State of California, hereby certify:

That the attached transcript of 3 page(s) has been compared with the record on file in this office, of which it purports to be a copy, and that it is full, true and correct.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of

MAY 13 2009

Debra Bowen

DEBRA BOWEN
Secretary of State

A0691273

ENDORSED - FILED
In the office of the Secretary of State
of the State of California

APR 30 2009

CERTIFICATE OF AMENDMENT TO

ARTICLES OF INCORPORATION

OF

BIGGS-GRIDLEY MEMORIAL HOSPITAL

The undersigned certify that:

I. They are the Chairman of the Board and the Secretary of BIGGS-GRIDLEY MEMORIAL HOSPITAL, a California nonprofit public benefit corporation.

II. The Articles of Incorporation of the Corporation are hereby amended and restated in full to read as set forth in EXHIBIT A attached hereto and incorporated herein by this reference.

III. Said Amended and Restated Articles of Incorporation have been duly approved by the Board of Directors of this Corporation.

IV. Said Amended and Restated Articles of Incorporation have been duly approved by the required vote of the member of this Corporation.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this Certificate are true and correct of our own knowledge.

Date: April 29, 2009
Gridley, California

Chairman of the Board

Secretary

EXHIBIT A

AMENDED AND RESTATED ARTICLES OF INCORPORATION

BIGGS-GRIDLEY MEMORIAL HOSPITAL

I.

That the name of said corporation shall be:

BIGGS-GRIDLEY MEMORIAL HOSPITAL

II.

A. This Corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. This Corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law of 1980 not otherwise applicable to it under Part 5 of Division 2.

C. The primary purposes of this corporation are:

1. To establish, equip and maintain one or more nonprofit hospitals, medical centers, institutions or other places for the reception and care of the sick, injured and disabled, with permanent facilities that include inpatient beds and medical services; to provide diagnosis and treatment for patients; and to provide associated services, outpatient care and home care in furtherance of this corporation's charitable purposes;

2. To promote and carry on educational activities related to the care of the sick, injured and disabled, or to the promotion of health;

3. To promote and carry on educational activities related to the care of the sick, injured and disabled, or to the promotion of health; and

4. To promote or carry out such other activities as may be deemed advisable for the betterment of the general health of the community served.

D. The general purpose of this corporation is to have and exercise all rights and powers conferred on nonprofit public benefit corporations under the laws of the State of California.

III.

E. This corporation is organized and operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and successor provisions thereto (the "Code").

F. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on:

1. By a corporation exempt from federal income tax under Section 501(c)(3) of the Code; or

2. By a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

G. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

IV.

The property of this corporation is irrevocably dedicated to charitable purposes and no part of the net income or assets of this corporation shall ever inure to the benefit of any director, officer or member thereof or to the benefit of any private person. Upon the dissolution or winding up of the corporation, its assets remaining after payment or provision for payment of all debts and liabilities of this corporation shall be transferred exclusively to and shall become the property of such nonprofit funds, foundations or corporations as are designated by the Board of Directors of this corporation and which:

1. Are organized and operated exclusively for religious, charitable, hospital, scientific purposes, or charitable *and* educational purposes meeting the requirements for exemption by Section 214 of the Revenue and Taxation Code; and

2. Have established their tax-exempt status under Section 501(c)(3) of the Code.

V.

The principal office for the transaction of the business of this corporation shall be located in Butte County; the State of California.

ORCHARD HOSPITAL

AMENDED AND RESTATED BYLAWS

OF

ORCHARD HOSPITAL

A nonprofit public benefit corporation
organized under the laws of the State of California

March, 2018

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ARTICLE ONE

NAME, OFFICES, PURPOSE AND POWERS

Section 1.1 Name of Corporation

The name of this corporation shall be as listed in the Articles of Incorporation ("the Articles"), namely ORCHARD HOSPITAL ("the Corporation"), a nonprofit public benefit corporation organized under the laws of the State of California.

Section 1.2 Office.

The principal office for the transaction of the business of this Corporation shall be located in Gridley, Butte County, California and this Corporation may have other offices within the State of California, as the Board may determine from time to time.

Section 1.3 Purpose.

As more particularly described in its Articles, this Corporation is primarily formed to establish, equip and maintain one or more nonprofit hospitals and its ancillary facilities.

Section 1.4 Powers

Consistent with the Articles, this Corporation may engage in any activity which the Board of Directors determines to be in the best interest of the Corporation.

ARTICLE TWO

MEMBERSHIP

There shall be no corporate members of the Corporation. All rights which would otherwise vest under the California Corporations Code in the members of a nonprofit public benefit corporation shall vest in the Directors, as hereinafter defined.

ARTICLE THREE

BOARD OF DIRECTORS

Section 3.1 Number and Qualification of Directors

(a) The authorized number of directors on the Board of Directors (the "Board") shall be no less than five (5) and no more than thirteen (13) persons satisfying the qualifications set forth in Section 3.1(b) of these Bylaws, and at least one (1) of whom shall be an individual who is licensed to practice medicine in the State of California, but shall not be under contract or an employee of Orchard Hospital. The Chief Executive Officer, Board Chief Financial Officer (if an employee of this Corporation), the Chief of Staff, and the Chief Nursing Officer shall, in the discretion of the Board, be *ex officio*, nonvoting, participants in the meetings (but not a member) of the Board.

(b) Qualifications for nomination and election as a Director shall include the following:

(1) Commitment to the improvement and development of community health care;

(2) Experience in organizational and community activities;

(3) Willingness and ability to participate effectively in fulfilling Board's responsibilities; and

(4) Adequate time to serve and to attend Board meetings as required by these Bylaws.

Section 3.2 Nomination and Selection

The Governance Committee shall nominate Director Nominees to the Board, and the Board shall elect the Directors of this Corporation at its annual meeting or at any other time designated by the Board. The Governance Committee shall nominate Director Nominees for full terms and Directors to fill vacancies created by resignation, removal or death occurring during a term. The candidates receiving the highest number of votes shall be the elected directors.

Section 3.3 Nondiscrimination

Membership on the Board shall not be restricted on the basis of sex, race, religion, creed, color, or national origin, or on the basis of any other criteria not relevant to the needs of the Board in exercising responsible oversight of the affairs of the Corporation.

Section 3.4 Powers and Responsibilities

(a) Subject to the provisions of the Code; the powers of the Corporation shall be exercised, its property controlled, and its affairs conducted by or under the direction of the Board.

(b) The Board may delegate the management of this Corporation to any person or persons, or committee however composed, provided that the activities and affairs of this Corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board.

(c) The Board shall have the sole authority to exercise this Corporation's rights as a member or shareholder of each and every corporation or other entity of which this Corporation is a corporate member or shareholder. The Board may, by resolution, authorize one or more of this Corporation's Officers to exercise its vote on any matter that comes before the membership or the shareholders of any such corporation or entity.

(d) The powers and responsibilities of the Board and its members include, but are not limited to, the following:

(1) To act as fiduciaries to fulfill the purposes of the Corporation as set forth in its Articles;

(2) To establish and monitor the Corporation's quality assurance activities, including all aspects of patient care evaluation, in accordance with guidelines established by the Board or its designee;

(3) To establish and monitor an effective medical and hospital care performance improvement program

(4) To monitor and assure that the Corporation has an effective ethics and compliance program;

(5) To establish and monitor a program of continuing education to be made available to all members of the Board;

(6) To conduct orientation of newly elected Board members to Board functions and procedures;

(7) To conduct periodic review of the Board's performance, including director self-assessment.

(8) To assure that the Corporation's community benefit programs are meeting the needs of the community served by the Corporation within the resources available to do so;

(9) To review operations with management to ensure that services are necessary to the Corporation's mission and are affordable when compared to like services in the community;

(10) To review and approve an annual operating and capital budget in accordance with guidelines established by the Board or the Finance Committee;

(11) To develop strategic plans which are consistent with and fully support progress toward achieving objectives of the Corporation;

(12) To select the Chief Executive Officer;

(13) In collaboration with the Chief Executive Officer or his/her designee, to ensure leadership succession plans are in place for the Chief Executive Officer and for all positions reporting to the Chief Executive Officer and other positions identified as critical to the organization;

(14) To oversee and support the philanthropic activities of the Corporation and the Orchard Hospital Foundation;

(15) To be loyal to the organization, always furthering the interests of the organization in its pursuit of its mission, and complying with all laws, regulations and Board policies regarding conflicts of interest;

(16) To be diligent in the fulfillment of Board responsibilities, including attendance at and active participation in Board meetings, and participation in continuing education opportunities;

(17) To respect the confidentiality of the Board room and discussions and actions of the Corporation; and

(18) To support the decisions and policies of the Board.

Section 3.5 Standard of Conduct

Each Director of this Corporation shall perform his or her duties in good faith, in a manner the Director believes to be in the best interests of the Corporation, and including such reasonable inquiry as an ordinarily prudent person in a like position, would use under similar circumstances. In performing the duties of a Director, each Director shall be entitled to rely on information, opinions, reports or statements (including financial statements and other financial data) as they are prepared or presented by:

(a) One or more Officers or employees of this Corporation whom the Director believes to be reliable and competent in the matters presented;

(b) Counsel, independent accountants or other persons, as to matters which the Director believes to be within such person's professional or expert competence; and

(c) A committee of the Board, upon which the Director does not serve, as to matters within its designated authority, which committee the Director believes to merit confidence.

Section 3.6 Restriction on Interested Persons Acting as Directors

No more than forty-nine percent (49%) of the persons serving on the Board may be "interested persons." An "interested person" is:

(a) Any person compensated by the Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director for his or her performance in such capacity; and

(b) Any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of such person.

A violation of the provisions of this Section shall not affect the validity or enforceability of any transaction entered into by the Corporation.

Section 3.7 Conflict of Interest

The Board shall promulgate a Conflict of Interest Policy developed by the Board or its designee regarding conflicts of interest relating to its own members, employees of the Corporation and members of the Corporation's Medical Staff. The Conflict of Interest Policy shall be consistent with the standards of conduct set forth in Sections 5230 through 5239 of the California Corporations Code. The Conflict of Interest Policy shall ensure full disclosure of financial interests and transactions where conflict of interest is a possibility, and shall ensure the avoidance of potential conflict of interest in choosing new Board members. The Conflict of Interest Policy shall impose upon each Board member the responsibility to be alert to possible conflicts of interest of himself or herself or of other Board members, and shall require that each Director annually declare his/her absence of conflict of interest on a declaration form provided for that purpose and disqualify himself or herself from making a decision where he/she has a conflict of interest.

Section 3.8 Self-Dealing Transactions Involving Directors

Except as otherwise provided under applicable law and these Bylaws, whenever a Director has a material financial interest in any proposed transaction to which this Corporation is a party, the Director shall disclose the nature of the interest at the earliest opportunity before the Board discusses or acts on any part of the transaction. In such cases after the disclosure of his or her interest, the interested Director may participate in any discussion of the proposed transaction, but may not vote on the matter.

Section 3.9 Term

The term of office shall be three (3) years. Except as to any *ex officio* members. The terms shall be for three (3) years with approximately one-third (⅓) of the Board being elected annually.

(a) Emeritus - Upon nomination by a Director currently serving in good standing, a Board member may be considered for an Emeritus position.

(b) Emeritus members are non-voting, but are eligible to receive all Board information typically provided other Board members.

(c) The Board of Directors will consider observation and/or recommendation provided by Emeritus in the usual course of Board activity.

(d) Emeritus member will serve at their own discretion unless otherwise removed in accordance with these bylaws. Emeritus members could attend executive sessions at approval of the Board.

Section 3.10 Resignation

Any Director may resign at any time by giving written notice to the Chairperson or the Secretary of the Board, except in cases where such resignation would leave the Corporation without a duly elected Director in charge of its affairs as described in Section 5226 of the California Corporations Code. Under those circumstances, notice to the Attorney General is required upon resignation. Any Director's resignation, which may or may not be made contingent on formal acceptance, will take effect on the date of receipt or at any later time specified in the written notice. If the resignation is effective at a future time, a successor Director may be elected to take office when the resignation becomes effective in accordance with Section 3.2 of these Bylaws.

Section 3.11 Removal of Directors

A Director may be removed from office with or without cause by the affirmative vote of a majority of the votes entitled to be cast. The Board may declare vacant the office of a Director who fails to satisfy the attendance requirements set forth in Section 4.13 of these Bylaws. The Board, by a majority vote of the Directors who meet all of the required qualifications to be a director, may declare vacant the office of any Director who fails or ceases to meet any of the qualifications set forth in Section 3.1(b) of these Bylaws.

Section 3.12 Vacancies

A vacancy on the Board of Directors shall be deemed to exist on the occurrence of the death, resignation, or removal of any Director, an increase of the authorized number of Directors, or in the event that the Board has determined that a Director has not been an active member of the Board following the review described in Section 3.11 of these Bylaws. The Directors shall elect Directors to fill vacancies in accordance with Section 3.2 of these Bylaws.

Section 3.13 Additional Advisors

The Board or Chairperson may invite additional persons with expertise in a pertinent area to meet with and assist the Board. Such advisors shall not vote or be counted in determining the existence of a quorum and may be excluded from any executive session.

Section 3.14 Compensation and Expenses

(a) Directors shall receive a stipend of $100.00 per regularly scheduled monthly meeting and monthly executive round table meeting attended and shall be reimbursed for any expense reasonably incurred by Directors in connection with the performance of official duties.

(b) Directors and beneficiaries will not be required to pay a co-pay when presenting themselves to any location of the entity with their current insurance ($1500 max per family).

(c) Subject to the provisions of California law and these Bylaws relating to the approval of contracts and transactions in which a Director or Directors has direct or indirect material financial interest, the Board may contract with one or more Directors for services as an employee or independent contractor.

ARTICLE FOUR

MEETINGS OF DIRECTORS

Section 4.1 Place of Meetings

All meetings of the Board are held at the principal office of the Corporation or at such other place as the Chairperson or majority of the Board of Directors recommends.

Section 4.2 Meetings Electronically

Any meeting, regular or special, may be held by conference telephone or similar communication equipment, in accordance with California Corporations Code Section 5211(a)(6) so long as the Directors participating in the meeting can hear one another, and all such Directors shall be deemed to be present in person at such meeting.

Section 4.3 Annual Meeting

The annual meeting shall be held on the fourth (4^{th}) Tuesday in March, or if no date is set for the regular board meeting of March, and shall be held for the purpose of organization, election of Officers, and the transaction of such other business as may appropriately come before the Board.

Section 4.4 Regular Meetings

Regular meetings shall be held without call or notice on the fourth (4^{th}) Tuesday of each month at a time and place to be designated by the Board. In the event that any meeting day falls on a

holiday, the meeting shall be held at the same time on the next day thereafter that is not a holiday or at such time as may be designated by the Board.

Section 4.5 Special Meetings

Special meetings of the Board for any purpose may be called at any time by the Chairperson of the Board, Vice Chairperson, Secretary, or any three (3) or more Directors.

Section 4.6 Notice

Notice shall be provided consistent with the provisions of California Corporations Code Section 5211. Special meetings of the Board shall be held upon four (4) days' notice to each Director by first-class mail or 48 hours' notice to each Director delivered personally, by telephone, facsimile transmission, or by electronic mail. The attendance of a Director at any meeting shall constitute a waiver of notice of the meeting, except where a Director attends a meeting only for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

Section 4.7 Quorum

Except as hereinafter provided, a majority of the Directors in office shall constitute a quorum for the transaction of business (except to adjourn as provided in these Bylaws). Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board.

A meeting at which a quorum is initially present may continue to transact business, notwithstanding a withdrawal of Directors, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as is required by the California Corporations Code, the Articles or these Bylaws.

Section 4.8 Voting

Each Director is entitled to one vote on any matter before the Board.

Section 4.9 Waiver of Notice

The transaction of any meeting of the Board, however called and noticed or wherever held, shall be valid as if taken at a meeting duly held after regular call and notice, if a quorum is present and, either before or after the meeting, each of the Directors not present signs a written waiver of notice, consent to holding the meeting, or an approval of the minutes. The waiver of notice or consent need not specify the purposes of the meeting. All waivers, consents, and approvals shall be filed with the corporate records or made a part of the minutes of the meeting. Notice of a meeting shall also be deemed given to any Director who attends the meeting without protesting before or at its commencement about the lack of adequate notice.

Section 4.10 Adjournment

A majority of the Directors present, whether or not constituting a quorum, may adjourn any meeting to another time and place.

Section 4.11 Notice of Adjournment

Notice of the time and place of holding an adjourned meeting need not be given unless the meeting is adjourned for more than forty-eight (48) hours, in which case notice of the time and place shall be given before the time of the adjourned meeting to the Directors who were not present at the time of adjournment.

Section 4.12 Action Without Meeting

An action required or permitted to be taken by the Board may be taken without a meeting if all of the Directors, individually or collectively, consent in writing or electronically to that action. Such action by written consent shall have the same force and effect as an unanimous vote of the Board. Such written consent or consents shall be filed with the Board's minutes.

Section 4.13 Attendance at Meetings

Directors are required to attend at least seventy- percent (75%), or a minimum of eight (8) regular and special meetings of the Board each year. Each Director must also attend seventy-five percent (75%) of all assigned committee meetings. If a Board member satisfies the foregoing attendance requirements but misses more than three (3) consecutive meetings, then the Board shall consider whether this constitutes grounds for removal, and if so, may remove the Director.

ARTICLE FIVE

OFFICERS

Section 5.1 Officers

The Officers of this Corporation shall be a Chairperson of the Board, a Vice Chairperson, a Secretary, a Board Chief Financial Officer, and such other Officers as the Board may elect or appoint. Any number of offices may be held by the same person, except that neither the Secretary nor the Chief Financial Officer may serve concurrently as the Chairperson of the Board.

Section 5.2 Election and Tenure

The Officers shall be elected by a majority vote of the Directors at the annual meeting of the Board of Directors for terms of one (3) year or until their successors are elected and qualified.

- 2018- Chair and Vice Chair elected to 3 year terms expiring in 2021.
- 2018- Secretary will serve 1 year term
- 2018-CFO- Serve 2 year term

- 2019- Nominate Secretary to serve 3 year term
- 2020- Nominate CFO to serve 3 year term
- 2021- Vice Chair will move to Chair where they will be nominated for another 3 year term
- 2021- Nominate new Vice Chair to serve 3 year term

Section 5.3 Resignation

Any Officer may resign at any time by giving written notice to the Chairperson or to the Secretary. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later time specified in it.

Section 5.4 Removal

Any elected or appointed Officer may be removed from office, with or without cause, by the majority vote of all the Directors.

Section 5.5 Vacancies

Any vacancies in any office because of death, resignation or removal, or any other cause, shall be filled by the Board to complete the unexpired term of office or until a successor is elected and qualified.

Section 5.6 Responsibilities of Officers

(a) Chairperson

The Chairperson of this Corporation presides at all meetings of the Board. The Chairperson may sign on behalf of this Corporation any documents or instruments which the Board has authorized to be executed, except where the signing and execution thereof is expressly delegated by the Board or these Bylaws to some other Officer or Agent. The Chairperson shall have such other powers and duties as may be prescribed by the Board or these Bylaws. The Chairperson shall recommend candidates to the Board for Board committees.

(b) Vice Chairperson

In the absence or disability of the Chairperson, the Vice Chairperson shall perform all the duties of the Chairperson, and when so acting shall have all the powers of, and be subject to all the restrictions upon, the Chairperson. In the event that the Vice Chairperson is not available to so act, the Chairperson shall designate another member of the Board to act as Chairperson in the Chairperson's absence. The Vice Chairperson shall have such other powers and perform such other duties from time to time as may be prescribed by the Board or the Chairperson.

(c) Secretary

The Secretary shall keep or cause to be kept at the principal office of this Corporation, a book of minutes of all meetings and actions of the Board and committees of the Board. Such records shall contain: the time and place of holding the meeting, whether the meeting was regular or special (and, if special, how authorized), the notice given, the names of those present at such meeting, and the proceedings of such meetings. It shall be the responsibility of the Secretary to give or cause to be given notice of all meetings of the Board required by these Bylaws. The Secretary shall keep the seal of this Corporation in safe custody. The Secretary shall also have such other powers and perform such other duties as may be prescribed by the Board or these Bylaws. In the absence or disability of the Secretary, the Vice Chair shall perform all the duties of the Secretary. Board Chief Financial Officer

The Board Chief Financial Officer shall keep or cause to be kept correct and accurate accounts of the properties and financial transactions of this Corporation. The Board Chief Financial Officer shall also perform all duties incident to the office, and such other duties as maybe assigned from time to time by the Board or the Chairperson. The Board Chief Financial Officer may delegate any of the Board Chief Financial Officer's duties to any duly elected or appointed Assistant Financial Officer. In the absence or disability of the Board Chief Financial Officer, the Vice Chair shall perform all the duties of the Board Chief Financial Officer.

ARTICLE SIX

COMMITTEES

Section 6.1 Board Committees

(a) Committees

(1) A majority of Directors then in office may establish and appoint Directors to one or more committees, each consisting of two or more Directors, as appropriate, to serve at the pleasure of the Board.

(2) A majority of the Directors then in office may establish committees comprised of both Directors and non-Directors, provided that such committees shall not exercise any authority of the Board and shall at all times be under the ultimate direction of the Board. Such committees shall be advisory in nature and may carry out functions of study or investigation and make reports and recommendations to the Board and implement Board actions.

(3) If a Board committee is established, the resolution creating it must designate:

1. The Directors who are to serve as the voting committee members;

2. The Chairperson of the committee;

3. Any limitations on the authority of the committee; and

4. The functions the committee shall discharge.

(b) Delegation of Powers

The Board may delegate any of its powers to a committee comprised solely of Board members. The Board may not delegate the following powers:

(1) Fill vacancies on the Board of Directors;

(2) Fix the compensation of the Directors for serving on the Board or any committee;

(3) Amend or repeal these Bylaws or adopt new bylaws;

(4) Amend or repeal any resolution of the Board which by its express terms is not able to be amended or repealed;

(5) Establish committees of the Board;

(6) Approve any self-dealing transaction as such transactions are defined under Section 5233 of the California Corporations Code, or a successor section, except as provided in such law.

(c) Term

Each committee member and committee Chairperson shall hold office until the next annual meeting of the Board of Directors or until an occurrence of one of the follow: (a) a successor is appointed, (b) a committee member ceases to be a Director, (c) resigns or (d) is removed from the committee. A committee member of a Board committee may be reappointed for successive terms.

(d) Resignation

Any committee member may resign at any time by giving written notice to the Chairperson of the committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.

(e) Removal

Any committee member except an *ex officio* participant may be removed at any time by a resolution adopted by a majority of the Directors then in office. An *ex-officio* committee member shall cease to be such if he or she ceases to hold a designated position which is the basis of the *ex-officio* committee member's membership.

(f) Vacancies

A vacancy on any Board committee or any increase in the membership thereof may be filled for the unexpired portion of the term in the same manner in which the original appointment to such committee was made.

(g) Meetings and Actions of Committee

Meetings and actions of the committee shall be under the direction of the Board. Minutes shall be kept of each meeting of any committee and shall be filed with the corporate records. The Board of Directors may adopt rules for the government of any committee. A majority of the members of a committee shall constitute a quorum.

(h) Attendance

Committee members shall attend at least seventy-two percent (75%) of the meetings of all committees to which assignment is made. Failure to satisfy these requirements may be grounds for removal from the Board or the committees in accordance with Section 4.13 of these Bylaws.

(i) Creation and Combination of Committees and Reassignment of Functions

(1) The creation of Board committees is discretionary with the Board. The Board may determine that any one or more of such committees should not exist, or it may assign the functions of such committee to a new or existing committee of the Board, or to the board acting as a committee of the whole, or to an individual Officer or Agent of this Corporation.

(j) Additional Participants

At the discretion of the Board, the Chief Executive Officer may be an *ex officio*, non-voting participant in committee meetings including the Executive Committee meetings.

Section 6.2 Standing Board Committees

(a) Executive Committee

(1) Composition: The Executive Committee shall be composed of the Chairperson, the Vice-Chairperson, the Board Chief Financial Officer (if not an employee of the Corporation), the Secretary, and the Immediate Past Chairperson. The Chief Executive Officer shall be *ex officio* non-voting participants in the meetings (but not members) of the Executive Committee at the discretion of the Board Chairperson.

(2) Functions: The Executive Committee shall have the authority and responsibility to:

1. Exercise all power and authority and to perform all duties and responsibilities as may be delegated to it from time to time by the Board subject to any limitations imposed by the Board. The Board may from time to time delegate to the Executive Committee any and all powers and authority of the Board in the management of the business and affairs of this corporation, except as provided in Section 5212(a) of the California Corporations Code or any successor statute, provided, however, that the delegation of such authority shall not operate to relieve the Board or any individual director of any responsibility imposed upon them by law, by the Articles or by these Bylaws;

2. Act on behalf of this Corporation in emergency situations provided that the Executive Committee shall have no power without approval of the Board to authorize any expenditure or commit this corporation in excess of the sum of $25,000.00;

3. Prepare written minutes of all of its meetings which shall be furnished to the Board at or prior to the next Board meeting;

4. Perform such other functions as may be assigned to it by the Board.

(3) Chairperson: The Chairperson of this Corporation shall serve as the Chairperson of the Executive Committee.

(4) Meetings: Meetings of the Executive Committee shall be held on call of the Chairperson.

(b) Finance and Planning Committee

(1) Composition: The Finance and Planning Committee shall be composed of at least three (3) Directors.

(2) Roles and Responsibilities: The Finance and Planning Committee shall be advisory in nature and shall carry out the following roles and responsibilities:

1. Recommending policies that maintain and improve the financial health and integrity of the organization.

2. Reviewing and recommending a long-range financial plan for the organization.

3. Reviewing and recommending an annual operating budget and annual capital budget consistent with the long-range financial plan and financial policies.

4. Reviewing and recommending capital expenditures and unbudgeted operating expenditures that exceed management's spending authority.

5. Reviewing the financial aspects of major proposed transactions, new programs and services, as well as proposals to discontinue programs or services, and making action recommendations to the Board.

6. Monitoring the financial performance of the organization as a whole and its major subsidiary organizations or business lines against approved budgets, long-term trends, and industry benchmarks.

7. Requiring and monitoring corrective actions to bring the organization into compliance with its budget and other financial targets.

8. Participating in annual continuing education pertinent to Committee responsibilities.

9. Acquiring and maintaining a working knowledge of payer contracts.

10. The Committee shall keep minutes from each meeting.

11. The Committee charter shall be reviewed annually.

12. Investment Policy responsibilities:

a. Recommending to the Board independent investments and pension plans.
b. Approving the selection of independent investment advisers and managers;
c. Reviewing reports from the independent investment advisers and managers;
d. Reviewing and reporting to the Board annually on investment and benefit plan performance;
e. Reviewing investment reports to see how each category of investments performed versus benchmarks.

(3) The Board Chief Financial Officer shall serve as Chairperson

(4) Meetings: Meetings of the Finance and Planning Committee shall be held on call of the Chairperson thereof.

(c) Quality Committee

(1) Composition: The Quality Committee shall be composed of at least two (2) Directors and any additional members as designated by the Board including at least one physician and the Chief Executive Officer, Chief Financial Officer, Chief of Staff, and Chief Nursing Officer

(2) Roles and Responsibilities: The Quality Committee shall be advisory in nature and shall carry out the following roles and responsibilities:

1. Develop, evaluate, modify, and approve the Quality Improvement Plan.

2. Set priorities for ongoing measurement of important processes.

3. Evaluate the need to reprioritize improvement activities in response to unusual or urgent events identified through measurement and/or changes in the environment of care or community.

4. Receive and review reports regarding the effectiveness of organization-wide QI (Quality Improvement) activities.

5. Review new service proposals ensuring they are in alignment with the organization's mission, philosophy, and appropriate quality measures are established.

6. Analyze and compare data with external sources when available.

7. Review and act upon Opportunity/Process Referral forms.

8. Support quality improvement teams, acting upon their recommendations.

9. Convene multidisciplinary QI teams for specific improvement efforts, some of which may be triggered by the results of ongoing measurement and/or customer feedback.

10. Communicate relevant activities, as necessary, throughout the organization.

11. Review Customer Service Surveys, QI Teams, Risk Management, Hospital Committees, Resource Management reports and other executive level data/information impacting organization quality and safety.

12. Evaluate the effectiveness of the QI activities of the hospital departments and teams.

13. Integrate findings and outcomes of reviews conducted by Medical Staff.

14. Determine the education and training needs of the organization related to Quality Improvement.

15. Evaluate and validate corrective action has resulted in improvement.

16. Report to the Peer Review/Credentialing Committee and/or Board of Trustees.

17. Maintain a permanent record of council proceedings.

18. Annually review and assess the adequacy of this charter and make recommendations to the Board for improvement.

(3) Chairperson: The Director of Quality and Compliance is the Chairperson.

(4) Meetings: Meetings of the Quality Committee shall be held quarterly or on the call of the Chairperson thereof.

(d) Governance Committee

(1) Composition: The Governance Committee shall be composed of at least three Directors.

(2) Functions: The Governance Committee shall be advisory in nature and shall carry the following functions

1.Assist the board to fulfill its responsibility for ensuring high levels of governance performance.

2.Assist the board with director selection, retention and replacement

3.Formulate policy to evaluate board governance effectiveness, efficiency, creativity and adaptability.

4.Enhance board medical staff relations.

5.Develop leadership and governance training programs.

6.Annually review the corporation's bylaws.

7.Review committee structure and make recommendations for changes as may be needed.

8.Formulate Chief Executive Officer evaluation process.

(3) The Vice Chair of the Board shall serve as Chiarperson of this committee.

(e) Audit and Corporate Compliance

(1) Composition: The Audit and Corporate Compliance Committee shall be composed of at least three (3) Directors.

(2) Functions: The Audit and Corporate Compliance Committee ("Committee") will assist the Board in fulling its oversight responsibility relating to Financial (1) the integrity of the company's financial statements, (2) the independent auditor's qualifications and independence, (3) the performance of the company's internal audit function and independent auditors, (4) the accounting and financial reporting processes of the company and audits of the financial statements of the company, The Audit and Corporate Compliance Committee ("Committee") will assist the Board in fulling its oversight responsibility relating to Compliance (1) legal and regulatory compliance systems, and (2) the anti-fraud program. The Committee shall also assist the Board in establishing a corporate culture that encourages a commitment to compliance with law, (3) the company's compliance with legal and regulatory requirements.

(3) Roles and Responsibilities: The duties and responsibilities of the Corporate Audit and Compliance Committee shall be:

Financial:

1. To recommend to the Board the selection of an external auditor for this Corporation and its subsidiary corporations.
2. To review the terms of the auditor's engagement at least every three (3) years, review scope of audits to be made and approve in advance non-audit services, if any, to be provided by the auditor.
3. To oversee the performance of the audit; review the results of the audit (including any Management Letter); confer with the auditor to ensure that the affairs of the corporation are in order; to review the implementation of internal financial controls adopted through the audit process; and based theron to make recommendations to the Board concerning the financial operation of this Corporation and its subsidiary corporations.

Compliance:

1. To oversee all corporate compliance and internal audit efforts of the Corporation in such manner as the Committee deems fit, subject to Board approval and to monitor the Corporation's response to potentially questionable corporate practices.
2. To oversee the Corporation's compliance with applicable laws, regulations, and accreditation standards, including but not limited to: Medicare Conditions of Participation and the DNV.
3. To meet at least annually, without anyone from management of the Corporation present (i.e., President/Chief Executive Officer, Chief Financial Officer, and any other officer that the Committee deems in its sole discretion to be a representative of management), with the

Corporation's external auditor, internal auditor if one is designated, and Corporate Compliance Officer, respectively.

4. Provide direction and assistance to the Compliance Program as it relates to the Seven Compliance Elements:

5. Provide direction and assistance to the Compliance Program as it relates to the Eight Specific Areas of Concern:

6. Meetings: Meetings of the Audit and Corporate Compliance Committee shall be held quarterly or on the call of the Chairperson thereof.

7. The Chairman is appointed by the Chairperson of the Board.

Section 6.3 Non-Directors Serving on Board Committees

(a) Notwithstanding any other provision of these Bylaws, non-Directors may be appointed to serve on any Board committee except the Executive Committee, including but not limited to the Standing Board Committees, and may participate in the discussion of issues before a Board committee, but shall not be entitled to vote and shall not be counted in determining the existence of a quorum.

(b) Each non-Director serving on a Board committee shall agree that he or she has a fiduciary duty to this Corporation, including but not limited to the provisions of Sections 3.5, 3.7 and 3.8 of these Bylaws. Each non-Director shall also have a duty of confidentiality to this Corporation, and shall agree that he or she shall not disclose any information received as part of this appointment to persons other than the Directors unless the Board shall have consented in writing. Non-Directors serving on a Board committee shall sign such an agreement and a conflict of interest form prior to the first meeting of the Board committee to which they are appointed.

ARTICLE SEVEN

CHIEF EXECUTIVE OFFICER

Section 7.1 Chief Executive Officer

(a) Appointment

The Board shall select and appoint a qualified person to serve as the Chief Executive Officer of this Corporation and be its direct executive representative in the management of this Corporation. The Chief Executive Officer shall have the

necessary authority and be held responsible for the management of this Corporation in all its activities, subject only to the policies enacted by the Board or any committees or persons to which the Board has specifically delegated power for such action. The Chief Executive Officer shall, attend all meetings of the Board and Board committees as an *ex officio*, non-voting participant providing support to the Board and Board committees as necessary or requested by the Board. The Chief Executive Officer shall act as a duly authorized representative of the Board in all matters except those in which the Board has formally designated another person or group to act. The Chief Executive Officer shall serve at the pleasure of the Board.

(b) Authority, Duties and Requirements

The Chief Executive Officer shall, subject to the directions of the Board:

(1) Be responsible to review and report updated Policies and Procedures to the Board;

(2) Be responsible for implementing policies established and plans authorized by the Board for the operation of this Corporation, and for advising the Board on the formation of these policies and plans;

(3) Send periodic reports to the Board on the overall activities of this Corporation, as well as on appropriate federal, state and local developments that affect the operation of this Corporation;

(4) Provide the Board and Board committees with such staff and administrative support and personnel as they may reasonably require;

(5) Organize the administrative functions of this Corporation, delegate duties, and establish formal means of accountability;

(6) Supervise the business affairs of this Corporation to assure that funds are expended to the best possible advantage for community health care;

(7) Attend, personally or by designee, all meetings of the Board and Board committees;

(8) Perform any other duties within the express or implicit terms of these Bylaws that may be necessary for the best interests of this Corporation;

(9) Designate, in writing, other individuals by name or position who are, in order of succession, authorized to act for the Chief Executive Officer during any period of absence from this corporation; and

(10) Perform such other duties as the Board shall from time to time direct.

(11) Recommend to the Board strategic and long range plans to fulfill the requirements of the mission statement.

ARTICLE EIGHT

MEDICAL STAFF

Section 8.1 Organization

The Board shall cause to be created a Medical Staff organization to be known as the Orchard Hospital Medical Staff (the "Medical Staff"), which shall be a distinct part of the hospital corporation and whose membership shall be comprised of all physicians, osteopaths, dentists, podiatrists, and others who are privileged to attend patients in this hospital. Only a member of the Medical Staff with admitting privileges shall admit patients to the Orchard Hospital. Membership in the Medical Staff shall be a prerequisite to the exercise of clinical privileges in the hospital except as otherwise specifically provided in the Medical Staff bylaws.

Section 8.2 Medical Staff Bylaws, Rules and Regulations

The Medical Staff bylaws and rules and regulations shall create an administrative unit to discharge the functions and responsibilities assigned to the Medical Staff by the Board, and such bylaws, rules and regulations shall be consistent with Joint Commission standards and recommendations, applicable law, applicable hospital policy and the Articles and Bylaws of this Corporation. The Bylaws, rules and regulations shall

(a) State the purposes, functions and organization of the Medical Staff;

(b) Set forth the policies by which the Medical Staff exercises and accounts for its functions and responsibilities; and

(c) Define relationships, responsibilities, authority and methods of accountability for each Medical Staff official, department officer and committee.

The Medical Staff Bylaws will specifically assure that only a member of the Medical Staff with admitting privileges shall admit patients to Orchard Hospital.

The Medical Staff shall have the initial responsibility to formulate, adopt, periodically review and recommend to the Board Medical Staff bylaws and amendments thereto and rules and regulations which will be effective when approved by the Board of Directors, which approval shall not be unreasonably withheld. If said bylaws or amendments thereto or rules and regulations or amendments thereto are not adopted in accordance with the standards set forth in this Section or are not adopted in a reasonable, timely and responsible manner, and after notice from the Board to such effect, including a reasonable period of time for response, then the Hospital will not be in compliance with state law and applicable accreditation standards. To the extent necessary for Orchard Hospital to comply with state law and applicable accreditation standards, the Board may resort to its own initiative in formulating or amending Medical Staff

bylaws or rules and regulations. In such event, Medical Staff recommendations and views shall be duly considered by the Board during its deliberations and in its actions.

Section 8.3 Medical Executive Committee

The Medical Staff Bylaws shall provide for an Executive Committee that represents the Medical Staff has responsibility for the effectiveness of all medical activities of the Staff and acts for the Medical Staff. The Executive Committee is a mechanism for providing a formal relationship between the Medical Staff organization and the Chief Executive Officer of the hospital. The members of the Executive Committee shall be selected as described in the Medical Staff Bylaws.

Section 8.4 Medical Staff Membership and Clinical Privileges

(a) Action by the Board of Directors

The Board shall refer to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges and corrective action, and shall require that the Staff make recommendations to it thereon. Final action on all such matters shall be taken by the Board after giving great weight to the Staff recommendations forwarded to it pursuant to paragraph (b) of this Section, and in no event will the Board act in an arbitrary or capricious manner. Notwithstanding the foregoing, the Board shall act in any event if the Staff does not adopt and submit any such recommendation within the time periods required by the Medical Staff Bylaws. Such Board action without a Staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for Staff recommendation and shall be taken only after providing written notice to the peer review body.

(b) Medical Staff Recommendations

The Medical Staff bylaws shall contain provisions for Staff to adopt and forward to the Board specific written recommendations on all matters of Medical Staff membership status, clinical privileges and corrective action, and to support and document these recommendations in a manner that will allow the Board to take informed action.

(c) Criteria for Board of Directors Action

(d) In acting on matters of Medical Staff membership status, the Board of Directors shall consider the Staff's recommendations, this Corporation's and the community's needs, and such other criteria as they are set forth in the Medical Staff bylaws. In granting and defining the scope of clinical privileges to be exercised by each practitioner, the Board shall give great weight to the Staff's recommendations, the supporting information on which they are based, and such criteria as are set forth in the Medical Staff bylaws. No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the bases of sex, race, creed, color or natural origin, or on the basis of any other criterion unrelated to good patient care at the hospital, or to professional ability and judgment, or to community needs. Any differences between the Medical Staff and the Board regarding recommendations concerning membership status, clinical privileges and corrective action shall be resolved by the Board and the Medical Staff, within a reasonable period of time as determined by the Board.
Terms and Conditions of Staff Membership and Clinical Privileges

The terms and conditions of membership status in the Medical Staff and of the exercise of clinical privileges shall be specified in the Medical Staff Bylaws. It shall be a condition of appointment to the Medical Staff of this hospital that a practitioner has malpractice insurance in amounts determined from time to time by the Board of Directors.

(e) Procedure

The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status, clinical privileges and corrective action shall be specified in the Medical Staff Bylaws.

Section 8.5 Hearing and Appellate Reviews

The Board shall require that any action taken by the Executive Committee of the Medical staff or by the Board, the effect of which is to adversely affect a practitioner as described in the Medical Staff bylaws, be accomplished in accordance with a Board-approved fair hearing plan then in effect, which must be set forth in the Medical Staff bylaws. Such plans shall provide for procedures to assure fair treatment and afford an opportunity for the presentation of all pertinent information.

Section 8.6 Allied Health Professionals

The Board shall refer to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to allied health professional's status, clinical privileges and corrective action, and shall require that the Staff make recommendations to it thereon. Allied Health Professional is defined as medical staff that require privileges, but are not physicians. Final action on all such matters shall be taken by the Board after considering the Staff recommendations forwarded to it pursuant to paragraph (b) of Section 8.4, provided that the Board shall act in any event if the Staff does not adopt and submit any such recommendations

within the time periods required by the Medical Staff Bylaws. Such Board action without a Staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for Staff recommendation. Allied health practitioners shall consist of health professionals who are not members of the Medical Staff, but who desire to practice in some capacity within the hospital. Allied health practitioners shall not have rights to fair hearing and appeals except as may expressly be provided in the Medical Staff Bylaws.

Section 8.7 Contractual, Medico-Administrative and Special Staff Officers

Medico-Administrative officer means a practitioner, engaged by or otherwise contracting with the hospital on a full or part-time basis, whose duties include certain responsibilities which may be both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner, such to require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of practitioners under his direction.

A practitioner engaged by the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the hospital and to the terms of his or her contract, or other conditions of engagement, and need not be a member of the Medical Staff. Conversely, a Medico-Administrative officer must be a member of the Medical Staff. His or her clinical privileges must be delineated in accordance with the Medical Staff bylaws. His or her Medical Staff membership and clinical privileges shall not be dependent upon his or her continued occupation of that position, unless otherwise provided in an employment agreement, contract or other arrangement or Board process that complies with state law.

Section 8.8 Chief Executive Officer

The Chief Executive Officer, and any other person designated by the Board shall be privileged to attend all meetings of the Medical Staff and shall be given notice of such meetings or Board process that complies with state law.

ARTICLE NINE

QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND RISK MANAGEMENT PROGRAM

Section 9.1 Board Responsibility

The Board shall establish, maintain, support and exercise oversight of an ongoing quality assessment/performance improvement program that includes specific and effective review, evaluation and monitoring mechanisms to assess, preserve and improve the overall quality and efficiency of patient care in the hospital.

Section 9.2 Delegation to Administration

The Board delegates to the Administration and holds it accountable for

(a) Providing the administrative assistance reasonably necessary to support and facilitate the implementation and ongoing operation of the Corporation's quality assessment/improvement performance and risk management program;

(b) Implementing the quality assessment/improvement performance and risk management program relating to all hospital personnel, medical and non-medical. Analyzing information and acting upon problems involving technical, administrative and support services and hospital policy.

Section 9.3 Delegation to the Medical Staff

The Board delegates to the Medical Staff and holds it accountable for conducting specific activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the hospital which activities include:

(a) Systematic evaluation of practitioner performance against explicit, predetermined criteria;

(b) Ongoing monitoring of critical aspects of care, including antibiotic and drug usage, transfusion practices, tissue, infections, mortalities and so on, and monitoring of unexpected clinical occurrences;

(c) Review of utilization of the hospital's resources to provide for their proper and timely allocation to patients in need of them;

(d) Provision of continuing professional education, fashioned in part on the needs identified through the review, evaluation, and monitoring activities and on new state-of-the-art developments;

(e) Definition of clinical privileges which may be appropriately granted within the hospital and within each department or service, delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment, and participation in assigning patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated abilities;

(f) Management of clinical affairs, including enforcement of clinical policies and consultation requirements, initiation of disciplinary actions, surveillance over requirements for performance monitoring and for the exercise of newly-acquired clinical privileges, and like clinically oriented activities; and

(g) Such other measures as the Board may, after considering the advice of each of the Medical Staff, the professional services and the facility management, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

Section 9.4 Documentation and Oversight

At least annually, the Board shall require, receive, consider and, as appropriate, act upon the findings and recommendations emanating from the activities required by Sections 9.2 and 9.3. All such findings and recommendations shall be in writing, signed by the persons responsible for conducting the activities and supported and accompanied by appropriate documentation and rationale upon which the Board can take informed action, as required or necessary and can exercise effective oversight of the quality assessment/performance improvement and risk management program.

Section 9.5 Professional Liability Insurance

The Board shall ensure that each practitioner granted clinical privileges in the Corporation's facilities shall maintain professional liability insurance in not less than the minimum amounts as from time to time may be determined by the Board, based upon the recommendation of the Executive Committee of the Medical Staff or as required by the Corporation's professional liability insurance carrier. The minimum amount of required coverage established pursuant to this provision shall not exceed the amount of professional liability insurance carried by the Corporation.

ARTICLE TEN

FISCAL YEAR

Section 10.1 Accounting Year

The accounting year of the corporation shall be established by resolution of the Board.

Section 10.2 Audit

At the end of the accounting year, the books of this Corporation shall be closed and audited by a certified public accountant selected by the Board. The financial report of the auditor shall be furnished to the Board of Directors.

Section 10.3 Annual Report

The audit referred to in Section 10.3 shall be included as a part of the annual report referred to in the California Non-profit Public Benefit Corporation Law. Such report shall contain the following information in reasonable detail:

(a) The assets and liabilities, including trust funds, of this Corporation as of the end of the fiscal year;

(b) The principle changes in assets and liabilities, including trust funds, during the fiscal year;

(c) The revenue or receipts of this Corporation, both unrestricted and restricted to particular purposes, for the fiscal year;

(d) The expenses of disbursements of this corporation, both general and restricted purposes, during the fiscal year;

(e) Any information required by California Corporations Code Section 6322; and

(f) All other information required by law.

ARTICLE ELEVEN

INDEMNIFICATION

Section 11.1 Indemnification of Directors, Officers, Employees, and Other Agents

(a) The Corporation shall, to the maximum extent permitted by the California Corporations Code, indemnify each of its Directors, Officers, employees, agents and others against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact any such person is or was an agent of the Corporation.

The Board may authorize the purchase and maintenance by the Corporation of insurance on behalf of any agent of the Corporation against liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not the Corporation is empowered to indemnify the agent against such liability under the provisions of this Article.

For purposes of this Article, an "agent" of the Corporation includes any person who is or was a director, officer, employee or other agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise or was a director, officer or employee or agent of a corporation which was a predecessor corporation of the Corporation or of another enterprise at the request of such predecessor corporation.

(b) Determination of Agent's Good Faith Conduct

The agent seeking indemnification must be found by the Board (as evidenced by a majority vote of a quorum consisting of Directors who are not parties to the proceedings) to have acted in good faith, in a manner the agent believed to be in the best interests of this corporation, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use in similar circumstances. The termination of any proceeding by judgment, order, settlement, conviction, or otherwise shall not, of itself, create a presumption that the person did not act in good faith. In the case of a criminal proceeding, the

person must have had no reasonable cause to believe that the conduct was unlawful. The Board's decision in this matter shall be final.

(c) Limitations

No indemnification or advance shall be made under this Section in any circumstances when it appears:

(1) The indemnification or advance would be inconsistent with a provision of the Articles, or an agreement in effect at the time of the accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnifications;

(2) The indemnification would be inconsistent with any condition expressly imposed by a court or other body in approving a settlement; or

(3) The indemnification is prohibited by law or regulation, or would jeopardize the exempt status of this or a supported or affiliated corporation.

(d) Contractual Rights of Non-Directors and Non-Officers

Nothing contained in this Section shall affect any right to indemnification to which persons other than Directors and Officers of either this Corporation or any supported or affiliate organization may be entitled by contract or otherwise.

Section 11.2 Bonding

All Officers and employees handling funds shall be properly bonded.

ARTICLE TWELVE

RECORDS, REPORTS AND INSPECTION RIGHTS

Section 12.1 Maintenance of Articles and Bylaws

The Corporation shall keep at its principal office the original or a copy of the Articles and of these Bylaws as amended to date.

Section 12.2 Maintenance of Other Corporation Records

The accounting books, records and minutes of proceedings of the Board and any committee(s) of the Board shall be kept at such place or places designated by the Board or, in the absence of such designation, at the principal executive office of the Corporation. The minutes shall be kept in written or typed form, and the accounting books and records shall be kept in wither written or typed form. All minutes, accounting books, records and any corporate records and documents

shall be kept and maintained in accordance with policies, procedures, or other directives that may be established by the Board.

Section 12.3 Inspection by Directors

Except as otherwise limited by law, every Director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every kind and the physical properties of the Corporation. This inspection by a Director may be made in person or by an agent or attorney, and the right of inspection includes the right to copy and make extracts of documents.

ARTICLE THIRTEEN

EXECUTION OF DOCUMENTS

The following persons shall be authorized to execute any deeds, mortgages, bonds, contracts, or other instruments which the Board has authorized to be executed and for which this Corporation has authority to act:

A. Any Officer or other person duly authorized by resolution of the Board to execute documents; or

B. In the absence of express authorization by Board resolution, the Chairperson or the President, and any one of the Secretary, or the Chief Financial Officer (all subject to such limitations as may be imposed by resolution of the Board).

ARTICLE FOURTEEN

GENERAL PROVISIONS

Section 14.1 Auxiliaries and Related Groups

The Board may establish or support the establishment of one or more auxiliary groups, including a Foundation, and/or related organizations willing to support the objectives of the Corporation or work in complementary ways with the Corporation. The Board reserves the right, subject to any charitable trust law requirements to allocate any such funds as may be donated by such bodies to uses or objectives consistent with the purposes of this Corporation. Additionally, for liaison purposes only, a member of the Board shall be appointed to attend Executive Committee meetings of the Foundation, Auxiliary, and other related organizations, and from time to time, but not less than annually, the Board shall receive a report, for information purposes only from the Foundation, Auxiliary, and all other related organizations as to the operations of that organization.

Section 14.2 Amendments

These Bylaws may be replaced or amended or new Bylaws may be adopted by a majority vote of the Directors at any annual meeting or at any other meeting called for that purpose.

Section 14.3 Construction and Definitions

Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California nonprofit public benefit corporation law shall govern the construction of these Bylaws. Without limiting the generality of the above, the masculine gender includes the feminine and neuter, the singular numbers include the plural, the plural numbers include the singular, and the term "person" includes both corporations and natural persons. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

Section 14.4 Corporate Seal

The Board shall provide a suitable seal for this Corporation.

Section 14.5 Meeting Procedure

All meetings of the Board and of committees shall be conducted in accordance with the standing rules and procedures established by the Board, and to the extent such rules and procedures are not specifically established by the Board, Roberts Rules of Order, as revised from time to time, shall be controlling as to procedure.

Section 14.6 Leave of Absence

(a) Directors may be granted leaves of absence by the affirmative vote of a majority of the Board for a definitely-stated period of time.

(b) Requests for leaves of absence shall be made to the Chairperson of the Board and shall state the beginning and ending dates of the requested leave and the reasons for the leave.

(c) No later than ninety (90) calendar days prior to the conclusion of the leave of absence, the individual may request, in writing to the Chairperson of the Board, to be reinstated. The request shall summarize the activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Board at that time.

(d) In acting upon the request for reinstatement, the Board may consider the individual for the first available vacancy on the Board, but shall not be required to appoint or elect the individual to fill that vacancy.

OFFICER'S CERTIFICATE

THIS IS TO CERTIFY that:

The undersigned persons are the Chairperson of the Board and the Secretary of Orchard Hospital, a California nonprofit public benefit corporation; and

The foregoing Amended and Restated Bylaws of Orchard Hospital were duly adopted and approved by the Board of Directors of this Corporation on the 27th day of March, 2018.

ORCHARD HOSPITAL

By _____
Chairperson of the Board

Date: March 27, 2018

By _____
Secretary

Date: March 27, 2018

March, 2018

License: 230000007
Effective: 12/01/2023
Expires: 11/30/2024
Licensed Capacity: 24

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

Orchard Hospital

to operate and maintain the following **General Acute Care Hospital**

Orchard Hospital

240 Spruce St
Gridley, CA 95948-2216

Bed Classifications/Services/Stations

24 General Acute Care
4 Intensive Care
20 Unspecified General Acute Care

Other Approved Services

Mobile Unit - Computed Tomography (CT) Scan
Mobile Unit - Magnetic Resonance Imaging (MRI)
Occupational Therapy
Outpatient Services - PCC at Orchard Hospital Medical Specialty Center, 284 Spruce Street, Gridley
Outpatient Services - Primary Care at Orchard Hospital Medical Specialty Center Oroville, 2990 Oro Dam Blvd. E Suite A, Oroville
Outpatient Services - Psychiatry - Geriatric Psychiatric Program
Physical Therapy
Respiratory Care Services
Social Services
Speech Pathology and/or Audiology Service
Standby Emergency Medical Services

(Additional Information Listed on License Addendum)

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, Chico District Office, 126 Mission Ranch Blvd, Chico, CA 95926, (530) 895-6711

POST IN A PROMINENT PLACE

State of California
Department of Public Health
License Addendum

License: 230000007
Effective: 12/01/2023
Expires: 11/30/2024
Licensed Capacity: 24

Orchard Hospital (Continued)
240 Spruce St
Gridley, CA 95948-2216

Approved Other Certifiable Parts

Rural Health Clinic
Orchard Hospital Medical Specialty Center Oroville
2990 Oro Dam Blvd E
Suite A
Oroville, CA 95966-5177

Rural Health Clinic
Orchard Hospital Medical Specialty Center
284 Spruce St
Gridley, CA 95948-2216

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
24 hospital beds approved as swing beds.
Critical Access Hospital

TOMÁS J. ARAGÓN, MD, DrPH
Director and State Public Health Officer

Chris Fong for
Michelle Dunlap, Staff Service Manager II

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, Chico District Office, 126 Mission Ranch Blvd, Chico, CA 95926, (530) 895-6711

POST IN A PROMINENT PLACE

This certificate is issued without verification that the holder is subject to or exempted from licensing by the state, county, federal government, or any other governmental agency.

City of Gridley

BUSINESS LICENSE

685 Kentucky St, , Gridley ,CA 95948

Sales or use tax may apply to your business activities. You may seek written advice regarding the application of tax to your particular business by willing to the nearest State Board of Equalization office

EXPIRATION
12/31/24

EFFECTIVE DATE
01/01/24

LICENSE NUMBER
0000000391

TYPE OF BUSINESS:
HEALTH CARE FACILITY/ HOSPITAL

BUSINESS ID
B081467

OWNER
ORCHARD HOSPITAL

MAILING ADDRESS
ORCHARD HOSPITAL
PO BOX 97
GRIDLEY CA 95948

BUSINESS ADDRESS
ORCHARD HOSPITAL
240 SPRUCE ST
GRIDLEY CA 95948

This license evidences that the person(s),firm or corporation named herein has paid the applicable tax required by the City of Gridley Municipal Code for the period indicated above. No License issued under the provisions of chapter 5 of Gridley Municipal Code shall be construed as authorizing the conduct or continuance of any illegal or unlawful operation in violation of any City Ordinance relating thereto.

Orchard HOSPITAL
Growing Healthy Communities

Community Health Needs Assessment 2022

Mission, Vision & Values

Our Mission

Our Mission is to Improve the Health and Well-being of our Community. Achieving this requires clear priorities, supportive leadership, and staff and community collaboration, which will be engrained in our HERO Values.

Our Vision

At Orchard Hospital, our Vision to ***Provide Quality Health Care Close to Home***, is consistent with the direction of the Orchard Hospital Board of Directors with three main goals in mind:

- Provide High-quality healthcare in the services we provide
- Promote healthy lifestyles with focus on obesity prevention and management, starting with our youth
- Implement key strategies important to our communities that allow us to achieve sustainable operating margins

Our Values

At Orchard Hospital, our governance and decision-making will always be based upon integrity, respect, innovative processes, ethical foundations, and continual self-improvement.

H - Honesty and Integrity

We will make decisions with honesty and integrity that will ensure Orchard Hospital's future.

E - Engaged and Empowered Staff

We will hire staff that are engaged and empowered to make a positive difference in the lives of our patients and each other.

R - Responsive

We will respond to the needs of our community by implementing programs that align with our Community Health Needs Assessment (CHNA).

O - Outcomes-Driven

We will be recognized for having excellent outcomes for the services we provide at Orchard Hospital.

Introduction

Orchard Hospital located in Gridley, California is a 501(c)(3) Critical Access

Hospital offering 24-hour emergency services, inpatient, outpatient, and rural health clinic services. Orchard Hospital is dedicated to always providing the finest personalized healthcare to North Valley communities by offering a wide range of integrated services, from prevention through treatment to wellness.

Orchard Hospital is the only acute care hospital in Gridley, as well as along the Highway 99 corridor between Sacramento and Chico, providing much-needed emergency care for travelers.

Orchard Hospital is certified for 24 general acute care beds (4 Monitored Beds and 20 Unspecified General Acute Care) and offers the following medical services.

Orchard Hospital Services
Cardiology
Social Services
Emergency Services
Inpatient/ Outpatient Surgery
Imaging Services
Respiratory Care
Cardiopulmonary
Laboratory
Physical Therapy
Senior Life Solutions
Clinic Services

Rural Health Clinic Services
Laboratory
Digital Radiology
DEXA Scanning
Digital Mammography
Ultrasound (General & Cardiac)
Physicals
Workers Comp
Industrial Medicine
Drug Screening
Psychotherapy
Physical Therapy
Internal Medicine

Purpose and Overview of the Community Health Needs Assessment

Under the Affordable Care Act, hospitals throughout the country are required to conduct a Community Health Needs Assessment (CHNA) every three years.

The primary purpose of conducting a CHNA is to objectively look at the current health needs of a community, as well as the existing resources available to address those needs, then prioritize the unmet health needs and create an action plan to address them in the coming years.

Using the community feedback and health data gathered, the resulting response and action plan will help shape programs over the next three years

Report Adoption, Availability and Comments

This CHNA report was adopted by the Orchard Hospital Board of Trustees on December 27, 2022.

This report is widely available to the public on the hospital's website, www.orchardhospital.com. Written comments on this report can be submitted to jbunn@orchardhospital.com

2019 CHNA Response

In 2019, Orchard Hospital partnered with Butte County Public Health and the three other hospitals in our county to conduct a Community Health Needs Assessment. The outcome was an action plan that committed the focus of our community outreach efforts on three main areas affecting the health of our community:

- Access to Care
- Mental health and Substance Use Disorders

- Chronic Disease and Conditions
- Adverse Childhood Experiences and Childhood Maltreatment

Orchard Hospital committed to identifying opportunities to collaborate with community partners throughout the region to break down barriers associated with these pressing health and social needs, as well as providing the education and other tools members of our community need to be proactive in their health and lifestyle choices.

Action Plan and Results from 2019 Community Health Needs Assessment:

Access to Care – Response to Need

Community Health Events

Orchard Hospital participated in community health events throughout the surrounding areas to ensure high-risk and underserved individuals had access to health care and health education:

- Town Hall Meeting at Gridley High School – The Town Hall meeting was in collaboration with Si Se Puede and the Nicotine Action Alliance coalition, Gridley High School, Butte County Public Health and Northern Valley Catholic Social Service. This event provided education on flavored tobacco, cessation resources, health screening resources for tobacco-related health issues, student-run town hall presentation.
- Sports Registration Night at Gridley High School – Orchard Hospital partnered with Gridley High School to provide free athletic physicals to high school students.
- Orchard Hospital Teddy Bear Clinic – The annual Teddy Bear clinic partners Orchard Hospital with Cal-Fire, Butte County Sheriff's Department, Gridley Police Department, and California Highway Patrol to educate and familiarize local children about emergency situations. The Teddy Bear clinic allows children to bring an "injured" stuffed animal to receive treatment from medical staff by starting at triage, radiology, X-ray and some cases visiting the surgical area designed just for the miniature teddy bear patient.

- Community Health Fair – Orchard Hospital partnered with the Gridley Lions Club to hold an annual Community Health Fair. This free event is offered to all ages and provides an opportunity to learn about many healthy lifestyle resources. A-1C testing for diabetes, blood glucose, blood pressure, free flu-vaccines, and free eye exams.
- Annual Flu & Covid Clinics – Orchard Hospital provides multiple Flu and Covid vaccine clinics annually throughout the community. Several clinics were in collaboration with Butte County Public Health and the local schools.
- Covid-19 Testing Clinics – Orchard Hospital provided ongoing Covid-19 testing for the community.

Mental Health and Substance Use – Response to Need

Orchard Hospital offered easy access at the hospital and clinic for safe disposal of medications and syringes.

Orchard Hospital implemented a program called Senior Life Solutions which provides assistance to individuals suffering from one or more of the following: crying, hopelessness, loneliness, restlessness, sadness, coping with loss, decreased energy, difficulty sleeping, low self-confidence and life transitions. We will continue to grow this program and offer another track.

Orchard Hospital will continue collaborating, partnering with and supporting other programs and organizations to extend our reach and impact in high needs areas, including, but not limited to:

- Butte County Behavioral Health
- Butte County Drug Abuse Prevention Task Force
- Butte County Tobacco Prevention Coalition
    - Smoking Cessation
- Orchard Hospital Senior Life Solutions
- Offering counseling for Mental Health

Chronic Disease and Conditions – Response to Need

Orchard Hospital recruited and retained a physician specializing in internal medicine and recruited and retained a Chiropractor. Orchard Hospital participated in the local annual Farmer's Market to promote healthy diet and educate the community on chronic conditions. Orchard Hospital implemented a patient portal that offers health records on Apple products like an iPhone, iPad, Apple Watch and iPod touch. With the health app, health records are available and easily assessable to patients.

Adverse Childhood Experiences and Child Maltreatment – Response to Need

Add the sports physical night in here to add mental health screening and at clinic. Personal Safety screening

Prioritization Process

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators that were identified in the secondary data were measured against benchmark data; specifically, county rates, state rates and/or Healthy People objectives. Indicators related to the health needs that performed poorly against one or more of these benchmarks met this criterion to be considered a health need.

The list of significant health needs informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs, and discover gaps in resources. Community focus groups and stakeholder interviews were used to gather input and prioritize the significant health needs.

Top priorities identified in partnership with our communities:

Significant needs were identified through a review of the secondary health data and validation through community stakeholder surveys. The significant needs identified are as follows:

- Access to Care
- Mental Health Issues
- Substance Use Disorders
- Chronic Diseases (Diabetes, Aging problems, Heart disease, Lung Disease, Stroke)
- Low crime/safe neighborhoods
- Adverse Childhood Experiences and Childhood Maltreatment
- Overweight & obesity

From 2023-2025, Orchard Hospital will address the following health needs through a commitment of community programs and resources.

Orchard Hospital's CHNA Oversight team:

Julie A. Bunn, Foundation, Grants and Community Outreach Coordinator

Stephanie Orozco, Marketing and Social Media Coordinator

Kami Duntsch, Chief Human Resource Officer

Kirsten Storne-Piazza, Chief Clinic Administrator

Service Area

Orchard Hospital is located at 240 Spruce St., Gridley, CA 95948. The service area includes five communities consisting of 5 ZIP Codes in Butte County.

Orchard Hospital Service Area	
Zip Code	**City**
95948	Gridley
95917	Biggs
95974	Richvale
95965	Oroville
95966	Oroville
95953	Live Oak

Community Profile

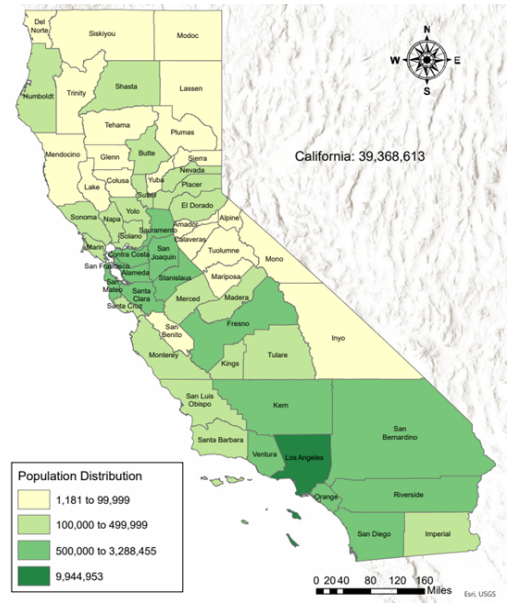


Figure 1: Population distribution

Source: State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year, July 1, 2021.

Butte County is in the Northern portion of the Sacramento Valley Region of North Central California and encompasses approximately 1,677 square miles, of which 1,636.5 square miles are land and 41 square miles are water. According to the 2021 California Department of Finance County Population State and County Population Estimates, California's population is 39,368,613, and Butte County is ranked the 28th largest county with a population of 201,158 (see Figure 1).

Primary Data Collection

Orchard Hospital conducted a survey in order obtain an estimate of the prevalence of behaviors and conditions in Butte County.

The full report and summary table of risk factors data from the 2022 Survey can be found in the Appendix.

Secondary Data Collection

Orchard Hospital staff spoke with representatives from Public Health, law enforcement agencies, neighboring hospitals, and clinic systems in order to gather insight and feedback for the Community Health Needs Assessment.

Participants were asked to share their professional and personal thoughts and experiences regarding access to health care, obstacles and barriers to quality health care and ability to live healthy lives.

The results of this feedback are included in the Executive Summary and assisted in the development of the Action Plan.

2022 Executive Summary

The results of were reviewed for their degree of commonality. Secondary health metric data was made to align with health survey and qualitative focus group data, such that those health factors with the greatest alignment became evident. The health factors most substantially implicated that emerged through this process are:

- Access to Care
- Mental Health Issues
- Substance Use Disorders
- Chronic Diseases (Diabetes, Aging problems, Heart disease, Lung Disease, Stroke)

Access to Care: Access to health services is a leading health indicator (LHI) for the Healthy People 2020 (HP-2020) national health objectives. A person's ability to access health services profoundly affects their health and well-being. Having a usual Primary Care Provider (PCP) is associated with: greater patient trust in the provider; better patient-provider communication; increased likelihood that patients will receive appropriate care; and lower mortality from all causes[i]. Access to mental health and oral health care are also both important, as both mental health conditions and oral health correlate strongly with physical health and well-being.

Access to Care | Primary Care Shortage: The Health Resources & Services Administration (HRSA) has determined that there are Primary Care Shortage Areas, Dental Care Shortage Areas, and Mental Health Shortage Areas in Butte County. While only parts of the county meet Primary Care Shortage and Dental Care Shortage Area criteria, the entire county meets Mental Health Shortage Area criteria. Population to provider ratios also demonstrate that Butte County has fewer Primary Care Physicians and Dental Care Providers per capita than the state overall; however, Butte County does have more Non-Physician Primary Care Providers (e.g. Physician's Assistants, Nurse Practitioners) and Mental Health Care providers per population than the state overall.

Table – Access 1: Population to Provider Ratios: Butte County and California, 2017 & 2021.

	Butte County		California	
	2017	2021	2017	2021
Primary Care Physician	1,570:1	1,650:1	1,280:1	1,250:1
Dental Care	1,440:1	1,340:1	1,250:1	1,150:1
Mental Health Care	190:1	140:1	350:1	270:1
Uninsured	13%	8%	14%	8%
Mammography Screening	60%	40%	60%	36%

Source: 2017 and 2021 Area Health Resource Data File via County Health Rankings. Retrieved From: http://www.countyhealthrankings.org/california/buttecounty

Access to Care | Preventative Practices: Preventive health practices are those that prevent illnesses or diseases, such as screenings and immunizations, or patient counseling to prevent illness[i]. Examples include standard immunizations; and screenings for blood pressure, cancer, cholesterol, depression, obesity, and Type 2 diabetes[ii]. In recent years, several vaccine-preventable diseases once on the verge of eradication, such as measles, have reemerged in the United States, with outbreaks

occurring throughout California, including Butte County. Likewise, sexually transmitted infections (STIs) once thought to be declining or close to eradication, such as syphilis, have shown increasing rates nationally. Many STIs are treatable, but if undetected, may continue to be transmitted; and many more are preventable through education and patient counseling.

The percentage of students having all required immunizations for enrollment into Butte County schools is slightly below the percentage of students statewide (93% vs. 96%), with more conditional entrants – students with some but not all required immunizations – attending Butte County schools than California schools overall (3.1% vs. 1.7%). According to the BRFS, 47.8% of Butte County respondents over the age of 65 have not had a flu shot in the past 12 months; and 29% had not received the pneumococcal vaccine, which was also greater than the percentage statewide (23.2%). Likewise, 73.2% of Butte County respondents age 50 or older have not been vaccinated against shingles, which was slightly greater than the percentage of respondent's state and nationwide (68.9% and 71.4%, respectively).

Rates of STIs (chlamydia, gonorrhea, and syphilis) were lower in Butte County than the state, except for syphilis. According to the California Department of Public Health, STD Control Branch 2018 Surveillance Report, in Butte County, rates of primary and secondary syphilis increased by 35.6 cases per 100,000 persons. Chlamydia was 579.4 cases per 100,000 persons and gonorrhea was 186.1 cases per 100,000 persons.

Pertaining to preventative practices for adult smoking, adult obesity, physical inactivity, excessive alcohol drinking, alcohol-impaired deaths, and teen births were all up in Butte County from 2017 to 2021 except teen births and alcohol-impaired driving deaths.

Table – Access 2: Population to Provider Ratios: Butte County and California, 2017 & 2021.

	Butte County		California	
	2017	2021	2017	2021
Adult Smoking	15%	17%	12%	11%

Adult Obesity	26%	23%	30%	24%
Physical Inactivity	19%	17%	23%	18%
Excessive Alcohol Drinking	21%	18%	22%	18%
Alcahol-Impaired Deaths	35%	29%	32%	29%
Teen Births	24	29	16	17

Mental Health and Substance Use Disorders: Like access to care, mental health is a LHI for the HP-2020 objectives. Mental health and physical health are inextricably linked. Evidence has shown that mental health disorders—most often depression—are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions, including diabetes, hypertension, stroke, heart disease, and cancer[i]. Suicide is the tenth leading cause of death in the nation, and the national suicide rate increased by 19.5% between 2007 and 2016.

Mental Health and Substance Use Disorders | Suicide and Depressive Disorders: Suicide rates also tend to be higher in rural areas than in urban settings. Of significant concern, the suicide rate per capita in Butte County is elevated to nearly twice that of California overall (18.1 vs. 10.4 per 100,000 population); and likewise elevated above the HP-2020 objective (10.2). This is especially alarming when viewed in the context of Butte County's co-occurring elevated metrics for drug induced deaths and excessive alcohol use; as nationally drug induced and alcohol related deaths in combination with suicide, collectively referred to as deaths of despair, have resulted in decreasing life expectancy in the United States since 2015. Rates of depressive disorders, a strong risk factor for suicide, also appear to be elevated in Butte County. Twenty-seven percent of BRFS respondents in Butte County indicated having been diagnosed with a depressive disorder, compared to 17% statewide, and 20% nationwide. Focus groups also overwhelmingly felt mental health was a top community health priority in Butte County, with 69% of total focus group participants ranking mental health as a very important community health priority area. The finding that all of Butte County meets HRSA Mental

Health Professional Shortage Area criteria highlights a disparity between the populations need for mental health services and the current capacity of the county's healthcare delivery system to meet this demand.

Mental Health and Substance Use Disorders | Opioid Use and Excessive Drinking: Substance use disorders are defined as both mental health disorders and chronic diseases. The American Society of Addiction Medicine defines addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry". The development of substance use disorders are often preceded by substance misuse, such as taking an opioid medication other than how it was prescribed before meeting criteria for opioid use disorder, or escalating episodes of excessive alcohol consumption before meeting criteria for alcohol use disorder. Across focus groups, 50% of the 88 total participants indicated substance misuse and substance use disorders to be a top community health concern.

The ongoing opioid epidemic continues to be the leading driver of drug-induced deaths nationally. In Butte County, the age-adjusted drug-induced death rate continues to be significantly elevated compared to the statewide rate (30.2 vs. 12.2), with Butte County holding the 5th highest rate out of California's 58 counties. In 2017, mortality attributed exclusively to opioids (e.g. no other class of substances detected) in Butte County was 7.6 per 100,000 population compared with a statewide rate of 5.23; and the rate of hospitalizations for opioid overdose were the highest of all California counties, with 40.3 hospitalizations due to opioids other than heroin per 100,000 population compared to 7.75 statewide; and a rate of 9.95 hospitalizations due to heroin compared to 1.78 statewide. Also, of significant concern is that according to the California Healthy Kids Survey (CHKS), 21% percent of Butte County 11th grade students have used prescription drugs recreationally, compared with 16% of 11th grade students statewide.

Excessive alcohol consumption—which includes binge drinking (4 or more drinks for women and 5 or more drinks for men within about 2 hours); heavy drinking (8 or more drinks a week for women and 15 or more drinks a week for men); and any drinking by pregnant women or those under 21 years of age, is responsible for 88,000 deaths in the United States each year. These include 1 in 10 deaths among working age adults (age

20-64 years), and in 2010, the estimated economic cost to the United States of excessive drinking was $249 billion. Binge drinking accounts for over half of the deaths and three-fourths of the economic costs due to excessive drinking. The most recently available data from the CDPH Safe and Active Communities Branch demonstrates that in Butte County, rates of emergency department treatment, non-fatal hospital admissions, and deaths due to alcohol were all considerably higher than statewide rates (1011.1 vs. 763.8 per 100,000; 306.6 vs. 143.4; and 16.2 vs. 11.9, respectively). Likewise, 42.5% of adult CHIS respondents in Butte County reported binge drinking, relative to 34.7% statewide. This discrepancy was further supported by the results of the BRFS, with 22.1% of Butte County respondents reporting binge drinking compared with 17.6% of respondents statewide. A similarly concerning trend among adolescents was demonstrated by the CHKS, with 20% percent of Butte County 11th grade students reporting binge drinking, compared with 11% of 11th grade students statewide.

Chronic Disease and Conditions: Chronic diseases and conditions such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States, accounting for 7 out of 10 deaths annually. They are also leading drivers of the nation's $3.3 trillion in annual health care costs, with 90% of healthcare dollars spent in the United States attributed to the treatment of people with chronic physical and mental health conditions[ii]. In Butte County, like the nation and the state, many of the leading causes of death are chronic conditions including heart disease and stroke, cancers, Alzheimer's disease, chronic lower respiratory disease. chronic liver disease, and diabetes. While the mortality rate was only higher for Butte County than the statewide and national rates for some chronic diseases and conditions (cancer, Alzheimer's disease, chronic lower respiratory disease, and chronic liver disease), (See Table X1); all chronic conditions result in substantial portions of health care spending in Butte County. A 2015 study estimated that over 51% of the $1.4 Billion total annual healthcare expenditures in Butte County could be attributed to six chronic conditions (arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression), while 42.% of total statewide healthcare expenditures could be attributed to these conditions (see Table X2). Forty-eight percent of total focus group participants in Butte County indicated chronic disease and conditions to be a significant community health concern, and 45.5% indicated

overweight/obesity, a predictive factor for many chronic diseases, to likewise be a top health concern. While most chronic conditions are of significant concern in Butte County, some emerged with greater emphasis including cancer, Alzheimer's disease, asthma, chronic lower respiratory disease, and chronic liver disease.

Chronic Disease and Conditions | Cancer: The age-adjusted death rate for cancer was significantly higher in Butte County than the statewide rate, with 162.2 and 140.2 deaths per 100,000 population, respectively. The five-year incidence rate for cancer from 2011 – 2015 was also elevated relative to the state rate at 452.4 and 395.2 cases per 100,000 population, respectively. These trends generally held for most forms of cancer, including lung, female breast, and colorectal cancers. The BRFS also indicated higher rates of cancer, with 8.4% of Butte County respondents reporting having ever been diagnosed with cancer (other than skin cancer), compared with 5.9% of survey respondents statewide.

Chronic Disease and Conditions | Alzheimer's Disease: The age-adjusted death rate for Alzheimer's disease was also significantly higher in Butte County than the statewide rate, with 51.1 and 34.2 deaths per 100,000 population, respectively.

Chronic Disease and Conditions | Asthma: In Butte County 9.7% of Medicare beneficiaries have been diagnosed with asthma, which is higher than the percentage of Medicare beneficiaries diagnosed statewide (7.5%). Results of the CHIS also demonstrate that slightly more adults in Butte County have been diagnosed with asthma than adults statewide (15.0% vs. 14.5%); while 18.3% of Butte County BRFS respondents indicated having ever been diagnosed with asthma, relative to 14.1% of statewide respondents; and 11.8% of Butte County respondents reported currently having asthma relative to 7.9% of statewide respondents.

Chronic Disease and Conditions | Chronic Lower Respiratory Disease: The age-adjusted death rate for chronic lower respiratory disease was significantly higher in Butte County than the statewide rate, with 45.8 and 32.1 deaths per 100,000 population, respectively. The BRFS also indicated higher rates of chronic obstructive pulmonary disease (COPD) – a type of chronic lower respiratory disease, with 7.1% of Butte County

respondents reporting having ever been diagnosed with COPD, compared with 4.5% of survey respondents statewide.

Chronic Disease and Conditions | Chronic Liver Disease: The age-adjusted death rate for chronic liver disease was significantly higher in Butte County than the statewide rate, with 18.4 and 12.2 deaths per 100,000 population, respectively.

Table X-2: Mortality Rates for Chronic Diseases and Conditions

Age-adjusted death per 100,000	Butte County	California	HP-2020	Rank out of 58 CA
All Causes	765.3	608.5	a	46
All Cancers	162.2	140.2	161.4	49
- Lung Cancer	37.7	28.9	45.5	49
- Female Breast Cancer	21.2	19.1	20.7	46
- Prostate Cancer	19.4	19.6	21.8	24
- Colorectal Cancer	15.7	12.8	14.5	54
Coronary Heart Disease	85.8	89.1	103.4	28
Alzheimer's Disease	51.1	34.2	a	55
Chronic Lower Respiratory Disease	45.8	32.1	a	42
Cerebrovascular Disease (Stroke)	39.3	35.3	34.8	39
Diabetes	18.9	20.7	b	26
Chronic Liver Disease & Cirrhosis	18.4	12.2	8.2	45

Adapted from: California Health Status Profiles, 2018. Available at: https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profi.aspx#pasteds

Table X-3: Healthcare costs with six chronic conditions

Healthcare costs	Total healthcare	Total cost of six chronic	Percent of total

	costs		conditions		healthcare costs due to six conditions	
Butte County	$1,372,360,000		$625,045,759		50.8%	
California	$232,390,177,528		$98,443,138,663		42.4%	
Percent of total healthcare costs	**Arthritis**	**Asthma**	**Cardiovascular disease**	**Diabetes**	**Cancer**	**Depression**
Butte County	7.78%	4.55%	19.99%	5.27%	7.95%	5.26%
California	6.16%	4.06%	16.13%	5.59%	6.01%	4.41%

Adapted from: Brown, P.M., et al. (2015). Economic Burden of Chronic Disease in California 2015. CA Department of Public Health. Sacramento, California:. http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1600

Chronic Disease and Conditions | Other Notable Chronic Condition: Butte County had a slightly higher age adjusted death rate than the statewide rate for stroke (39.3 vs. 35.3 per 100,000 population). Likewise, a slightly higher percentage of Butte County BRFS respondents (3.3%) reported having ever had a stroke than statewide respondents (2.2%). Approximately one-third (32.2%) of Butte County respondents also reported having high blood pressure, which was slightly higher than for statewide respondents (28.4%). A 2016 UCLA Center for Health Policy Research study estimated the percent of adults in Butte County that are pre-diabetic (43%) was slightly lower than the statewide estimate (46%), and a lower percentage Butte County CHIS respondent reported being diagnosed with diabetes than statewide respondents (7.4% vs. 9.3%). This discrepancy was also found in BRFS results (7.0% vs. 10.5%); however, a slightly higher percentage of CHIS respondents age 65 and over from Butte County were diagnosed with diabetes than the percent of respondents statewide (23.5% vs. 21.4%). Major risk factors for the development of chronic conditions and premature death include being overweight/obese and smoking tobacco products. While the percent of adult CHIS respondents that reported being overweight or obese was marginally lower in Butte County than statewide (60.3% vs. 61.5%), the percent of Butte County BRFS respondents that indicated having no physical activity in the past 30 days was higher than the percent of statewide respondents (28.5% vs. 20.0%); and significantly more Butte County respondents indicated being current smokers than statewide respondents (20.6%

vs.11.3%).

Conclusion and Action Plan

Once the health needs were prioritized by the Orchard Hospital Administration team and Board of trustees, the final step in the CHNA process was to develop an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified. This strategy will include a written plan that addresses each of the community health needs identified through the CHNA, describe how the hospital plans to meet the health needs, and identify health needs the hospital does not intend to meet and why.

The following implementation strategy components within each priority were addressed:

1. Objectives/Strategy
2. How
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 6. In summary, the following priorities were addressed through the implementation strategy:

- Access to Care
- Mental Health and Substance Use Disorders
- Chronic Disease and Conditions

The implementation strategy detail for each priority is located in Appendix ___ and provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration.

Supporting Documents

Community Engagement
Community Health Needs Assessment
Survey

Community Engagement- Survey

Orchard HOSPITAL
Growing Healthy Communities

Please take a moment to complete the survey below. The purpose of this survey is to seek your input regarding community health problems in south Butte County. Orchard Hospital will use the results of this survey to identify and take action of community needs.

1. Where do you go for routine healthcare?
   _____ Primary care physician
   _____ Urgent Care
   _____ ER
   _____ Other
   _____ None

2. Are there issues that prevent you from accessing healthcare?
   _____ Language barriers
   _____ Don't know how to find doctors
   _____ No insurance
   _____ Other barriers
   _____ No barriers

3. In the following list, what do you think are the three most important factors for a "Healthy Community?"
   Check only three:
   _____ Good place to raise children
   _____ Low crime / safe neighborhoods
   _____ Low level of child abuse
   _____ Good schools
   _____ Access to health care (e.g., family doctor)
   _____ Parks and recreation
   _____ Arts and cultural events
   _____ Good jobs and healthy economy
   _____ Strong family life
   _____ Healthy behaviors and lifestyles
   _____ Low death and disease rates
   _____ Religious or spiritual values
   _____ Other_____

4. In the following list, what do you think are the three most important "health problems" in our community? (Those problems which have the greatest impact on overall community health.)
   Check only three:
   _____ Aging problems
   _____ Cancer
   _____ Child abuse / neglect
   _____ Dental problems
   _____ Diabetes
   _____ Domestic Violence
   _____ Firearm related injuries
   _____ Motor vehicle crash injuries
   _____ Respiratory / lung disease
   _____ Suicide
   _____ Heart disease and stroke
   _____ High blood pressure
   _____ HIV / AIDS
   _____ Homicide
   _____ Death
   _____ Infectious Diseases (e.g., Hepatitis, TB, etc.)
   _____ Mental health issues
   _____ Rape / sexual assault
   _____ Other _____

P.O. Box 97 | 240 Spruce Street | Gridley, California 95948
(530) 846-9000 | Fax (530) 797-3522
www.OrchardHospital.com

5. In the following list, what do you think are the three most important "risky behaviors" in our community? (Those behaviors which have the greatest impact on overall community health.)
Check only three:

_____ Alcohol abuse
_____ Being overweight
_____ Dropping out of school
_____ Drug abuse
_____ Lack of exercise
_____ Poor eating habits
_____ Not getting "shots" to prevent disease
_____ Tobacco use
_____ Not using birth control
_____ Not using seat belts / child safety seats
_____ Unsafe sex
_____ Other_____

6. How would you rate our community as a "Healthy Community?"
___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

7. How would you rate your own personal health?
___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

8. Approximately how many hours per month do you volunteer your time to community service?
___ None ___ 1 - 5 hours ___ 6 - 10 hours ___ Over 10 hours

9. Zip code where you live: _____

10. Age:
_____ 25 or younger
_____ 26-39
_____ 40-54
_____ 55-64
_____ 65 or over

11. Sex: Male___ Female___ Non Binary___ Other:_____

12. Ethnic group you most identify with:
_____ African American / Black
_____ Asian / Pacific Islander
_____ Hispanic / Latino
_____ Native American
_____ White / Caucasian
_____ Other _____

13. Marital Status:
_____ Married / co-habitating
_____ Not married / Single

14. Education:
_____ Some high school
_____ High school diploma or GED
_____ College degree or higher
_____ Other_____

15. Household income
_____ Less than $25,000
_____ $25,000 to $49,999
_____ $50,000 to $74,999
_____ Over $75,000

16. How do you pay for your health care? **(check all that apply)**
_____ Pay cash (no insurance)
_____ Private Health insurance
_____ Medi-cal
_____ Other _____
_____ Medicare
_____ Veterans Administration
_____ Indian Health Services

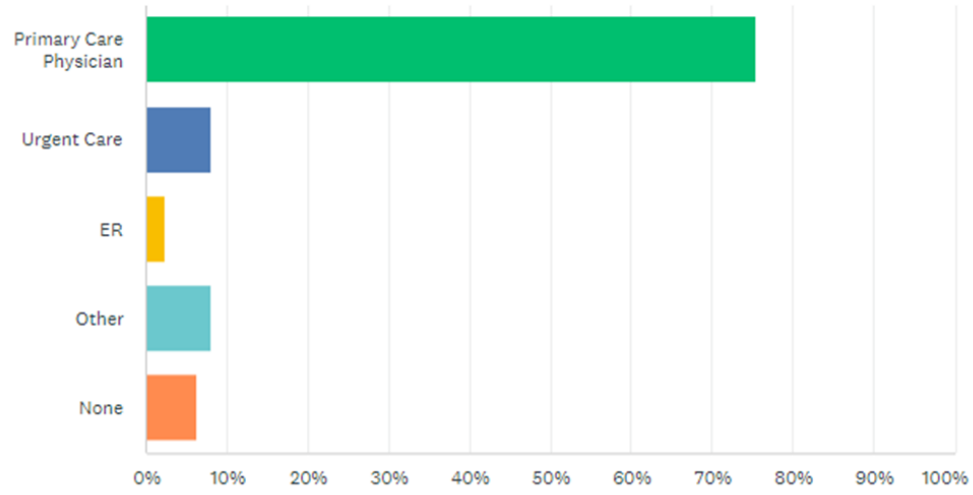
17. Where / how you got this survey: **(check one)**
_____ Church
_____ Community Meeting
_____ Grocery Store / Shopping Mall
_____ Mail
_____ Other _____
_____ Newspaper
_____ Newsletter
_____ Personal Contact
_____ Workplace

Supporting Documents

Community Health Needs Assessment
Survey Answers

Where do you go for routine healthcare?

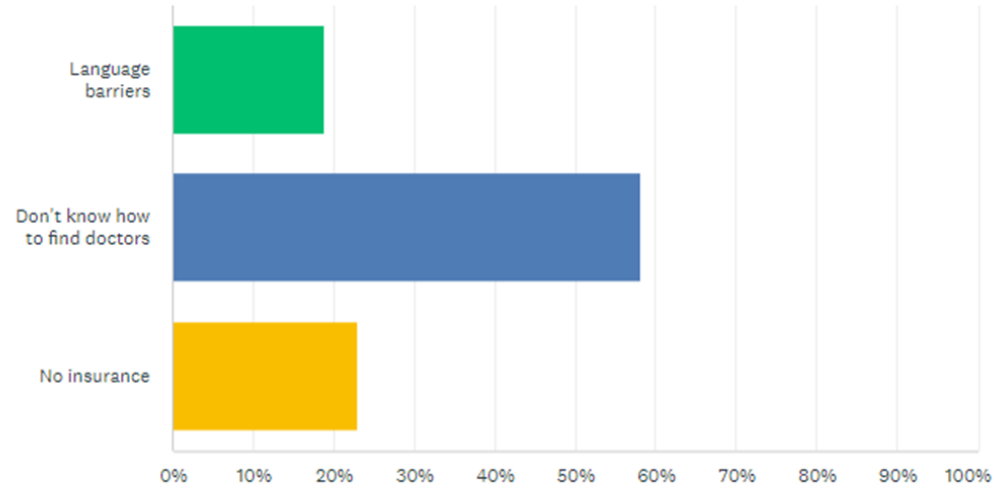
Answered: 288 Skipped: 2



Orchard Hospital Survey - Community Health Needs (0)

Are there issues that prevent you from accessing healthcare?

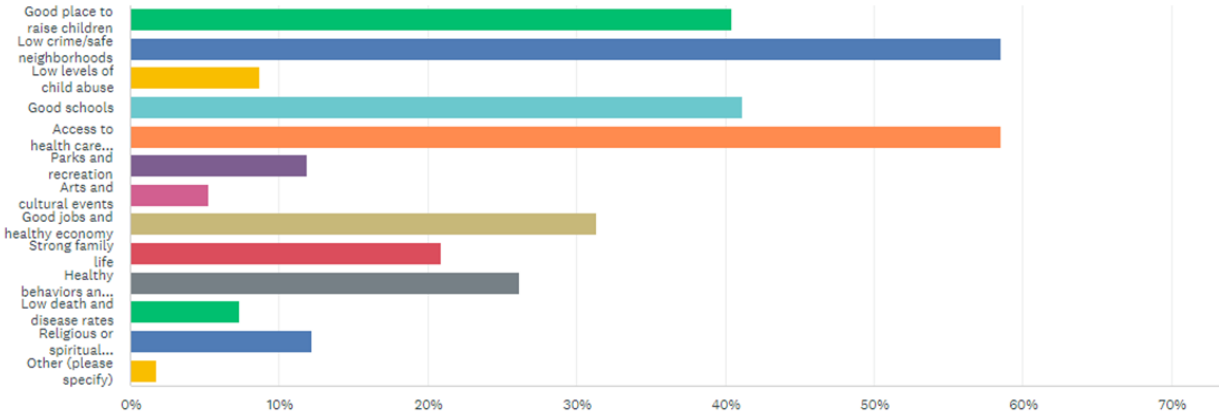
Answered: 74 Skipped: 216



Orchard Hospital Survey - Community Health Needs (0)

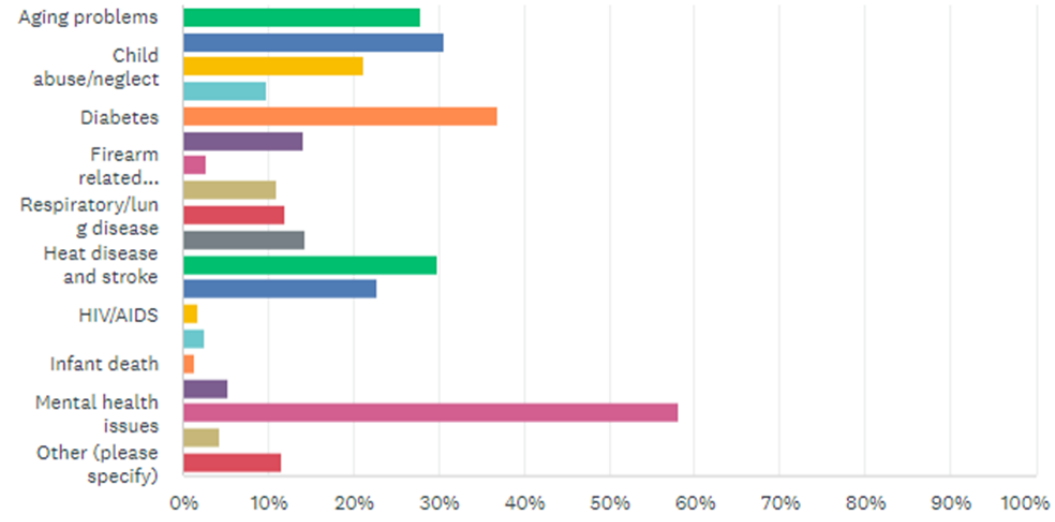
In the following list, what do you think are the three most important factors for a "Healthy Community?" (check only three)

Answered: 287 Skipped: 3



In the following list, what do you think are the three most important "...

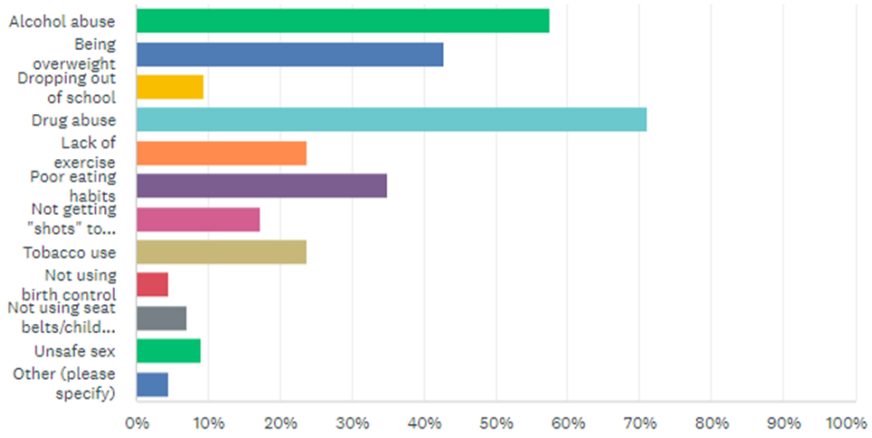
Answered: 284 Skipped: 6



Orchard Hospital Survey - Community Health Needs (0)

In the following list, what do you think are the three most important "...

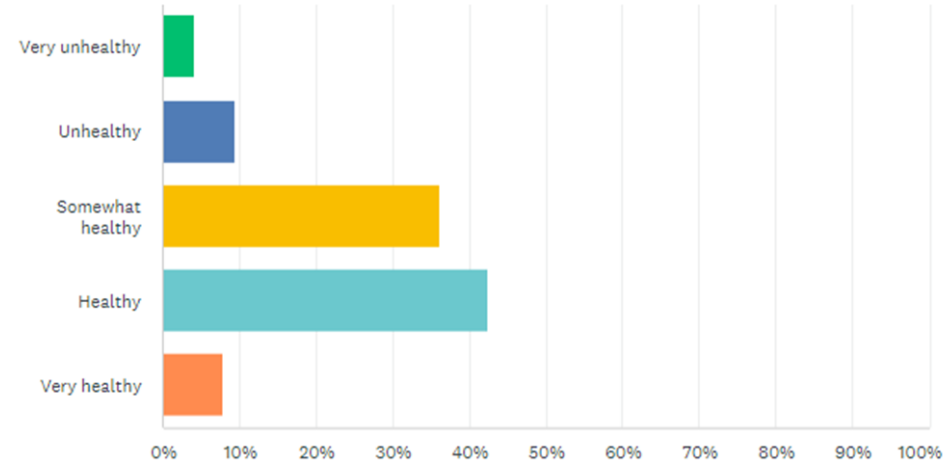
Answered: 266 Skipped: 24



Orchard Hospital Survey - Community Health Needs (0)

How would you rate your own personal health?

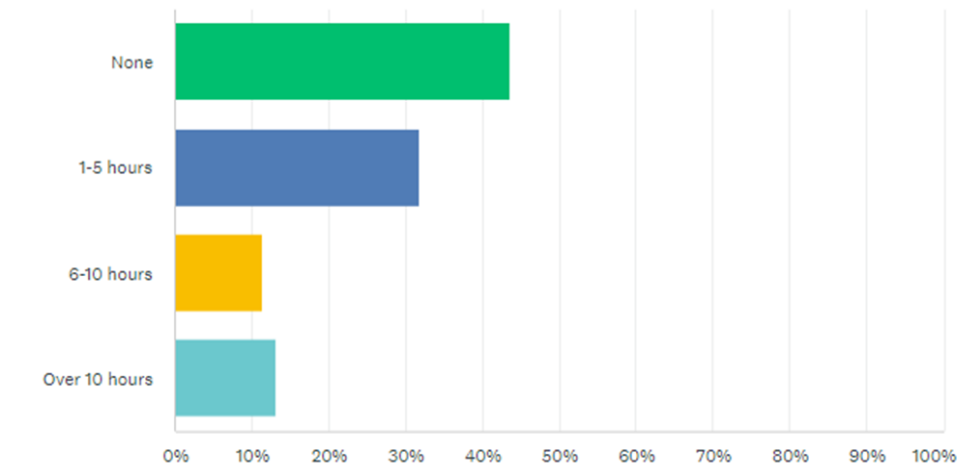
Answered: 266 Skipped: 24



Orchard Hospital Survey - Community Health Needs (0)

Approximately how many hours per month do you volunteer your tim...

Answered: 264 Skipped: 26



Orchard Hospital Survey - Community Health Needs (0)

What is the zip code where you live?

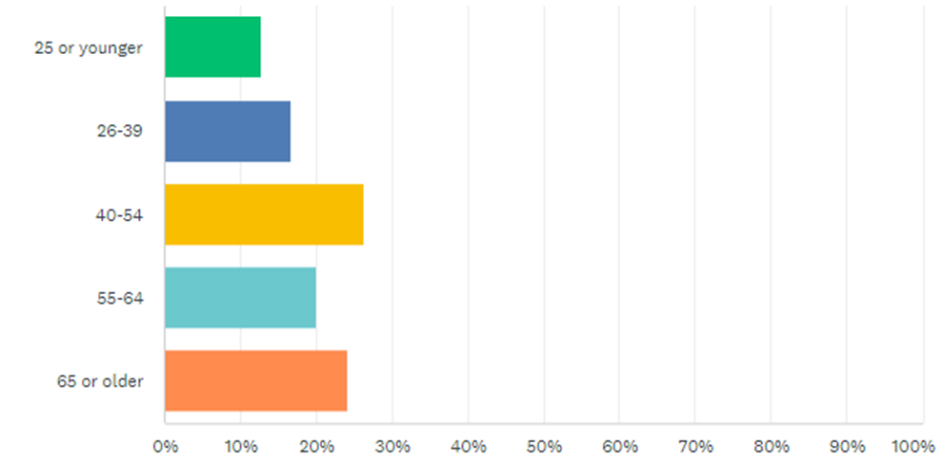
Answered: 250 Skipped: 40

95966
95948
95917
95966
95966
95965
95966
95966
95965

Orchard Hospital Survey - Community Health Needs (0)

How old are you?

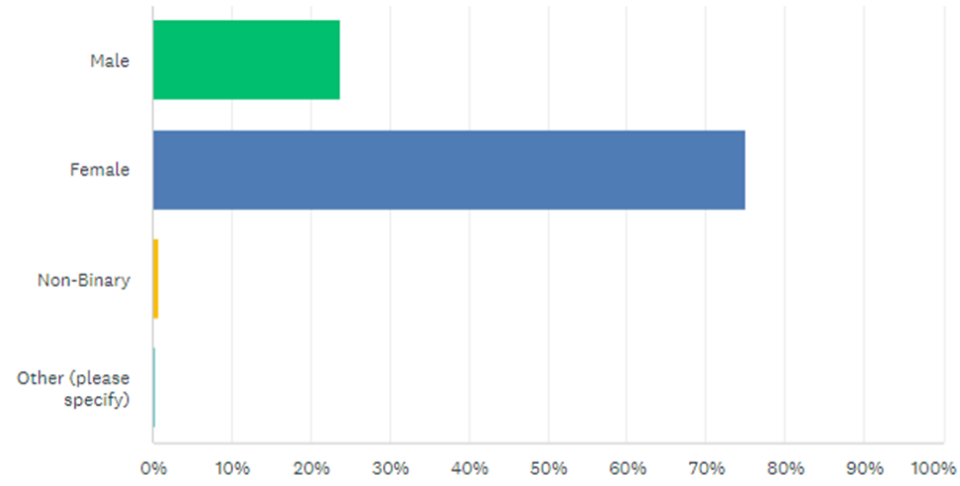
Answered: 265 Skipped: 25



Orchard Hospital Survey - Community Health Needs (0)

What is your gender?

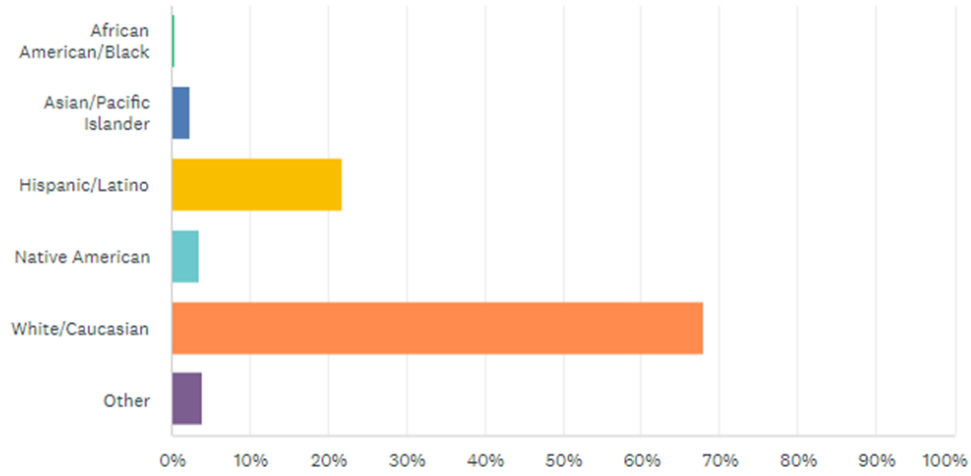
Answered: 232 Skipped: 58



Orchard Hospital Survey - Community Health Needs (0)

What ethnic group do you most identify with?

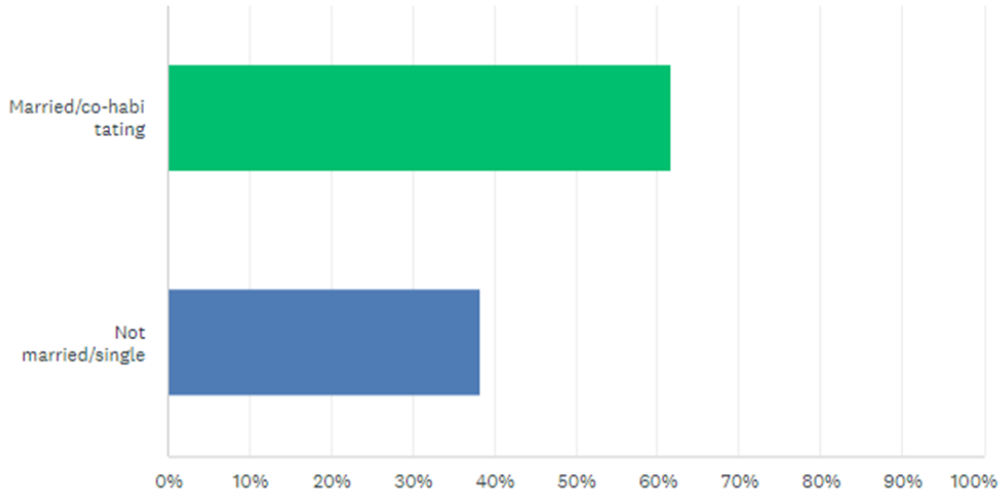
Answered: 253 Skipped: 37



Orchard Hospital Survey - Community Health Needs (0)

What is your marital status?

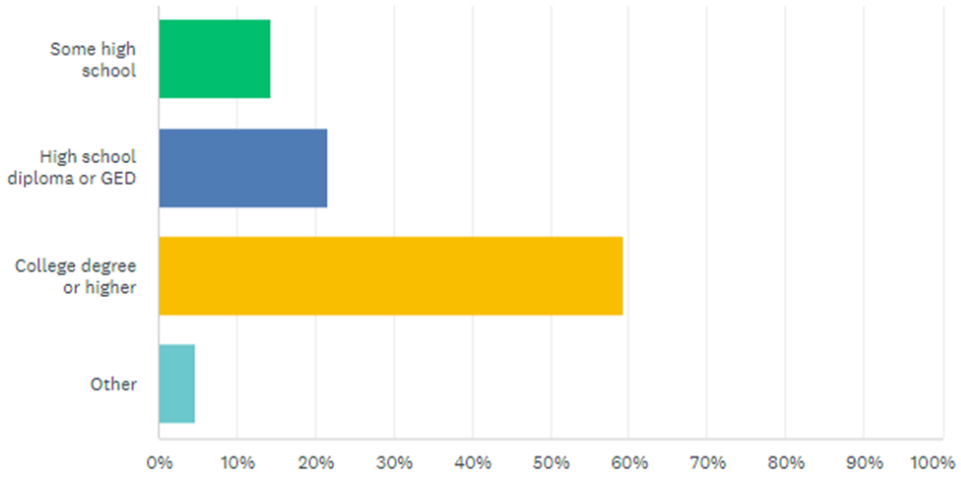
Answered: 259 Skipped: 31



Orchard Hospital Survey - Community Health Needs (0)

What is your highest level of completed education?

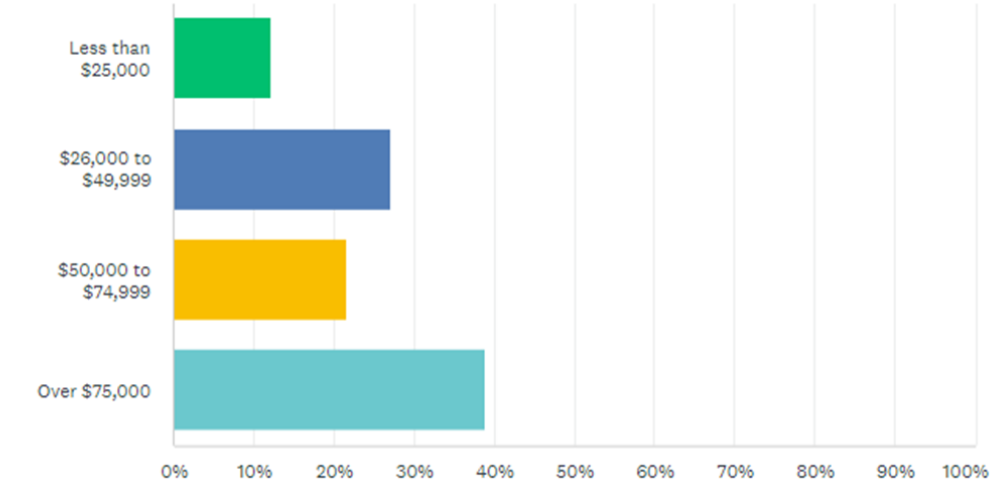
Answered: 231 Skipped: 59



Orchard Hospital Survey - Community Health Needs (0)

What is your annual household income?

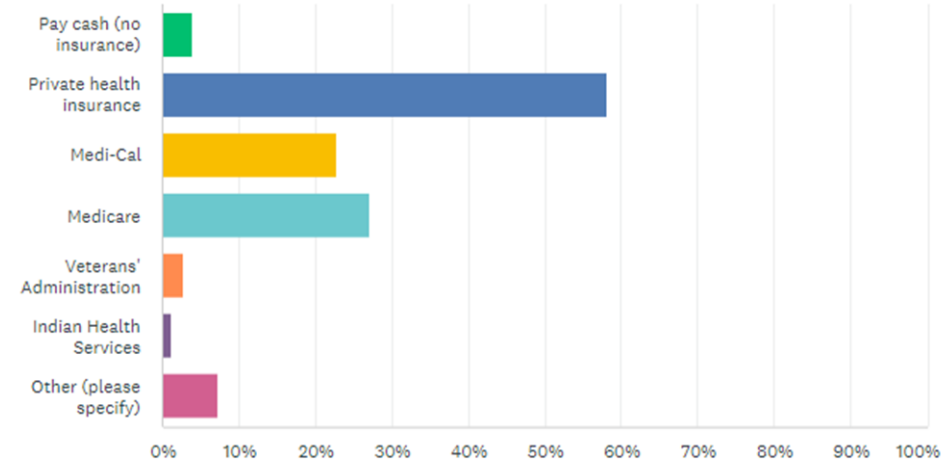
Answered: 254 Skipped: 36



Orchard Hospital Survey - Community Health Needs (0)

How do you pay for your healthcare? Check all that apply

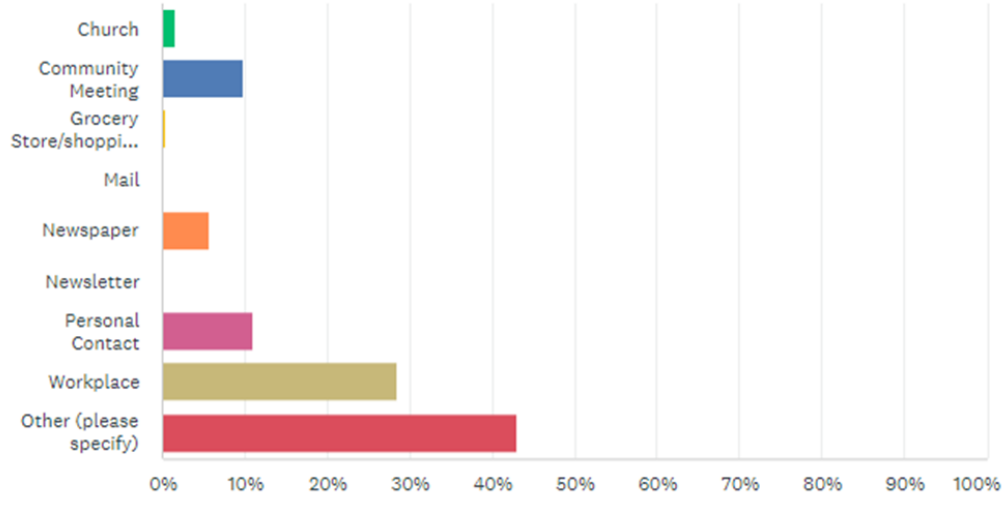
Answered: 251 Skipped: 39



Orchard Hospital Survey - Community Health Needs (0)

Where/how did you get this survey? Check one

Answered: 263 Skipped: 27



Orchard Hospital Survey - Community Health Needs (0)

Supporting Documents

Press Releases and Media Coverage

Orchard HOSPITAL

Growing Healthy Communities

Orchard Hospital Health Needs Survey

We need your help!

Results impact decisions that affect your health!

240 Spruce St., Gridley CA 95948 | (530) 846-9000 | orchardhospital.com

Appendix: 1

Implementation Plan

2022

Table of Contents:

Priority: Access to Health Care

Objective/Strategy

The lack of providers and not knowing how to find doctors in Butte County was the dominant theme reflected from responses to the survey. Improving access to healthcare was not just a matter of making it more affordable it is about the services and making them available in our area. Improving access to healthcare is the main focus of Orchard Hospital. Orchard Hospital will continue to offer Specialties and enhance our current service lines to help eliminate those needing to leave the area for healthcare.

How:

Improving access to healthcare services helps to ensure that patients have a usual and ongoing source of care (that is, a provider or facility where one regularly receives care). Patients with a usual source of care have better health outcomes, fewer disparities, and lower costs. We plan on improving this by:

- Improve access to healthcare by expanding care and services in Butte County.
    - Expand Services offered at the Gridley and Oroville Clinics
- Increase number of Providers at the Medical Specialty Centers
    - Hiring more providers with new specialty service lines
    - Providers that speak a second language
    - Increase number or Primary care providers (PCP)
        - Guiding patients to establish a PCP
- Timeliness:
    - Availability of appointments and care for illness or injury when it is needed
    - Time spent waiting in doctors' offices and emergency departments (EDs)
- Substance Use Navigator:
    - Offering Emergency Department and Inpatients access to Substance Use resources

- Free Flu and Covid-19 Vaccination clinics

- Collaborating with local health department to continue to offer Flu and Covid-19 Vaccinations

Priority: Mental Health and Substance Use Disorders

Objective/Strategy

Metal illness & Substance abuse ; including but not limited to alcohol, tobacco, illicit drugs and opioids, continue to rise toward the top of the pressing health needs facing Butte County residents. Orchard Hospital will continue to promote smoking cessation among young people and adults within our community in order to decrease the % of those who smoke or use smokeless tobacco. We will also continue to provide our community with a pain management provider, manage prescription pain medications, and provide mental health.

How

Upgrade website to include marketing of programs and services available throughout our community related to mental Health, Substance Use and the use of tobacco. Communicate services offered at Orchard Hospital through existing and new community marketing. Orchard Hospital employees will be encouraged to participate.

- Implement best-practices for managing prescription pain medications
- Implement Substance Use Navigator program in the Emergency Department
- Provide Continuing Medical Education (CME) for Butte County prescribing providers regarding prescription opioid misuse and abuse.
- Implement Orchard Hospital Adolescent Services Center
- Continue to offer Mental Health Services:
    - Senior Life Solutions
    - Family Licensed Therapist
    - Emergency Room offers Tele-Med Psychiatry

Priority: Chronic Diseases

Objective/Strategy

Enhance care for Chronic Diseases including, but not limited to obesity and diabetes

How

- Communicate service offered through local Service Clubs, Schools, Churches, and at Orchard Hospital through existing and new community marketing.
- Utilize the website and social media outlets to include marketing of programs and services available throughout our community for childhood obesity.
- Continue education through the Health Ambassador Program
  - GHS Nursing Pathway Students will be instructed on how to educate elementary students and junior high students on nutrition and fitness (play 60)
  - Orchard Hospital will be able to reaching children ages 9-18 in our service area
  - Educate on how to make healthy snacks and 60 min fitness activity.

Programs/Resources to Commit

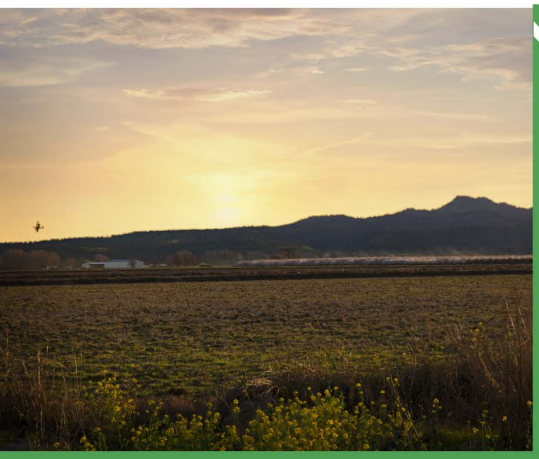
Collaborate with local schools and partner with school nurses and the Center for Nutrition & Activity Promotion. Offer nutritional and fitness program to local schools utilizing the play 60 activities and help children and young adults learn how to move for 60 minutes.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous Community Health Needs Assessment and annual implementation strategies were made widely available to the public on the website www.OrchardHospital.com . To date, no comments have been received.

2019
Community Health Needs Assessment

Orchard Hospital



2019

COMMUNITY

HEALTH

NEEDS
ASSESSMENT

Orchard
HOSPITAL

Growing Healthy Communities

Table of Contents

Mission, Vision, and Values

Our Mission

Growing Healthy Communities

Our Vision

Orchard Hospital will be a Health Center of Excellence, nationally recognized for providing quality, compassionate, and personalized care that improves the health and well-being of our patients and their communities.

Our Values

At Orchard Hospital, our governance and decision making will always be based upon integrity, respect, innovative processes, ethical foundations, and continual self-improvement.

H - Honesty and Integrity

We will make decisions with honesty and integrity that will ensure Orchard Hospital's future.

E - Engaged and Empowered Staff

We will hire staff that are engaged and empowered to make a positive difference in the lives of our patients and each other.

R - Responsive

We will respond to the needs of our community by implementing programs that align with our Community Health Needs Assessment (CHNA).

O - Outcomes-Driven

We will be recognized for having excellent outcomes for the services we provide at Orchard Hospital.

Growing Healthy Communities

Introduction

Orchard Hospital located in Gridley, California is a 501(c)(3) Critical Access Hospital offering 24 hour emergency services, inpatient, outpatient and rural health clinic services. Orchard Hospital is dedicated to always providing the finest personalized healthcare to North Valley communities by offering a wide range of integrated services, from prevention through treatment to wellness.

Orchard Hospital is the only acute care hospital in Gridley, as well as along Highway 99 between Sacramento and Chico, providing needed emergency and inpatient services.

Orchard Hospital is certified for 24 general acute care beds (4 Monitored Beds and 20 Unspecified General Acute Care).

SERVICES AVAILABLE

- Acute/Skilled Inpatient Care
- Cardiology
- Cardiopulmonary
- Emergency Services
- Geriatric Clinic Services
- Inpatient/Outpatient GeneralSurgery
- Laboratory Services
- Long Term Care
- Occupational Therapy
- Physical Therapy
- Primary and Specialty Clinic Services
- Radiology Services
- Speech Language Pathology
- Social Services

Rural Health Clinic Services

- DEXA Scanning
- Digital Mammography
- Digital Radiology
- Drug Screening
- Industrial Medicine
- Internal Medicine
- Interventional
- Laboratory
- MRI
- Nephrology
- Pain Management
- Pathology
- Physicals
- Physical Therapy
- Podiatry
- Psychotherapy
- Ultrasound
- Workers Comp

OrchardHospital.com

@ORCHARDHOSPITAL

Orchard Hospital
240 Spruce Street
Gridley, CA 95948

(530)846-9000

Purpose and Overview of the Community Health Needs Assessment

Under the Affordable Care Act, hospitals throughout the country are required to conduct a Community Health Needs Assessment (CHNA) every three years.

The primary purpose of conducting a CHNA is to objectively look at the current health needs of a community, as well as the existing resources available to address those needs, then prioritize the unmet health needs and create an action plan to address them in the coming years. In Butte County, this has been a comprehensive and collaborative project, bringing together Orchard Hospital, Enloe Medical Center, Adventist Health Feather River, and Butte County Public Health.

Using the community feedback and health data gathered, the resulting response and action plan will help shape programs over the next three years

Report Adoption, Availability, and Comments

This CHNA report was adopted by the Orchard Hospital Board of Directors on November 2019.

This report is widely available to the public on the hospital's web site, www.orchardhospital.com. Written comments on this report can be submitted to llittle@orchardhospital.com.

2016 CHNA Response

In 2016, Orchard Hospital partnered with Butte County Public Health and the three other hospitals in our county to conduct the Community Health Needs Assessment. The outcome was an action plan that focused our community outreach efforts on three main areas affecting community health:

- Social determinants of health
- Chronic diseases
    - Obesity
    - Diabetes
- Substance abuse and mental illness

Orchard Hospital is committed to identifying opportunities to collaborate with community partners throughout the region to break down barriers associated with these pressing health and social needs as well as providing the education and other tools members of our community need to be proactive in their health and lifestyle choices.

Action Plan and Results from the 2016 Community Health Needs Assessment:

Social Determinates of Health:

The Centers for Medicare and Medicaid Services promotes the concept of an accountable healthy community model for addressing social needs that can improve health outcomes and reduce costs. Orchard Hospital will continue fostering relationships throughout the community that support this model and promote connections between community members and essential services such as access to healthy foods, transportation, safe living environments, etc.

Response - Through community partnerships and outreach events such as Orchard Hospital's annual community health fair and other health education programs, we increased awareness and access to necessary support services. Programs and activities included:

- Orchard Hospital Health Ambassador Program
    - Educating youth on healthy eating options and fitness goals.
- Orchard Hospital Case Management
    - Offering support services for patients and family members during their inpatient status and following discharge.
- Center for Healthy Communities, CalFresh Outreach Program
    - Nutrition education and CalFresh
    - Referrals to food benefits for qualified individuals
- Help Central Inc./Butte 2-1-1
    - Community resource database and referral assistance
- California Health Care Options
    - Education and enrollment support for Medi-Cal benefits
- Passages
    - Education and enrollment support for Medicare benefits

Chronic Disease:

Butte County residents have a higher than average incidence of chronic conditions including adult/childhood obesity, chronic obstructive pulmonary disease (COPD, asthma), and depression. Addressing the unmet social needs and influencing the health of the community is one way in

which we can work to lower the incidence of these chronic conditions. There is also the expressed need for one-on-one, inpatient, outpatient, and community education to empower individuals to take charge of their health and move toward wellness.

Response- Throughout the last three years, Orchard Hospital has hosted community health education programs and provided opportunities for individuals to learn directly from health care professionals in the specialty areas linked to top identified health needs.

In addition to facilitating physician-community engagement opportunities through community events, Orchard Hospital was able to create a new program called Accessible Intervention Respiratory Education program (AIRE). This program was designed to assess and monitor disease, reduce risk factors, manage stable COPD, and manage exacerbations. We were able to teach our community members suffering from lung disease about living a healthier and active lifestyle with minimal exacerbations.

Orchard Hospital partnered with Gridley Unified School District to offer the Health Ambassador Program to help curb and prevent childhood obesity. Through weekly P.E. classes, Health Science Pathway students from Gridley High School mentored middle school and elementary-aged children about the importance of nutrition and fitness. The Health Ambassadors taught 15-20 minute nutritional lessons using MyPlate and provided a healthy snack along with a 25-minute fitness lesson from play 60.

Orchard Hospital will continue extending our reach and impact in high need areas through collaboration, partnerships, and support of programs including:

- Center for Healthy Communities
- Gridley Unified School District
- Diabetes Prevention Education
- Nutritional Counseling
- MyPlate Education
- AIRE Program
- Orchard Hospital Senior Life Solutions
- Psychotherapy

Substance Abuse & Mental Illness:

Mental illness and substance abuse; including alcohol, tobacco, illicit drugs, and prescription opioids, continue to rise toward the top of pressing health needs facing Butte County residents. In

our region, nearly one-third of youth and adults struggle with mood disorders, such as depression, and roughly 20% of youth and adults experience a form of substance use disorder.

Feedback from participants in the focus group discussions called for a community-wide focus on prescription overdose problems, easy access to safe disposal of medications, and a need to educate youth on the consequences of flavored tobacco, vaping, e-cigarettes, and nicotine. Orchard Hospital partnered with local programs, agencies, coalitions, and task-forces dedicated to addressing these needs.

Response: Orchard Hospital offers easy access for safe disposal of medications and syringes.

Orchard Hospital implemented best-practices for managing prescription pain medications by hiring an integrated pain management physician to help provide additional approaches to pain management. Orchard Hospital is also providing Continuing Medical Education (CME) for Butte County prescribing providers regarding prescription opioid misuse and abuse.

Orchard Hospital created a program called Senior Life Solutions. This program helps individuals suffering from depression, anxiety, loss/grief, trauma, life transition, and other mild to moderate forms of psychiatric issues. We will continue to grow this program to serve our geriatric patients better.

In the spirit of an accountable health community model, Orchard Hospital will continue collaborating, partnering with and supporting other programs and organizations to extend our reach and impact in high needs areas including:

- Butte County Behavioral Health
- Butte County Drug Abuse Prevention Task Force
- Butte County Tobacco Prevention Coalition
    - Smoking Cessation
- Orchard Hospital Pain Management Doctor
- Orchard Hospital Senior Life Solutions
- Psychotherapy

Representatives from these areas span health care, law enforcement, treatment providers, pharmacists, educators, advocates, and community members at large. Together, we provide educational opportunities and develop and promote policy changes to improve contributing factors such as density of retail alcohol and tobacco establishments, public smoking (including the use of vaping devices), and substance use among youth.

A Commitment to Our Community

Work on the 2019 Butte County Community Health Needs Assessment (CHNA) began in the Spring/Summer of 2018 with the convening of core partners who share a common service area: Butte County Public Health, Orchard Hospital, Enloe Medical Center, and Adventist Health Feather River Hospital. This collaborative effort has reduced redundancies and increased data collection efficiency. Of note, the most destructive wildfire in California's history, the Camp Fire, interrupted these collaborative CNHA efforts in the Fall of 2018 through the Spring of 2019; which dramatically affected Butte County across a myriad of health care delivery system factors and community health determinants. The full impact of natural disaster has had on the community's health will not be evident for some time, and the results of the current assessment do not adequately address them.

Prioritization Process

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine the size or severity of the problem, the health need indicators identified in the secondary data were measured against benchmark data from county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs that compared unfavorably against one or more of the benchmarks met the "health need" criteria.

The list of significant health needs informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs, and discover gaps in resources. Community focus groups and stakeholder interviews were used to gather input and prioritize the significant health needs.

Top priorities identified in partnership with our communities:

Community stakeholders were asked to rank order the significant health needs according to the highest level of importance in the community.

- Access to Care
- Mental Health
- Substance Use Disorders
- Chronic Conditions
- Adverse Childhood Experiences and Childhood Maltreatment
- Dental health
- Overweight & obesity
- Transportation
- General Health

From 2020-2022, Orchard Hospital will address the following health needs through a commitment of community programs and resources.

Lead members of the collaborative team include:

Orchard Hospital | Lyndi Little Wallace, Director of, Physician Recruitment, Marketing & Community Outreach

Enloe Medical Center | Suzie Lawry-Hall, Community Outreach Coordinator

Adventist Health Feather River Hospital | Paul Sandman, Senior Community Integration Analyst Mission Integration

Butte County Public Health | Gene Azparren, Program Manager, Accreditation, and Sandy Henley, MS, MHPA, Public Health Epidemiologist

Service Area

Orchard Hospital is located at 240 Spruce St., Gridley, CA 95948. The service area includes four communities consisting of 5 ZIP Codes in Butte County.

Orchard Hospital Service Area

ZIP Code	Place
95948	Gridley
95917	Biggs
95974	Richvale
95965	Oroville
95966	Oroville

Community Profile

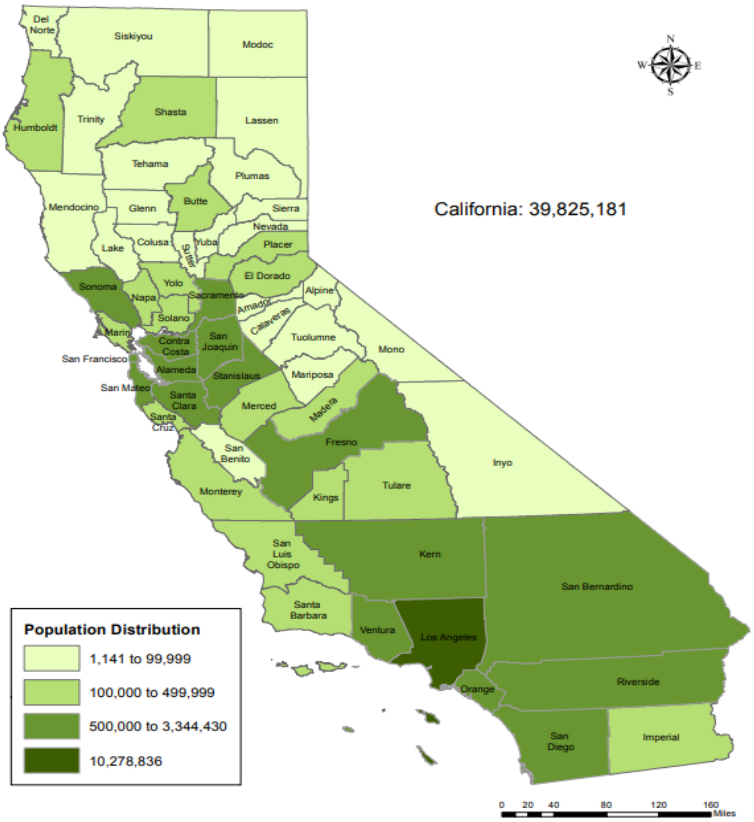


Figure 1: Population distribution

Source: State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year, July 1, 2010-2018. Sacramento, California, December 2018

Butte County is in the northern portion of the Sacramento Valley Region of North Central California and encompasses approximately 1,677 square miles, of which 1,636.5 square miles are land, and 41 square miles are water. According to the 2018 California Department of Finance County Population State and County Population Estimates, California's population is 39,825,181, and Butte County is ranked the 27th largest county with a population of 227,837 (see Figure 1).

Population estimates for California have increased every year since 2010. Butte County estimates have also increased every year since 2010. California had an average estimated increase in population of 0.8% each year while Butte County's population estimates increased by an average of 0.4% each year (see Table 1).

Table 1: Population of Butte County and California, 2010-2013

	Butte County		California	
	Number	Percent	Number	Percent
2010	220,202	-	37,334,578	-
2011	220,636	0.20%	37,678,534	0.92%
2012	221,823	0.54%	38,045,271	0.97%
2013	222,541	0.32%	38,425,695	1.00%
2014	223,978	0.65%	38,756,940	0.86%
2015	224,533	0.25%	39,076,128	0.82%
2016	225,094	0.25%	39,328,337	0.65%
2017	226,661	0.70%	39,610,556	0.72%
2018	227,837	0.52%	39,825,181	0.54%

Source: State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year — July 1, 2010–2018, December 2018

Age and Gender

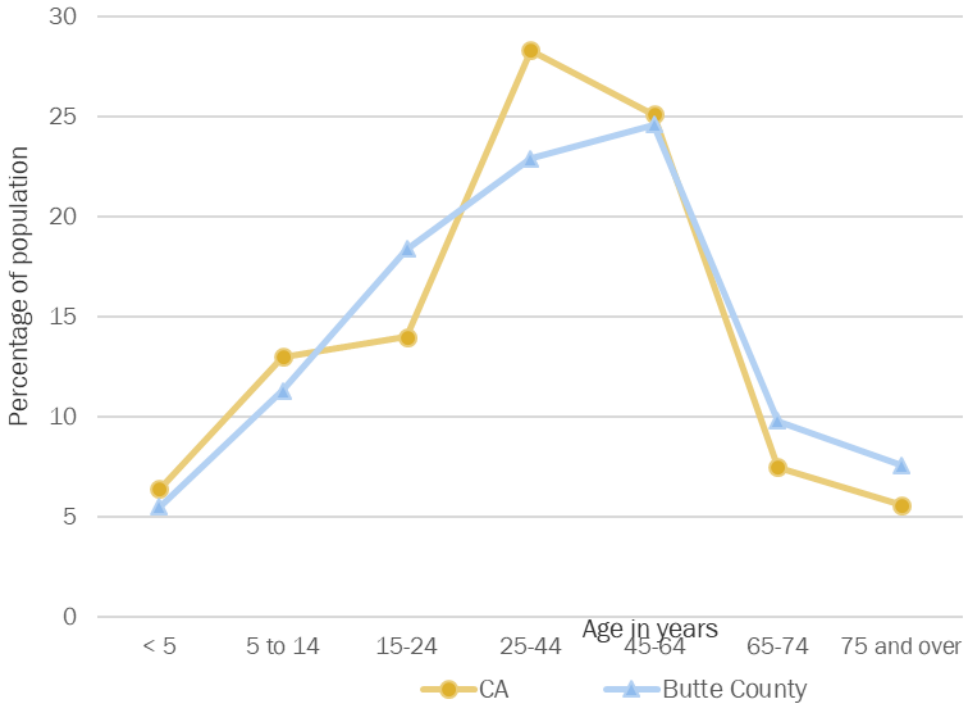


Figure 2: Population by age group: Butte County and. California, 2013-2017

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0101

The population of Butte County is slightly older than the population of California. The median age in Butte County is 36.9 years old compared to California, which is 36.1 years old1. Butte County has a higher percentage of individuals, ages 15 to 24 years old, and seniors, over the age of 65 years old, but a lower percentage of adults, ages 25 to 64 years old, when compared to California (see Figure-2).

The population increase has been steady in Butte County with an increase between 2015 and 2017 of 3,883 (1.7%) people. As predicted in a growing population, many age groups had increasing numbers. Exceptions included children under age 5, which remained unchanged in population; and decreases in the number of school-age children, between the ages of 5 and 9, young teens, between the ages 10 and 14, and teens and young adults, between the ages 15 and 24 (see Table 2).

[1] U.S. Census Bureau, 2013-217 American Community Survey 5-Year Estimates, Table S0101

Table 2: Age distribution in Butte County, 2015-2017					
	2015		2017		Trend, 2015-2017
	Number	Percent	Number	Percent	
Total population	225,411		229,294		↑
Under 5 years	12,172	5.4%	12,387	5.4%	↔
5 to 9 years	15,103	6.7%	14,888	6.5%	↓
10 to 14 years	11,045	4.9%	10,780	4.7%	↓
15 to 24	41,025	18.2%	40,138	17.5%	
25 to 64	106,394	47.2%	109,678	47.9%	
65 to 84	33,586	14.9%	35,887	15.6%	
85 and over	5,635	2.5%	5,536	2.6%	

Source: U.S. Census Bureau, 2015 and 2017 American Community Survey 1-Year Estimates. Table-S0101-age and sex

In 2017, the distribution of males to females in Butte County was similar to that of California (see Table 3). Although there are more females than males in Butte County, men (67%) outnumber women (64.7%) among working-age adults, ages 15 to 64 years old. For seniors, ages 70 and over, there is a greater percentage of females (13%) compared to males (10.1%).

Table 3: Gender distribution in Butte County, 2017				
	Butte County		**California**	
	Number	Percent	Number	Percent
Male	113,399	49.5%	19,650,051	49.7%
Female	115,895	50.5%	19,886,602	50.3%

Source: U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates. T-S0101 - age and sex

Race and Ethnicity

Based on the U.S. Census Bureau there are seven major race and ethnicity categories: African American/Black, American Indian/Alaska Native, Asian, Hispanic/Latino, Native Hawaiian/Pacific Islander, White, and other. In addition, an individual may identify as belonging to two or more races, and an individual who identifies as being Hispanic/Latino may identify as belonging to any race. These race and ethnicity categories are self-determined, meaning that individuals identify their own race or ethnicity in the census. *Race* refers to groups of people who have differences and similarities in biological traits deemed by society to be socially significant, addition, a lower percentage of Butte County residents spoke Spanish at home than residents of California (see Table 5).

Table 5: Language other than English spoken at home				
	Butte County		**California**	
Language at home, ages 5 to 17 years				
English only	85.6%	185,707	55.6%	20,596,574
Spanish	9.0%	19,495	28.9%	10,698,137
Other	5.4%	11,705	15.6%	5,781,517
Language at home, ages 18 years and over				
English only	88.3%	155,805	64.4%	16,526,703
Spanish	7.1%	12,465	21.3%	5,455,874
Other	4.6%	8,171	14.3%	3,667,878

Source: 2017 American Community Survey 1-Year Estimates. Table S1601

Most people over the age of 5 in Butte County spoke only English at home (85.7%). Of these English speakers, 15.2% were between the ages of 5 and 17, 65.1% were between the ages of 18 and 64, and 19.7% were age 65 or older (see *Table 6*).

Table 6: Characteristics of people by language spoken at home, Butte County, 2013-2017			
	Total	People who speak only English at home	People who speak a language other than English at home
Total population, 5 years and over	212,825	182,365 (85.7%)	30,460, (14.3%)
5 to 17 years	15.5%	15.2%	17.6%
18 to 64 years	66.2%	65.1%	72.3%
65 years and over	18.3%	19.7%	10.1%

Source: 2013-2017 American Community Survey 5-Year Estimates. Table - S1603

Disability Prevalence

According to the Centers for Disease Control and Prevention (CDC), the number of adults reporting a disability is expected to increase, along with the need for appropriate medical and public health services. People with disabilities face many barriers to good health. Studies show that individuals with disabilities are more likely than people without disabilities to report having poorer overall health, less access to adequate health care, limited access to health insurance, skipping medical care because of cost, and engaging in risky health behaviors including smoking and physical inactivity.

Independent living difficulty

The percent of the population with an independent living difficulty is based on the 2013-2017 American Community Survey question asked of persons ages 15 and older: "Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?" with response categories "yes" or "no."

Self-care difficulty

The percentage of the population with a self-care difficulty provides a narrower measure of the need for personal assistance services, similar to having difficulty in one or more activities of daily living (ADL). It is based on questions from the 2013-2017 American Community Survey questionnaire asked in a series to person's ages 5 years and older: "Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions? Does this person have serious difficulty walking or climbing stairs? Does this person have difficulty dressing or bathing?" with response categories "yes" or "no."

In Butte County, a higher percentage of adults, between the ages of 18 and 64, have disabilities than in the state (see Table 7).

Table 7: Disability prevalence, Butte County and California, 2013- 2017

	Ages 18-64			Ages 65 and over		
	With an independent living difficulty	With a self-care difficulty	Total persons	With an independent living difficulty	With a self-care difficulty	Total persons
Butte County	5.8%	2.7%	139,388	16.1%	9.8%	37,864
California	3.0%	1.6%	24,335,458	17.2%	9.9%	5,052,924

Source: 2013-2017 American Community Survey 5-Year Estimates. Table S1810

Household Characteristics

Like the state of California, the majority of households in Butte County are family households. Married-couple families make up slightly less than half of the county's households. The percentage of single-parent families in Butte County is lower than the statewide average and a notably greater percentage of Butte County residents live alone or in non-family households than the statewide average. Nearly 13% of Butte County households include adults, ages 65 and over (see *Table 8*).

Table 8: Household characteristics, 2013-2017

	Butte County	California
Total households	86,167	12,888,128
Family households (families)	59.8%	68.8%
Married-couple family	43.4%	49.5%
Male householder, no wife present, family	5.1%	5.9%
Female householder, no husband present, family	11.3%	13.3%
Non family household	40.2%	31.2%
Aged 65 years and over	12.8%	9.1%
Number of grandparents responsible for own grandchildren under 18 years	2,001 of 4,298 (46.6%)	270,310 of 1,149,466 (23.5%)
Grandparents responsible who are female	61.9 %	61.7%
Grandparents responsible who are married	73.6%	71.1%

Source: 2013-2017 American Community Survey 5-Year Estimates; Tables S1101; S1201; DPO2

Primary and Secondary Data Sources Were Gathered

Primary health survey sample data was collected in Spring/Summer 2019 from over 700 Butte County residents using the Behavioral Risk Factor Surveillance System (BRFSS) survey protocol and methodology. Results are hereafter referred to as the Behavioral Risk Factor Survey (BRFS) and treated as equivalent to state and national BRFSS results for comparisons. Qualitative focus group data with underrepresented groups and other hard to reach subpopulations were also conducted in the Spring and Summer of 2019. Quantitative secondary data was collected beginning in the Fall of 2018 from several sources including the Robert Wood Johnson Foundation (RWJF), California Health Interview Survey (CHIS), Office of Statewide Health Planning and Development (OSHPD), and the California Department of Public Health (CDPH).

Primary Data Collection

In 2019,the Butte County Public Health Department partnered with Orchard Hospital, Enloe Medical Center, and Adventist Health Feather River Hospital to retain the services of Issues & Answers Network, Inc. to administer the Butte County Behavioral Risk Factor Survey in order obtain an estimate of the prevalence of behaviors and conditions in Butte County. This survey also follows the CDC protocol for the BRFSS and uses the standardized core questionnaire and modules.

Respondents were drawn from a random sample of Butte County residents. The phone call campaign resulted in 711 completed interviews, 184 refusals, 2,359 non-working or disconnected numbers, 6,357 no answers, 1,849 numbers that were not private residences, 2,348 numbers and/or respondents with undetermined eligibility, 61 households and/or respondents with physical or mental impairment, 66 eligible respondents selected but not interviewed, 176 households and/or eligible respondents with language barriers, 946 households with telecommunication barriers and special technological circumstances, 537 households on a do-not-call list, 498 households that were out-of-sample, 149 fax or modem lines, 5,038 answering machines, 68 pagers, 28 landline numbers in the cell phone sample, and 126 interviews that were terminated/partial completes. The American Association for Public Opinion Research (AAPOR) response rate was 18.41%. The refusal rate was 1.48%.

All of the interviews were completed between April 17 and June 16, 2017, with each completed interview lasting, on average, approximately 35 minutes.

Moreover, considering the 2018 November Campfire, additional steps were taken to ensure that the temporarily relocated residents of Paradise (95965) and Magalia (95954) were included and adequately represented in the survey process. This was achieved via a series of screening questions asked of respondents (both landline and cell phone) who said they did not live in Butte County.

The collected BRFSS data were weighted to adjust for gender, age, and race using the 2010 Butte County Census population distributions.

The full report and summary table of risk factors data from the 2019 Butte County Risk Factors Survey can be found in the Appendix.

Secondary Data Collection

To gather valuable insights from community members to inform the Community Health Needs Assessment, Butte County Public Health (BCPH) contracted the firm Morrision and Company (Chico, California) to facilitate numerous community focus groups.

Representatives from Orchard Hospital, Enloe Medical Center, Adventist Health Feather River, and BCPH organized each focus group, collaborating with existing Butte County community organizations on several occasions to host focus groups in coordination with previously scheduled events or meetings. This leveraged the established relationships these groups have with the individuals they serve, facilitating active participation by community members. Focus groups were also held at various times throughout the day to best accommodate the schedules of participants. The focus groups ranged in size, with an average of 10 attendees per group.

In total, 12 focus groups reaching 114 participants were conducted, with participants representing a broad spectrum of the community. Participation was received from seniors, college students, individuals receiving mental health services, individuals participating in programs at both the African American Family and Cultural Center and the Hmong Cultural Center, high-school students, physicians, general community members, veterans, and individuals experiencing homelessness. Of those 114 participants, 88 completed a written survey utilized in data collection as displayed for the purposes of this reporting section. A series of questions were designed with input from representatives from Orchard Hospital, Enloe Medical Center, Adventist Health Feather River, and Butte County Public Health, as well as the Morrison facilitator. Participants were asked questions as a group and encouraged to share their own personal experiences or anecdotal experiences observed from friends and family in accessing health care and living healthy lives.

The full report and summary of data from the 2019 Butte County Focus Groups can be found in the Appendix: 3 Supporting Documents Community Engagement Focus Group Summary, Morrison Inc.

2019 Executive Summary

The results of all three-assessment methods were reviewed for their degree of commonality. Secondary health metric data was made to align with health survey and qualitative focus group data, such that those health factors with the greatest alignment became evident. The health factors most substantially implicated that emerged through this process are:

- Access to Care
- Mental Health and Substance Use Disorders
- Chronic Disease and Conditions
- Adverse Childhood Experiences and Childhood Maltreatment

***Access to Care*:** Access to health services is a leading health indicator (LHI) for the Healthy People 2020 (HP-2020) national health objectives. A person's ability to access health services profoundly affects their health and well-being. Having a usual primary care provider (PCP) is associated with: greater patient trust in the provider; better patient-provider communication; increased likelihood that patients will receive appropriate care; and lower mortality from all causesi. Access to mental health and oral health care are also important, as both mental health conditions and oral health correlate strongly with physical health and well-being.

Primary Care Shortage: The Health Resources & Services Administration (HRSA) has designated Butte County as provider "shortage areas" in primary care, dental care, and mental health. While only parts of the county meet primary care and dental care shortage area criteria, the entire county meets "Mental Health Shortage Area" criteria. Population to provider ratios also demonstrate that Butte County has fewer primary care physicians and dental care providers per capita than the statewide average; however, Butte County does have more non-physician primary care providers (e.g. physician's assistants and nurse practitioners) and mental health care providers per capita than the statewide average.

Table – Access 1: Population to Provider Ratios: Butte County and California, 2012 & 2016.

	Butte County			Statewide Average		
	2012	2016	Percent Change	2012	2016	Percent Change
Primary Care Physician	1497:1	1660:1	10.9%	1294:1	1270:1	-1.9%
Other Primary Care (Non Physician)	1241:1	1042:1	-16.0%	2406:1	1770:1	-26.4%
Dental Care	1461:1	1410:1	-3.5%	1291:1	1200:1	-7.0%
Mental Health Care	238:1	170:1	-28.6%	388:1	310:1	-20.1%

Source: 2012 and 2016 Area Health Resource Data File via County Health Rankings. Retrieved From: http://www.countyhealthrankings.org/app/california/2019/rankings/butte/county/outcomes/overall/snapshot

The BRFS indicated slightly more than one-third (34.1%) of Butte County adult respondents do not have a personal doctor or health care provider, which is substantially above California state and national averages (24.5% and 22.5%, respectively.) In addition, 14.5% of Butte County respondents reported not seeing a doctor because of the cost, while just 11.8% of respondents statewide cited cost as a barrier to seeking medical care. Focus group results revealed that access to care was ranked as the most important health topic across all groups, with 81% of the 88 total focus group participants ranking access to care as very important for community health in Butte County and 40.9% ranking transportation as a substantial barrier to care for county residents.

Preventative Practices: Preventive health practices are health services that prevent illnesses or diseases, such as screenings and immunizations, or patient counselling to prevent illnessii. Examples include standard immunizations; and screenings for blood pressure, cancer, cholesterol, depression, obesity, and Type 2 diabetesiii. In recent years, several preventable diseases once on the verge of eradication, such as measles, have reemerged in the United States, with outbreaks occurring throughout California, including Butte County. Likewise, sexually transmitted infections (STIs) once thought to be declining or close to eradication, such as syphilis, have shown increasing rates nationally. Many STIs are treatable, but if undetected, may continue to be transmitted; and many more are preventable through education and patient counseling.

The percentage of students having all required immunizations for enrollment into Butte County schools is slightly below the statewide percentage (93% vs. 96%). Likewise, conditional entrant enrollments – students with some but not all required immunizations – attending Butte County schools is higher than California schools overall (3.1% vs. 1.7%). According to the BRFS, 47.8% of Butte County respondents over the age of 65 have not had a flu shot in the past 12 months; and 29% had not received pneumococcal vaccine, which was also greater than the percentage statewide (23.2%). Likewise, 73.2% of Butte County respondents age 50 or older have not been vaccinated against shingles, which was slightly greater than the percentage of respondent's state and nationwide (68.9% and 71.4%, respectively).

Rates of STIs (chlamydia, gonorrhea, and syphilis) for both the county and the state have demonstrated a steadily increasing trend from 2013 to 2017. Especially concerning are the increasing rates of syphilis. In Butte County, rates increased from 0.9 cases per 100,000 residents in 2013 to 33.6 in 2017; and from 16.8 cases per 100,000 residents to 34.6 statewide during this time period. While rates of congenital syphilis showed an increasing but statistically unreliable trend in Butte County, the statewide rate increased from 11.7 to 58.2, indicating that the

statistically underpowered trend observed in Butte County is likely accurate. Also concerning, is that a slightly lower percentage (37.9%) of Butte County BRFS respondents reported ever having an HIV test than respondents statewide (40.8%).

Pertaining to preventative practices for excessive alcohol use, 17.0% of Butte County BRFS respondents reported being advised on harmful levels of drinking during a routine checkup with a healthcare provider, compared with 24.2% of respondents statewide; and 11.5% of Butte County respondents were advised to drink less compared with 12.5% of survey respondents statewide.

***Mental Health and Substance Use Disorders**: M*ental health is a leading health indicator for the HP-2020 objectives. Mental health and physical health are inextricably linked. Evidence has shown that mental health disorders—most often depression—are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions including diabetes, hypertension, stroke, heart disease, and canceriv.

Suicide and Depressive Disorders: Suicide is the tenth leading cause of death in the nation, and the national suicide rate increased by 19.5% between 2007 and 2016. Suicide rates tend to be higher in rural areas than in urban settings. Of significant concern, the suicide rate per capita in Butte County is elevated to nearly twice that of California overall (18.1 vs. 10.4 per 100,000 population); and likewise elevated above the HP-2020 objective (10.2). This is especially alarming when viewed in the context of Butte County's co-occurring elevated metrics for drug induced deaths and excessive alcohol use; as nationally drug induced and alcohol related deaths in combination with suicide, collectively referred to as deaths of despair, have resulted in decreasing life expectancy in the United States since 2015. Rates of depressive disorders, a strong risk factor for suicide, also appear to be elevated in Butte County. Twenty-seven percent of BRFS respondents in Butte County indicated having been diagnosed with a depressive disorder, compared to 17% statewide, and 20% nationwide. Focus groups also overwhelmingly felt mental health was a top community health priority in Butte County, with 69% of total focus group participants ranking mental health as a very important community health priority area. The finding that all of Butte County meets HRSA Mental Health Professional Shortage Area criteria highlights a disparity between the populations need for mental health services and the current capacity of the county's healthcare delivery system to meet this demand.

Opioid Use and Excessive Drinking: Substance use disorders are defined as both mental health disorders and chronic diseases. The American Society of Addiction Medicine defines addiction as "a primary, chronic disease of brain reward, motivation, memory, and related circuitry." The development of substance use disorders are often preceded by substance misuse (taking an opioid medication other than how it was prescribed) or escalating episodes of excessive

alcohol consumption before meeting criteria for alcohol use disorder. Across focus groups, 50% of the 88 total participants indicated substance misuse and substance use disorders to be a top community health concern.

The ongoing opioid epidemic continues to be the leading driver of drug-induced deaths nationally. In Butte County, the age adjusted drug induced death rate continues to be significantly elevated compared to the statewide rate (30.2 vs. 12.2), with Butte County holding the 5th highest rate out of California's 58 counties. In 2017, mortality attributed exclusively to opioids (e.g. no other class of substances detected) in Butte County was 7.6 per 100,000 population compared with a statewide rate of 5.23; and the rate of hospitalizations for opioid overdose were the highest of all California counties, with 40.3 hospitalizations due to opioids other than heroin per 100,000 population compared to 7.75 statewide; and a rate of 9.95 hospitalizations due to heroin compared to 1.78 statewide. Also, of significant concern is that according to the California Healthy Kids Survey (CHKS), 21% percent of Butte County 11th-grade students have used prescription drugs recreationally, compared with 16% of 11th grade students statewide.

Excessive alcohol consumption—which includes binge drinking (4 or more drinks for women and 5 or more drinks for men within about 2 hours); heavy drinking (8 or more drinks a week for women and 15 or more drinks a week for men); and any drinking by pregnant women or those under 21 years of age, is responsible for 88,000 deaths in the United States each year. These include 1 in 10 deaths among working age adults (age 20-64 years), and in 2010, the estimated economic cost to the United States of excessive drinking was $249 billion. Binge drinking accounts for over half of the deaths and three-fourths of the economic costs due to excessive drinking. The most recently available data from the CDPH Safe and Active Communities Branch demonstrates that in Butte County, rates of emergency department treatment, non-fatal hospital admissions, and deaths due to alcohol were all considerably higher than statewide rates (1011.1 vs. 763.8 per 100,000; 306.6 vs. 143.4; and 16.2 vs. 11.9, respectively). Likewise, 42.5% of adult CHIS respondents in Butte County reported binge drinking, relative to 34.7% statewide. This discrepancy was further supported by the results of the BRFS, with 22.1% of Butte County respondents reporting binge drinking compared with 17.6% of respondents statewide. A similarly concerning trend among adolescents was demonstrated by the CHKS, with 20% percent of Butte County 11th grade students reporting binge drinking, compared with 11% of 11th grade students statewide.

***Chronic Disease and Conditions**:* Accounting for 7 out of 10 deaths annually, chronic diseases and conditions such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $3.3 trillion in annual health care costs, with 90% of healthcare dollars in the United States spent on treatment of people with chronic physical and mental health conditionsv. In Butte County, like the nation and the state, the leading causes of death include many of the same chronic conditions, such as heart disease and stroke, cancers, Alzheimer's disease, chronic lower respiratory disease, chronic liver disease, and diabetes. While the mortality rate was

only higher for Butte County than the statewide and national rates for some chronic diseases and conditions (cancer, Alzheimer's disease, chronic lower respiratory disease, and chronic liver disease), (See Table X1); all chronic conditions comprise a substantial portion of health care spending in Butte County. A 2015 study estimated that over 51% of the $1.4 Billion total annual healthcare expenditures in Butte County could be attributed to six chronic conditions (arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression), while 42.% of total statewide healthcare expenditures could be attributed to these conditions (see Table X2). Forty-eight percent of total focus group participants in Butte County indicated chronic disease and conditions to be a significant community health concern, and 45.5% indicated overweight/obesity, a predictive factor for many chronic diseases, to likewise be a top health concern. While most chronic conditions are of significant concern in Butte County, some emerged with greater emphasis including: cancer, Alzheimer's disease, asthma, chronic lower respiratory disease, and chronic liver disease.

Cancer: The age-adjusted death rate for cancer was significantly higher in Butte County than the statewide rate, with 162.2 and 140.2 deaths per 100,000 population, respectively. The five-year incidence rate for cancer from 2011 – 2015 was also elevated relative to the state rate at 452.4 and 395.2 cases per 100,000 population, respectively. These trends generally held for most forms of cancer, including lung, female breast, and colorectal cancers. The BRFS also indicated higher rates of cancer, with 8.4% of Butte County respondents reporting having ever been diagnosed with cancer (other than skin cancer), compared with 5.9% of survey respondents statewide.

Alzheimer's Disease: The age-adjusted death rate for Alzheimer's disease was also significantly higher in Butte County than the statewide rate, with 51.1 and 34.2 deaths per 100,000 population, respectively.

Asthma: In Butte County 9.7% of Medicare beneficiaries have been diagnosed with asthma, which is higher than the percentage of Medicare beneficiaries diagnosed statewide (7.5%). Results of the CHIS also demonstrate that slightly more adults in Butte County have been diagnosed with asthma than adults statewide (15.0% vs. 14.5%); while 18.3% of Butte County BRFS respondents indicated having ever been diagnosed with asthma, relative to 14.1% of statewide respondents; and 11.8% of Butte County respondents reported currently having asthma relative to 7.9% of statewide respondents.

Chronic Lower Respiratory Disease: The age-adjusted death rate for chronic lower respiratory disease was significantly higher in Butte County than the statewide rate, with 45.8 and 32.1 deaths per 100,000 population, respectively. The BRFS also indicated higher rates of chronic obstructive pulmonary disease (COPD) – a type of chronic lower respiratory disease, with 7.1% of Butte County respondents reporting having ever been diagnosed with COPD, compared with 4.5% of survey respondents statewide.

Chronic Liver Disease: The age-adjusted death rate for chronic liver disease was significantly higher in Butte County than the statewide rate, with 18.4 and 12.2 deaths per 100,000 population, respectively.

Table X-2: Mortality Rates for Chronic Diseases and Conditions:

Age Adjusted Death Rate per 100,000	Butte County	California	HP-2020	Rank out of 58 CA
All Causes	765.3	608.5	a	46
All Cancers	162.2	140.2	161.4	49
• (Lung Cancer)	(37.7)	(28.9)	(45.5)	(49)
• (Female Breast Cancer)	(21.2)	(19.1)	(20.7)	(46)
• (Prostate Cancer)	(19.4)	(19.6)	(21.8)	(24)
• (Colorectal Cancer)	(15.7)	(12.8)	(14.5)	(54)
Coronary Heart Disease	85.8	89.1	103.4	28
Alzheimer's Disease	51.1	34.2	a	55
Chronic Lower Respiratory Disease	45.8	32.1	a	42
Cerebrovascular Disease (Stroke)	39.3	35.3	34.8	39
Diabetes	18.9	20.7	b	26
Chronic Liver Disease and Cirrhosis	18.4	12.2	8.2	45

Adapted from: California Health Status Profiles, 2018. Available at: https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profi.aspx#pasteds

Table X-3: Healthcare Costs with Six Chronic Conditions:

Healthcare Costs	Total Healthcare Costs		Total Cost of Six Chronic Conditions		Percent of Total Health Care Costs Due to Six Conditions	
Butte County	$1,372,360,000		$625,045,759		50.8%	
California	$232,390,177,528		$98,443,138,663		42.4%	
Percent of Total Healthcare Costs	Arthritis	Asthma	Cardio-vascular disease	Diabetes	Cancer	Depression
Butte County	7.78%	4.55%	19.99%	5.27%	7.95%	5.26%
California	6.16%	4.06%	16.13%	5.59%	6.01%	4.41%

Adapted from: Brown, P.M., et al. (2015). Economic Burden of Chronic Disease in California 2015. California Department of Public Health. Sacramento, California. Available at: http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1600

Chronic Disease and Conditions | Other Notable Chronic Condition: Butte County had a slightly higher age adjusted death rate than the statewide rate for stroke (39.3 vs. 35.3 per 100,000 population). Likewise, a slightly higher percentage of Butte County BRFS respondents (3.3%) reported having ever had a stroke than statewide respondents (2.2%). Approximately one-third (32.2%) of Butte County respondents also reported having high blood pressure, which was slightly higher than for statewide respondents (28.4%). A 2016 UCLA Center for Health Policy Research study estimated the percent of adults in Butte County that are pre-diabetic (43%) was slightly lower than the statewide estimate (46%), and a lower percentage Butte County CHIS respondent reported being diagnosed with diabetes than statewide respondents (7.4% vs. 9.3%). This discrepancy was also found in BRFS results (7.0% vs. 10.5%); however, a slightly higher

percentage of CHIS respondents age 65 and over from Butte County were diagnosed with diabetes than the percent of respondents statewide (23.5% vs. 21.4%). Major risk factors for the development of chronic conditions and premature death include being overweight/obese and smoking tobacco products. While the percent of adult CHIS respondents that reported being overweight or obese was marginally lower in Butte County than statewide (60.3% vs. 61.5%), the percent of Butte County BRFS respondents that indicated having no physical activity in the past 30 days was higher than the percent of statewide respondents (28.5% vs. 20.0%); and significantly more Butte County respondents indicated being current smokers than statewide respondents (20.6% vs.11.3%).

***Adverse Childhood Experiences and Childhood Maltreatment**:* Adverse childhood experiences (ACEs) are traumatic events in forms of neglect, abuse, or household challenges that occur during childhood and can negatively influence an individual's overall health and wellbeing throughout their lifespan. Early childhood adversity has been associated with increased likelihood of risky behaviors, chronic disease, poor quality of life, and decreased life expectancyvi. Research suggest that there is a dose response curve for ACEs and poor health, that is the likelihood of adverse health outcomes increases with the number of ACEs experienced; with individuals having experienced four or more ACEs being at substantially greater risk than individuals experiencing three or fewer ACEsvii. A top priority of the Surgeon General of California's Office is addressing social determinants that influence early childhood development and health. Within the states Let's Get Healthy California campaign, the Healthy Beginnings objectives focus on maternal and infant health; as well as child and adolescent physical, mental, and social health – for which ACEs rates are key health indicators.

Butte County has notably higher childhood maltreatment rates than California overall, including neglect and abuse allegations (74.0 vs. 54.3 per 1,000 children), substantiations (9.9 vs. 7.7) and entries into protective care (6.5 vs. 3.1)viii. A 2014 Center for Youth Wellness report found that from 2008 -2013, 76.5% Butte County residents reported having one or more ACEs; which was the highest rate of all California counties and significantly higher than for California overall (61.7%). In addition, nearly twice the percentage of Butte County residents as California residents reported having four or more ACEs (30.3% vs. 15.9%)ix. Similarly, results of the 2019 BRFS demonstrated that 77% of Butte County respondents had one or more ACEs, which was considerably higher than the most recent data for statewide respondents (65.5%). Further, Butte County respondents had higher rates than statewide respondents across all ACEs categories, with the most frequent being: substance use by a household member (37.8% vs. 26.1%); parental separation or divorce (37.3% vs. 26.7%); emotional or verbal abuse (35.2% vs. 34.9%,); household member with mental illness (28.4% vs. 15.0%,); and witnessing domestic violence (19.3% vs. 17.5%).

Conclusion and Action Plan

Once the health needs were prioritized by the Orchard Hospital Administration team and Board of trustees, the final step in the CHNA process was to develop an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified. This strategy will include a written plan that addresses each of the community health needs identified through the CHNA, describe how the hospital plans to meet the health needs, and identify health needs the hospital does not intend to meet and why.

The following implementation strategy components within each priority were addressed:

1. Objectives/Strategy
2. How
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 6. In summary the following priorities were addressed through the implementation strategy:

- Access to Care
- Mental Health and Substance Use Disorders
- Chronic Disease and Conditions
    - Obesity
    - Diabetes

The implementation strategy detail for each priority is located in Appendix 6 and provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration.

Appendix: 1

Supporting Documents

2019 Behavior Risk Factor Survey

2019 Behavioral Risk Factor Survey

Butte County, CA

Butte County Public Health

Orchard Hospital — Growing Healthy Communities

Enloe Medical Center

Adventist Health Feather River

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Introduction

In 1990, *Healthy People 2000, National Health Promotion and Disease Prevention Objectives*, was released to the public. The document outlined the U.S. government's plan to improve the health of individuals, communities, and the nation. This plan was revised in 1999 (*Healthy People 2010,*) and, subsequently, in 2010 (*Healthy People 2020.*)

Healthy People 2020 documents 10-year health objectives organized into 4 over-arching goals and 42 Focus Areas (page 4.) These Focus Areas address factors such as behavior, biology, physical environment and social environment that interact to influence health. In addition to the Focus Areas, a smaller subset of 12 indicators called Leading Health Indicators (page 5) was developed. The LHIs reflect a life stage perspective, with the intent to draw attention to both individual and societal determinants that affect the public's health and contribute to health disparities from infancy through old age. This approach recognizes that specific risk factors and determinants of health vary across the life span. Health and disease result from the accumulation, over time, of the effects of risk factors and determinants. Therefore, intervening at specific points in the life course can help reduce risk factors and promote health.

How do behaviors fit into this framework? Behaviors are individual responses or reactions to internal stimuli and external conditions. It has been estimated that behavioral and environmental factors are responsible for approximately 70% of all premature deaths in the United States. Obtaining information surrounding behaviors that put one at risk for poor health is instrumental in developing policies and interventions.

This report explores the behaviors that put Butte County residents at risk for poor health. Leading Health Indicators are presented accompanied by their *Healthy People 2020* Objective/Focus Area.

Healthy People 2020 Goals & Focus Areas

Healthy People 2020 Goals

1. Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity, eliminate disparities, and improve the health of all groups.
3. Create social and physical environments that promote good health for all.
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

Healthy People 2020 Focus Areas

1. Access to Health Services
2. Adolescent Health
3. Arthritis, Osteoporosis, and Chronic Back Conditions
4. Blood Disorders and Blood Safety
5. Cancer
6. Chronic Kidney Disease
7. Dementias, Including Alzheimer's Disease
8. Diabetes
9. Disability and Health
10. Early and Middle Childhood
11. Educational and Community-Based Programs
12. Environmental Health
13. Family Planning
14. Food Safety
15. Genomics
16. Global Health
17. Health Communication & Health Information Technology
18. Health-Related Quality of Life & Well-Being
19. Healthcare-Associated Infections
20. Hearing and Other Sensory or Communication Disorders
21. Heart Disease and Stroke
22. HIV
23. Immunization and Infectious Diseases
24. Injury and Violence Prevention
25. Lesbian, Gay, Bisexual and Transgender Health
26. Maternal, Infant, and Child Health
27. Medical Product Safety
28. Mental Health and Mental Disorders
29. Nutrition and Weight Status
30. Occupational Safety and Health
31. Older Adults
32. Oral Health
33. Physical Activity
34. Preparedness
35. Public Health Infrastructure
36. Respiratory Diseases
37. Sexually Transmitted Diseases
38. Sleep Health
39. Social Determinants of Health
40. Substance Abuse
41. Tobacco Use
42. Vision

Healthy People 2020 Leading Health Indicators

1. Access to Health Services
2. Clinical Preventive Services
3. Environmental Quality
4. Injury and Violence
5. Maternal, Infant, and Child Health
6. Mental Health
7. Nutrition, Physical Activity, and Obesity
8. Oral Health
9. Reproductive and Sexual Health
10. Social Determinants
11. Substance Abuse
12. Tobacco

Methodology

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing, state-based telephone surveillance system supported by the Centers for Disease Control and Prevention (CDC.) Through a series of monthly telephone interviews, states uniformly collect data on the behaviors and conditions that place adults at risk for chronic diseases, injuries, and preventable infectious diseases that are the leading causes of illness and death in the United States. The annual California surveys follow the overall CDC telephone survey protocol for the BRFSS. California Behavioral Risk Factor Survey (BRFS) data is collected by the Public Health Survey Research program (PHSRP) of California State University, Sacramento.

In 2019, in order to obtain an estimate of the prevalence of these behaviors and conditions in Butte County, the Butte County Public Health Department partnered with Enloe Medical Center, Adventist Health Feather River Hospital and Orchard Hospital to retain the services of Issues & Answers Network, Inc. The Butte County Behavioral Risk Factor Survey also follows the CDC protocol for the BRFSS and uses the standardized core questionnaire and modules.

For the needs of the 2019 Butte County BRFSS, the interviews were administered via telephone (via landline and cell phone) to randomly selected adults from a sample of households in the County.

- ✓ The sample of landline telephone numbers was selected using a list-assisted, random-digit-dialed methodology with disproportionate stratification based on "listedness."
- ✓ The cell phone sample included the application of Cellular Working Identification Number Service, which identified inactive telephone numbers within the cellular RDD sample. In order to improve the efficiency of the sample further and reduce the number of out-of-scope calls, a zip code matching process was also used.

Moreover, in light of the 2018 November Campfire, additional steps were taken to ensure that the temporarily relocated residents of Paradise (95965) and Magalia (95954) were included and adequately represented in the survey process. This was achieved via a series of screening questions asked of respondents (both landline and cell phone) who said they did not live in Butte County. The questions were as follows:

S4.1 Do you now live or have you lived in Butte County, California?

1. Currently live in Butte
2. Previously lived in Butte (GO TO S4.2)
3. No – never lived in Butte (THANK AND TERMINATE)

S4.2 Did you move out of Butte County due to the recent fires?

1. Yes (GO TO S4.3)
2. No (THANK AND TERMINATE)

S4.3 Is this a permanent move or a temporary move?

1. Permanent (THANK AND TERMINATE)
2. Temporary

The collected BRFSS data were weighted to adjust for gender, age, and race using the 2010 Butte County Census population distributions.

Sample Results

All of the respondents who were included in the final sample were drawn from a random sample of Butte County residents. Among the calls that were attempted, there were 711 completed interviews, 184 refusals, 2,359 non-working or disconnected numbers, 6,357 no answers, 1,849 numbers that were not private residences, 2,348 numbers and/or respondents with undetermined eligibility, 61 households and/or respondents with physical or mental impairment, 66 eligible respondents selected but not interviewed, 176 households and/or eligible respondents with language barriers, 946 households with telecommunication barriers and special technological circumstances, 537 households on a do-not-call list, 498 households that were out-of-sample, 149 fax or modem lines, 5,038 answering machines, 68 pagers, 28 landline numbers in the cell phone sample, and 126 interviews that were terminated/partial completes. The American Association for Public Opinion Research (AAPOR) response rate was 18.41%. The refusal rate was 1.48%.

All of the interviews were completed between April 17 and June 16, 2017, with each completed interview lasting, on average, approximately 35 minutes.

Please note that, when available, comparisons to California and national results presented in this report are based on the 2017 California and U.S. Behavioral Risk Factor Surveys (the most recent surveys released to the public.)

In a few instances, for question topics due to be released at a later time (September 2017,) older state BRFSS data (years 2008-2016) were used for comparisons. These questions are marked with asterisks.

California BRFSS data is not available for the Intimate Partner Violence topic. National BRFSS data is not available for a handful of topics including Other Tobacco Use, Marijuana Use, and Intimate Partner Violence.

Analysis of Selected Risk Factors

Summary Table: At a Glance

Factor	Butte County	California
Perceived Health Status (fair/poor)	19.0%	17.6%*
Quality of Life: Poor physical health (14+ days)	16.0%	11.1%*
Quality of Life: Poor mental health (14+ days)	18.8%	10.6%*
Disability	20.9%	21.9%*
Health Care Access: No Health Care Coverage (age 18-64)	10.8%	12.7%*
Health Care Access: No Personal Health Care Provider	34.1%	24.5%*
Health Care Access: No Health Care Access Due to Cost	14.5%	11.8%*
Health Care Access: No Routine Checkup	30.5%	32.4%*
Chronic Health Conditions: Ever told had a heart attack	3.7%	3.1%*
Chronic Health Conditions: Ever told had angina or coronary artery disease	2.8%	2.8%*
Chronic Health Conditions: Ever told had a stroke	3.3%	2.2%*
Chronic Health Conditions: Ever told had asthma	18.3%	14.1%*
Chronic Health Conditions: Still have asthma	11.8%	7.9%*
Chronic Health Conditions: Ever told had COPD	7.1%	4.5%*
Chronic Health Conditions: Ever told you had some form of arthritis	24.1%	19.4%*
Chronic Health Conditions: Ever told had a depressive disorder	27.5%	17.3%*
Chronic Health Conditions: Ever told had kidney disease	3.0%	3.3%*
Chronic Health Conditions: Ever told had skin cancer	8.5%	5.9%*
Chronic Health Conditions: Ever told had any other types of cancer	8.4%	5.9%*
Cancer Survivorship: Survivors currently receiving cancer treatment	6.8%	12.9%**
Cancer Survivorship: Survivors who participated in clinical trial	2.1%	N/A**
Cancer Survivorship: Survivors who received a survivorship care plan	76.2%^^	47.6%**
Hypertension Awareness: Ever told had high blood pressure	32.2%	28.4%*
Cholesterol Awareness: Blood cholesterol not checked within last 5 years	10.8%	12.4%*
Cholesterol Awareness: Had blood cholesterol checked and told it was high	24.0%	30.8%*

**Note: Based on 2017 BRFSS of California Residents*
***Note: Based on 2009 BRFSS of California Residents*
^Items marked in red are below the statewide figures and may require the County's attention. Items marked in green indicate results above the statewide figures
^^Caution: Fewer than 30 respondents

Analysis of Selected Risk Factors – cont'd.

Summary Table: At a Glance

Factor	Butte County	California
Diabetes: Ever told had diabetes (excluding pregnancy-related)	7.0%	10.5%*
Tobacco Use: Current Smoker	20.6%	11.3%*
Other Tobacco Use: Have ever used chewing tobacco	28.1%	4.2%**
Other Tobacco Use: Current user of chewing tobacco	4.0%	0.6%**
Other Tobacco Use: Have ever used cigars/cigarillos	39.0%	15.2%**
Other Tobacco Use: Current user of cigars/cigarillos	4.9%	1.7%**
Other Tobacco Use: Have ever used tobacco pipe	14.8%	4.5%**
Other Tobacco Use: Current user of tobacco pipe	0.4%	0.2%**
Other Tobacco Use: Have ever used hookah water pipe	16.0%	6.3%**
Other Tobacco Use: Current user of hookah water pipe	0.0%	0.6%**
Marijuana Use: Smoked 1+ day within past 30 days	17.7%	10.5%***
Alcohol Consumption: Binge drinking	22.1%	17.6%*
Alcohol Consumption: Heavy drinking	4.2%	6.3%
Alcohol Screening & Brief Intervention: Did not discuss alcohol use with a health professional at last routine checkup	22.5%	22.1%****
Alcohol Screening & Brief Intervention: Advised about harmful drinking	17.0%	24.2%****
Alcohol Screening & Brief Intervention: Advised to reduce or quit drinking	11.5%	12.5%****
Fruit Consumption (<1 time/day)	41.9%	32.5%*
Vegetable Consumption (<1 time/day)	16.8%	21.4%*
Physical Activity: No activity during past month	28.5%	20.0%*
Seatbelt Use: Do not always use seatbelt	6.7%	2.2%*
Adult Immunization: No flu shot in past year (age 65+)	47.8%	40.7%*
Adult Immunization: Never had pneumococcal vaccination (age 65+)	29.0%	23.2%*
Adult Immunization: Never had shingles/zoster vaccination	73.2%	68.9%*
HIV/AIDS: Ever had an HIV test	37.9%	40.8%*

**Note: Based on 2017 BRFSS of California Residents*
***Note: Based on 2015 BRFSS of California Residents*
****Note: Based on 2016 BRFSS of California Residents*
*****Note: Based on 2014 BRFSS of California Residents*
^Items marked in red are below the statewide figures and may require the County's attention. Items marked in green indicate results above the statewide figures

Analysis of Selected Risk Factors – cont'd.

Summary Table: At a Glance

Factor	Butte County	California
Adverse Childhood Experience: Emotional/verbal abuse (more than once)	35.2%	34.9%*
Adverse Childhood Experience: Parental separation or divorce	37.3%	26.7%*
Adverse Childhood Experience: Substance abuse by household member	37.8%	26.1%*
Adverse Childhood Experience: Physical abuse (more than once)	21.0%	19.9%*
Adverse Childhood Experience: Witness to domestic violence (more than once)	19.3%	17.5%*
Adverse Childhood Experience: Household member with mental illness	28.4%	15.0%*
Adverse Childhood Experience: Sexual abuse (ever)	13.8%	11.4%*
Adverse Childhood Experience: Incarcerated household member	14.6%	6.6%*
Intimate Partner Violence: Threatened physical (past 12 months)	4.3%	N/A
Intimate Partner Violence: Completed physical (past 12 months)	3.8%	N/A
Intimate Partner Violence: Attempted control (past 12 months)	5.1%	N/A
Intimate Partner Violence: Unwanted sex (past 12 months)	0.6%	N/A

**Note: Based on combined 2008-2013 BRFSS of California Residents*
^Items marked in red are below the statewide figures and may require the County's attention. Items marked in green indicate results above the statewide figures

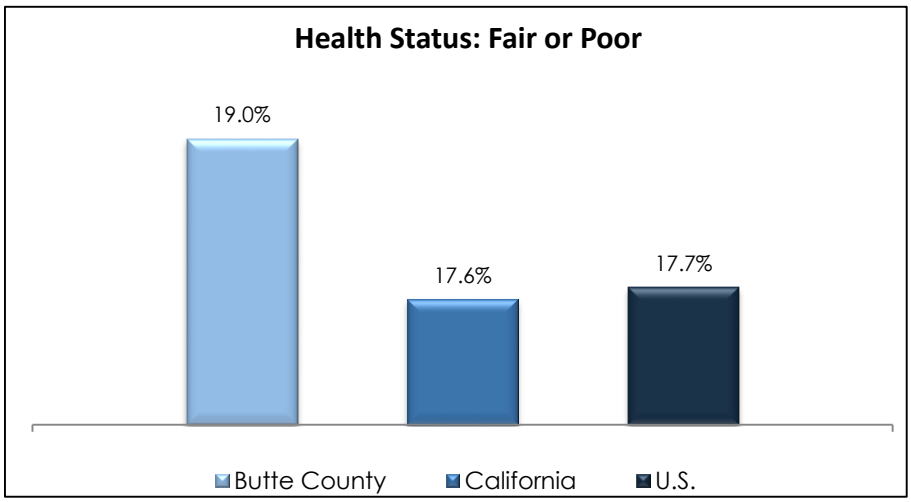
Perceived Health Status

Healthy People 2020 objective HRQOL/WB-1: Increase the proportion of adults who self-report good or better health

A primary goal of Healthy People 2020 is to help individuals improve their quality of life. General health status is a reliable self-rated assessment of one's perceived health, which may be influenced by all aspects of life, including behaviors, environmental factors, and community. Self-rated general health status is useful in determining unmet health needs, identifying disparities among subpopulations, and characterizing the burden of chronic diseases within a population. The prevalence of self-rated fair or poor health status has been found to be higher within older age groups, females, and minorities, and has also been associated with lower socioeconomic status in the presence or absence of disease.

At 19%, Butte County residents are slightly more likely than Californians and Americans as a whole to report fair or poor general health (17.6% and 17.7%, respectively.)

The self-reported rate of fair/poor health is highest among residents older than 45 years of age, with over one-fifth giving this response. Additionally, non-Hispanics (20.8%,) residents with less than a high school education (35.6%,) and those with less than $35,000 in an annual household income (roughly three in ten) are among the most likely to rate their health as fair or poor.



Percentage of respondents who said their health, in general, was fair or poor

Demographic Characteristics	General Health Fair or Poor
Total	19.0%
Age	
18-24	14.0%
25-34	12.3%
35-44	15.7%
45-54	20.4%
55-64	31.4%
65+	20.6%
Gender	
Male	19.7%
Female	18.4%
Race	
White	18.6%
Black**	17.2%
Hispanic	10.3%
Non-Hispanic	20.8%
Education	
< High School	35.6%
High School Grad	21.1%
Some College	19.3%
College Graduate	13.8%
Household Income	
<$20,000	32.0%
$20,000-$34,999	27.6%
$35,000-$$49,999**	10.8%
$50,000-$74,999	18.9%
$75,000 or more	10.1%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Quality of Life

Healthy People 2020 objective HRQOL/WB-1.1: Increase the proportion of adults who self-report good or better physical health

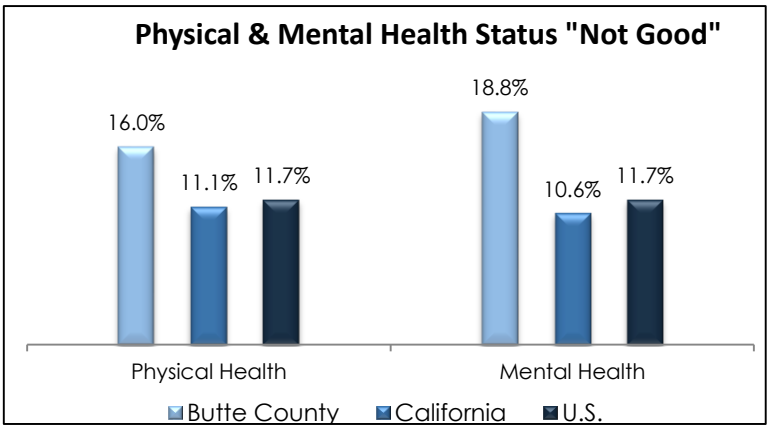
Healthy People 2020 objective HRQOL/WB-1.2: Increase the proportion of adults who self-report good or better mental health

Health-related quality of life reflects a personal sense of physical and mental health and the ability to react to factors in the physical and social environments. The key indicator used in this analysis is the number of days in the past month that residents experienced physical or mental health problems, and in particular, whether they had experienced problems for 14 or more days within that timeframe.

A total of 16% of Butte County residents report having 14 or more days of poor physical health, and 18.8% say the same about their mental health. Both quality of life metrics are notably above the state and U.S. figures.

Residents most likely to report poor physical health are those with less than high school education (40.6%,) those with income of under $35,000 per year (just under one-quarter), as well as those over the age of 55 (more than two in ten.)

In terms of poor mental health, its incidence is driven mostly by residents ages 25-54 (more than two in ten,) females (24.1%,) Black and Hispanic residents (22.2% and 25.1%, respectively,) those without a high school diploma (33.2%,) and respondents in the bottom income bracket (29.7%.)



Percentage of respondents with 14 or more days of poor physical or mental health

Demographic Characteristics	Physical Health Not Good	Mental Health Not Good
Total	16.0%	18.8%
Age		
18-24	3.8%	19.0%
25-34	18.5%	24.3%
35-44	14.0%	21.3%
45-54	15.3%	26.4%
55-64	25.9%	17.2%
65+	19.6%	8.3%
Gender		
Male	14.2%	13.4%
Female	17.7%	24.1%
Race		
White	14.9%	16.7%
Black**	17.2%	22.2%
Hispanic	18.9%	25.1%
Non-Hispanic	15.8%	18.1%
Education		
< High School	40.6%	33.2%
High School Grad	11.7%	16.7%
Some College	15.9%	19.7%
College Graduate	14.2%	16.1%
Household Income		
<$20,000	23.1%	29.7%
$20,000-$34,999	24.6%	11.8%
$35,000-$$49,999**	9.5%	11.9%
$50,000-$74,999	13.1%	10.3%
$75,000 or more	11.6%	14.3%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Disability

Healthy People 2020 objective DH-13: Increase the proportion of adults with disabilities aged 18 years and older who participate in leisure, social, religious or community activities

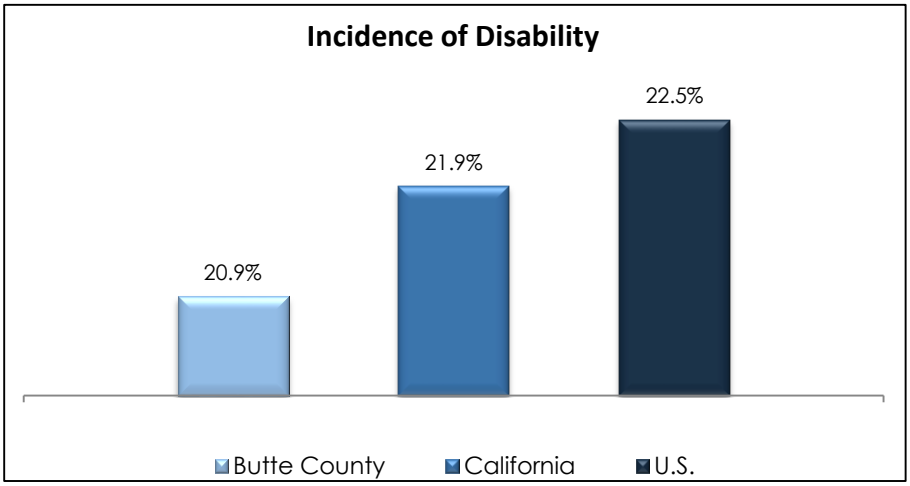
Healthy People 2020 objective DH-14: Increase the proportion of children and youth with disabilities who spend at least 80 percent of their time in regular education programs

Healthy People 2020 objective goal DH-16: Increase employment among people with disabilities

One of the Healthy People 2020 goals is to "promote the health and well-being of people with disabilities." There are many ways in which disability can be defined, ranging from experiencing difficulty in participating in certain activities (such as lifting and carrying objects, seeing, hearing, talking, walking or climbing stairs) to having more severe disabilities that require assistance in personal care needs (i.e. bathing) or routine care needs (i.e. housework). In this report, disability is defined as being limited in any activities because of physical, mental, or emotional problems.

Approximately one-fifth (20.9%) of the Butte County adult population lives with a disability, which is essentially consistent with the state- and nationwide results (21.9% and 22.5%, respectively.)

The prevalence of disability in Butte County is highest among African Americans (64.2%,) respondents in the lowest income bracket (36%,) and those with less than high school education (38.1%.) Moreover, residents over the age of 35 are more likely to report disability than their younger counterparts, with a peak among those age 55-64 (30.2%.)



Percentage of respondents limited in activities because of physical, mental or emotional problems

Demographic Characteristics	Disability
Total	20.9%
Age	
18-24	10.1%
25-34	19.1%
35-44	24.2%
45-54	21.2%
55-64	30.2%
65+	22.0%
Gender	
Male	22.7%
Female	19.8%
Race	
White	21.5%
Black**	64.2%
Hispanic	12.3%
Non-Hispanic	22.5%
Education	
< High School	38.1%
High School Grad	20.4%
Some College	19.2%
College Graduate	18.6%
Household Income	
<$20,000	36.0%
$20,000-$34,999	15.7%
$35,000-$$49,999**	18.9%
$50,000-$74,999	18.2%
$75,000 or more	14.6%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Health Care Access: No Health Care Coverage

Healthy People 2020 objective AHS-1.1: Increase the proportion of persons with medical insurance

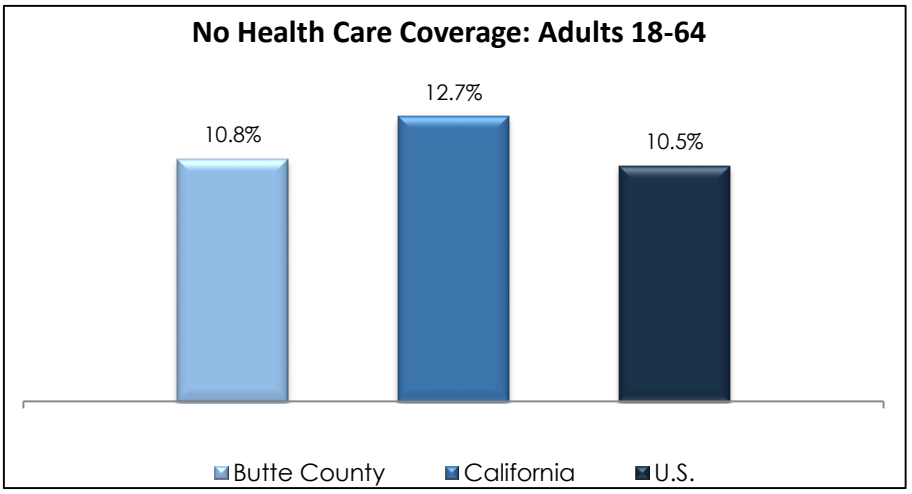
Health insurance coverage is an important determinant of access to health care. Uninsured individuals are substantially less likely to have a usual source of health care or a recent health care visit than their insured counterparts.[10] Utilization of preventive health care services, such as mammography, Pap tests, prostate exams, influenza vaccinations, and cholesterol tests, could reduce the prevalence and severity of diseases and chronic conditions in the United States. The Healthy People 2020 target for health care coverage is to have 100% insured by 2020.[11]

An estimated 10.8% of the Butte County residents between the ages of 18 and 64 have no health insurance coverage – a rate below the state figure (12.7%) and on par with the national score (10.5%.)

Access to health care is closely related to several socio-economic factors. Specifically, at 22.6%, the Hispanic segment of Butte County residents is substantially less likely to have coverage than their non-Hispanic counterparts. Male residents are somewhat more likely than females to have no coverage. Predictably, the likelihood to be insured is directly proportional to the income and educational attainment levels. Finally, age is closely associated with health care coverage, as younger individuals are more apt to report that they do not have health insurance coverage than those age 35+.

Percentage of respondents age 18-64 who have no health care insurance coverage

Demographic Characteristics	No Health Insurance
Total	10.8%
Age	
18-24	16.2%
25-34	15.5%
35-44	7.2%
45-54	8.6%
55-64	5.7%
Gender	
Male	13.6%
Female	8.2%
Race	
White	7.3%
Black**	9.4%
Hispanic	22.6%
Non-Hispanic	8.7%
Education	
< High School	18.4%
High School Grad	13.1%
Some College	12.7%
College Graduate	5.0%
Household Income	
<$20,000	18.6%
$20,000-$34,999	11.5%
$35,000-$$49,999**	15.6%
$50,000-$74,999	11.7%
$75,000 or more	1.4%



**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Health Care Access: Limited Health Care Coverage

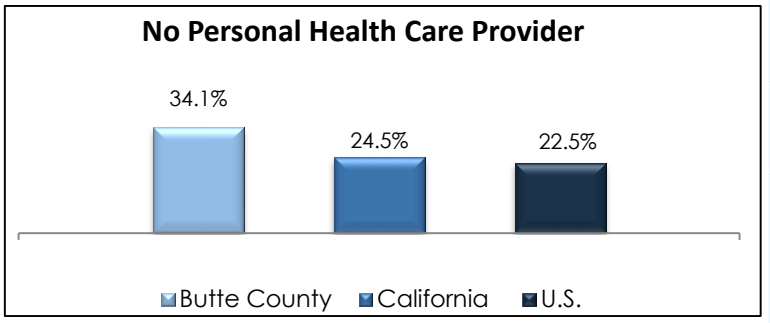
Healthy People 2020 objective AHS-3: Increase the proportion of persons with a usual primary care provider

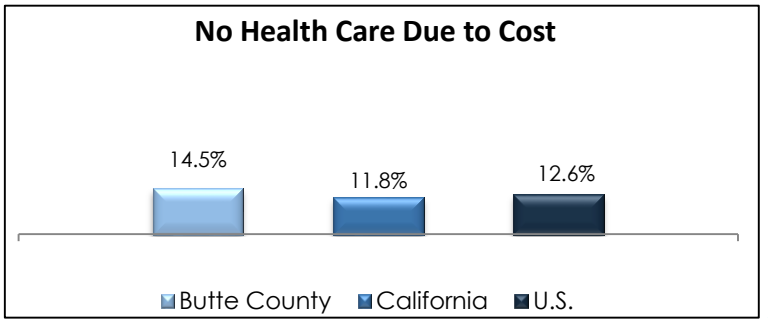
Healthy People 2020 objective AHS-6: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines

Two additional indicators that address issues related to health care access include not having a personal doctor or health care provider and having had a time during the past 12 months when health care was needed but could not be obtained because of cost.

More than one-third (34.1%) of Butte County adults do not have a personal doctor or health care provider – a figure substantially above state- and nationwide rates (24.5% and 22.5%, respectively.) Moreover, 14.5% of Butte County residents could not see a doctor because of the cost.

As in the past, men are more likely than women to have no personal health care provider (38% vs. 30.2%.) Moreover, no access to a personal provider and cost barriers are cited more often among less educated and less affluent population segments. Hispanics are the most likely cohort to report having no personal health care provider. Finally, the likelihood of having a personal provider is lowest among those under the age of 35, and the likelihood of not being able to see a doctor due to cost is highest among those under the age of 24.





Percentage of respondents with no personal health care provider and percentage of respondents who reported an instance of not obtaining care due to cost

Demographic Characteristics	No Personal Health Care Provider	No Health Care Access Due to Cost
Total	34.1%	14.5%
Age		
18-24	51.7%	23.4%
25-34	52.9%	17.9%
35-44	33.0%	16.2%
45-54	32.6%	15.7%
55-64	17.9%	8.8%
65+	17.5%	6.5%
Gender		
Male	38.0%	15.0%
Female	30.2%	13.9%
Race		
White	31.9%	12.8%
Black**	34.3%	19.2%
Hispanic	46.2%	16.6%
Non-Hispanic	31.8%	14.3%
Education		
< High School	48.1%	28.9%
High School Grad	34.6%	12.0%
Some College	38.4%	18.0%
College Graduate	26.0%	9.4%
Household Income		
<$20,000	42.8%	18.4%
$20,000-$34,999	30.9%	26.9%
$35,000-$$49,999**	23.4%	7.6%
$50,000-$74,999	26.0%	14.8%
$75,000 or more	25.4%	7.6%

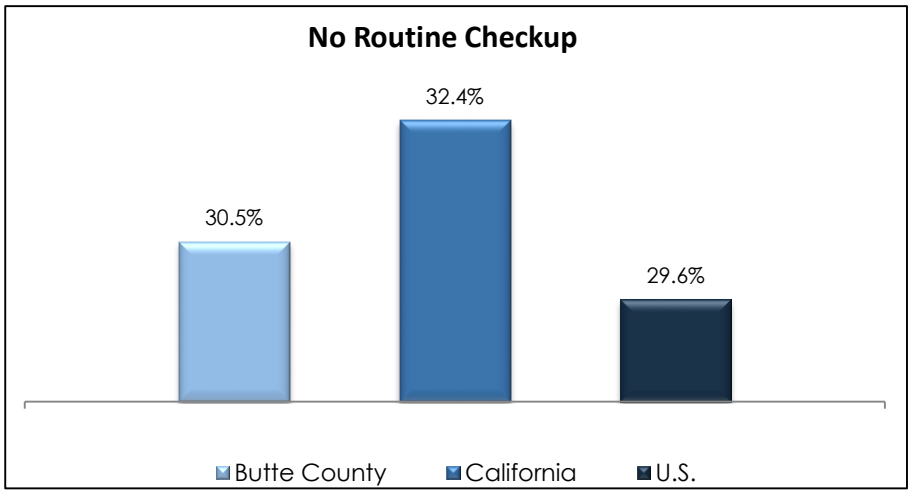
**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Health Care Access: No Routine Checkup

A yearly routine checkup with a health care professional provides an opportunity to raise awareness regarding adult preventive services, conduct individual risk assessments, promote informed decision-making, and potentially benefit from early detection.

Butte County residents are less likely than Californians overall to report not having a routine checkup within the past year (30.5% vs. 32.4%.) The figure observed in the County is consistent with the nationwide results (29.6%.)

A more in-depth analysis reveals that males are more likely to have had no checkup than females (35.3% vs. 25.9%)..Moreover, African Americans (54.3%) and Hispanic residents (55.3%) are more likely to report no checkup than their Caucasian counterparts (28.2%.) Finally, the likelihood of having an annual checkup increases proportionately to residents' age and income.



Percentage of respondents who had no routine checkup in the past year

Demographic Characteristics	No Routine Checkup
Total	30.5%
Age	
18-24	46.9%
25-34	48.1%
35-44	32.5%
45-54	26.2%
55-64	21.2%
65+	11.4%
Gender	
Male	35.3%
Female	25.9%
Race	
White	28.2%
Black**	54.3%
Hispanic	55.3%
Non-Hispanic	26.4%
Education	
< High School	37.5%
High School Grad	34.9%
Some College	30.8%
College Graduate	25.7%
Household Income	
<$20,000	40.3%
$20,000-$34,999	37.4%
$35,000-$$49,999**	35.4%
$50,000-$74,999	23.1%
$75,000 or more	20.0%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Heart Attack

Healthy People 2020 objective HDS-1: Increase overall cardiovascular health in the U.S. population

Healthy People 2020 objective HDS-16: Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a heart attack

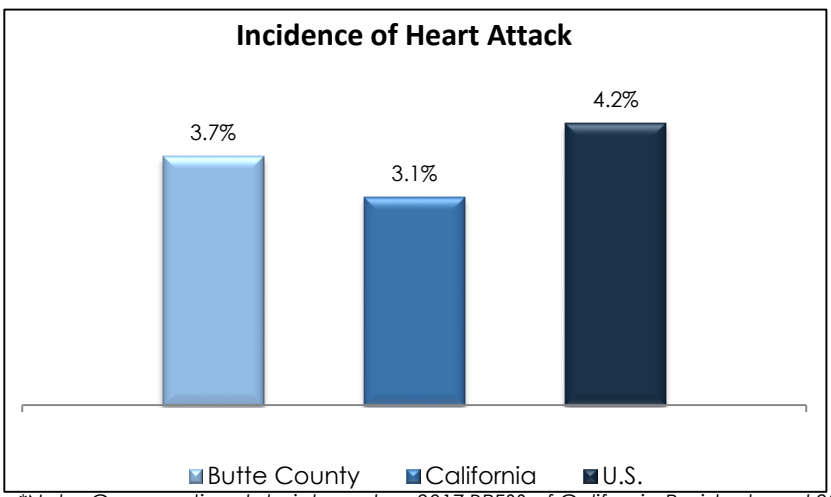
In 2015, an estimated 114,023 deaths were attributable to heart attacks in the United States. An estimated 720,000 heart attacks and 335,000 recurrent heart attacks occur yearly among U.S. adults. The cost of heart attacks was $12.1 billion in 2013, which includes health care services, medication, and lost productivity.[33] Many risk factors for heart attack are the same as those for coronary artery disease, including high blood pressure, high cholesterol, smoking, family history of heart disease, obesity, physical inactivity, diabetes, and excessive alcohol consumption.[26]

A total of 3.7% of Butte County residents have ever been told that they had a heart attack. This result is only marginally higher than the California figure (3.1%) and on par with the national result (4.2%.)

Unsurprisingly, the prevalence of heart attacks is highest among residents age 55+.

Percentage of respondents who were told by a doctor that they had a heart attack

Demographic Characteristics	Ever Told You Had Heart Attack
Total	3.7%
Age	
18-24	1.9%
25-34	-
35-44	1.5%
45-54	3.2%
55-64	6.4%
65+	7.4%
Gender	
Male	4.0%
Female	3.4%
Race	
White	3.9%
Black**	8.6%
Hispanic	1.0%
Non-Hispanic	4.2%
Education	
< High School	2.1%
High School Grad	3.7%
Some College	2.6%
College Graduate	5.1%
Household Income	
<$20,000	4.8%
$20,000-$34,999	2.9%
$35,000-$$49,999**	7.0%
$50,000-$74,999	6.4%
$75,000 or more	1.9%



**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Heart Disease

Healthy People 2020 objective HDS-1: Increase overall cardiovascular health in the U.S. population

Healthy People 2020 objective HDS-2: Reduce coronary heart disease deaths

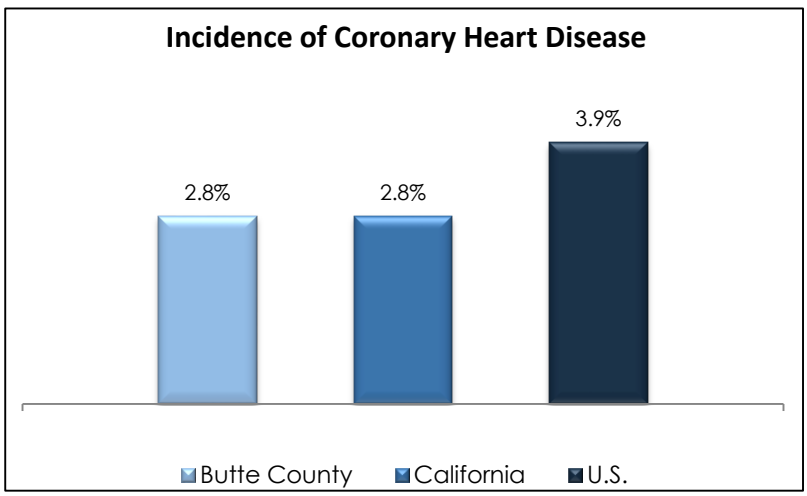
Heart disease and stroke are leading causes of death in the United States for both genders and across all ethnic groups. In 2017, in California, heart disease was the primary cause of death, claiming 62,797 lives.[12] Approximately 5.7 million people nationwide have heart failure, and about one-half of these individuals will die within five years of diagnosis. Cardiovascular disease costs the nation an estimated $31 billion annually.[13] Modifying cardiovascular disease risk factors offers the greatest potential for reducing death and disability.

Among Butte County adults, 2.8% have been told at some point that they had angina or coronary heart disease. This figure is on par with the current state data, and below the nationwide prevalence data.

Unsurprisingly, residents over the age of 65 report a significantly higher rate of heart disease than younger individuals.

Percentage of respondents who were told by a doctor that they had angina or coronary heart disease

Demographic Characteristics	Ever Told You Have Angina or Coronary Heart Disease
Total	2.8%
Age	
18-24	-
25-34	-
35-44	3.3%
45-54	-
55-64	2.5%
65+	10.0%
Gender	
Male	3.2%
Female	2.4%
Race	
White	2.9%
Black**	8.6%
Hispanic	0.5%
Non-Hispanic	3.2%
Education	
< High School	5.0%
High School Grad	3.2%
Some College	1.1%
College Graduate	3.7%
Household Income	
<$20,000	4.0%
$20,000-$34,999	-
$35,000-$$49,999**	8.8%
$50,000-$74,999	5.8%
$75,000 or more	1.1%



**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Stroke

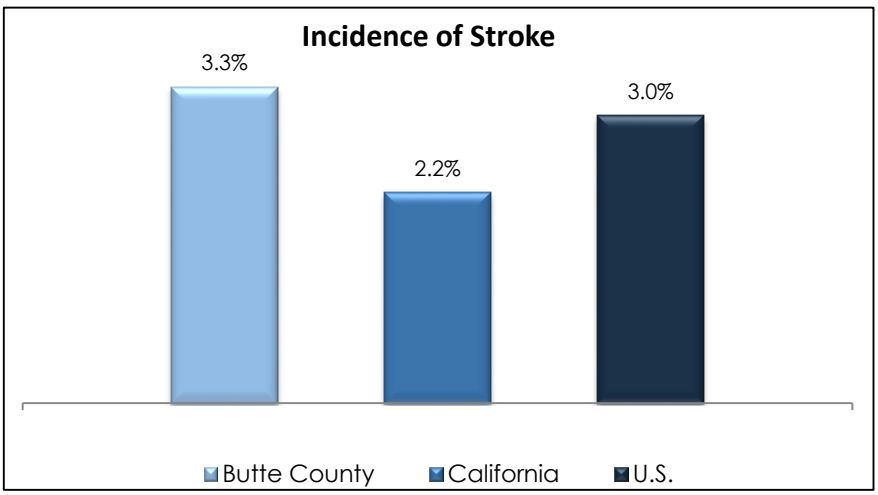
Healthy People 2020 objective HDS-3: Reduce stroke deaths

Healthy People 2020 objective HDS-17: Increase the proportion of adults aged 20 years and older who are aware of the symptoms and how to respond to a stroke

Stroke kills nearly 140,000 Americans each year – that's 1 of every 20 deaths. Stroke and Cardiovascular Heart Disease share many of the same risk factors. Although the health complications from stroke are severe, the risk of stroke can be greatly reduced by increasing physical activity, eating a balanced diet, avoiding drinking too much alcohol, and quitting smoking.[14]

The overall rate of stroke among Butte County adults is 3.3%. This figure is slightly above the state rate (2.2%,) but on par with the nationwide prevalence data (3.0%.)

Mirroring the patterns noted for other cardiovascular conditions, stroke is most common in the oldest age cohort (65+ years olds.)



Percentage of respondents who were told by a doctor that they had a stroke

Demographic Characteristics	Ever Told You Had a Stroke
Total	3.3%
Age	
18-24	-
25-34	-
35-44	3.3%
45-54	0.9%
55-64	3.0%
65+	11.6%
Gender	
Male	3.0%
Female	3.6%
Race	
White	3.7%
Black**	-
Hispanic	2.2%
Non-Hispanic	3.6%
Education	
< High School	3.1%
High School Grad	3.4%
Some College	3.3%
College Graduate	3.3%
Household Income	
<$20,000	5.7%
$20,000-$34,999	2.1%
$35,000-$$49,999**	5.2%
$50,000-$74,999	1.4%
$75,000 or more	2.2%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Asthma

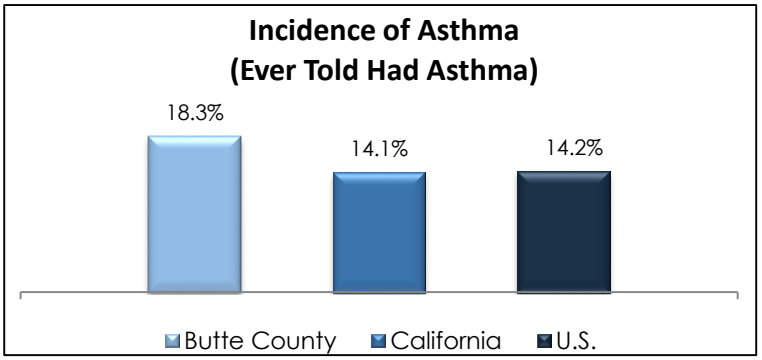
Healthy People 2020 objective RD-1: Reduce asthma deaths

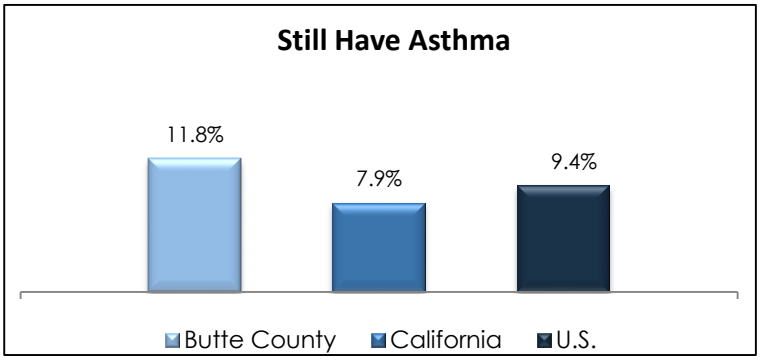
Healthy People 2020 objective RD-7: Increase the proportion of persons with current asthma who receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines

Asthma is a chronic inflammatory disorder of the lungs, and is characterized by wheezing, nighttime or early morning coughing, difficulty breathing, and chest tightness. Asthma attacks can be triggered by a variety of factors, such as pollution, tobacco smoke, dust mites, pets, mold, and/or respiratory infections. At present, over 25,000 Americans suffer from asthma. In 2016, the condition caused 188,968 hospitalizations, more than 1.8 million emergency department visits, and 9.8 million doctor visits.[15]

The incidence of self-reported asthma among Butte County adults is at 18.3%. This result is above the statewide and national rates (14.1% and 14.2%.) The prevalence of asthma peaks in the 25-34 age segment, as well as among females.

A total of 11.8% of Butte County residents currently have asthma – notably more than California and U.S.-wide figures (7.9% and 9.4%, respectively.) Residents most likely to still have asthma also include those ages 25-34, females, as well as those with lower income and education levels.





Percentage of respondents who have ever been told by a doctor that they had asthma, and percentage of respondents who still have asthma

Demographic Characteristics	Ever Told Have Asthma	Still Have Asthma
Total	18.3%	11.8%
Age		
18-24	17.5%	15.6%
25-34	31.7%	17.2%
35-44	19.5%	7.3%
45-54	18.2%	12.4%
55-64	14.6%	12.0%
65+	11.7%	6.8%
Gender		
Male	14.3%	10.5%
Female	22.2%	13.0%
Race		
White	17.1%	10.7%
Black**	16.0%	16.0%
Hispanic	22.5%	15.4%
Non-Hispanic	18.0%	11.4%
Education		
< High School	25.9%	12.1%
High School Grad	21.0%	17.0%
Some College	18.9%	11.4%
College Graduate	14.1%	8.2%
Household Income		
<$20,000	27.0%	19.9%
$20,000-$34,999	17.7%	15.9%
$35,000-$$49,999**	28.5%	13.6%
$50,000-$74,999	25.7%	13.2%
$75,000 or more	9.6%	7.3%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: COPD, Emphysema or Bronchitis

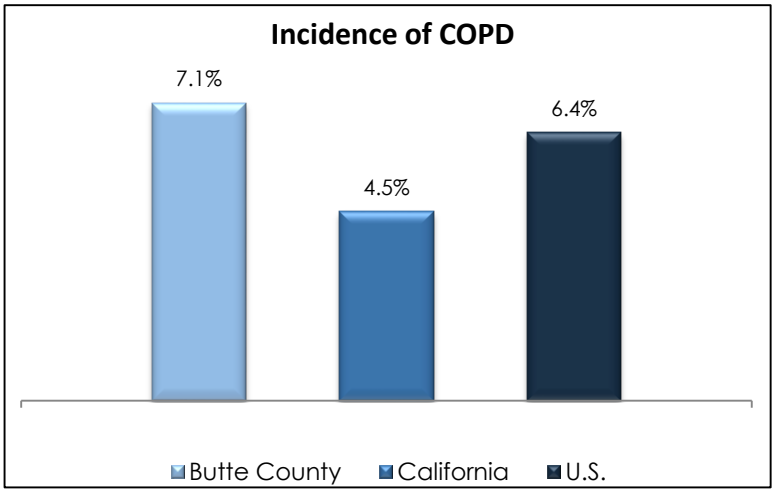
Healthy People 2020 objective RD-10: Reduce deaths from chronic obstructive pulmonary disease (COPD)

Healthy People 2020 objective RD-11: Reduce hospitalizations from chronic obstructive pulmonary disease (COPD)

People with chronic obstructive pulmonary disease (COPD) experience persistent breathing problems and low respiratory function. Three-quarters of COPD cases are linked to a history of smoking, with genetics and exposure to environmental irritants also contributing to the disease. A total of 16 million of Americans have been diagnosed with this condition, while 12 million more may have undiagnosed COPD. [26]

A total of 7.1% of Butte County residents has ever been told that they had COPD, emphysema, or chronic bronchitis. This figure is above the statewide data (4.5%), but only marginally higher than the national result (6.4%).

Like many other conditions, COPD is notably more prevalent among residents over the age of 55. It is also more frequent among non-Hispanic population of the County. Finally, residents with less than high school education, as well as those making under $50,000 per year, are more apt to report this diagnosis than their more educated and more affluent counterparts.



Percentage of respondents who were told by a doctor that they had COPD, emphysema or chronic bronchitis

Demographic Characteristics	Ever Told Had COPD, Emphysema or Chronic Bronchitis
Total	7.1%
Age	
18-24	-
25-34	4.2%
35-44	4.8%
45-54	4.6%
55-64	15.9%
65+	12.9%
Gender	
Male	6.4%
Female	7.9%
Race	
White	7.4%
Black**	17.2%
Hispanic	1.0%
Non-Hispanic	8.3%
Education	
< High School	13.7%
High School Grad	7.7%
Some College	7.8%
College Graduate	4.6%
Household Income	
<$20,000	13.3%
$20,000-$34,999	11.3%
$35,000-$$49,999**	12.2%
$50,000-$74,999	4.4%
$75,000 or more	4.2%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Arthritis, Rheumatoid Arthritis, Gout, Lupus or Fibromyalgia

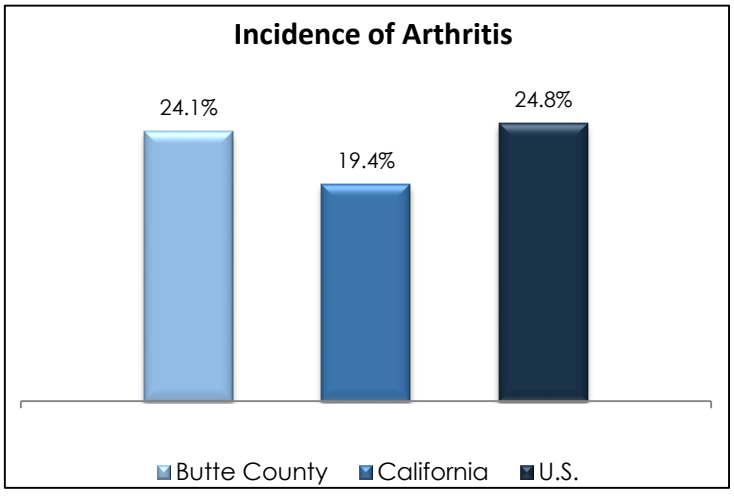
Healthy People 2020 objective AOCBC-1: Reduce the mean level of joint pain among adults with doctor-diagnosed arthritis

Healthy People 2020 objective AOCBC-7: Increase the proportion of adults with doctor-diagnosed arthritis who receive health care provider counseling

Over 54 million Americans have arthritis, a condition that can cause severe, chronic joint pain. Arthritis is a leading cause of disability, and over half of people living with this condition says it interferes with their daily activities.[26] Arthritis can take many forms such as rheumatoid arthritis (an autoimmune disease causing painful swelling,) gout (a form of inflammatory arthritis affecting one joint at a time) fibromyalgia (a condition causing abnormal pain perception processing)[39] or lupus (an autoimmune disease that can damage any part of the body.)[40]

Nearly one-quarter (24.1%) of Butte County residents have been diagnosed with some form of arthritis. This result is above the statewide figure (19.4%,) and on par with the national data (24.8%.)

The incidence of arthritis increases in proportion to residents' age. It is also more common among non-Hispanic respondents, and slightly more prevalent among females.



Percentage of respondents who were told by a doctor that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia

Demographic Characteristics	Ever Told Had Arthritis, Rheumatoid Arthritis, Gout, Lupus or Fibromylagia
Total	24.1%
Age	
18-24	3.8%
25-34	3.3%
35-44	14.5%
45-54	21.8%
55-64	45.2%
65+	51.4%
Gender	
Male	21.1%
Female	27.0%
Race	
White	25.5%
Black**	37.3%
Hispanic	11.2%
Non-Hispanic	26.3%
Education	
< High School	25.5%
High School Grad	24.7%
Some College	23.1%
College Graduate	24.5%
Household Income	
<$20,000	31.9%
$20,000-$34,999	27.5%
$35,000-$$49,999**	26.8%
$50,000-$74,999	33.5%
$75,000 or more	23.9%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Depressive Disorder

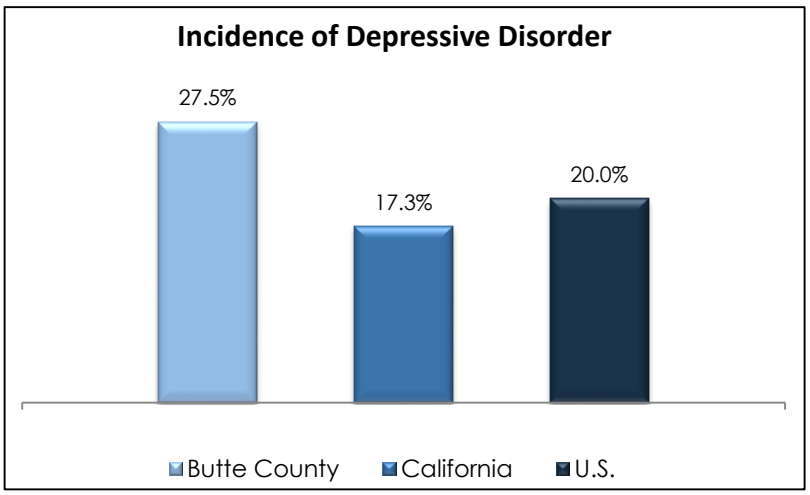
Healthy People 2020 objective MHMD-11: Increase depression screening by primary care workers

Healthy People 2020 objective MHMD-4: Reduce the proportion of persons who experience major depressive episodes (MDEs)

Depression is a common and treatable mental disorder characterized by changes in mood, and cognitive and physical symptoms over a period of time. It is the leading cause of disability in the U.S., associated with high societal costs and greater functional impairment than many other chronic diseases, including diabetes and arthritis.[41] The most commonly diagnosed form of depression is major depressive disorder. In 2015, approximately 16.1 million Americans had experienced at least one major depressive episode in the last year. [42]

Nearly three in ten residents of Butte County (27.5%) have ever been told that they had a depressive disorder (depression, major depression, dysthymia) or minor depression. This rate is considerably above the figure observed for California as a whole (17.3%,) as well as above the national data (20%.)

The likelihood of this diagnosis is inversely proportional to residents' age, with younger individuals being more likely to suffer from depression than their older counterparts. Moreover, females are more apt to be depressed than males. Finally, the lower income segments (and particularly those with less than $20,000 per year) are more likely to feel this way than their more affluent counterparts.



Percentage of respondents who were told by a doctor that they had a depressive disorder, or minor depression

Demographic Characteristics	Ever Told Had Depressive Disorder
Total	27.5%
Age	
18-24	30.2%
25-34	36.0%
35-44	35.3%
45-54	29.0%
55-64	27.1%
65+	13.2%
Gender	
Male	21.6%
Female	33.3%
Race	
White	27.0%
Black**	39.4%
Hispanic	35.7%
Non-Hispanic	26.7%
Education	
< High School	22.0%
High School Grad	29.1%
Some College	32.2%
College Graduate	22.9%
Household Income	
<$20,000	44.1%
$20,000-$34,999	25.4%
$35,000-$$49,999**	14.4%
$50,000-$74,999	19.4%
$75,000 or more	20.4%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Kidney Disease

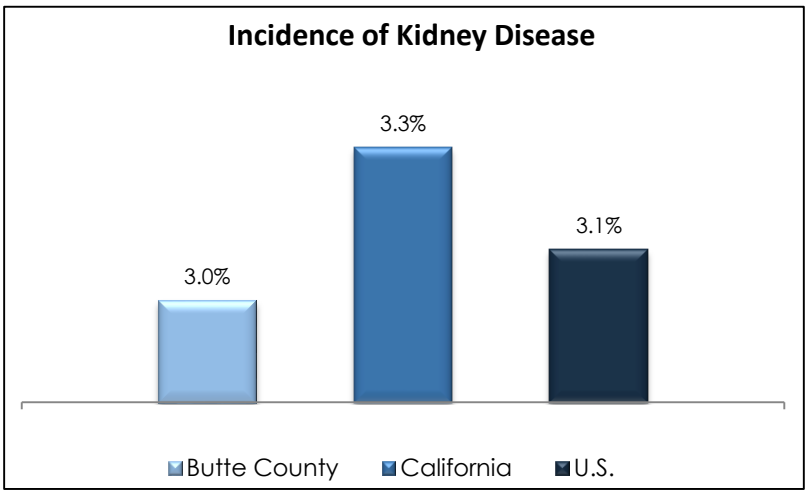
Healthy People 2020 objective CKD-1: Reduce the proportion of the U.S. population with chronic kidney disease

Healthy People 2020 objective CKD-7: Reduce the number of deaths among persons with chronic kidney disease

Chronic kidney disease (CKD) is a condition in which kidneys are damaged and cannot filter blood the way they should. In early stages, CKD may go undetected, and the only way to diagnose the condition is through specific blood and urine tests. Adults with diabetes, high blood pressure, heart disease, obesity, lupus, and a family history of CKD have a higher risk of developing the condition.[43] If untreated, the disease may progress to kidney failure – a condition currently affecting more than 661,000 Americans. Each year, kidney disease kills more people than breast and prostate cancer.[44] Eating more fruit and vegetables, staying physically active, and getting regular checkups are the best prevention methods.[43]

At 3%, the incidence of kidney disease in Butte County is on par with the statewide and nationwide rates (3.3% and 3.1%, respectively.)

Residents over the age of 65% are the highest risk of this condition.



Percentage of respondents who were told by a doctor that they had kidney disease

Demographic Characteristics	Ever Told Had Kidney Disease
Total	3.0%
Age	
18-24	-
25-34	-
35-44	-
45-54	3.0%
55-64	4.8%
65+	9.0%
Gender	
Male	3.1%
Female	3.0%
Race	
White	3.5%
Black**	-
Hispanic	-
Non-Hispanic	3.6%
Education	
< High School	2.7%
High School Grad	4.3%
Some College	2.9%
College Graduate	2.2%
Household Income	
<$20,000	2.8%
$20,000-$34,999	5.3%
$35,000-$$49,999**	3.6%
$50,000-$74,999	4.8%
$75,000 or more	3.8%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Skin Cancer

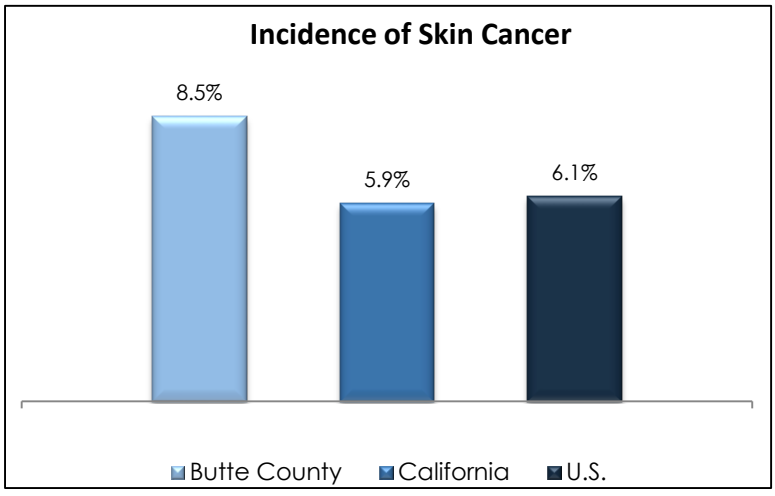
Healthy People 2020 objective C-8: Reduce the melanoma cancer death rate

Healthy People 2020 objective C-20: Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn

In the U.S., more than 9,500 people are diagnosed with skin cancer every day. On an annual basis, that is more than all other cancers combined.[35] In 2016, the melanoma type of skin cancer was the 6th most common cancer as measured by new cases nationwide. In the same year, 9,535 melanoma cases were reported in California.[36] The annual cost of treating skin cancers in the U.S. is estimated at $8.1 billion.[35]

The overall rate of skin cancer among Butte County adults is 8.5%. This figure is above both the state rate (5.9%) and the national prevalence data (6.1%).

The incidence of skin cancer is directly proportional to residents' ages, with a peak in the 65+ age segment. White respondents are also notably more likely to report having skin cancer than their Hispanic counterparts.



Percentage of respondents who were told by a doctor that they had skin cancer

Demographic Characteristics	Ever Told You Had Skin Cancer
Total	8.5%
Age	
18-24	1.9%
25-34	1.5%
35-44	4.5%
45-54	5.1%
55-64	12.7%
65+	22.8%
Gender	
Male	7.5%
Female	9.5%
Race	
White	9.4%
Black**	14.6%
Hispanic	3.2%
Non-Hispanic	9.1%
Education	
< High School	5.3%
High School Grad	6.1%
Some College	9.6%
College Graduate	9.9%
Household Income	
<$20,000	6.3%
$20,000-$34,999	9.1%
$35,000-$$49,999**	17.5%
$50,000-$74,999	19.1%
$75,000 or more	7.4%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

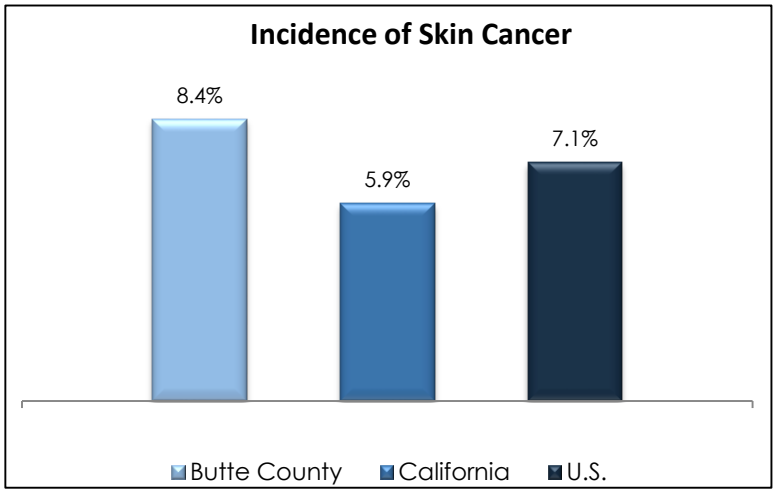
Chronic Health Conditions: Other Types of Cancer

Healthy People 2020 objective C-1: Reduce the overall cancer death rate

Cancer is the second-leading cause of death in the United States, behind heart disease. The most common cancers in the nation – breast, prostate, lungs and bronchus, and colorectal cancer – are responsible for the most deaths. Smoking is a factor in 32% of cancer deaths, and avoiding tobacco use is the best way to reduce that rate.[26] In 2017, in California, cancer was the cause of 59,516 deaths.[12] The cost of cancer care is expected to increase to nearly $158 billion by 2020.[37] The estimated cost of lost productivity from cancer mortality is $146.7 billion in 2020.[38]

The overall rate of cancer (other than skin cancer) among Butte County adults is 8.4%. This figure is higher than the state rate (5.9%) and somewhat above the national prevalence data (7.1%.)

Residents age 55+ are more likely than those younger to develop other types of cancer. Non-Hispanics are also slightly more likely to have been diagnosed with cancer than Hispanic respondents, and those in the bottom income and education brackets are somewhat more likely to have been told they had it than their more educated and more affluent counterparts.



Percentage of respondents who were told by a doctor that they had any other types of cancer

Demographic Characteristics	Ever Told Had Any Other Types of Cancer
Total	8.4%
Age	
18-24	3.5%
25-34	1.5%
35-44	8.4%
45-54	2.3%
55-64	11.9%
65+	20.4%
Gender	
Male	8.0%
Female	8.9%
Race	
White	8.3%
Black**	-
Hispanic	2.5%
Non-Hispanic	9.4%
Education	
< High School	20.4%
High School Grad	7.9%
Some College	7.2%
College Graduate	7.6%
Household Income	
<$20,000	11.0%
$20,000-$34,999	8.1%
$35,000-$$49,999**	9.1%
$50,000-$74,999	7.6%
$75,000 or more	9.3%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Cancer Survivorship: Treatment & Clinical Trial Participation

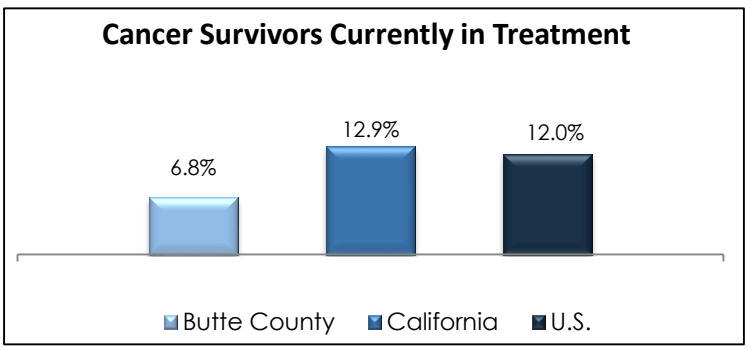
Healthy People 2020 objective C-1: Reduce the overall cancer death rate

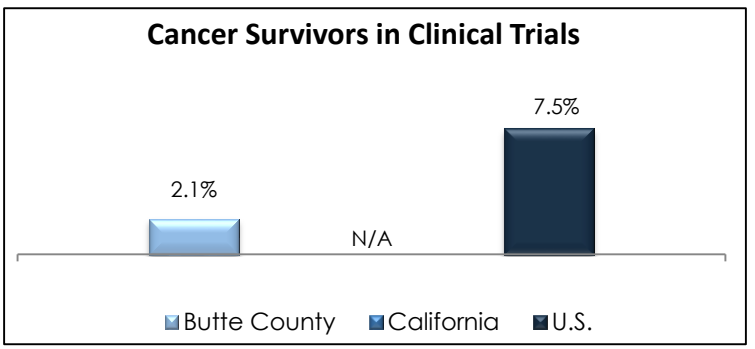
The term "cancer survivor" refers to any person with a history of cancer, from the time of the diagnosis through the remainder of their life. There are three phases of cancer survival: the time from diagnosis to the end of initial treatment, the transition from treatment to extended survival, and long-term survival.

Cancer treatments may include surgery, chemotherapy, radiation therapy, hormone therapy, immunotherapy, or stem cell/bone marrow transplant. Treatments may be used alone or in combination, depending on the kind and stage of cancer. Patients may also choose to join a clinical trial to help find out which treatments are safe and if they work well. In 2016, an estimated 15.5 million Americans survived cancer. Among them were 1.7 million Californians.[15]

A total of 6.8% of Butte County residents are cancer survivors who are currently in treatment. This is roughly half of the percentages estimated for the state and the U.S. as a whole (12.9% and 12.0%, respectively.)

Additionally, 2.1% of those who completed treatment participated in clinical trials. This is notably less than the 7.5% noted nationwide.





Percentage of respondents who are currently in treatment, and percentage of respondents who participated in clinical trial

Demographic Characteristics	Currently in Treatment	Participated in Clinical Trial
Total	6.8%	2.1%
Age		
18-24	-**	-**
25-34	-**	-**
35-44	-**	-**
45-54	-**	-**
55-64	12.1%**	-**
65+	8.4%	4.6%**
Gender		
Male**	10.6%	2.2%
Female	4.0%	2.0%
Race		
White	6.7%	2.4%%
Black**	-	-
Hispanic**	-	-
Non-Hispanic	7.5%	2.3%
Education		
< High School**	10.8%	-
High School Grad**	7.6%	2.0%
Some College**	5.4%	-
College Graduate**	6.6%	5.0%
Household Income		
<$20,000**	11.9%	2.5%
$20,000-$34,999**	16.4%	-
$35,000-$$49,999**	-	-
$50,000-$74,999**	4.6%	-
$75,000 or more**	5.5%	9.7%

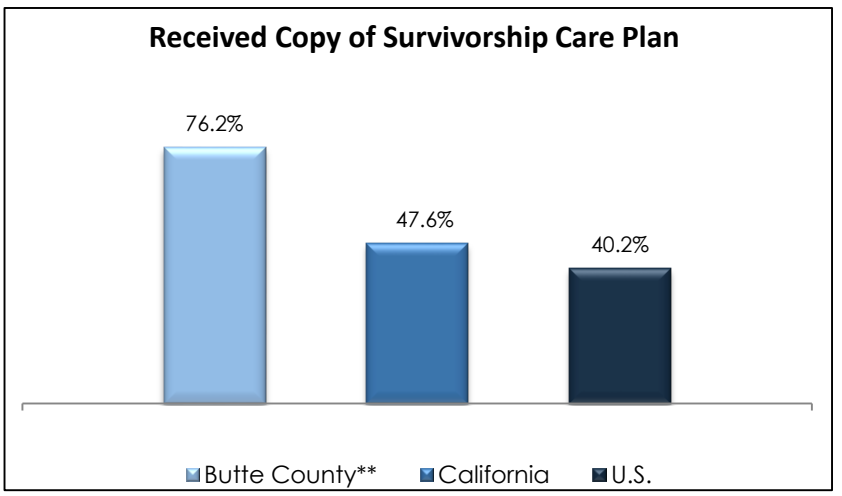
**Note: Comparative data is based on 2009 BRFSS of California Residents and 2009 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Cancer Survivorship: Survivorship Care Plan

Healthy People 2020 objective C-13: Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis

A survivorship care plan is a record of the survivor's cancer and treatment history, as well as any checkups or follow-up tests needed in the future. It may also list ideas for staying healthy. It is recommended that survivorship care plans address the chronic effects of cancer (pain, fatigue, depression/anxiety), as well as monitoring for and preventing late effects (osteoporosis, heart disease, second malignancies.) They should also explicitly identify the providers responsible for each aspect of ongoing care and provide information on resources available for psychosocial issues that may arise as a result of the prior cancer diagnosis.[32]

More than three-quarters of Butte County cancer survivors received a copy of their survivorship care plan. This percentage is observably above the state- and nationwide figures (47.6% and 40.2%;) however, this result needs to be treated with caution due to a very small sample size (n=14.)



Percentage of respondents who received copy of survivorship care plan

Demographic Characteristics	Received copy of survivorship care plan
Total**	76.2%
Age	
18-24**	-
25-34**	100%
35-44**	-
45-54**	100%
55-64**	80.0%
65+**	67.1%
Gender	
Male**	54.4%
Female**	87.8%
Race	
White**	75.5%
Black**	100.0%
Hispanic**	100.0%
Non-Hispanic**	75.5%
Education	
< High School**	-
High School Grad**	100.0%
Some College**	86.1%
College Graduate**	83.5%
Household Income	
<$20,000**	100.0%
$20,000-$34,999**	71.5%
$35,000-$$49,999**	72.5%
$50,000-$74,999**	66.5%
$75,000 or more**	100.0%

**Note: Comparative data is based on 2009 BRFSS of California Residents and 2009 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Hypertension Awareness

Healthy People 2020 objective HD S-5: Reduce the proportion of adults with hypertension

High blood pressure, also known as hypertension, is a major and modifiable risk factor for heart disease and stroke. In 2015, there were 427,631 deaths in the United States with any mention of high blood pressure, 78,862 of which were primarily attributable to high blood pressure. As of 2017, nearly half of Americans (45.6%) were estimated to have high blood pressure,[33] but because it often has no sign or symptoms, only 54% of adults with the condition have it under control.[34] High blood pressure is influenced by factors such as smoking, obesity, physical inactivity, poor diet, and excessive alcohol use.[26]

Approximately one-third of Butte County residents have ever been told by a doctor that they had high blood pressure. This is above the state figure (28.4%) and on par with the nationwide result (32.3%).

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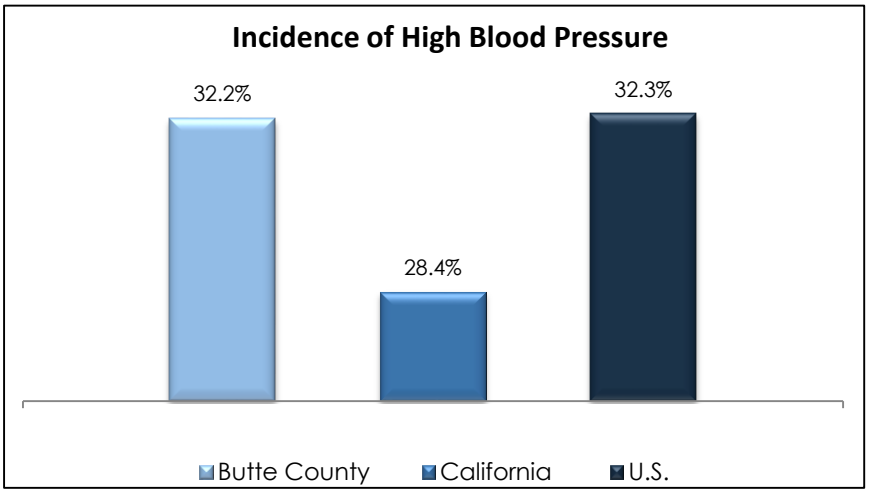
The incidence of high blood pressure increases proportionately to age and is most prevalent among African American residents.



Percentage of respondents who have ever been told by a doctor that they had high blood pressure

Demographic Characteristics	Ever Told Have High Blood Pressure
Total	32.2%
Age	
18-24	11.6%
25-34	14.8%
35-44	28.3%
45-54	32.2%
55-64	48.0%
65+	55.6%
Gender	
Male	30.6%
Female	33.8%
Race	
White	33.5%
Black**	46.9%
Hispanic	21.6%
Non-Hispanic	34.2%
Education	
< High School	32.7%
High School Grad	27.7%
Some College	31.8%
College Graduate	36.2%
Household Income	
<$20,000	38.0%
$20,000-$34,999	29.1%
$35,000-$$49,999**	34.8%
$50,000-$74,999	40.0%
$75,000 or more	36.8%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Cholesterol Awareness

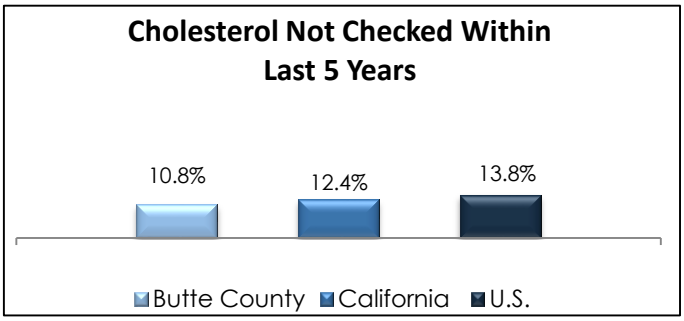
Healthy People 2020 objective HD S-6: Reduce the proportion of adults with who have had their blood cholesterol checked within the preceding 5 years

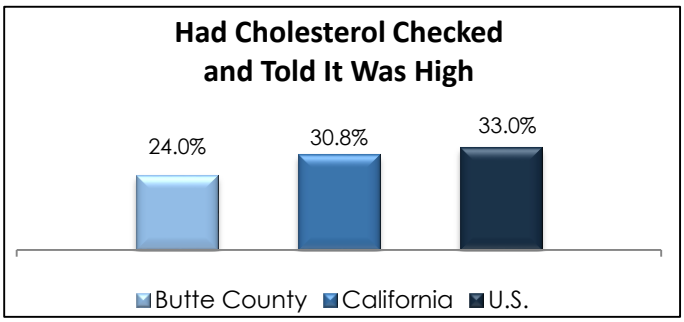
Healthy People 2020 objective HD S-7: Reduce the proportion of adults with high total blood cholesterol levels

High cholesterol is a major and modifiable risk factor for heart disease and stroke. The American Heart Association recommends adults aged 20+ have their cholesterol checked every 4-to-6 years. High cholesterol has no symptoms, but it can be detected with a simple blood test.[26] At present, an estimated 28.5 million Americans have high cholesterol levels.[33]

A total of 11% of Butte County residents have not had their blood cholesterol checked within the last 5 years. This result is below the figures noted for California as a whole (12.4%) and the U.S. (13.8%). Respondents most likely not to have their cholesterol checked include those with less than high school education and those with incomes below the $35,000 threshold.

Additionally, just under one-quarter (24%) had their blood cholesterol checked and have been told that it was high. Again, this is below the state- and nationwide figures (30.8% and 33%, respectively.) High cholesterol levels are most prevalent among non-Hispanics, and increase proportionately to residents' age.





Percentage of respondents who have had blood cholesterol checked within the last 5 years, and percentage of respondents told it was high

Demographic Characteristics	Cholesterol Not Checked Within Last 5 Years	Cholesterol Checked and Told It Was High
Total	10.8%	24.0%
Age		
18-24	10.2%	2.0%
25-34	25.9%	10.3%
35-44	11.1%	18.7%
45-54	4.2%	27.5%
55-64	10.0%	36.5%
65+	4.9%	42.2%
Gender		
Male	12.3%	24.5%
Female	9.1%	23.5%
Race		
White	10.5%	25.8%
Black**	8.6%	22.9%
Hispanic	13.8%	17.1%
Non-Hispanic	10.5%	25.0%
Education		
< High School	17.0%	24.9%
High School Grad	9.5%	22.3%
Some College	10.8%	19.0%
College Graduate	10.3%	29.7%
Household Income		
<$20,000	13.3%	26.2%
$20,000-$34,999	28.4%	26.5%
$35,000-$$49,999**	5.0%	35.3%
$50,000-$74,999	3.7%	29.3%
$75,000 or more	4.5%	27.6%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

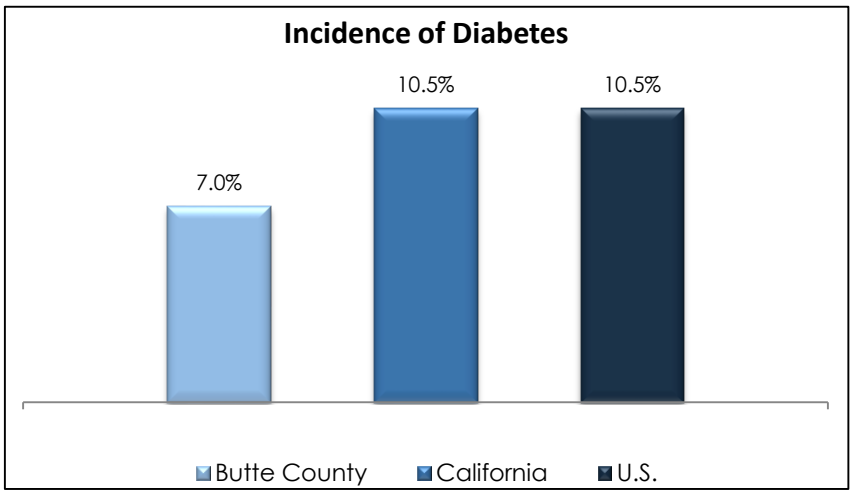
Diabetes

Healthy People 2020 objective D-1: Reduce the annual number of new cases of diagnosed diabetes in the population

Diabetes mellitus is a chronic disease characterized by high glucose levels, owing to insufficient production of insulin by the pancreas or to a reduction in the body's ability to use insulin. In the last 20 years, the number of adults diagnosed with diabetes has more than tripled as the US population has aged and become more overweight.[16] In California, diabetes was the seventh leading cause of death with 9,595 deaths in 2017.[17] Obesity, physical inactivity, being 45 years or older, and/or having a family history of diabetes are just a few of the known risk factors that are associated with the development of diabetes.[18]

At 7.0%, the incidence of diabetes among Butte County residents is considerably lower than the state- and nationwide rates (10.5% each.)

Incidence of diabetes increases substantially with the age of residents. It is also somewhat higher among individuals with less than high school education, and among those with lower income levels (up to $49,999 per year.)



Percentage of respondents who had ever been told by a doctor that they have diabetes (excluding gestational diabetes)

Demographic Characteristics	Ever Told You Have Diabetes
Total	7.0%
Age	
18-24	-
25-34	-
35-44	4.2%
45-54	7.1%
55-64	13.5%
65+	15.6%
Gender	
Male	6.9%
Female	7.1%
Race	
White	6.8%
Black**	13.2%
Hispanic	5.6%
Non-Hispanic	7.4%
Education	
< High School	14.2%
High School Grad	4.5%
Some College	6.6%
College Graduate	7.8%
Household Income	
<$20,000	7.3%
$20,000-$34,999	15.5%
$35,000-$$49,999**	11.9%
$50,000-$74,999	5.1%
$75,000 or more	4.6%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

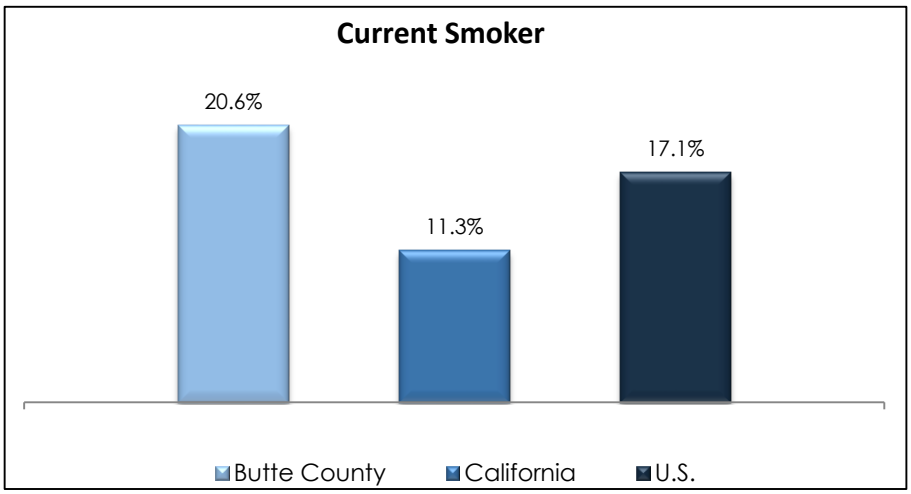
Tobacco Use

Healthy People 2020 objective TU-1: Reduce tobacco use by adults
Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

Smoking contributes to the development of many kinds of chronic conditions, including cancers, respiratory diseases, diabetes, and cardiovascular diseases. It is "the leading cause of preventable death"[19] and "one of the biggest public health threats the world has ever faced, killing more than 8 million people a year."[20] It has been estimated that smoking costs the United States more than $170 billion in annual medical costs and another $156 billion in lost economic productivity,[21] as well as over 5 million years of potential life lost each year.[22] Current smoking status is defined as ever having smoked 100 cigarettes (five packs) and smoking cigarettes now, either every day or on some days.

Approximately one-fifth (20.6%) of Butte County residents are current smokers, based on the definition cited above. This figure is substantially above the state- and nationwide rates (11.3% and 17.1%).

Prevalence of smoking is least common among respondents under the age of 24 and over the age of 65, as well as college graduates. Females are also slightly less likely to be current smokers than males.



Percentage of respondents who are current smokers

Demographic Characteristics	Current Smoker
Total	20.6%
Age	
18-24	18.8%
25-34	25.9%
35-44	28.6%
45-54	22.7%
55-64	22.6%
65+	10.2%
Gender	
Male	23.1%
Female	18.2%
Race	
White	21.1%
Black**	37.3%
Hispanic	16.7%
Non-Hispanic	20.9%
Education	
< High School	30.6%
High School Grad	25.4%
Some College	23.6%
College Graduate	11.9%
Household Income	
<$20,000	28.1%
$20,000-$34,999	31.7%
$35,000-$$49,999**	5.3%
$50,000-$74,999	28.6%
$75,000 or more	8.7%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

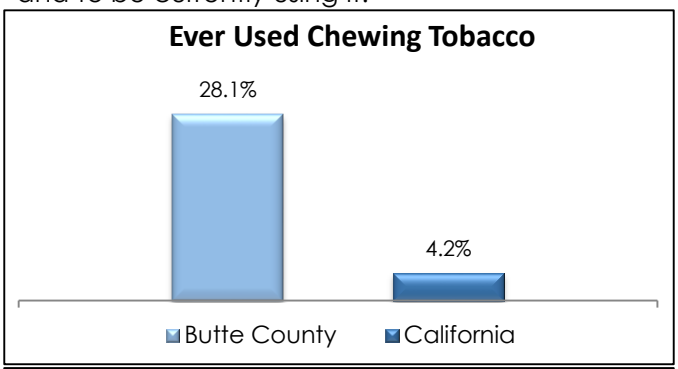
Other Tobacco Use: Chewing Tobacco

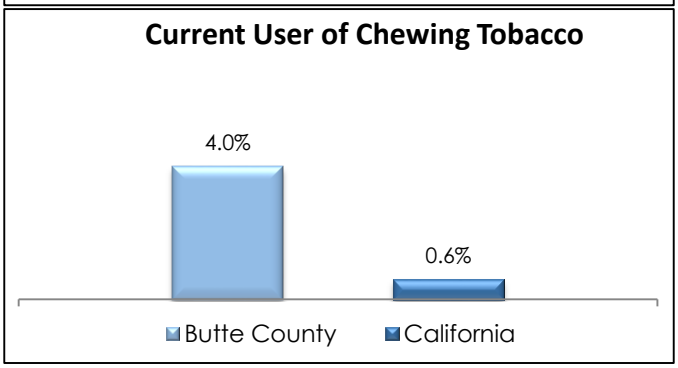
Healthy People 2020 objective TU-1.2: Reduce use of smokeless tobacco products by adults

Chewing tobacco and snuff are commonly used forms of tobacco in the United States in addition to cigarettes. Several oral health problems are associated with smokeless tobacco including receding gums, mouth sores and plaques, dental cavities and tooth abrasions.[22] Smokeless tobacco is a known cause of oral cancer and oral disease, and also may increase risk of pancreatic cancers, early delivery and stillbirth, heart disease and stroke.[22] Current user status is defined as having used chewing tobacco at least once during lifetime and using it on 1 or more day in the past 30 days.

Nearly three in ten residents of Butte County have ever used chewing tobacco, and a total of 4% are current users, as defined above. Both metrics are notably above statewide figures.

Males are notably more likely than females to have ever used chewing tobacco and to be current users. Likewise, residents in the top income bracket ($75+) are more likely than their less affluent counterparts to have ever tried it and to be currently using it.





Percentage of respondents who have ever used chewing tobacco, and percentage of respondents who are current users of chewing tobacco

Demographic Characteristics	Ever Used Chewing Tobacco	Current User of Chewing Tobacco
Total	28.1%	4.0%
Age		
18-24	18.2%	2.4%
25-34	35.0%	8.9%
35-44	42.0%	7.3%
45-54	42.7%	3.2%
55-64	26.9%	3.6%
65+	10.8%	0.8%
Gender		
Male	45.7%	7.1%
Female	10.8%	1.1%
Race		
White	30.7%	4.4%
Black**	41.8%	8.6%
Hispanic	25.0%	2.2%
Non-Hispanic	27.9%	4.4%
Education		
< High School	25.4%	9.7%
High School Grad	35.1%	5.5%
Some College	28.0%	2.0%
College Graduate	23.5%	3.8%
Household Income		
<$20,000	23.7%	3.6%
$20,000-$34,999	27.5%	1.5%
$35,000-$$49,999**	14.9%	4.1%
$50,000-$74,999	20.1%	2.8%
$75,000 or more	32.6%	6.5%

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

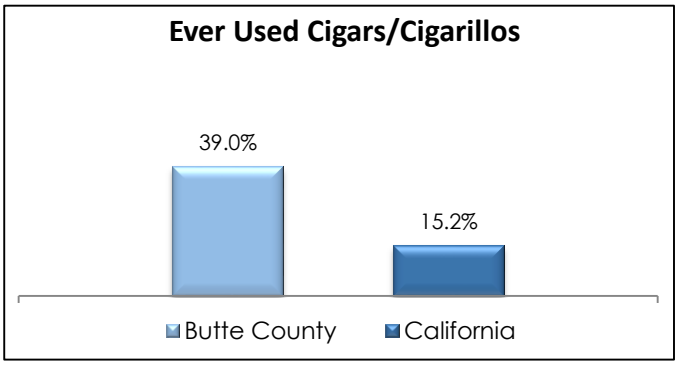
Other Tobacco Use: Cigars/Cigarillos

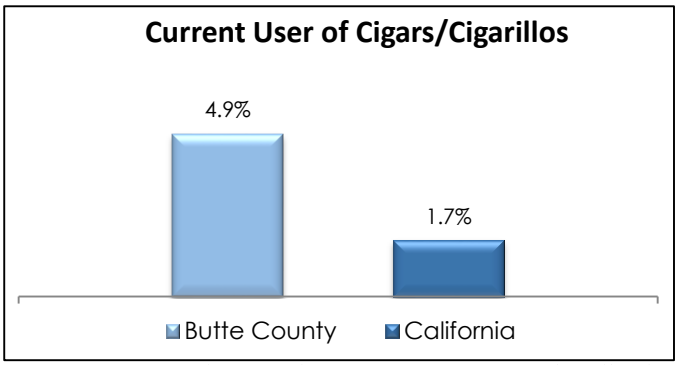
Healthy People 2020 objective TU-1.3: Reduce use of cigars, cigarillos, and little filtered cigars by adults

Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

In the United States, cigarette consumption declined during 2000-2011. However, consumption of cigars more than doubled during the same period.[47] The three major types of cigars sold in the U.S. are large cigars, cigarillos and little cigars. All of them contain the same toxic and carcinogenic compounds found in cigarettes, and are associated with an increased risk for cancers of the lung, oesophagus, larynx, and oral cavity. They are also linked to gum disease and tooth loss, coronary heart disease, and lung diseases (such as emphysema and chronic bronchitis).[48] Current user status is defined as having used cigars/cigarillos at least once during lifetime and using them on 1 or more day in the past 30 days.

Approximately four in ten residents of Butte County have ever used cigars or cigarillos/little cigars, and a total of 4.9% are current users. Both metrics are notably above statewide figures. Males are more likely than females to have ever used and to be currently using cigars/cigarillos,





Percentage of respondents who have ever used cigars/cigarillos, and percentage of respondents who are current users of cigars/cigarillos

Demographic Characteristics	Ever Used Cigars/ Cigarillos	Current User of Cigars/ Cigarillos
Total	39.0%	4.9%
Age		
18-24	25.5%	5.9%
25-34	49.5%	8.1%
35-44	49.6%	8.2%
45-54	38.0%	3.3%
55-64	42.6%	4.5%
65+	34.1%	1.3%
Gender		
Male	54.2%	6.6%
Female	24.1%	3.3%
Race		
White	41.1%	4.5%
Black**	34.1%	-
Hispanic	39.2%	5.2%
Non-Hispanic	38.4%	4.9%
Education		
< High School	38.6%	9.7%
High School Grad	37.7%	6.7%
Some College	41.2%	4.5%
College Graduate	37.8%	3.0%
Household Income		
<$20,000	34.2%	6.7%
$20,000-$34,999	47.8%	5.2%
$35,000-$$49,999**	32.3%	2.1%
$50,000-$74,999	41.6%	10.8%
$75,000 or more	48.4%	0.6%

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

Other Tobacco Use: Tobacco Pipe

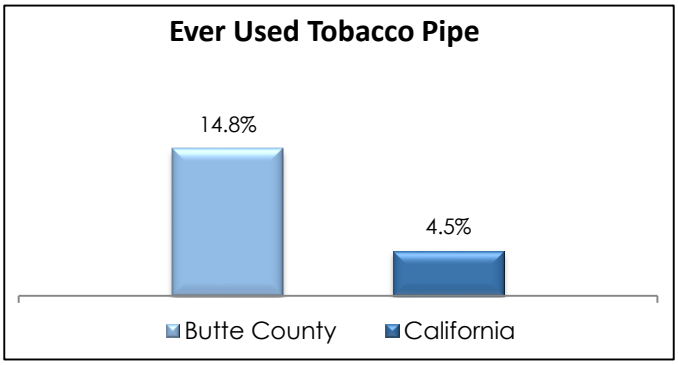
Healthy People 2020 objective TU-1: Reduce tobacco use by adults

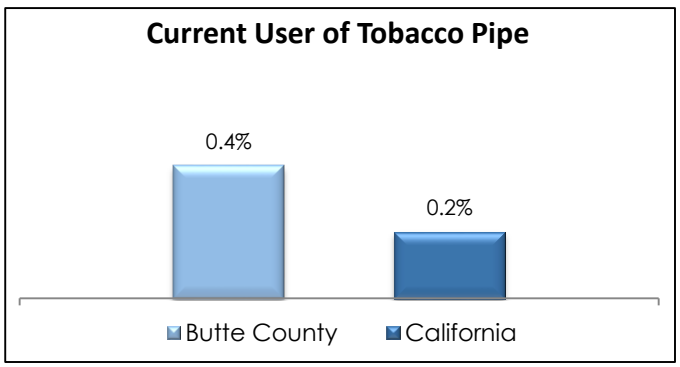
Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

Pipe smoking consists of loose leaf tobacco that is fire-cured and burned in a traditional pipe with a bowl and a mouthpiece. Although pipe smoking has dwindled over the years, the proportion of respondents who have ever used it varies by state and ranges from 3% to 12%.[6] Like cigarettes, pipe tobacco contains toxic chemicals that increase the risk for some cancers. Current user status is defined as having used tobacco pipe at least once during lifetime and using it on 1 or more day in the past 30 days.

A total of 14.8% of Butte County residents have ever used a tobacco pipe – a figure much above the rate observed for California. The current use of tobacco pipes is marginal, at 0.4%; this result is consistent with the statewide result (0.2%.)

Males and white/non-Hispanic residents are most likely to have ever used, and to be currently using, tobacco pipe.





Percentage of respondents who have ever used tobacco pipe, and percentage of respondents who are current users of tobacco pipe

Demographic Characteristics	Ever Used Tobacco Pipe	Current User of Tobacco Pipe
Total	14.8%	0.4%
Age		
18-24	3.5%	-
25-34	10.8%	-
35-44	23.8%	3.3%
45-54	12.7%	-
55-64	14.7%	-
65+	24.2%	-
Gender		
Male	24.1%	0.5%
Female	5.7%	0.4%
Race		
White	15.9%	0.5%
Black**	5.3%	-
Hispanic	7.6%	-
Non-Hispanic	16.0%	0.5%
Education		
< High School	20.8%	-
High School Grad	15.4%	-
Some College	15.4%	0.7%
College Graduate	12.6%	0.6%
Household Income		
<$20,000	18.7%	-
$20,000-$34,999	16.1%	-
$35,000-$$49,999**	12.0%	-
$50,000-$74,999	22.6%	-
$75,000 or more	21.1%	1.1%

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

Other Tobacco Use: Hookah Water Pipe

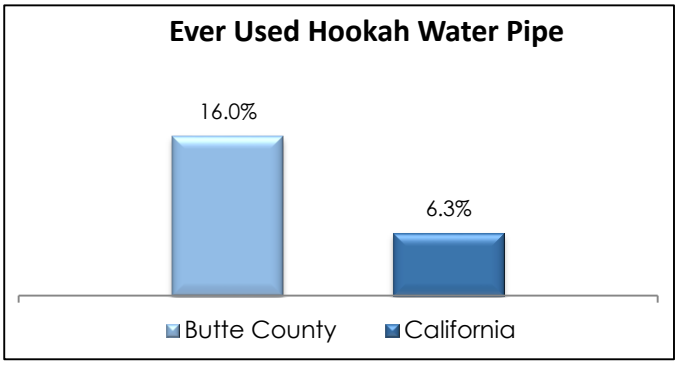
Healthy People 2020 objective TU-1: Reduce tobacco use by adults

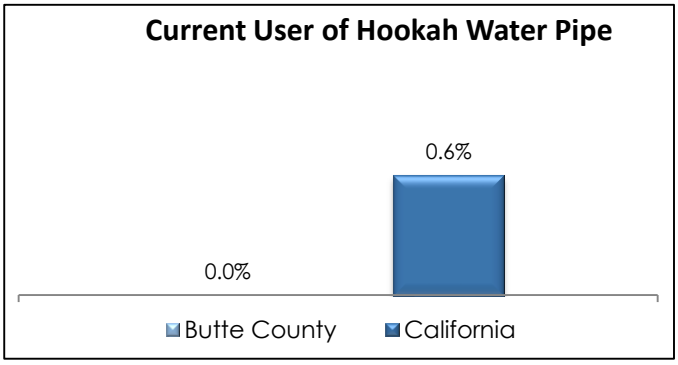
Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

Hookahs are water pipes that are used to smoke specially made tobacco that comes in different flavors. Although many users think it is less harmful, hookah smoking has many of the same risks as cigarette smoking, including oral cancer, lung cancer, stomach cancer, cancer of the oesophagus, and reduced lung function.[49] Current user status is defined as having used hookah at least once during lifetime and using it on 1 or more day in the past 30 days.

A total of 16.0% of Butte County residents have ever used a hookah pipe – a figure much above the rate observed for California (6.3%.) However, there are no current users of hookah in the County – a result fairly consistent with the state figure of only 0.6%.

Residents age 25-44 are most likely to have ever tried hookah, and males are more likely to have done so than females. Additionally, Hispanic residents and those with some college-level work completed report having tried it more often than their counterparts.





Percentage of respondents who have ever used hookah water pipe, and percentage of respondents who are current users of hookah water pipe

Demographic Characteristics	Ever Used Hookah Water Pipe	Current User of Hookah Water Pipe
Total	16.0%	-
Age		
18-24	17.0%	-
25-34	37.4%	-
35-44	21.0%	-
45-54	6.9%	-
55-64	11.4%	-
65+	5.8%	-
Gender		
Male	20.5%	-
Female	11.6%	-
Race		
White	15.0%	-
Black**	4.6%	-
Hispanic	28.6%	-
Non-Hispanic	13.7%	-
Education		
< High School	8.4%	-
High School Grad	13.7%	-
Some College	20.0%	-
College Graduate	15.3%	-
Household Income		
<$20,000	11.0%	-
$20,000-$34,999	23.7%	-
$35,000-$$49,999**	13.1%	-
$50,000-$74,999	21.2%	-
$75,000 or more	23.0%	-

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

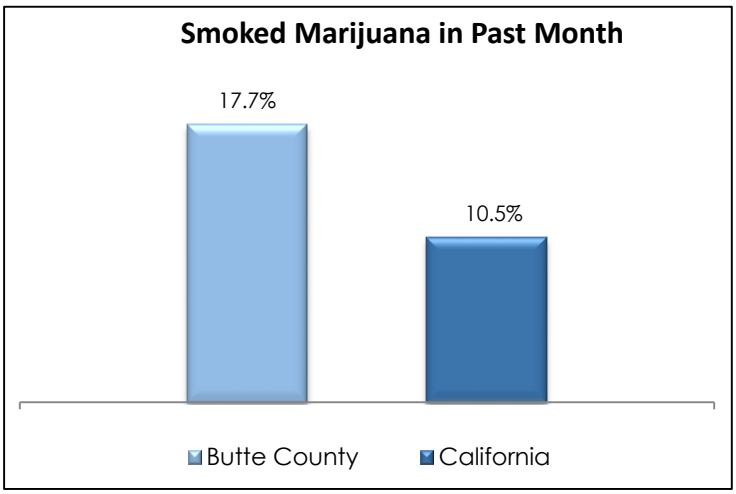
Marijuana Use

Healthy People 2020 objective SA-13: Reduce past-month use of illicit substances

While legalized in many states, marijuana is still considered an illicit substance in others. Its use is on the rise, with 37.6 million users in the U.S. in 2016.[50] Only from 2002 to 2014, the prevalence of past month marijuana use went up by 35% among persons age 12+, with the increases being greatest among adults age 55+.[51] Heavy or frequent marijuana use has a negative effect on attention, memory, and learning, and has been linked to depression and anxiety.[52] Smoked marijuana also includes many of the same substances found in tobacco smoke, which are harmful to the lungs and cardiovascular system, and could lead to increased risk of stroke and heart disease.[53]

A total of 17.7% of Butte County residents have smoked marijuana or hashish at least once within the past 30 days. This is notably above the figure noted for California as a state (10.5%.)

This result is driven mostly by respondents in the younger age categories (up to 44 years old,) males, and Caucasians. The likelihood to report having smoked marijuana in the past month is also inversely proportional to the education level.



Percentage of respondents who smoked marijuana/hashish 1+ day within past 30 days

Demographic Characteristics	Smoked Marijuana/Hashish 1+ Day Within Past 30 Days
Total	17.7%
Age	
18-24	22.6%
25-34	22.5%
35-44	24.6%
45-54	14.6%
55-64	17.0%
65+	8.1%
Gender	
Male	22.7%
Female	12.9%
Race	
White	18.5%
Black**	5.3%
Hispanic	15.9%
Non-Hispanic	17.8%
Education	
< High School	33.1%
High School Grad	27.4%
Some College	14.2%
College Graduate	10.7%
Household Income	
<$20,000	23.7%
$20,000-$34,999	15.1%
$35,000-$$49,999**	4.8%
$50,000-$74,999	21.1%
$75,000 or more	8.6%

*Note: Comparative data is based on 2016 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents

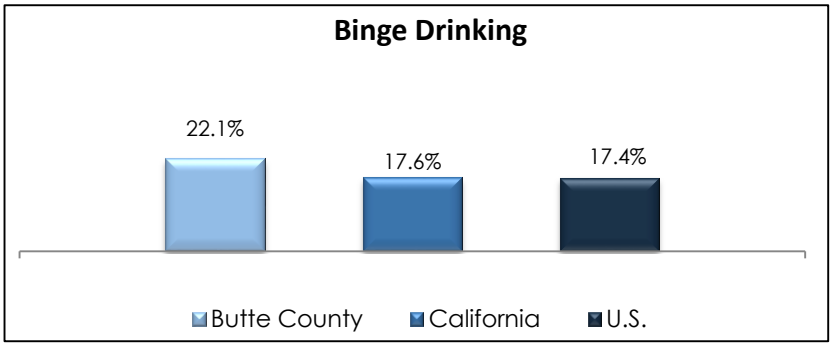
Alcohol Consumption

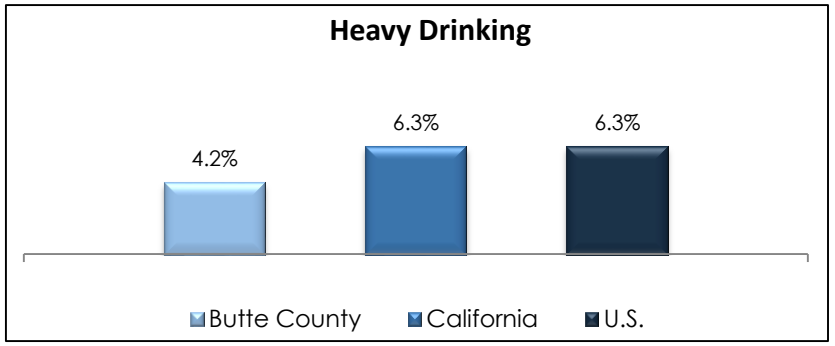
Healthy People 2020 objective SA-8.3: Reduce the proportion of persons engaging in binge drinking during the past 30 days – adults aged 18 years and older

Healthy People 2020 objective SA-15: Reduce the proportion of adults who drank excessively in the previous 30 days

Alcohol abuse has been associated with serious health problems such as cirrhosis of the liver, high blood pressure, stroke, and some types of cancer, and can increase the risk for motor vehicle accidents, injuries, violence, and suicide. In California, the percent of fatal motor vehicle crashes that involved any alcohol was 31% in 2017.[23] Binge drinking is defined as consuming five or more drinks per occasion (for men) or 4 or more drinks per occasion (for women) at least once in the past month, while heavy drinking is defined as consuming more than two alcoholic drinks per day (for men) or more than one drink per day (for women) in the past month.

At 4.2%, the rate of heavy drinking among Butte County residents is below state and nationwide levels (6.3% each.) At the same time, however, the rate of binge drinking (22.1%) exceeds the California and U.S. figures (17.6% and 17.4%, respectively). The highest rates of binge drinking are observed among respondents under the age of 54, as well as Caucasian males, and respondents without a college degree. Heavy drinking is driven by males.





Percentage of respondents reporting heavy drinking and percentage of respondents reporting binge drinking

Demographic Characteristics	Heavy Drinking	Binge Drinking
Total	4.2%	22.1%
Age		
18-24	5.3%	30.5%
25-34	1.5%	23.9%
35-44	3.1%	36.4%
45-54	2.3%	26.7%
55-64	6.4%	14.8%
65+	5.3%	5.5%
Gender		
Male	6.3%	31.2%
Female	2.1%	13.2%
Race		
White	4.6%	23.7%
Black**	-	5.3%
Hispanic	3.9%	21.3%
Non-Hispanic	4.2%	21.5%
Education		
< High School	0.9%	31.7%
High School Grad	5.6%	25.7%
Some College	4.4%	23.7%
College Graduate	3.6%	15.8%
Household Income		
<$20,000	5.7%	22.9%
$20,000-$34,999	1.0%	16.7%
$35,000-$$49,999**	5.3%	11.1%
$50,000-$74,999	3.1%	20.7%
$75,000 or more	4.0%	16.9%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

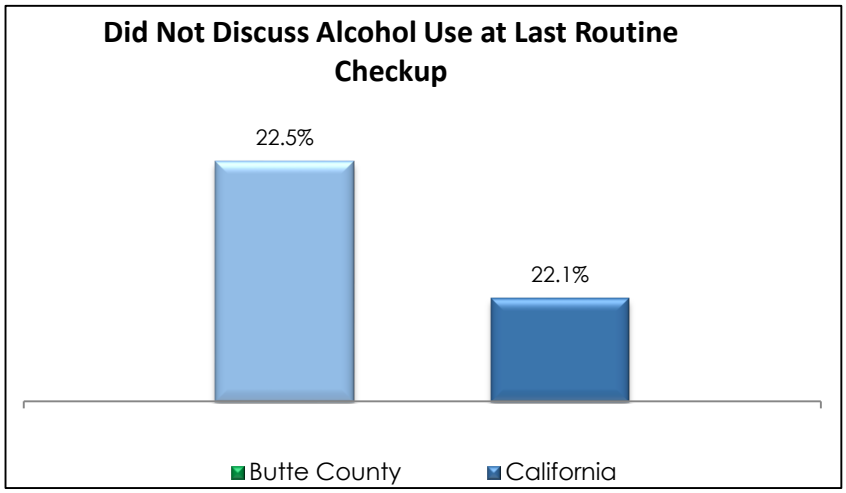
Alcohol Screening & Brief Intervention: Screened for Alcohol Consumption

Healthy People 2020 objective SA-8.3: Increase the proportion of persons who need alcohol abuse or dependence treatment and received specialty treatment for abuse or dependence in the past year

Risky alcohol use (heavy and binge drinking) contributes to a wide range of negative health and social consequences, including motor vehicle crashes, intimate partner violence, and fetal alcohol spectrum disorders. Over time, it can result in serious medical conditions, such as hypertension, gastritis, liver disease and various cancers. Alcohol Screening & Brief Intervention (ASBI) is a preventive service like hypertension or cholesterol screening that can occur as a part of a patient's wellness visit. ASBI involves a brief set of screening questions designed to identify patients' drinking patterns, a short conversation with those who are drinking too much, and referral to treatment, as appropriate.[56]

More than one-fifth (22.5%) of Butte County residents who had their routine checkup reports that they did not discuss alcohol use with their health care provider. This result is on par with California statistics (22.1%.)

Older respondents (65+ years of age), as well as those with lower levels of education (high school graduate or less) are most likely to say they were not screened for alcohol consumption.



*Note: Comparative data is based on 2014 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents

Percentage of respondents not screened for alcohol consumption at last routine checkup

Demographic Characteristics	Not Screened for Alcohol Consumption
Total	22.5%
Age	
18-24	19.8%
25-34	29.5%
35-44	10.1%
45-54	15.2%
55-64	18.9%
65+	36.8%
Gender	
Male	21.5%
Female	23.4%
Race	
White	21.2%
Black**	33.9%
Hispanic	17.9%
Non-Hispanic	23.0%
Education	
< High School**	29.9%
High School Grad	30.6%
Some College	16.7%
College Graduate	21.2%
Household Income	
<$20,000	22.2%
$20,000-$34,999	20.8%
$35,000-$$49,999**	26.0%
$50,000-$74,999**	25.3%
$75,000 or more	16.8%

Alcohol Screening & Brief Intervention: Given Advise on Harmful Levels of Drinking

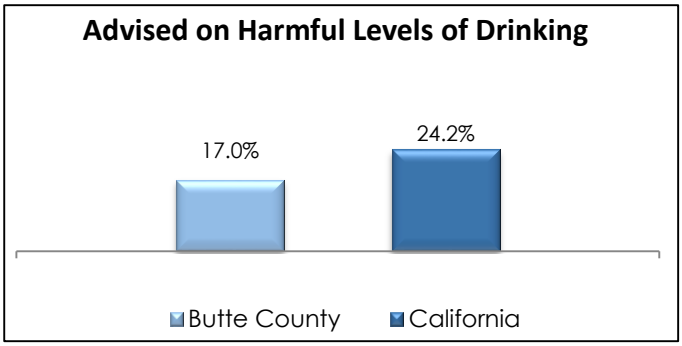
Healthy People 2020 objective SA-8.3: Increase the proportion of persons who need alcohol abuse or dependence treatment and received specialty treatment for abuse or dependence in the past year

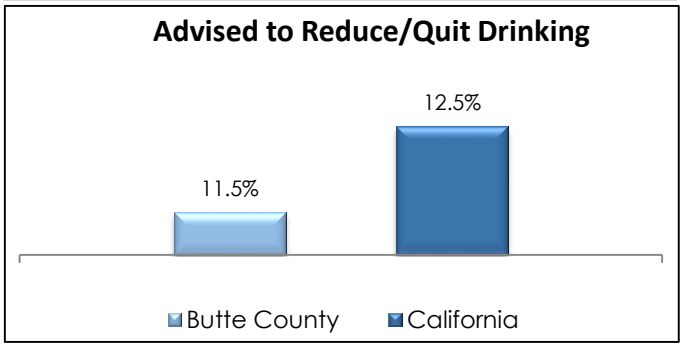
ASBI aims to increase a person's awareness of their alcohol use and motivate them to reduce risky drinking patterns and/or seek treatment. [57] *A review of studies shows a reduction in alcohol consumption from 13% to 34% among those who received brief intervention.*[58]

A total of 17.0% of Butte County residents say they were advised on harmful levels of drinking during their routine checkup, and 11.5% were advised to drink less. Both metrics are below the statewide results (24.2% and 12.5%, respectively.)

Older residents, i.e., those age 45+ are less likely to have discussed risky levels of drinking, as are females and those in the middle income categories ($20,000-$74,999.)

Among those asked about drinking, respondents most likely to receive advice on limiting alcohol consumption include individuals age 35-44, males, and those in the bottom and top income brackets (under $20,000 and over $75,000.)





Percentage of respondents who were offered advise on harmful levels of drinking, and percentage of respondents advised to drink less

Demographic Characteristics	Advised on Harmful Levels of Drinking	Advised to Reduce/Quit Drinking
Total	17.0%	11.5%
Age		
18-24	25.2%	10.9%
25-34	19.7%	14.0%
35-44	28.5%	18.9%
45-54	13.7%	10.9%
55-64	14.1%	6.2%
65+	7.8%	10.2%
Gender		
Male	24.4%	18.0%
Female	10.2%	5.3%
Race		
White	17.4%	10.9%
Black	31.7**	24.0%**
Hispanic	26.9%	12.7%**
Non-Hispanic	15.6%	11.5%
Education		
< High School	12.9%**	26.4%**
High School Grad	14.2%	6.4%
Some College	17.7%	9.5%
College Graduate	19.2%	14.0%
Household Income		
<$20,000	18.3%	19.5%
$20,000-$34,999	4.9%	3.8%**
$35,000-$$49,999	9.7%**	6.5%**
$50,000-$74,999	9.5%**	5.4%**
$75,000 or more	19.4%	16.6%

**Note: Comparative data is based on 2014 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

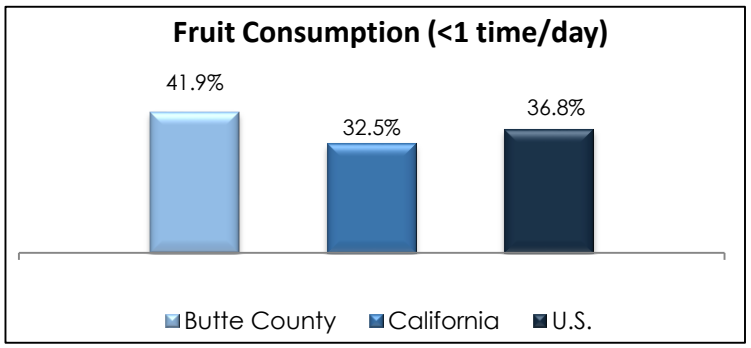
Fruit & Vegetable Consumption

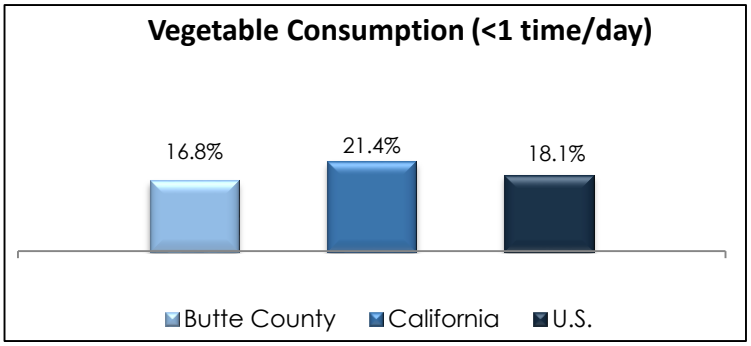
Healthy People 2020 objective NWS-14: Increase the contribution of fruits to the diets of the population aged 2 years and older

Healthy People 2020 objective NWS-15: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older

Eating a diet rich in fruits and vegetables can help reduce the risk of developing many chronic diseases, including heart disease, diabetes, some cancers and obesity.[24] Fruits and vegetables are also major contributors of a number of nutrients (such as potassium, dietary fiber, magnesium, as well as vitamins A, C, and K) that are currently underconsumed in the United States.[25] National findings indicate that, on average, adults consume 1.4 fruits per day and 1.9 vegetables per day.[26] Currently, only 12.2% of adults meet their daily fruit recommendation (2 cups daily), and only 9.3% meet the vegetable recommendation (2.5 cups).[27]

More than four in ten Butte County residents (41.9%) consume fruit less than 1 time per day, and 16.8% consume vegetables less than 1 time per day. Limited fruit consumption exceeds the figures reported in state- and nationwide BRFS studies. However, limited vegetable consumption is lower than what was reported in Michigan and the U.S. in general. The lowest fruit and vegetable consumption is reported by males, respondents with less than high school diploma, and those with incomes under $20,000.





Percentage of respondents who reported limited fruit and vegetable consumption

Demographic Characteristics	Fruits (<1 time/day)	Vegetables (<1 time /day)
Total	41.9%	16.8%
Age		
18-24	52.1%	19.1%
25-34	37.5%	21.7%
35-44	52.1%	11.1%
45-54	45.3%	12.4%
55-64	39.7%	20.4%
65+	29.6%	16.3%
Gender		
Male	48.5%	18.6%
Female	35.6%	15.1%
Race		
White	41.2%	16.4%
Black**	15.5%	8.6%
Hispanic	42.9%	18.1%
Non-Hispanic	42.2%	16.2%
Education		
< High School	61.3%	35.6%
High School Grad	42.6%	14.3%
Some College	45.0%	16.5%
College Graduate	34.0%	15.3%
Household Income		
<$20,000	53.7%	27.0%
$20,000-$34,999	36.7%	19.6%
$35,000-$$49,999**	26.9%	16.3%
$50,000-$74,999	37.6%	18.2%
$75,000 or more	46.6%	14.2%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

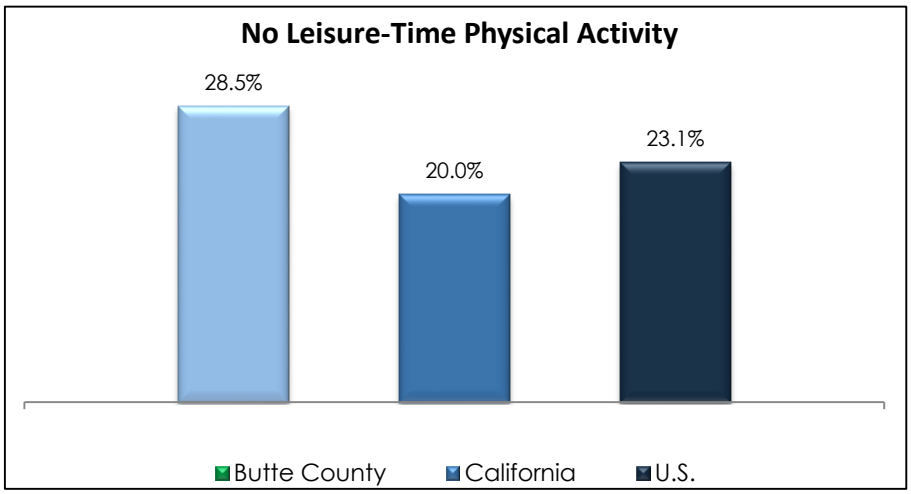
Physical Activity

Healthy People 2020 objective PA-1: Reduce the proportion of adults who engage in no leisure-time physical activity

Regular physical activity has been shown to reduce the risk of premature mortality and a number of chronic diseases, such as cancer, cardiovascular disease, and diabetes. Keeping physically active not only helps maintain a healthy body weight and normal muscle strength, bone mass, and joint function, but it can also relieve symptoms of anxiety and depression, and improve sleep.[28] The Healthy People target for no leisure-time physical activity is set at 32.6%.

The percentage of Butte County residents who report no leisure-time physical activity stands at 28.5%, which is above the state- and nationwide rates (20% and 23.1%, respectively). The prevalence of no leisure-time activity among Butte County adults is currently 4.1 points below the 2020 target of 32.6%, indicating that this Healthy People objective can be considered met.

Leisure-time physical activity is least prevalent among those age 25-34, as well as the oldest respondent segment (age 65+.) Moreover, the likelihood of engaging in physical activity increases in proportion to respondents' income, with those making less than $35,000 per year being most apt to report no activity.



Percentage of respondents who reported no leisure-time physical activity

Demographic Characteristics	No Physical Activity
Total	28.5%
Age	
18-24	26.3%
25-34	37.2%
35-44	20.5%
45-54	28.4%
55-64	28.2%
65+	30.9%
Gender	
Male	30.3%
Female	26.7%
Race	
White	27.9%
Black**	25.8%
Hispanic	31.8%
Non-Hispanic	27.6%
Education	
< High School	33.8%
High School Grad	28.6%
Some College	32.4%
College Graduate	23.5%
Household Income	
<$20,000	42.7%
$20,000-$34,999	44.5%
$35,000-$$49,999**	20.0%
$50,000-$74,999	19.9%
$75,000 or more	16.7%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

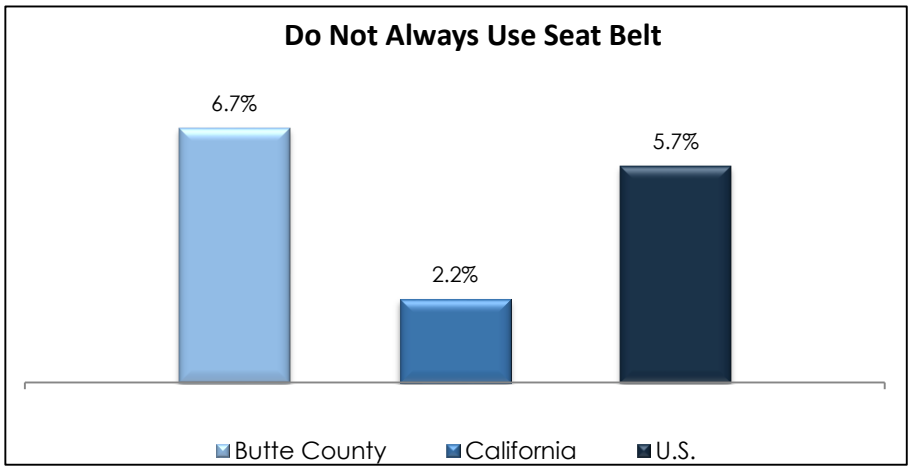
Seatbelt Use

Healthy People 2020 objective IVP-13: Reduce motor vehicle crash-related deaths
Healthy People 2020 objective IVP-15: Increase use of safety belts

In 2017, 3,602 people died in automobile accidents in California, with an additional 14,188 people sustaining serious injuries. Among the fatalities, 600 passengers were unrestrained.[23] Seatbelt use has been proven to save lives and prevent injuries. It has been estimated that, among drivers and front seat passengers, seat belts reduce the risk of death by 45%, and cut the risk of serious injury by 50%.[30] With 97.8% reporting consistent seatbelt use, California is the healthies state on this metric.

A total of 6.7% of Butte County residents do not always use a seatbelt when driving or riding in a car. This is substantially above the California-wide rate (2.2%) and somewhat below the nationwide figure (5.7%.)

The youngest respondents (18-24 years of age,) as well as males and those with less than a college degree are more likely than their counterparts to say they do not always wear a seatbelt.



Percentage of respondents who do not always use seatbelts when driving/riding in the car

Demographic Characteristics	Do Not Always Use Seatbelt
Total	6.7%
Age	
18-24	12.7%
25-34	3.3%
35-44	7.3%
45-54	2.1%
55-64	6.7%
65+	7.4%
Gender	
Male	8.6%
Female	4.8%
Race	
White	6.5%
Black**	-
Hispanic	11.2%
Non-Hispanic	5.7%
Education	
< High School	6.3%
High School Grad	9.6%
Some College	7.5%
College Graduate	3.7%
Household Income	
<$20,000	3.9%
$20,000-$34,999	6.2%
$35,000-$$49,999**	2.1%
$50,000-$74,999	10.4%
$75,000 or more	5.7%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Adult Immunization: Flu and Pneumonia Shots

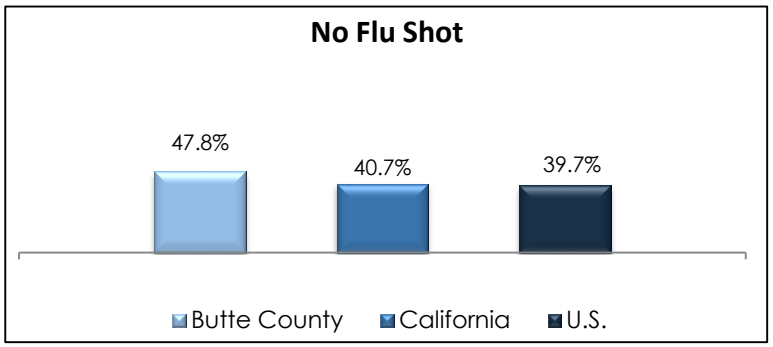
Healthy People 2020 objective IID-12.12: Increase the percentage of noninstitutionalized adults aged 18 years and older who are vaccinated annually against seasonal influenza

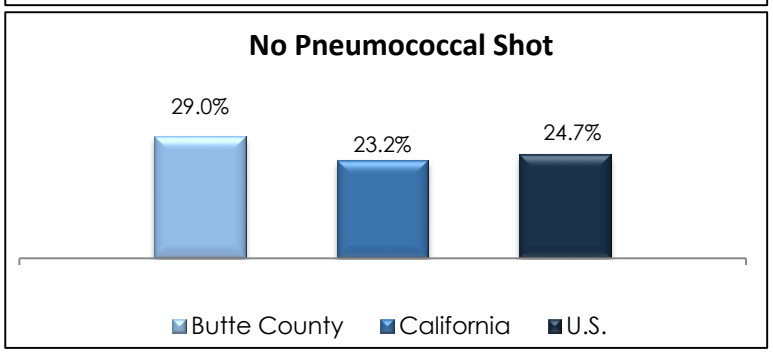
Healthy People 2020 objective IID-13.1: Increase the percentage of noninstitutionalized adults aged 65 years and older who are vaccinated against pneumococcal disease

Currently, the Advisory Committee on Immunization Practices recommends immunizing adults against 15 infectious diseases, including influenza and pneumonia. However, the adult coverage rates for these vaccines remain substantially below the target levels.[31] Influenza and pneumonia were the 8th leading cause of death in 2017 in California, attributing to over 6,300 deaths.[12] A Healthy People 2020 objective is to ensure that 70% of adults aged 18 years and older are vaccinated annually against influenza, and 90% of those aged 65+ have ever been vaccinated against pneumococcal disease.

Almost half (47.8%) of Butte County residents over the age of 65 have not had a flu shot in the past 12 months. Additionally, nearly three in ten Butte County residents (29%) have never been vaccinated against pneumonia.

Both results exceed the state and national figures.





Proportion of respondents age 65 years and older who have not had a flu shot in the past 12 months and who never had a pneumonia shot

Demographic Characteristics	No Flu Shot	Never Had Pneum. Shot
Total	47.8%	29.0%
Age		
65-74	52.0%	37.7%
75+	43.4%	20.0%
Gender		
Male	44.9%	31.7%
Female	50.4%	26.4%
Race		
White	47.9%	28.1%
Black**	46.3%	100.0%
Hispanic**	53.8%	30.7%
Non-Hispanic	47.1%	28.4%
Education		
< High School**	57.1%	40.4%
High School Grad**	41.7%	21.9%
Some College**	50.9%	31.5%
College Graduate	47.3%	28.9%
Household Income		
<$20,000**	39.9%	34.2%
$20,000-$34,999**	56.3%	18.8%
$35,000-$$49,999**	52.9%	23.2%
$50,000-$74,999**	53.8%	36.6%
$75,000 or more**	45.3%	27.5%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

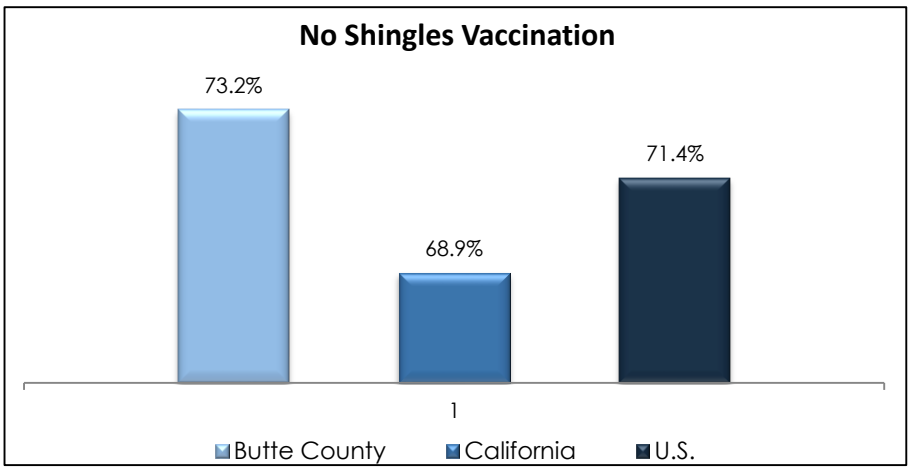
Adult Immunization: Shingles Vaccination

Healthy People 2020 objective IID-12.12: Increase the percentage of adults who are vaccinated against zoster (shingles)

A total of 1 out of every 3 people in the United States will develop shingles during their liftetime. Shingles is a painful rash that usually develops on one side of the body, often the face or torso. The rash consists of blisters that typically scab over in 7-10 days and clears up within 2-4 weeks. For 1 in 10 people, however, the nerve pain, can last for months or even years after the rash goes away. This long-lasting pain is called postherpetic neuralgia (PHN,) and is the most common complication of shingles. Other serious complications may lead to blindness, pneumonia, hearing problems, brain inflammation, or even death. The risk of getting shingles, PHN, and other complications increases with age. Therefore, it is recommended that people 50 or older get vaccinated. [64]

More than seven in ten Butte County residents (73.2%) age 50 or older have not been vaccinated against shingles. This result is above the state- and nationwide figures (68.9% and 71,4%, respectively.)

The likelihood of having been vaccinated increases with age and peaks in the 70+ category. It is also directly proportional to residents' level of education. Finally, those in lower income categories (under $35,000) are somewhat less likely than their more affluent counterparts to have been vaccinated against shingles.



Percentage of respondents age 50+ who have ever had the shingles or zoster vaccine

Demographic Characteristics	Never Had Shingles Vaccination
Total	73.2%
Age	
50-59	90.1%
60-69	76.9%
70+	50.0%
Gender	
Male	74.8%
Female	71.9%
Race	
White	71.0%
Black**	100.0%
Hispanic**	78.4%
Non-Hispanic	72.7%
Education	
< High School**	83.7%
High School Grad	77.2%
Some College	74.8%
College Graduate	68.3%
Household Income	
<$20,000	79.2%
$20,000-$34,999	70.9%
$35,000-$$49,999**	64.0%
$50,000-$74,999	64.7%
$75,000 or more	66.8%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

HIV/AIDS

Healthy People 2020 objective HIV-1: Reduce new HIV diagnoses

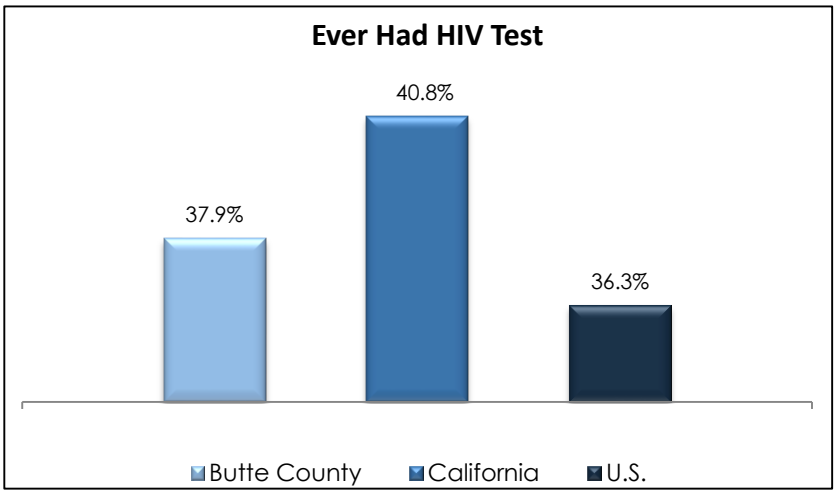
Healthy People 2020 objective HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months

Healthy People 2020 objective HIV-12: Reduce deaths from HIV infection

As of 2016, 132,405 people were living with diagnosed HIV infection in California.[32] Early awareness of the infection through HIV testing can prevent further spread of the disease, and an early start on antiretroviral therapy can increase the lifespan and quality of life among those who are living with HIV/AIDS.

A total of 37.9% of Butte County residents has ever been tested for HIV. This percentage is below the figure noted for California as a whole (40.8%,) but above the nationwide data (36.3%.)

A segment analysis reveals that the youngest and oldest respondents (age 18-24 and 65+) are least likely to indicate they have ever been tested. Additionally, those in the lowest income bracket (under $20,000) are most likely to report a prior HIV test, and females are slightly more likely to do so than males.



Percentage of respondents who have ever had an HIV test

Demographic Characteristics	Ever Tested for HIV
Total	37.9%
Age	
18-24	20.6%
25-34	49.2%
35-44	63.5%
45-54	46.4%
55-64	38.9%
65+	19.3%
Gender	
Male	34.0%
Female	41.8%
Race	
White	39.9%
Black**	52.6%
Hispanic	35.1%
Non-Hispanic	38.5%
Education	
< High School	42.5%
High School Grad	32.3%
Some College	40.1%
College Graduate	38.7%
Household Income	
<$20,000	43.6%
$20,000-$34,999	34.5%
$35,000-$$49,999**	30.4%
$50,000-$74,999	39.3%
$75,000 or more	26.0%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Adverse Childhood Experience: Emotional/Verbal and Physical Abuse

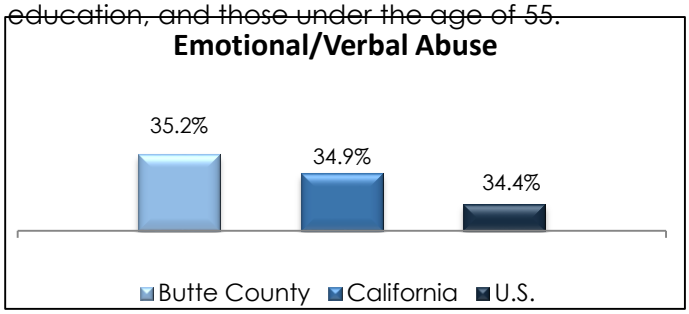
Healthy People 2020 objective EMC-2.2: Increase the proportion of parents who use positive communication with their child

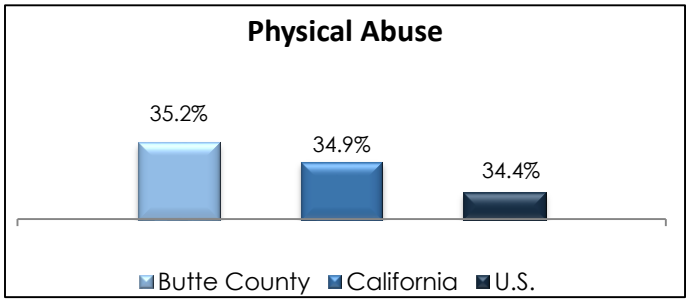
Healthy People 2020 objective IVP-38: Reduce nonfatal child mistreatment

Adverse Childhood Experiences (ACEs) is a term used to describe a range of traumatic experiences that may occur during a person's first 17 years of life, including child abuse, neglect, and other household dysfunctions. Over 60% of Californians report experiencing at least one ACE before age 18. Approximately one in four Californians reports having three or more ACEs.[61] At 35%, the most common ACE among California adults is emotional (or verbal) abuse.[62]

More than one-third (35.2%) of Butte County residents report having been emotionally and/or verbally abused by adults in their home before they were 18. This figure is on par with the statewide and nationwide data (34.9% and 34.4%, respectively.) Residents most likely to report emotional abuse are non-Hispanic and younger than 65+.

Additionally, just over one-fifth (21%) recalls physical abuse in their childhood – a result marginally above the California-wide rate, and higher than the national figure. This is attributable mostly to white residents with less than high school education, and those under the age of 55.





**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 States (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Percentage of respondents who were emotionally/verbally abused more than once, and percentage of respondents who were physically hurt by adults more than once (before age 18)

Demographic Characteristics	Emotional Abuse	Physical Abuse
Total	35.2%	21.0%
Age		
18-24	41.3%	27.0%
25-34	51.9%	22.9%
35-44	30.4%	22.2%
45-54	34.3%	23.2%
55-64	32.1%	19.5%
65+	23.2%	12.7%
Gender		
Male	34.4%	22.4%
Female	36.0%	19.7%
Race		
White	33.0%	17.5%
Black**	43.3%	15.8%
Hispanic	31.4%	25.6%
Non-Hispanic	36.2%	20.8%
Education		
< High School	44.1%	32.5%
High School Grad	34.7%	22.8%
Some College	36.3%	22.4%
College Graduate	32.8%	15.9%
Household Income		
<$20,000	39.5%	26.2%
$20,000-$34,999	25.1%	19.3%
$35,000-$$49,999**	30.8%	6.2%
$50,000-$74,999	45.8%	28.7%
$75,000 or more	33.6%	13.3%

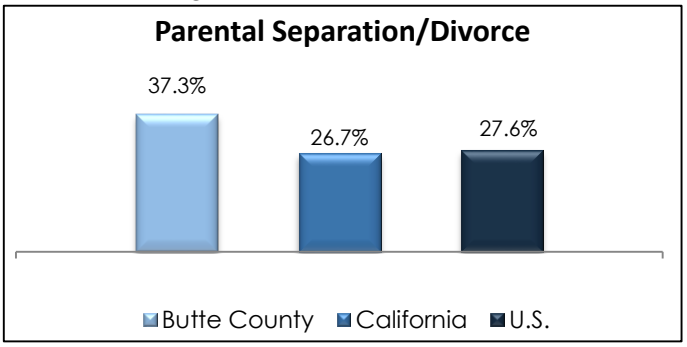
Adverse Childhood Experience: Separation/ Divorce and Incarcerated Household Member

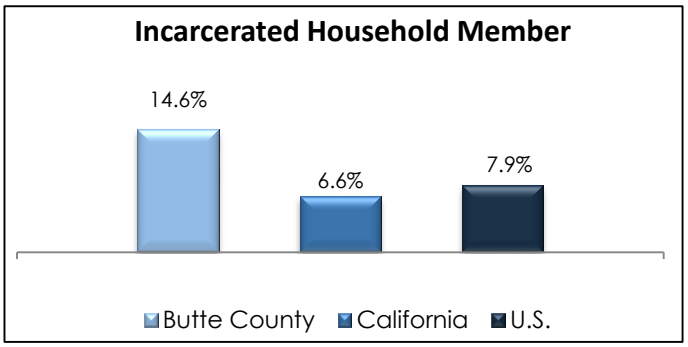
ACEs affect every community in California. Butte County is among California's counties with the highest number of ACEs; 77% of residents have 1 or more adverse childhood experiences. However, even in counties with the lowest prevalence of ACEs, 1 out of every 2 residents, or 50%, has at least one adverse experience in childhood. Parental separation or divorce is the second most prevalent ACE after emotional/verbal abuse, reported by 27% of adults.[62]

Almost four in ten Butte County residents (37.3%) have experienced parental separation or divorce before the age of 18. This is reported notably less often by residents age 65+, and those with at least some college education.

A total of 14.6% was growing up with a household member who served time in a prison, jail, or other corrections facility. This response is given mostly by residents under the age of 44, Hispanics, and those in lower education and income brackets.

Both ACEs are observably above the state- and nationwide figures.





Percentage of respondents whose parents separated/divorced, and percentage of respondents who lived with anyone who served time in prison/jail (before age 18)

Demographic Characteristics	Parental Separation/ Divorce	Incarcerated Household Member
Total	37.3%	14.6%
Age		
18-24	38.0%	23.0%
25-34	51.6%	31.9%
35-44	39.1%	18.4%
45-54	44.6%	7.4%
55-64	34.6%	6.6%
65+	21.2%	3.7%
Gender		
Male	35.7%	14.0%
Female	39.0%	15.1%
Race		
White	37.2%	13.3%
Black**	56.3%	13.9%
Hispanic	42.3%	26.6%
Non-Hispanic	36.6%	12.5%
Education		
< High School	54.0%	18.5%
High School Grad	41.1%	20.0%
Some College	39.9%	16.4%
College Graduate	28.6%	7.7%
Household Income		
<$20,000	39.8%	14.1%
$20,000-$34,999	40.3%	23.8%
$35,000-$$49,999**	27.7%	9.5%
$50,000-$74,999	37.7%	10.9%
$75,000 or more	29.3%	9.0%

**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 states (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Adverse Childhood Experience: Sexual Abuse and Witness to Domestic Violence

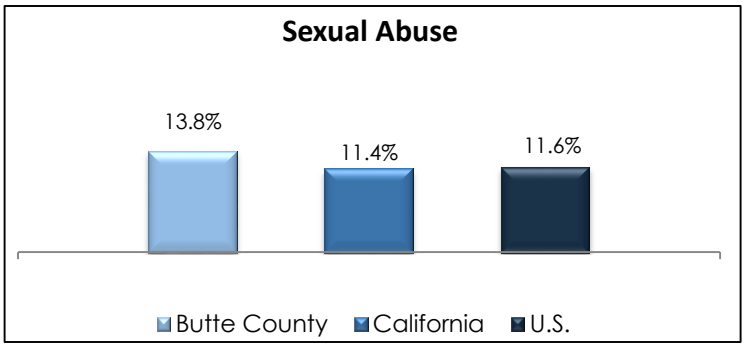
Healthy People 2020 objective IVP-40: Reduce sexual violence

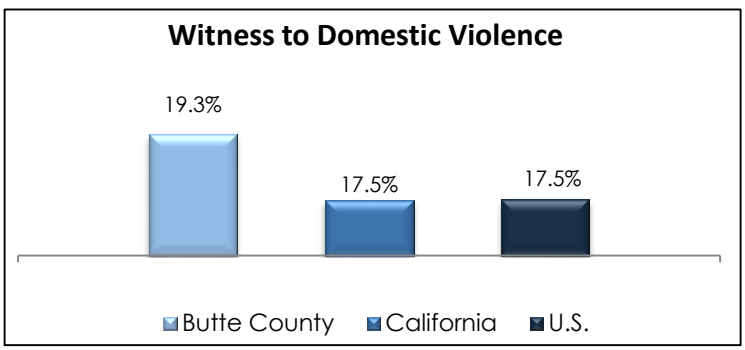
Healthy People 2020 objective IVP-42: Reduce children's exposure to violence

There is a strong relationship between exposure to ACEs and subsequent negative health behaviors and conditions later as adults, including smoking, unintended pregnancies, alcoholism, illicit drug use, binge drinking, depression, suicide attempts, COPD, asthma, obesity, stroke, heart disease, cancer, diabetes, kidney disease, and liver disease. [61, 62]

A total of 13.8% of Butte County residents have ever experienced sexual abuse as a child – a figure slightly above the state- and nationwide statistics (11.4% and 11.6%, respectively.) Females are notably more likely than males to report this ACE.

Witnessing domestic violence before the age of 18 is reported by nearly a fifth of residents (19.3%) – a result higher than the nationwide and California prevalence data (17.5% each.) The rates of this ACE are higher among residents with incomes of under $20,000, and are decreasing with respondents' age.





**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 states (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Percentage of respondents who reported having ever experienced sexual abuse, and percentage of respondents who witnessed domestic violence more than once (before age 18)

Demographic Characteristics	Sexual Abuse	Witness to Domestic Violence
Total	13.8%	19.3%
Age		
18-24	13.2%	30.6%
25-34	19.1%	25.8%
35-44	8.4%	19.7%
45-54	15.3%	16.6%
55-64	16.1%	16.0%
65+	11.3%	9.4%
Gender		
Male	7.5%	20.1%
Female	20.0%	18.6%
Race		
White	12.4%	15.8%
Black**	24.3%	38.8%
Hispanic	17.1%	19.1%
Non-Hispanic	13.4%	19.9%
Education		
< High School	13.6%	31.2%
High School Grad	17.0%	13.4%
Some College	13.1%	26.4%
College Graduate	12.1%	14.4%
Household Income		
<$20,000	16.6%	25.1%
$20,000-$34,999	14.9%	18.8%
$35,000-$$49,999**	9.6%	10.2%
$50,000-$74,999	20.0%	11.8%
$75,000 or more	8.7%	16.5%

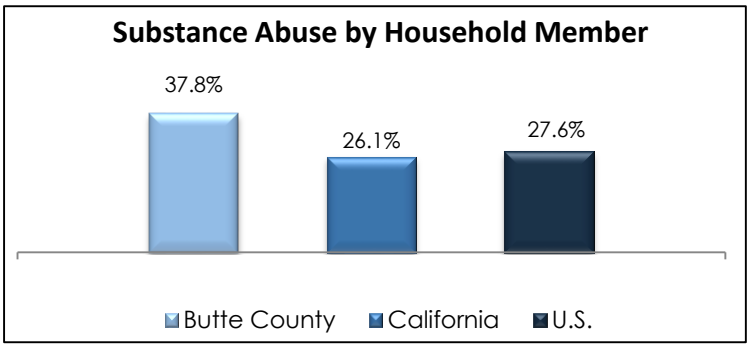
Adverse Childhood Experience: Substance Abuse and Household Member with Mental Illness

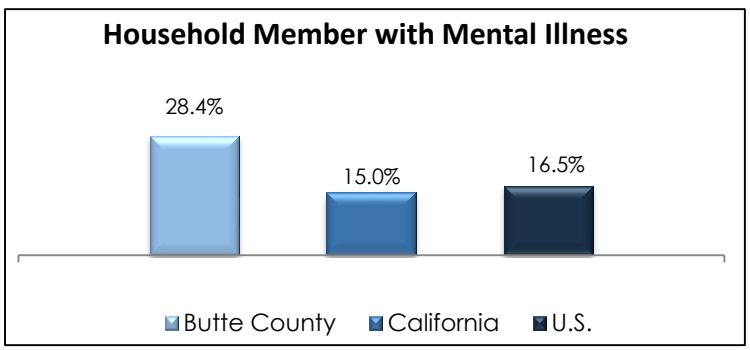
Substance abuse by a household member is the third most frequently reported ACE in California, as cited by 26% of adults. [61]

Nearly four in ten Butte County residents (37.8%) lived with a household member who had a substance abuse problem before they were 18 years old. This figure is attributable mostly to respondents who have high school education or less, and is least common among the oldest residents (65+.)

Close to three in ten (28.4%) lived with a household member who was depressed, mentally ill, or suicidal. The incidence of this adverse experience is lowest in the 65+ age category, and among males. It is also slightly more prevalent among those who completed high school or less.

Both ACEs are above the state- and nationwide levels.





**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 states (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Percentage of respondents who lived with anyone who was a problem drinker/alcoholic/drug user, and percentage of respondents who lived with anyone who was mentally ill (before age 18)

Demographic Characteristics	Substance Abuse	Household Member with Mental Illness
Total	37.8%	28.4%
Age		
18-24	38.7%	39.3%
25-34	53.3%	50.1%
35-44	45.9%	24.9%
45-54	40.4%	30.3%
55-64	31.2%	20.7%
65+	23.3%	9.5%
Gender		
Male	36.3%	21.9%
Female	39.2%	34.8%
Race		
White	36.7%	26.8%
Black**	42.8%	38.0%
Hispanic	36.9%	31.8%
Non-Hispanic	37.7%	27.9%
Education		
< High School	65.4%	35.1%
High School Grad	44.0%	33.7%
Some College	35.8%	27.5%
College Graduate	29.2%	23.9%
Household Income		
<$20,000	38.3%	31.9%
$20,000-$34,999	42.0%	31.9%
$35,000-$$49,999**	26.9%	19.9%
$50,000-$74,999	32.1%	27.7%
$75,000 or more	32.9%	22.0%

Intimate Partner Violence: Threatened and Completed Physical Violence

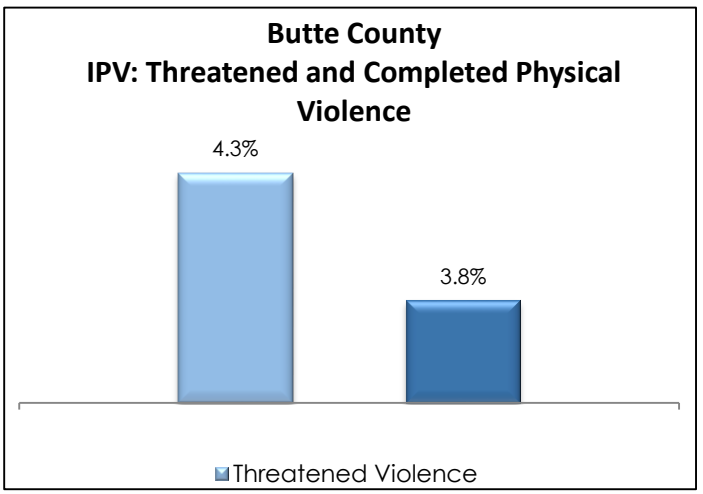
Healthy People 2020 objective IPV-39.1: Reduce physical violence by current or former intimate partners

Healthy People 2020 objective IPV-39.3: Reduce psychological abuse by current or former intimate partners

Intimate Partner Violence (IPV) is violence that occurs in a close relationship, including current or former spouses and dating partners. It includes physical violence, sexual violence, stalking, and psychological aggression. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate that about 1 in 4 women and 1 in 10 men have experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime. Additionally, over 43 million women and 38 million men experienced psychological aggression by an intimate partner. [32]

Within the past year, 4.3% of Butte County residents have been frightened for the safety of themselves, their family or friends because of the threats of their partner (or a former partner.) This result was driven by women and respondents who were high school graduates or less.

The completed physical violence rate is lower, with 3.8% reporting that their partner pushed, hit, slapped, kicked, choked, or physically hurt them in any way within the past 12 months. Again, the likelihood of being physically assaulted is higher among residents with lower educational attainment (high school graduate or less.)



Proportion of respondents frightened for safety of self/family/friends because of partner's threats, and proportion of respondents assaulted by partner (past 12 months)

Demographic Characteristics	Threatened Violence	Completed Violence
Total	4.3%	3.8%
Age		
18-24	6.8%	11.6%
25-34	-	-
35-44**	12.8%	6.4%
45-54	5.9%	4.0%
55-64	2.2%	1.1%
65+	-	-
Gender		
Male	1.0%	2.9%
Female	7.0%	4.5%
Race		
White	3.6%	3.0%
Black**	-	-
Hispanic**	16.2%	9.7%
Non-Hispanic	2.5%	3.0%
Education		
< High School**	14.7%	15.1%
High School Grad	6.6%	9.5%
Some College	0.9%	-
College Graduate	4.1%	0.6%
Household Income		
<$20,000	4.2%	2.7%
$20,000-$34,999**	4.6%	4.6%
$35,000-$$49,999**	-	-
$50,000-$74,999**	2.1%	-
$75,000 or more**	2.3%	2.3%

**Note: No comparative BRFSS data (California or national) is available for this category **Caution: Fewer than 30 respondents*

Intimate Partner Violence: Attempted Control and Unwanted Sex

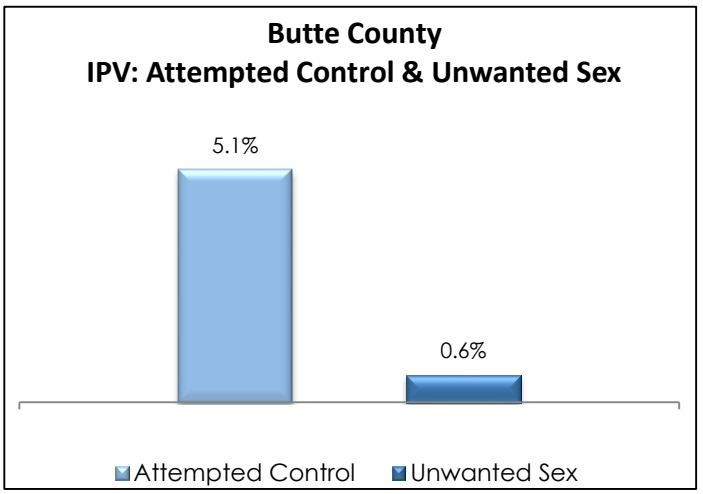
Healthy People 2020 objective IPV-39.2: Reduce sexual violence by current or former intimate partners

Healthy People 2020 objective IPV-39.3: Reduce psychological abuse by current or former intimate partners

Intimate Partner Violence (IPV) has been shown to have serious health consequences for both women and men, including poor general health, depressive symptoms, substance abuse, and elevated rates of chronic diseases.[60]

A total of 5.1% of Butte County residents has/had a partner (or former partner) who tried to control most or all of their daily activities. This appears to be more prevalent among respondents who are high school graduates or less.

Only 0.6% of residents report having been forced into unwanted sexual activity within the past year after they told their partner (or former partner) that they did not want it.



Proportion of respondents whose partner tried to control their daily activities, and proportion of respondents sexually assaulted by partner (past 12 months)

Demographic Characteristics	Attempted Control	Unwanted Sex
Total	5.1%	0.6%
Age		
18-24	11.6%	-
25-34	3.7%	-
35-44**	10.0%	3.5%
45-54	4.0%	-
55-64	2.2%	-
65+	0.6%	0.5%
Gender		
Male	4.4%	-
Female	5.8%	1.1%
Race		
White	4.6%	0.7%
Black**	-	-
Hispanic**	13.4%	3.7%
Non-Hispanic	4.0%	0.1%
Education		
< High School**	5.8%	-
High School Grad	12.7%	-
Some College	1.8%	0.3%
College Graduate	1.5%	1.5%
Household Income		
<$20,000	5.0%	0.5%
$20,000-$34,999**	2.9%	-
$35,000-$$49,999**	-	-
$50,000-$74,999**	-	-
$75,000 or more**	1.3%	-

**Note: No comparative BRFSS data (California or national) is available for this category **Caution: Fewer than 30 respondents*

Demographics

The following is a comparison of the demographic characteristics of the Butte County BRFSS respondents to those of the state and national BRFSS participants.

Demographic Characteristics	Butte County	California	U.S.
Age			
18-24	18.4%	12.6%	12.6%
25-34	15.2%	19.0%	17.0%
35-44	13.3%	17.3%	16.1%
45-54	16.5%	17.0%	16.4%
55-64	16.5%	15.8%	16.9%
65+	19.3%	18.3%	21.0%
Gender			
Male	49.5%	49.2%	48.7%
Female	50.5%	50.8%	51.3%
Race			
White	72.7%	40.7%	72.3%
Black	1.2%	5.4%	6.3%
Hispanic	13.8%	35.1%	8.3%
American Indian or Alaskan Native	4.3%	0.6%	1.0%
Asian	2.2%	15.3%	2.3%
Native Hawaiian or Other Pacific Islander	0.2%	0.2%	0.0%
Other race	1.2%	1.2%	0.0%
Multiracial, non-Hispanic	3.5%	1.5%	1.3%
Education			
< High School	7.0%	17.7%	11.5%
High School Grad	25.7%	21.9%	28.8%
Some Post High School / Some College	33.9%	31.8%	31.8%
College Graduate	33.2%	28.7%	26.0%

**Note: The comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories)*

***"Refused" and "Don't Know" responses not shown / percentages may not add up to 100%*

Demographics – cont'd.

Demographic Characteristics	Butte County	California	U.S.
Household Income			
<$15,000	14.3%	14.9%	9.1%
$15,000-$24,999	9.9%	13.2%	16.5%
$25,000-$34,999	6.0%	9.3%	10.5%
$35,000-$49,999	5.4%	10.8%	14.2%
$50,000 or more	25.2%	51.8%	49.0%
Employment Status			
Employed	44.9%	47.3%	49.2%
Self-employed	8.7%	10.4%	8.9%
No work < year	1.8%	3.3%	2.7%
No work > year	2.6%	2.8%	2.5%
Homemaker	3.8%	7.9%	5.6%
Student	8.6%	6.5%	5.4%
Retired	18.1%	16.2%	18.8%
Unable to work	10.2%	5.6%	6.5%
Marital Status			
Married	39.2%	49.5%	51.4%
Divorced	14.7%	9.2%	11.5%
Widowed	8.4%	5.8%	6.9%
Separated	1.2%	3.1%	2.2%
Never married	31.8%	26.0%	23.8%
Partnered	3.9%	6.4%	4.7%

**Note: The comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories)*

***"Refused" and "Don't Know" responses not shown / percentages may not add up to 100%*

Demographics – cont'd.

Demographic Characteristics	Butte County	California	U.S.
Number of Children Under 18 Years of Age in Household			
5+ children	1.2%	0.9%	1.0%
4 children	1.1%	1.9%	2.0%
3 children	3.7%	6.4%	5.5%
2 children	9.9%	13.7%	12.5%
1 child	12.8%	16.5%	14.5%
None	57.1%	60.6%	64.4%
Home Ownership			
Own	50.2%	57.0%	69.4%
Rent	37.0%	37.8%	24.7%
Other	10.5%	5.3%	5.9%
Veteran Status			
Served on Active Duty in the US Armed Forces	10.7%	8.2%	11.4%
Never served on Active Duty in the US Armed Forces	89.3%	91.8%	88.6%
Internet Use			
Used Internet in Past 30 Days	87.9%	85.1%	85.0%
Did Not Use Internet in Past 30 Days	11.6%	14.9%	15.0%

**Note: The comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories)*

***"Refused" and "Don't Know" responses not shown / percentages may not add up to 100%*

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Appendix: 2

Community Engagement
Focus Group Summary, Morrison Inc.

COMMUNITY ENGAGEMENT- FOCUS GROUPS

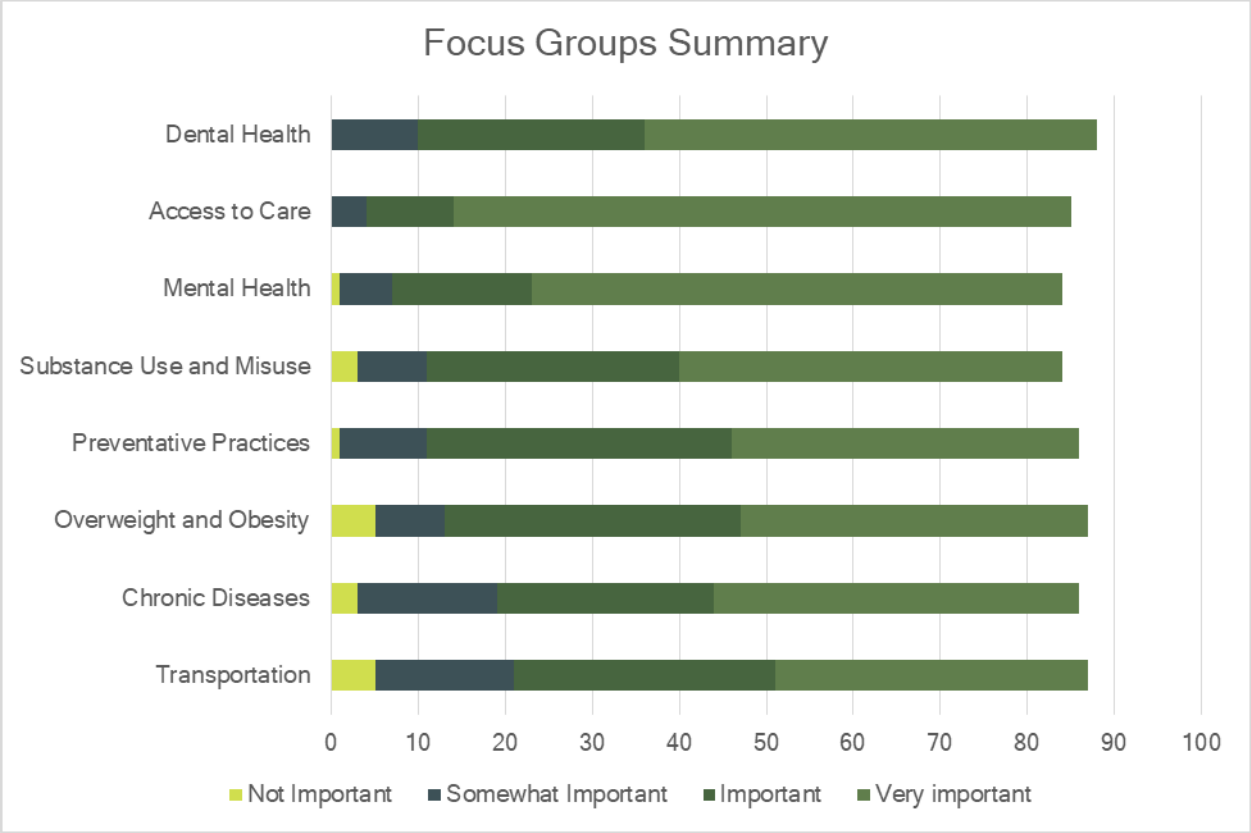
In an effort to gather valuable insights from community members to inform the Community Health Needs Assessment, Butte County Public Health contracted the firm Morrision and Company (Chico, California) to facilitate numerous community focus groups.

Representatives from Enloe Medical Center, Adventist Health Feather River, Orchard Hospital, and BCPH organized each focus group, collaborating with existing Butte County community organizations on several occasions to host focus groups in coordination with previously scheduled events or meetings. This leveraged the established relationships these groups have with the individuals they serve, facilitating active participation by community members. Focus groups were also held at various times throughout the day to best accommodate the schedules of participants. The focus groups ranged in size, with an average of 10 attendees per group.

In total, 12 focus groups reaching 114 participants were conducted, with participants representing a broad spectrum of the community. Participation was received from seniors, college students, individuals receiving mental health services, individuals participating in programs at both the African American Family and Cultural Center and the Hmong Cultural Center, high-school students, physicians, general community members, veterans, and individuals experiencing homelessness. Of those 114 participants, 88 completed a written survey utilized in data collection as displayed for the purposes of this reporting section. A series of questions were designed with input from representatives from Enloe Medical Center, Adventist Health Feather River, Orchard Hospital, and Butte County Public Health, as well as the Morrison facilitator. Participants were asked questions as a group and encouraged to share their own personal experiences or anecdotal experiences observed from friends and family in accessing health care and living healthy lives.

Featured below is a summarized collection of responses received across all focus groups that reference the existing successes and signs of health in Butte County communities, as well as issues that need to be addressed within those communities. These responses are oriented toward themes covered within the groups such as: dental health, access to healthcare, mental health, substance us and misuse, preventative practices, overweight and obesity, chronic diseases, and transportation. Quotations provided are from focus group members regarding the topics mentioned above.

FOCUS GROUPS SUMMARY



Total number of participants: 88

Ranked most important across all the focus groups:

1. Access to care – 81%
    - 71 out of 88 participants
2. Mental health – 69%
    - 61 out of 88 participants
3. Dental health – 59%
    - 52 out of 88 participants

Identified Successes

Noted successes in Butte County communities included an annual free dental clinic offered by local providers, the availability of low cost services from various providers, a mobile dental unit, events and services specifically for veterans, classes available for dental education, and interventional programs for children. The theme supporting much of the participants' feedback when discussing success appears to be programs available over a wide variety of locations, wherein positive intervention might be implemented like dental education, referrals to practitioners, providing detailed information about how to access dental care, or providing on-scene, low-cost/no-cost dental care in a nontraditional location.

"THERE IS A FLOURIDE VARNISH PROGRAM, THEY PROVIDE PARENTAL AND CHILD TRAINING, AND DENTAL EDUCATION." -MEMBER OF THE BCPH CAMP FIRE RECOVERY GROUP

Issues to Address

Issues focused on by groups were largely a lack of available dental providers, and a lack of providers that accepted specific forms of coverage, whether that be Medi-Cal or certain types of private insurance. Parents either being uninformed about proper dental care for children or neglectful of their children's dental care needs was mentioned as an issue, as well as a lack of providers for young children under three with dental issues. Participants stated that some coverages incentivized pulling teeth rather than preventative dentals care, and often these extractions must be performed outside Butte County. It was mentioned that issues often need to be extreme in order to be prioritized to receive care from some programs. Areas for improvement mentioned by participants included expanded access to dental care through school clinics, availability for evening or weekend appointments, and more flexibility overall from providers, and a consideration that dental care might be considered healthcare.

"DENTAL CARE IS SUCH A CHALLENGE IN BUTTE COUNTY THAT I HAVE HAD TO SCHEDULE TEETH TO BE PULLED BEFORE PERFORMING UNRELATED SURGERIES, DUE TO THE RISK OF INFECTION FROM UNTREATED DENTAL ISSUES." -LOCAL MEDICAL PROVIDER

ACCESS TO CARE

Identified Successes

Programs and organizations providing a variety of medical screenings for residents who lacked coverage or income to pay for services were named as successful supports. Organizations providing case management services who were able to assist clients in completing applications for medical coverage, and refer clients and other community members to medical providers and specialty services were also discussed as successes. Programs, organizations, and providers that provided counseling and therapy for people who had experienced trauma and secondary trauma, as well as organizations that had pursued training to become trauma informed in their approach, were mentioned as successful. Multiple local hospice programs were mentioned as successful, as well as one emergency room and a rural health provider in a smaller community within the county. Programs providing community members with healthy food through subsidy or reduced cost, along with nutritional education, were cited as successes. Generally, the programs, organizations, and providers mentioned as successful by focus group participants appear to be focused on bridging gaps in coverage, getting important information revolving around care to community members, and focused on serving vulnerable and underrepresented groups in the community.

Issues to Address

When discussing access to care, participants mentioned that their insurances coverage often acted as a barrier to receiving the care that was most appropriate for their situation. It was brought up that certain providers being unwilling to take Medi-Cal patients limited availability of providers for a large subset of the populations. Ongoing issues regarding contract negotiations between major medical providers and major insurance providers in the area were cited as possibly having a huge impact on availability of care if an agreement could not be worked out. Some participants felt the eligibility window of five years after ending active duty for Veteran's Affairs insurance was too restrictive. Participants stated that some payment systems often incentivized treatment being withheld until the late state or high acuity levels of health issues, and that often symptoms were addressed rather than root causes when care was sought. Some participants felt that eligibility for Medi-Cal or other, low-cost insurance programs was too restrictive based on income levels. It was expressed that there was a significant equity gap between community members with good, private insurance coverage, and individuals who were on Medi-Cal.

"THERE'S A LOT OF TRIAL AND ERROR TO FIND A PROVIDER TO RECEIVE NEEDED SERVICES…YOU NEED TO INVEST A LOT OF PERSONAL TIME AND MONEY." - PARTICIPANT FROM THE IVERSEN CENTER

A lack of access to every type of medical provider, and especially to mental health providers was a key issue mentioned in discussions of access to care; community members were having to wait too long for appointments, and that waiting period was only extended when referred to specialists. The process of connecting to the appropriate care provider was considered very costly and time intensive by some participants. The lack of an

easily available resource to ascertain which providers were accepting new patients, which insurance providers accepted, and other common questions was noted as an obstacle for access to care. It was mentioned by multiple groups that there was not enough accessibility to providers on evenings and weekends, and that there was a lack of transparency in the process of providing care. Issues with reimbursements to doctors were brought up, with added detail that a restructuring of fee systems may often result in higher costs for patients. Lack of reliability in the local public transportation network, and the lack of on-demand services catered specifically for seniors were considered obstacles in physically traveling to locations to receive care.

MENTAL HEALTH

Identified Successes

Regarding mental health, organizations that focused on services for veterans, students, those pursuing treatment for substance use and misuse, and groups focusing on secondary trauma were all praised as being successful in assisting members of the community support mental health issues. A key development discussed was the expansion of telehealth services for providers to be available long-distance; this was cited as a success, and continued expansion could help alleviate the deficit in available mental health professionals in Butte County. Local churches and cultural centers for different ethnic communities were also cited as successful in engaging community members in ways that helped them with mental health issues. Community members cite success for a wide range of locales; from informal groups at cultural meeting spaces to clinical, government programs, an underlying theme of indiscriminate appreciation for mental health providers and spaces to process mental health issues was present throughout group discussions.

> "I FEEL LIKE BEING DIAGNOSED AS A 51-50 IS THE ONLY WAY TO GET ADMITTED." - PARTICIPANT FROM THE JESUS CENTER

Issues to Address

A shortage of psychiatrists and counselors, often leading to long wait times for appointments, were a significant obstacle in receiving mental health care; there was a significant concern mentioned by participants that the additional trauma experienced in the community due to the Camp Fire would place even more strain on local mental health care providers. The process to receive care was considered long; a lack of clear resources for finding a counselor or therapist that provided services for the milder end of the spectrum of mental health issues was mentioned as an obstacle to receiving mental health care. A lack of providers willing to accept Medi-Cal, and the lack of affordable mental health services even for those with substantial private insurance plans was cited as a major issue by participants. A lack of programs focusing on service to vulnerable communities like recent immigrants and refugees was mentioned as an issue around mental health care. A lack of aftercare for patients that had received intensive psychiatric services was mentioned as a barrier to mental health care. A lack of knowledge or availability regarding quality services and programs for community members was a dominant them in discussing issues of mental health care for the groups. Some community members felt

"WE HAVE A FRAGMENTED MENTAL HEALTH & SOCIAL SERVICES DELIVERY SYSTEM." - MEMBER OF THE BCPH CAMP FIRE RECOVERY GROUP

that providers might be too reliant on medication as a form of mental health care. At least one participant felt that there was a prevalence of misdiagnosis of mental health issues that created issues for patients. Some participants felt that being placed on a 51/50 hold was the only way to quickly access mental health care

The stigma of being open about struggles with one's mental health was a common topic as an obstacle to mental health care in groups as well; participants felt that mental health issues were still viewed as weakness by a large portion of the community. A lack of demographic representativeness amongst providers was cited as an obstacle for some populations to connect with mental health providers. Some participants felt that some providers did not show respect for patients. Some participants stated that the idea that mental health care might be done as a preventative measure rather than a treatment of acute symptoms was still foreign to much of the community. Participants cited the fear of punishment should mental health services be accessed as a significant source of stigma within the community, particularly the fear that one might lose the ability to own firearms should they seek mental health care.

SUBSTANCE USE AND ABUSE

Identified Successes

"PHARMACY DRUG TAKEBACK PROGRAMS FOR UNUSED OR EXPIRED DRUGS ARE HELPFUL." -PARTICIPANT FROM THE CALIFORNIA HEALTH COLLECTIVE

Participants discussed outpatient treatment programs, residential treatment programs, twelve step organizations, programs that offered education and early intervention, and harm reduction programs, as well as the local Drug Court when asked about successful programs to prevent or treat drug, alcohol, and tobacco usage. Multiple harm reduction measures were mentioned; Nalaxone training, needle exchange, and pharmacy medicine collection bins. The noticeable trend in discussion about helpful programs was toward positive intervention meeting people struggling with substances in places that were familiar and comfortable for them, taking proactive measures for high risk populations to make them aware of treatment structures, and the fact that there are people available looking to address addiction with community members struggling with substance use, abuse, or addiction.

Issues to Address

Issues mentioned by participants that tied in to obstacles with treating and avoiding substance use and misuse included loneliness, the cycle of addiction, stigma for those struggling with addiction, a lack of education around addiction for community members, and an overemphasis on individual responsibility for finding appropriate treatment. The view of vaping as a healthy alternative to smoking rather than another harmful addiction was cited as an obstacle to healthy relationships to substances. Stigma around addiction and fear of being honest with healthcare professionals due to possible punishment was also mentioned. Members of the community using substances to self-medicate was mentioned, and a lack or dual-diagnosis programs available was also a concern for participants. Participants felt substances that might be abused were easy to access, and that drugs being marketed as glamorous were both issues that contributed to substance use and misuse. With the legalization of marijuana in California, the issue was raised that many parents grow marijuana in their home, and are either not educated or are willfully endangering their children due to constant exposure to marijuana when growing large amounts in confined spaces. Some participants did not feel that school officials were easy to connect regarding substance use and abuse issues for youth enrolled at school.

> "THE ADDICTION TREATMENT SYSTEM IS BROKEN; LACK OF FOCUS ON REUNIFICATION; THERE ARE BROKEN FAMILIES, BROKEN HOUSEHOLDS." - PARTICIPANT FROM THE IVERSEN CENTER

PREVENTATIVE PRACTICES – SCREENING, VACCINATIONS, INJURY PREVENTION

Identified Successes

Successful preventative outlets for preventative practices mentioned included low-cost/no-cost immunization and inoculation clinics, and other free health clinics provided by local and statewide healthcare providers. Outreach and education provided through social media was mentioned, along with classes available through educational providers, healthcare providers, churches, and other faith-based organizations. Businesses and organizations that provide exercise classes and resources for exercise, particularly to vulnerable groups, were cited. Early intervention programs that provided information, screening, and healthcare for infants and toddlers were considered a success by participants. Again, the focus for participants appears to be low-cost or no-cost providers for intervention and education, many of whom are not located in traditional healthcare locations. Culturally specific services, particularly for underrepresented groups, were mentioned.

Issues to Address

Cost of preventative practices was cited repeatedly as an issue. The impact of anti-vaccination discourse was cited as having an effect on community members' willing to be vaccinated and vaccinate their children. Lack of screening and education for adult asthma was brought up by a group. At least one participant felt there was too much information available on screenings and vaccinations, which caused a paralysis; they

would prefer a clear, efficient path to their preventative practices. A lack of information for community members was also mentioned multiple times. Distrust of scientific information and of government institutions was cited as an obstacle to preventative practices, as well as cultural barriers, including a reliance on traditional forms of medicine that may lack the same base of evidence as the preventative practices mentioned in the title of this subsection. Fear of discovering that they have some other health problem was a dissuading influence on community members seeking preventative care according to some participants. Residual effects of vaccinations were also mentioned as a dissuading influence by participants.

"[BASED ON VOLUME OF AVAILABLE INFORMATION] IT'S DIFFICULT TO UNDERSTAND AND MAKE AN INFORMED DECISION, SO INDIVIDUALS CHOOSE TO WAIT UNTIL SOMETHING BAD HAPPENS, RATHER THAN [SEEK OUT] PREVENTATIVE CARE." - PARTICIPANT FROM THE CALIFORNIA HEALTH COLLECTIVE

OVERWEIGHT AND OBESITY

Identified Successes

Community Successes in addressing being overweight or obese included education from a variety of sources and programs connecting the public with medical professionals in nontraditional locations. Many of the successes cited were opportunities to exercise for no cost outdoors, access to public areas of recreation for people of all ages, and communities that centered on forming a consistent social group to participate in those activities together. Likewise, community groups that provided healthy, communal meals on a regular basis were mentioned as a success. Government programs and food pantries that provided access to nutritious food for those that lacked resources to purchase or access such foods were also cited.

"MENTAL HEALTH ISSUES AND MEDICATION CAN IMPACT YOUR LEVEL OF PHYSICAL ACTIVITY." - PARTICIPANT FROM THE IVERSEN CENTER

Issues to Address

Prevalence and convenience of fast food was an issue brought up by participants. Current technology contributing to less physical activity by giving people many sedentary entertainment options at all times was mentioned in multiple groups. A lack of free time to pursue exercise was brought up repeatedly, as well as individual laziness and a lack of motivation to be healthy for some members of the community. A lack of healthy options for students at school, and open campuses that give the option of traveling to fast food restaurants to students were both brought up as issues contributing to children and youth being obese and overweight. A lack of public recreation programs and centers, whose programs are cited as a positive but were not considered to be widely enough available by participants. Private gyms and fitness clubs are not

affordable to many members of the community was a repeated sentiment in focus groups; the public pools are only available during the summer months rather than year-round, which could be a recreational outlet for families more often if that capability were changed. Budget cuts to physical education programs at schools were mentioned as contributing factors to being overweight or obese, as well as a lack of open access to school weight rooms, with preferences being given to school sports teams. Participants mentioned that Chico's bike paths are unsafe and should be made safer. Participants stated that Oroville was not very walkable, due to concerns over safety, and specifically the relatively large amount of dogs off the leash. It was expressed that many community members struggled to afford fresh, healthy food. It was mentioned multiple times that mental health issues made it difficult to pursue regular physical activity. At least one participant brought up that being physically active might be seen as a sign of privilege, and some community members might be afraid that their benefits would be stripped if they were seen to be exercising in public.

CHRONIC DISEASE - ASTHMA, DIABETES, HEART DISEASE, STROKE, LIVER DISEASE, ETC.

Identified Successes

Community organizations, recovery-based communities, and existing medical providers, especially government programs, were mentioned as successful in helping people prevent or care for chronic diseases. New technology like fitness bands were also mentioned.

Issues to Address

Lack of support for specific conditions, like epilepsy, Parkinson's, and Multiple Sclerosis, was mentioned as an issue. It was mentioned that resource classes for people with diabetes were poorly attended due to a bad location and a lack of availability. There is a lack of specialists in smaller communities, and a lack of pediatric specialists in the county according to participants. Long wait times were cited again as an issue for receiving care. Difficulties with the system for obtaining prescriptions if there are complications like a lost prescription. Side effects from multiple medications, and community members' concerns that side effects were causing more issues in their daily lives than the actual conditions they were treating were considered obstacles for chronic diseases. A lack of understanding about underlying causes for community members who have chronic diseases, and how factors like lifestyle choices may contribute was expressed as a concern by groups. The effect of the toxic air and water from local wildfires, especially the camp fire, and the resultant uptick in people with chronic conditions and the symptoms those with chronic disease will struggle with were mentioned as a concern by participants. Some participants felt that providers sometimes "pre-diagnose" based on race or ethnicity. Participants at the Hmong Cultural Center stated that a lack of family history knowledge regarding genetic possibilities for chronic health conditions is an issue specifically for Hmong community members.

TRANSPORTATION

Identified Successes

Programs offered to assist special populations with transport were cited as successful in getting people access to necessary transportation. Programs that provide bus passes at low cost or no cost were cited, with the B-Line local bus system being mentioned as a positive success, especially some of the newer routes. Calling the Butte County information line as a way to access transport was an example of success in increasing access to crucial, specialized transportation like getting a ride to medical appointments. The availability of services like Uber and Lyft were mentioned as a method that has increased on-demand access to transportation. Cabs, and cab driver's generosity were cited as successes in transportation access, as well as certain cultural organizations that provided a more expansive definition of essential transport, like rides to the grocery store, when contacted ahead of time to set up an appointment. Buses provided by local medical providers were mentioned as a key success for necessary transport to and from medical services, as well as emergency flightcare. The amount of bike paths and the accessibility they provide, particularly in Chico, was mentioned as a strength for providing transportation access.

Issues to Address

"[RIDESHARING APPLICATIONS] REQUIRE TECHNOLOGY AND A DEBIT OR CREDIT CARD."
- PARTICIPANT FROM THE IVERSEN CENTER

Participants listed a variety of issues for transportation in Butte County. One participant stated there are not enough paratransit services available in the county. Bus services to Paradise and Magalia are limited according to participants. The feeling that transport that specifically caters to elderly community members is not widely available enough was expressed multiple times in groups. The B Line bus system does not run on Sundays, and is not always frequent enough, resulting in long wait times and significant time devoted to travel even for small errands, and at least one participant felt the bus stops are too infrequent and far apart from one another. It was mentioned that there was a lack of trust in newer ridesharing applications, and that people seek a more low-cost, reliable way to get to a pharmacy or a grocery store on an individual basis. Participants mentioned that cars are expensive to own and maintain. Ridesharing applications require a certain level of technology that is not universally accessible, as well as a debit or credit card, which were issues of accessibility for participants. There were not enough accessible alternatives for people unable to obtain driver's license due to being differently abled according to participants. Driver's education programs are not widely available enough at public schools, and private programs can be costly, which affects the ability of young people to become properly licensed drivers.

Appendix: 3

Press Release

BUTTE COUNTY HEALTH NEEDS SURVEY

Your voice matters in improving the health and well-being of our community.

Calls Coming

Answer Your Phone!

Results impact decisions that affect your health.

Supported by Enloe Medical Center, Adventist Health, Orchard Hospital and Butte County Public Health. Visit ***www.enloe.org/chna*** for more information.

ENLOE MEDICAL CENTER

AdventistHealth

Orchard HOSPITAL

Butte County PUBLIC HEALTH

Appendix: 4

Form 990 Scheduled H Reference Chart

Form 990 (Schedule H) Reference Chart

Form 990 Question No.	Description	Reference Page in CHNA Document
	Fiscal Year End	June 30th
	State	CA
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8. If "Yes," indicate what the Needs Assessment describes (check all that apply):	Yes
A	A definition of the community served by the hospital facility	Pg 2
B	Demographics of the community	Pg 5
C	Existing health care facilities and resources within the community that are available to respond to the health needs of the community	Appendix 5
D	How data was obtained	Pg 2
E	The health needs of the community	Pg 12
F	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Pg 12
G	The process for identifying and prioritizing community health needs and services to meet the community health needs	Pg 12 and Appendix 4
H	The process for consulting with persons representing the community's interests	Appendix 1 and 2
I	Information gaps that limit the hospital facility's ability to assess all of the community's health needs	Pg 4
J	Other (describe in Part VI)	Appendix 3: Survey
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 2013	2016
3	In conducting the most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	Yes

Form 990 (Schedule H) Reference Chart (continued)

Form 990 Question No.	Description	Reference Page in CHNA Document
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.	Yes (See Part VI)
5	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	Yes
A	Hospital facility's website	Yes
B	Available upon request from the hospital facility	Yes
C	Other (describe in Part VI)	See Part VI
6	If the hospital facility addressed needs identified in its most recently conducted needs Assessment, indicate how (check all that apply):	Yes
A	Adoption of an implementation strategy to address the health needs of the hospital facility's community	Appendix 6
B	Execution of the implementation strategy	Appendix 6
C	Participation in the development of a community-wide community benefit plan	Appendix 6
D	Participation in the execution of a community-wide community benefit plan	Appendix 6
E	Inclusion of a community benefit section in operational plans	Appendix 6
F	Adoption of a budget for provision of services that address the needs identified in the Needs Assessment	N/A
G	Prioritization of health needs in its community	Appendix 6
H	Prioritization of services that the hospital facility will undertake to meet health needs in its community	Appendix 6
I	Other (describe in Part VI)	N/A
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	Yes

Other: Part VI

#4 – Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.

Orchard Hospital worked collaboratively with the following hospitals and public health entity to complete the data gathering process for the Community Health Needs Assessment:

- Enloe Medical Center
- Feather River Hospital Adventist Health
- Butte County Department of Public Health

#5C – Did the hospital facility make its Needs Assessment widely available to the public? Other (describe in Part VI).

1. Notification to the public that the Orchard Hospital Community Health Needs Assessment was available for review and was placed in the local newspaper with the website link to access the report.
2. Notification to all of our employees has been made through a facility-wide mass email. Email included a link to the report on our website and an attachment (PDF) of the report.
3. Notification to our employees was also placed on our intranet along with a PDF of the report.

Appendix: 5

Implementation Plan 2019

Table of Contents:

Priority: Access to Health Care

Objective/Strategy

Improving access to healthcare is a major focus for Orchard Hospital, and lack of providers in Butte County was a dominant theme reflected across all focus groups. Improving access to healthcare is not just a matter of *affordability*, but also *availability* in our primary and secondary service areas. Orchard Hospital will continue to enhance our current service lines and expand specialty services in order to reduce the need to leave the area for healthcare.

How:

Improving access to healthcare services helps to ensure that patients have a medical home (a provider or facility where one regularly receives care). Patients with a medical home exhibit better health outcomes, fewer disparities, and lower costs. Orchard Hospital will:

- Increase access to healthcare by expanding care and services in Butte County
    - Medical Specialty Center-Oroville
    - Expand Services offered at the Oroville Clinic
- Offer transportation
    - Senior Life Solutions
    - FEMA Site
- Increase number of providers at the Medical Specialty Centers
    - Hire more providers with new specialty service lines
    - Recruit providers that speak a second language
    - Increase number of primary care providers (PCP)
    - Guiding patients to establish a PCP
- Timeliness of service:
    - Availability of appointments and care for illness or injury when needed
    - Time spent waiting in doctors' offices and emergency departments (EDs)
- Add Tele Psychiatry:
    - Offering emergency department and acute care patients access to mental health consultations via online conferencing and consultation
- Emergency department pediatric care:
    - Partnership with the University of California - Davis allows us to expand the pediatric care program to our community
- Long-term care
    - Skilled nursing facility
        - Keep patients close to home
    - Increase resident capacity
- Free influenza vaccination clinics
    - Collaborating with local health department

Priority: Access to Health Care

Programs/Resources to Commit

- Increase the number of providers
- Transportation- Uber, Lyft, Gridley Feather Flyer and taxi
- Medicare Seminars- long term care
- Increased Skilled Nursing Facility to 82 beds

Impact of Programs/Resources on Health Need

- Orchard Hospital Community Financial Assistance
- Butte County B-Line
- Gridley Feather Flyer
- Preventive Service
- Medicare Seminar

Accountable Parties

- Administrator of the Medical Specialty Center
- Director of Physician Recruitment, Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Utilization Review and Discharge Planning
- Director of Senior Life Solutions
- Administration - Hovlid Community Care Center – DP/SNF

Partnerships/Collaboration

- Orchard Hospital will work with the City of Gridley, CSU Chico (dietary intern), Butte County Social Services (intern), Rural Health Nursing student, Gridley Feather Flyer Program, Butte County Department of Public Health, community outreach programs/service clubs and other local hospitals.

Priority: Mental Health and Substance Use Disorders

Objective/Strategy

Metal illness and substance abuse including alcohol, tobacco, illicit drugs, and opioids, continue to rise toward the top of the health needs for Butte County residents. Orchard Hospital will continue to promote smoking cessation among young people and adults within our community to decrease the percentage of those who smoke or use smokeless tobacco. We will also continue to provide our community with a pain management provider, manage prescription pain medications, and provide mental health referrals.

How

Upgrade website to include marketing of programs and services available throughout our community related to mental health, substance use, and the use of tobacco. Communicate services offered at Orchard Hospital through existing and new community marketing campaigns. Orchard Hospital employees will be encouraged to participate.

Implement best-practices for managing prescription pain medications

- Continue to offer Pain Management Provider
- Provide Continuing Medical Education (CME) for Butte County prescribing providers regarding prescription opioid misuse and abuse.
- Continue to offer Mental Health Services:
    - Senior Life Solution
    - Family Licensed Therapist
    - Emergency Room offers Tele-Med Psychiatry

Programs/Resources to Commit

Orchard Hospital is currently collaborating with the Butte County Department of Public Health and Butte County Drug Abuse Task Force to continue to implement the smoking cessation program. Work with the Local School Districts and the local Parks and Recreation Departments to roll- out programs to the youth. Promotion of this program will continue to be communicated to patients through staff and physicians. Work with our current human resource department and healthcare insurance to offer incentives to our employees for participating in smoking cessation. Orchard Hospital will also provide Accessible Intervention and Respiratory Education (AIRE program) for those that have lung disease.

Community Resources:

Substance Use and Misuse

- Alcoholics Anonymous
- Butte County Public Health Department
- Chico Rescue Mission
- Narcotics Anonymous
- No Butts
- Skyway House
- Smoke Free North State
- Tobacco Use Prevention Education
- Vet Center

Mental Health

- Orchard Hospital Senior Health Solutions
- African American Family & Cultural Center
- Butte County Behavioral Health
- Chico Veteran Center
- Hmong Cultural Center

Impact of Programs/Resources on Health Need

- Decline in percentage of those who smoke or use smokeless tobacco
- Additional education to front line staff.

Accountable Parties

- Administrator of the Medical Specialty Center
- Director of Physician Recruitment, Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Utilization Review and Discharge Planning
- Director of Senior Life Solutions
- Administration - Hovlid Community Care Center – DP/SNF

Partnerships/Collaboration

Orchard Hospital will work with Butte County Department of Public Health and Partner with the Rural County Opioid Group.

Priority: Chronic Diseases: Obesity

Objective/Strategy

Enhance care for Childhood Obesity. Orchard Hospital will provide a weight loss management program at the Medical Specialty Center Oroville. Orchard Hospital will continue to offer educational information and to increase the outreach for the Health Ambassador Program.

How

- Weight Loss Management Program
    - Healthcare Provider will counsel Patient and refer patient to clinic Registered Dietician
- Orchard Hospital employees will be encouraged to participate.
- Communicate service offered through local Service Clubs, Schools, Churches, and at Orchard Hospital through existing and new community marketing.
- Utilize the website and social media outlets to include marketing of programs and services available throughout our community for childhood obesity.
- Health Ambassador Program
    - Gridley High School Nursing Pathway Students will be instructed on how to educate elementary students and junior high students on nutrition and fitness (play 60).
    - Orchard Hospital will be able to reach children ages 9-18 in our service area.
    - Educate on how to make healthy snacks and 60 min fitness activity.

Programs/Resources to Commit

Collaborate with local schools and partner with school nurses and the Center for Nutrition & Activity Promotion. Offer nutritional and fitness program to local schools utilizing the play 60 activities and help children and young adults learn how to move for 60 minutes.

Impact of Programs/Resources on Health Need

- See a marked improvement in the management of individual weight and nutrition. This will be proven by increased activity among children/teens as well as weight loss.

Accountable Parties

- Administrator of the Medical Specialty Center
- Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Nutritional Services Utilization Review and Discharge Planning
- Director of Senior Life Solutions
- Administration

Partnerships/Collaboration

Butte County Public Health, Orchard Hospital Nutritional Services, Medical Specialty Center clinic, Partnership with CSU Chico for Dietary Intern, CSU Chico for Social Services Intern and Rural Health Nursing students, Local Service Clubs, and the Local School Districts.

Priority: Chronic Diseases: Diabetes

Objective/Strategy

Enhance care for Diabetes. Orchard Hospital will provide diabetes education to patients identified by providers at the Medical Specialty Center. A provider will refer a patient to diabetic counseling with the registered dietician as needed.

How

Upgrade website to include marketing of programs and services available throughout our community for diabetes. Patients will be referred when newly diagnosed with diabetes and receive lifestyle/self-care information.

Programs/Resources to Commit

Orchard Hospital Dietitian and or Provider (MD or FNP) will meet with the patient and provide a diabetic counseling session.

Impact of Programs/Resources on Health Need

- See a marked improvement in the management of diabetes. This will be evidenced by lower blood sugar levels and weight loss when applicable.

Accountable Parties

- Administrator of the Medical Specialty Center
- Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Registered Dietician in Nutritional Services
- Utilization Review and Discharge Planning
- Administration

Partnerships/Collaboration

Initially, this process will be in-house (utilizing the services of our Nutritional Services Department and the Medical Specialty Center Clinic). We will collaborate and partner with Butte County Public Health, other Hospitals, CSU Chico for Dietary Intern, Social Services Intern, and Rural Health Nursing students.

Appendix: 6

Public Comment

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous Community Health Needs Assessment, and annual implementation strategies were made widely available to the public on the website www.OrchardHospital.com . To date, no comments have been received.

Appendix: 7

Works Cited

Works Cited:

[i] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services

[ii] https://www.healthcare.gov/glossary/preventive-services/

[iii] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Clinical-Preventive-Services

[iv] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health

[v] https://www.cdc.gov/chronicdisease/about/index.htm

[vi] Centers for Disease Control and Prevention (April 2, 2019). About the CDC-Kaiser ACE Study |Violence Prevention|Injury Center|CDC. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

[vii] Center for Youth Wellness. Findings on Adverse Childhood Experiences in California. Retrieved from https://centerforyouthwellness.org/wp-content/themes/cyw/build/img/building-a-movement/hidden-crisis.pdf

[viii] Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008 - 2013. Public Health Institute, Survey Research Group

Department of Health Care Access and Information

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2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
Phone: (916) 440-8300
Fax: (916) 274-0102
www.hcai.ca.gov/facilities/building-safety/

March 29, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01688

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00090 at the above referenced facility is determined herein as Acceptance Pending Field Confirmation. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided pending a confirmation by the Compliance Officer. Please schedule a field visit with the Compliance Officer.

The Compliance Officer for your facility can be found at Facility Details Web Page.

If there are any questions, please contact me at 213-897-9773 or by email at Kamalpreet.Kalsi@hcai.ca.gov.

Kamalpreet Kalsi,
Senior Structural Engineer

cc: Facility Representative

Department of Health Care Access and Information

Office of Statewide Hospital Planning and Development
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
Phone: (916) 440-8300
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www.hcai.ca.gov/facilities/building-safety/

March 29, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01701

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00094 at the above referenced facility is determined herein as Acceptance Pending Field Confirmation. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided pending a confirmation by the Compliance Officer. Please schedule a field visit with the Compliance Officer.

The Compliance Officer for your facility can be found at Facility Details Web Page.

If there are any questions, please contact me at 213-897-9773 or by email at Kamalpreet.Kalsi@hcai.ca.gov.

Kamalpreet Kalsi,
Senior Structural Engineer

cc: Facility Representative

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2020 West El Camino Avenue, Suite 800
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Fax: (916) 274-0102
www.hcai.ca.gov/facilities/building-safety/

March 29, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01700

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00100 at the above referenced facility is determined herein as Acceptance Pending Field Confirmation. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided pending a confirmation by the Compliance Officer. Please schedule a field visit with the Compliance Officer.

The Compliance Officer for your facility can be found at Facility Details Web Page.

If there are any questions, please contact me at 213-897-9773 or by email at Kamalpreet.Kalsi@hcai.ca.gov.

Kamalpreet Kalsi,
Senior Structural Engineer

cc: Facility Representative

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

COMMUNITY CARE FINANCIAL ASSISTANCE POLICY

POLICY:

Orchard Hospital realizes the need to provide service to patients who cannot otherwise afford health care. This policy is to provide financial assistance to patients who have health care needs and are uninsured, under-insured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual needs.

A graduate schedule based on the annual HHS Poverty Guidelines, as well as assessment of the patient's monetary assets will be used to determine the qualifying income and asset levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Community Care Policy.

PROCEDURE:

1. Standard Eligibility Criteria for Participation in the Community Care Program:

a. A patient qualifies for Community Care if all of the following conditions are met:

The patient does not have private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, or Medi-Cal as determined and documented by the hospital.

The patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.

The patient's household income does not exceed 75% (see matrix) of the Federal Poverty Level; **and**

The patient's allowable monetary assets do not exceed $5,000.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

1. In determining a patient's monetary assets, the hospital **shall not** consider:
   Retirement or deferred compensation plans qualified under the Internal Revenue Code.
   Non-qualified deferred compensation plans.
   The first ten thousand dollars ($10,000) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000).

b. Family size to determine federal poverty level is defined as follows:
   The patient's legal spouse or domestic partner
   the patient's legal guardian or parent
   Children under 21 whether living at home or not Caretaker relatives.

2. Special Eligibility and Enrollment Exceptions:

a. High Medical Costs/Medically Indigent

A patient whose family income does not exceed 400% (see matrix) of the federal poverty and their annual out-of-pocket medical expenses for non-elective/medically necessary services with

Orchard Hospital and other health care providers exceed 10% of the patient's family gross income in the prior 12 months, would then be considered as "Medically Indigent" as defined by AB774.

1. For those who have been informally determined to be Medically Indigent or have incurred high medical costs will be offered the chance to complete a Community Care application by the Financial Counselor.

2. Supporting documentation to show what medical expenses have been paid in the prior 12 months is required to determine eligibility.

b. Homeless/Indigent Patients

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Patients who are determined to be indigent/homeless by either clinical documentation or are unable to provide sufficient demographic information such as a mailing address, phone number, or residential address will/can be considered for Community Care.

1. No application will be required by a patient who has been determined to be indigent/homeless.

2. Only emergency/medically necessary services will be considered. Should a patient who presents for outpatient services, financial counseling will be done at the time of service.

c. Deceased No Estate

Upon receipt of confirmation that a patient is deceased and who has no estate, third party coverage, or spouse, will be automatically eligible for Community Care upon receipt of the following items.

1. Notification from county in which patient expired in.
2. Received copy of death certificate from patient family notifying OH of death and no estate exists.
3. Confirmation that patient does not have a living spouse who would be liable for outstanding/unpaid debt.
4. Confirmation from another facility of patients' expiration and that no estate or pending probate exist.
5. Upon notification from collections agency that collections accounts are being cancelled back due to deceased/no estate.
6. Knowledge that patient has expired based on clinical documentation for services provided by OH.

d. Administrative Community Care

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

In cases where medically necessary services are provided to a patient who has been screened by the financial counselor, and it has been determined that the patient is unable to complete the standard application process due to medical, social, or other documented circumstances, charges may be considered for Community Care on a case-by-case basis.

1. Account(s) should be written up for Community Care adjustment with all supporting documentation attached and be presented to the Manager of Business Office/Registration and Chief Financial Officer for approval.

3. Standard Enrollment Process:

An informal determination of Community Care eligibility will be determined by the Patient Financial Counselor and Credit/Collection Specialist, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor and Credit/Collection Specialist; however, the recommendation of the Patient Financial Counselor and Credit/Collection Specialist is not required in choosing to fill out the Community Care Application.

Upon being submitted for consideration by the Patient Financial Counselor and Credit/Collection Specialist, all properly submitted applications will be reviewed and considered for implementation within 10 business days.

All application packets must be filled out completely and accurately with each of the following required documentation attached, to be considered:

Documentation of non-coverage from Medi-Cal for the service on the date performed; Documentation of household income, as provided by:

1. Current W-2 withholding form or Income Tax statement form from the previous year, **or**
2. Pay stubs from the previous three months

Documentation of monetary assets, to include:

1. Most current bank statement, and any additional information or statements on all monetary assets
    a. Statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2. Signed waiver or release from the patient or the patient's family, authorizing the hospital to obtain account information from financial and/or commercial institutions, or other entities that hold or maintain monetary assets, to verify their value.

Completed Medicare Secondary Payer (MSP) Questionnaire indicating the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance.

b. Any additional accounts with outstanding balances at time of application will be screened for Community Care eligibility using the same information collected above.
c. Verification of accuracy of application information, including contacting employers for verification of employment, will be made.
d. A letter of either approval or denial will be submitted to each applicant.

The approval letter will include a demand statement for the service in question with adjustments and a balance of zero dollars ($0) and contact information for any questions that may arise.

The denial letter will include reason for denial; indication of potential eligibility under the Discount Payment Program, Payment Plan Program, or other self-pay policy; and information and request to contact the Patient Financial Counselor and Credit/Collection Specialist as soon as possible.

e. Any additional services rendered up to a year after the submission date of an approved Community Care Application will additionally require updated documentation of non-coverage for the service on the date performed; and a completed MSP Questionnaire indicating the patient's injury is not a compensable injury.
f. Any disputes regarding a patient's eligibility to participate in the Community Care Program shall be directed to the Manager of Business Office/Registration and will be resolved within 10 business days.
   If it is determined that the patient is ineligible to participate, the number of days spent on dispute resolution shall not be counted toward the minimum 150 days prior to reporting any amount to a credit reporting bureau.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

4. Participant Accounts Maintenance:

A record for each Community Care applicant will be created, and will include the following items:

a. Patient information and application
b. A copy of every correspondence between Orchard Hospital and the participant
c. Detailed bills on all accounts to be included in the application.
d. Adjustment form with adjustments taken on accounts.
e. Any additional notations and pertinent information

5. Availability of the Community Care Policy:

a. Notice of the Community Care Policy shall be posted clearly posted in locations visible to the public, including but not limited to:

Emergency department
Billing office
Admissions office
Other outpatient locations

b. In the event of the hospital providing service to a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the hospital shall provide a notice to the patient that includes, but is not limited to:

A statement of charges for services rendered by Orchard Hospital; and

A request that the patient inform Orchard Hospital if the patient has health insurance coverage, Medicare, Medi-Cal or other coverage, and if the patient does not, that the patient may be eligible for such coverage, and can obtain an application for such coverage from Orchard Hospital; and

A statement that indicates the patient may qualify for Community Care if they meet the eligibility criteria set forth in this policy; and

The name and telephone number of the Patient Financial Counselor and Credit/Collection Specialist from whom the patient may obtain information about the Community Care policy and other assistance policies, and about how to apply for that assistance.

REFERENCES:

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

The processes and procedures described above are designed to comply with CA SB 1276 (Chapter 758, Statutes of 2014), CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007).

Questions regarding SB 1276, AB 774 and SB 350 can be addressed by the Patient Financial Counselor or by California's Office of Statewide Health Planning and Development's website, at

http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.
http://aspe.hhs.gov/poverty/14poverty.shtml

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2023 HHS POVERTY GUIDELINES – 75% FPL

Persons in Family or Household	75% US Poverty Level
1	$ 10,935
2	$ 14,720
3	$ 18,545
4	$ 22,500
5	$ 26,355
6	$ 30,210
7	$ 34,065
8	$ 37,920
For each additional person, add	$ 5,140

To determine community care eligibility according to income level:

Count the number of people in your family/household.

a. For persons 18 years of age and older, including spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not
b. For persons under 18 years of age, include parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Calculate the household income (annual).

On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled “75% US Poverty Level.”

If your household income is less than 75% US Poverty Level amount, your income supports your eligibility for Community Care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

To determine community care eligibility according to total monetary assets:

Calculate your total monetary assets (referred to as "ASSETS" in the equation below)

- Assets included in retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included.

Insert total assets into the following equation:

- (ASSETS – 10,000)/2

If the remaining amount is less than $5,000, your total asset level supports your eligibility for Community Care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2023 HHS POVERTY GUIDELINES - 400% FPL

Household Size	400% US Poverty Level
1	$58,320
2	$78,880
3	$99,440
4	$120,000
5	$140,560
6	$161,120
7	$181,680
8	$202,240
9	$222,800
10	$243,360

To determine Medically Indigent eligibility according to income level:

Count the number of people in your family/household.

- For persons 18 years of age and older, include spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not
- For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

Calculate the household income (annual).

On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled “400% US Poverty Level.”

If paid medical expenses for medically necessary services exceed 10% of household income in the prior 12 months, then additional expenses beyond that 10% incurred would then be considered eligible for community care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Note: Pursuant to AB 774 Sect. 127405(2), Orchard Hospital has established eligibility levels for financial assistance and community care at less than 350 percent of the federal poverty level as appropriate to maintain its financial and operational integrity.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

DISCOUNT PAYMENT POLICY

POLICY:

Orchard Hospital realizes the need to provide service to patients who cannot otherwise afford health care. This policy applies to all uninsured or underinsured patients who meet the guidelines of this policy and who agree to its terms. A sliding fee schedule based on the annual HHS Poverty Guidelines will be used to determine the qualifying income levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Discount Payment Policy.

PROCEDURE:

1. Enrollment Process

An informal determination of Discount Payment eligibility will be determined by the Patient Financial Counselor and Credit/Collection Specialist, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor and Credit/Collection Specialist; however, the recommendation of the Patient Financial Counselor and Credit/Collection Specialist is not required in choosing to fill out the Discount Payment Application.

Upon being submitted for consideration by the Patient Financial Counselor and Credit/Collection Specialist, all properly submitted applications will be reviewed and considered for implementation within 10 business days.

All applications must be filled out completely and accurately with one of the following required documentations attached, to be considered:

- Current W-2 withholding form or Income Tax statement form from the previous year, **or**
- Pay stubs from the previous three months

Verification of accuracy of application information, including contacting employers for verification of employment, will be made.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

A letter of either approval or denial will be submitted to each applicant. The letter will contain: the percent discount; adjusted balance (if more than one account, each will be combined into one account for accounting and billing/statement purposes); and the required monthly payment due each month. Also included in the envelope will be a payment schedule and a discount card.

Updates will be conducted at the end of each calendar year for continued eligibility, or as needed with updated information/changes to guarantor accounts.

2. Discount Payment Account Billing Process, Terms and Settlement

All accounts will be billed out on a monthly basis.

Participants are requested to remain current on their outstanding balances. In order to remain current, participants must pay the balance due by the 15th of the following month. If unable to meet these requirements, prior arrangements must be made with the Business Office/Patient Financial Counselor and Credit/Collection Specialist.

If participant information changes, the participant shall submit changes to the Business Office/Patient Financial Counselor and Credit/Collection Specialist to update their applications or to complete/submit a new application.

If a participant does not pay within 15 days past due, without prior arrangements with the Business Office/Patient Financial Counselor and Credit/Collection Specialist, he/she will be removed from the program.

Upon removal from the program, a 6-month grace period will be enforced where all amounts will be due, and the patient will not be eligible for the program. Accounts on the program will have the discounted amount removed, original balance reinstated minus any payments, and prepared for collections. These accounts will not be considered a part of the new application once the participant is eligible for the program again.

A new application on new accounts may be submitted after the grace period for consideration.

Accounts that are removed from the program and that still contain a positive balance after the 6-month grace period will be forwarded to an outside collection agency who will, at their discretion and in accordance with rules and regulations put forth by California Assembly Bill 774, notify credit reporting bureaus. Under no circumstances will an account be reported to a credit reporting bureau under 150 days from the first bill date.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

3. Participant Accounts Maintenance

All accounts will be reviewed monthly for fee adjustments, monthly payments and co-payments. Notices will be sent to all accounts which are non-compliant.

Collections efforts may be pursued for accounts that violate the terms set herein.

In the folder for each application the following items are required:

- Patient information and application
- A copy of every correspondence between Orchard Hospital and the participant
- Detailed bills on all accounts to be included in the application.
- Adjustment form with adjustments taken on accounts
- Any additional notations and pertinent information

The processes and procedures described above are designed to comply with CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007). Questions regarding AB 774 and SB 350 can be addressed by the Patient Financial Counselor and Credit/Collection Specialist or by California's Office of Statewide Health Planning and Development's website, at http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.

REFERENCES:

Pursuant to AB 774 Sect. 127405(2), Orchard Hospital has established eligibility levels for financial assistance and community care at less than 400 percent of the federal poverty level as appropriate to maintain its financial and operational integrity. Mayers Memorial Hospital is a rural hospital as defined in Section 124840. http://aspe.hhs.gov/poverty/12poverty.shtml

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

2023 HHS POVERTY GUIDELINES

Household Size	100% US Poverty Level	150% US Poverty Level	200% US Poverty Level
	80% Discount	60% Discount	40% Discount
1	$14,580	$21,870	$29,160
2	$19,720	$29,580	$39,440
3	$24,860	$37,290	$49,720
4	$30,000	$45,000	$60,000
5	$35,140	$52,710	$70,280
6	$40,280	$60,420	$80,560
7	$45,420	$68,130	$90,840
8	$50,560	$75,840	$101,120
9	$55,700	$83,550	$111,400
10	$60,840	$91,260	$121,680

To determine discount eligibility:

Count the number of people in your family/household.

a. For persons 18 years of age and older, spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not

b. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Calculate the household income (annual).

Sliding across the row corresponding to the number of persons in your family/household above, stop in the first bucket that has an amount greater than the household income.

At the top of that column, the % discount is displayed.

REPAYMENT SCHEDULE

Total Patient Responsibility	Maximum Repayment Term	Minimum Monthly Payment
$50 or less	In Full	In Full
$51 - $100	2 Months	$40
$101 - $300	3 Months	$55
$301 - 4600	6 Months	$75
$601 - $1,000	9 Months	$100
$1,001 - $3,000	12 Months	$150
$3,001 - $6,000	15 Months	$250
$6,000 And over	18 Months	$350

To determine repayment schedule parameters:

Establish estimated or calculated total patient charges prior to discount.

a. The Patient Financial Counselor and Credit/Collection Specialist and/or Department Personnel can provide a list of anticipated charged services and supplies, summed to Total Charges

b. Per AB 774 Sect 127405(d), the Total Charges amount will be adjusted to mirror the amount of payment the hospital would receive as if it were providing the same services and supplies to Medicare.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	**All Orchard Hospital entities**		**Medical Specialty Center**		**Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Once the total liabilities reflect the amount payable by Medicare, the discount percentage established above will be applied. The resulting amount is “TOTAL PT RESPONSIBILITY” that can be inserted into the table above.

Determine which row applies to your “TOTAL PT LIABILITIES” amount by putting the amount in the appropriate range above.

Sliding to the right, the repayment of the discounted Total Patient Liabilities must be performed within the corresponding parameters.

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Purpose:

To ensure that patients with limited English proficiency, or patients who are hearing impaired, are not denied access to basic health care services. To ensure compliance with State Health and Safety Code 1259.0, regarding hospital interpreter services.

Definitions:

For the purpose of this policy, "Limited English Proficiency" (LEP) applies to those individuals who demonstrate a limited ability, or inability, to speak, read, write or understand the English language at a level that permits the person to interact effectively with healthcare providers or social service agencies.

For the purpose of this policy, "Interpreter" means someone fluent in English and in the necessary second language, who can accurately speak, read and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters must have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages.

For the purpose of this policy, "Language Barrier" applies to those individuals who are limited English speaking or non-English speaking.

For the purpose of this policy, "Communication Barrier" applies to those individuals who are deaf, and whose primary communication is sign language.

For the purposes of this policy, "Employee Language Interpreters" applies to those employees who have volunteered to act as interpreters and have been tested by an outside agency and found to be proficient in the interpretation abilities.

Statement of Policy:

Orchard Hospital will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of Orchard Hospital is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

Orchard Hospital will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

Procedure:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

Orchard Hospital will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients, residents, or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTEPRETER

Human Resources department (530-846-9038) is responsible for:

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff;

(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language:

Interpretive Services are available through:

If a patient has a need for a TDD phone, one may be obtained from the Acute Care Nursing Station. The phone number for California Relay Service is 800-735-2922 and is available 24 hours a day.

CYRACOM ACCOUNT INFORMATION - call 1-800-481-3289

Orchard Hospital Account Number 501022152

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

(Account should auto-populate their system based on our phone number but in case it doesn't please provide them the above account number and the appropriate pin number designated below)

Department PINS:

Emergency Department = 2323

Medical Specialty Center (Gridley) = 2756

Medical Specialty Center (Oroville) = 9699

Acute Care = 6030

Physical Therapy = 7259

Radiology = 4040

ASL Video Interpretation Login Information

Please navigate to https://video.cyracom.com/login

User Name = cyracom@orchardhospital.com

Password = OrchardHospital240

In order to initiate video interpretation, primarily ASL, you will need to go to https://video.cyracom.com/login.

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's chart. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

(a) When translation of vital documents is needed, each unit in Orchard Hospital will submit documents for translation into frequently-encountered languages to Health Information Management department. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) Orchard Hospital will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

Orchard Hospital will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to registration, the emergency room, outpatient areas, etc. Notification will also be provided through one or more of the following: Orchard Hospital website, outreach documents, telephone voice mail menus, local newspapers, radio and television stations, and/or community-based organizations.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, Orchard Hospital will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, Orchard Hospital will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc.

References: DNV-NIAHO Critical Access Hospital Accreditation Program: Patient Rights: PR.3 Language and Communication- SR.1; California Code of Regulations: Title 22, Section 70721, 71521; Office for Civil Rights; Title VI: Civil Rights Act, 42 USC 2000d et. Seq.

Subject	Staffing
Department(s)	Critical Access Hospital (CAH)
Reference #	1317

Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

POLICY:

As a Critical Access Hospital (CAH), Orchard Hospital maintains a professional health care staff that includes doctors of medicine or osteopathy; physician assistants, nurse practitioners and/or clinical nurse specialists. Physician assistants, nurse practitioners and/or clinical nurse specialists, while utilized in the rural health clinics and emergency department, do not have admitting privileges in the acute hospital and are not utilized for the admission of patients. Certified Registered Nurse Anesthetists (CRNAs) are utilized in the acute hospital and their practice is governed by the medical staff by-laws.

PROCEDURE:

Orchard Hospital will modify staffing to ensure effective patient care and process outcomes are achieved. This will be validated through periodic reporting of variance from core staffing, and outline the justification and link for that justification with patient process and outcomes, including any untoward patient events or process failures. Validation of staff monitors will be completed at least monthly and reported to Quality Management Oversight.

- The CRNAs are supervised by the professional staff.
- Any ancillary personnel are supervised by the professional staff.
- Orchard Hospital's staff is sufficient to provide the services essential to the operation of the hospital.
- A doctor of medicine or osteopathy is available to furnish patient care services at all times the hospital operates.
- A registered nurse is on duty whenever the hospital has one or more inpatients.

Responsibilities of the Doctor of Medicine or Osteopathy:

- The doctor through the medical staff provides medical direction for the hospital's health care activities and consultation for the medical supervision of the health care staff.
- The CAH shall have a Medical Staff that is appropriate to provide the services offered.
- In conjunction with the professional staff participates in developing, executing, and periodically reviewing the hospital's written policies governing the services it furnishes.
- In conjunction with the professional staff, periodically reviews the hospital's patient records, provides medical orders, and provides medical care services to the patients of the hospital.
- A physician is present every day that patients are admitted or seen in the emergency department of the CAH.

Subject	Staffing				
Department(s)	Critical Access Hospital (CAH)				
Reference #	1317				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

- Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialists are utilized in the care of emergency patients, but this does not include inpatients.
- Arranges for, or refers patients to, needed services that cannot be furnished at Orchard Hospital, and assures that adequate patient health records are maintained and transferred as required when patients are referred.

REFERENCES: DNV-NIAHO Critical Access Hospital Accreditation Program: Nursing Services NS.1 Nursing Service, SR.4a; Medical Staff MS.1 Organized Medical Staff SR.1, SR.2 SR.3, SR.4; MS.2 Accountability/Responsibility SR.1, SR.2; CMS Conditions of Participation: 485.631(a); 485.631(a)(2); 485.631(a)(3); 485.631(a)(4); 485.631(a)(5); 485.631(b)(1); 485.631(b)(1)(ii);485.631(b)(1)(iv); 485.631(b)(2); 485.631(c)(1); 485.631(c)(2)(ii); 485.618(2)

Orchard Hospital

240 Spruce Street
Gridley, California 95948

(530) 846-9000
www.OrchardHospital.com

Please see information below:

(2) The written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) of these regulations shall include a section entitled "Fair Market Value" that contains the following information:
(A) The estimated market value of all cash, property, stock, notes, assumption or forgiveness of debt, and any other thing of value that the applicant would receive for each health facility or facility that provides similar health care covered by the proposed agreement or transaction. $5,488,245 (As of June 30, 2023)

(B) The estimated market value of each health facility, facility that provides similar health care or other asset to be sold or transferred by the applicant under the proposed agreement or transaction. $2,826,970 (As of June 30, 2023)

(C) A description of the methods used by the applicant to determine the market value of any assets involved in the proposed agreement or transaction. This description shall include a description of the efforts made by the applicant to sell or transfer each health facility or facility that provides similar health care that is the subject of the proposed agreement or transaction. The valuation for all net assets was based on the book value from Orchard Hospital's audited financial statements as of June 30, 2023. The estimated value provided under 2(A) excludes $2,470,018 of board designated investments per the management services agreement dated July 1, 2023, between Orchard Hospital and American Advanced Management, Inc.

(D) Reports, analysis, Requests for Proposal, and any other documents that refer or relate to the valuation of any asset involved in the agreement or transaction.
See audited financial statements for Orchard Hospital for fiscal year ending June 30, 2023.

ORCHARD HOSPITAL
GRIDLEY, CA

Unaudited Financial Statements

for

For the Month Ended May 31, 2024

Unaudited Balance Sheet - Assets

ORCHARD HOSPITAL

GRIDLEY, CA

For the Month Ended May 31, 2024

	ASSETS				Audited
	Current Month 5/31/2024	Prior Month 4/30/2024	Month Over Month Change	Percentage Change	Prior Year End 6/30/2023
Current Assets					
Cash and Cash Equivalents	$ 1,885,699	$ 1,341,608	$ 544,091	40.56%	$ 3,495,530
Gross Patient Accounts Receivable	16,909,770	16,263,931	645,839	3.97%	13,117,536
Less: Bad Debt and Allowance Reserves	(11,916,447)	(11,497,685)	(418,761)	3.64%	(9,571,204)
Net Patient Accounts Receivable	4,993,323	4,766,246	227,078	4.76%	3,546,332
Other Receivables	4,817,985	5,063,129	(245,143)	-4.84%	5,393,313
Inventories	458,363	455,853	2,510	0.55%	444,006
Prepaid Expenses	206,256	158,940	47,316	29.77%	1,087,882
Other Current Assets	542,814	517,176	25,638	4.96%	-
Total Current Assets	**12,904,441**	**12,302,951**	**601,490**	**4.89%**	**13,967,063**
Assets Whose Use is Limited					
Board Designated Funds	2,515,077	2,480,922	34,155	1.38%	171,899
Other Limited Use Assets	-	-	-	0.00%	-
Total Limited Use Assets	**2,515,077**	**2,480,922**	**34,155**	**1.38%**	**171,899**
Property, Plant, and Equipment					
Land and Land Improvements	285,930	285,930	-	0.00%	285,930
Building and Building Improvements	4,534,793	4,534,793	-	0.00%	4,534,793
Equipment	9,275,488	9,192,611	82,877	0.90%	8,691,731
Construction In Progress	54,706	54,706	-	0.00%	80,866
Gross Property, Plant, and Equipment	14,150,917	14,068,040	82,877	0.59%	13,593,320
Less: Accumulated Depreciation	(10,817,680)	(10,771,817)	(45,863)	0.43%	(10,345,535)
Net Property, Plant, and Equipment	**3,333,237**	**3,296,223**	**37,014**	**1.12%**	**3,247,785**
TOTAL UNRESTRICTED ASSETS	**19,517,135**	**18,844,476**	**672,659**	**3.57%**	**17,386,747**
TOTAL ASSETS	**$ 19,517,135**	**$ 18,844,476**	**$ 672,659**	**3.57%**	**$ 17,386,747**

Unaudited Balance Sheet - Liabilities and Net Assets

ORCHARD HOSPITAL
GRIDLEY, CA
For the Month Ended May 31, 2024

	LIABILITIES AND FUND BALANCE				Audited
	Current Month 5/31/2024	Prior Month 4/30/2024	Month Over Month Change	Percentage Change	Prior Year End 6/30/2023
Current Liabilities					
Accounts Payable	$ 3,505,297	$ 3,183,115	$ 322,182	10.12%	$ 3,723,656
Notes and Loans Payable	1,167,638	1,165,712	1,926	0.17%	1,235,292
Accrued Payroll	581,295	439,032	142,262	32.40%	670,255
Accrued Payroll Taxes	32,134	25,399	6,735	26.52%	39,287
Accrued Benefits	534,096	533,457	639	0.12%	562,649
Due to Third Party Payers	1,237,916	1,041,555	196,361	18.85%	1,000,314
Current Portion of LTD/Leases	515,375	515,375	-	0.00%	523,846
Other Current Liabilities	3,000,000	3,000,000	-	0.00%	-
Total Current Liabilities	**10,573,750**	**9,903,645**	**670,106**	**6.77%**	**7,755,299**
Long Term Debt					
Leases Payable	1,016,342	1,061,113	(44,771)	-4.22%	1,294,545
LT Note Payable	140,332	140,642	(310)	-0.22%	143,730
Total Long Term Debt (Net of Current)	**1,156,674**	**1,201,755**	**(45,081)**	**-3.75%**	**1,438,275**
Other Long Term Liabilities					
Other	481,913	481,913	-	0.00%	234,910
Total Other Long Term Liabilities	**481,913**	**481,913**	**-**	**0.00%**	**234,910**
TOTAL LIABILITIES	**12,212,338**	**11,587,313**	**625,025**	**5.39%**	**9,428,490**
Net Assets:					
Unrestricted Fund Balance	7,678,580	7,678,580	(0.10)	0.00%	9,533,399
Net Revenue/(Expenses)	(373,783)	(421,417)	47,634	-11.30%	(1,575,136)
TOTAL NET ASSETS	**7,304,797**	**7,257,163**	**47,634**	**0.66%**	**7,958,263**
TOTAL LIABILITIES AND NET ASSETS	**$ 19,517,135**	**$ 18,844,476**	**$ 672,659**	**3.57%**	**$ 17,386,747**

Unaudited Statement of Revenue and Expense

ORCHARD HOSPITAL
GRIDLEY, CA
For the Month Ended May 31, 2024

	YEAR-TO-DATE				Audited
	Actual 5/31/2024	Budget 5/31/2024	Positive (Negative) Variance	Percentage Variance	Prior Year 6/30/2023
Gross Patient Revenue					
Inpatient Revenue	$ 12,400,041	$ 14,027,465	$ (1,627,424)	-11.60%	$ 12,811,743
Inpatient Routine Swing Bed Revenue	6,741,180	5,195,661	1,545,519	29.75%	4,690,845
Outpatient Revenue	38,268,220	40,160,592	(1,892,372)	-4.71%	38,850,080
Clinic	4,269,516	5,427,659	(1,158,144)	-21.34%	4,122,967
Emergency Room Revenue	30,314,994	29,712,653	602,342	2.03%	31,727,719
Total Gross Patient Revenue	91,993,950	94,524,030	(2,530,080)	-2.68%	92,203,355
Deductions From Revenue					
Discounts and Allowances	(66,526,851)	(68,769,548)	2,242,697	-3.26%	(66,330,591)
Bad Debt Expense	(2,804,785)	(2,541,301)	(263,484)	10.37%	(2,725,406)
Denials	(258,438)	(222,413)	(36,025)	16.20%	(191,472)
Hospital Fee Program	3,560,174	3,750,926	(190,752)	-5.09%	3,942,396
Charity Care	(209,429)	(231,027)	21,598	-9.35%	(162,965)
Total Deductions From Revenue	(66,239,330)	(68,013,364)	1,774,034	-2.61%	(65,468,037)
Net Patient Revenue	25,754,621	26,510,666	(756,046)	-2.85%	26,735,318
340(B) Revenue	253,548	228,740	24,809	10.85%	189,360
Other Operating Revenue	376,007	184,964	191,043	103.29%	410,718
Total Operating Revenue	**26,384,176**	**26,924,370**	**(540,194)**	**-2.01%**	**27,335,396**
Operating Expenses					
Salaries and Wages	12,875,177	13,239,833	364,656	2.75%	13,752,177
Employee Benefits	2,773,257	2,913,188	139,931	4.80%	3,751,131
Professional Fees	4,581,476	4,329,247	(252,229)	-5.83%	4,858,155
Purchased Services	2,282,808	2,184,541	(98,267)	-4.50%	2,437,577
Supply Expense	1,691,323	1,710,215	18,892	1.10%	1,757,952
Utilities	576,396	687,635	111,239	16.18%	653,511
Repairs and Maintenance	479,308	403,591	(75,716)	-18.76%	580,436
Insurance Expense	364,917	361,531	(3,386)	-0.94%	371,026
All Other Operating Expenses	495,497	433,647	(61,851)	-14.26%	550,788
Leases and Rentals	244,428	258,790	14,362	5.55%	295,280
Operating Expenses Before Depreciation and Interest	26,364,586	26,522,218	157,631	0.59%	29,008,034
Earnings Before Depreciation and Interest	**19,589**	**402,152**	**(382,562)**	**-95.13%**	**(1,672,638)**
Depreciation and Amortization	472,145	479,255	7,110	1.48%	557,785
Interest Expense	144,401	115,357	(29,044)	-25.18%	189,214
Depreciation and Interest	616,546	594,612	(21,934)	-3.69%	746,999
Total Operating Expenses	**26,981,132**	**27,116,830**	**135,698**	**0.50%**	**29,755,033**
Net Operating Surplus/(Loss)	**(596,957)**	**(192,461)**	**(404,496)**	**210.17%**	**(2,419,637)**
Non-Operating Revenue:					
Contributions	12,314	53,655	(41,341)	-77.05%	128,704
Investment Income	204,446	77,000	127,446	165.51%	144,518
Other Non-Operating Revenue/(Expenses)	6,413	22,856	(16,443)	-71.94%	571,278
Total Non Operating Revenue/(Expense)	**223,173**	**153,511**	**69,662**		**844,501**
Total Net Surplus/(Loss)	**$ (373,784)**	**$ (38,950)**	**$ (334,834)**	**859.66%**	**$ (1,575,136)**
Operating Margin	**-2.26%**	**-0.71%**			**-8.85%**
Total Profit Margin	**-1.42%**	**-0.14%**			**-5.76%**
EBIDA	**0.07%**	**1.49%**			**-6.12%**
Cash Flow Margin	**0.92%**	**2.06%**			**-3.03%**