



2019 Mendocino County Community Health Needs Assessment

APPENDIX C Community Health Status Assessment

October 2019

TABLE OF CONTENTS

Community Health Status Assessment

Introduction	1
Methodology and Limitations.....	1

Results

Demographic Information	3
Socioeconomic Characteristics	4
Social Determinants of Health.....	12
Behavioral Risk Factors	21
Maternal Child and Adolescent Health.....	29
Healthcare and Preventive Services	36
Dental Health.....	38
Death, Disease and Chronic Conditions.....	39

Sources	43
----------------------	----

Addendum

Data Dictionary	44
-----------------------	----

Cover Photo credit Brendan McGuigan

COMMUNITY HEALTH STATUS ASSESSMENT

Introduction

The Community Health Status Assessment (CHSA) is a method of reviewing key data indicators that answer the questions, “How healthy are our residents?” and “What does the health status of our community look like?” The CHSA is one data-gathering component of the 2019 Mendocino County Community Health Needs Assessment (CHNA).

The 2019 CHNA is sponsored by a coalition of local organizations and agencies: Adventist Health Howard Memorial, Adventist Health Ukiah Valley, Alliance for Rural Community Health & Community Health Resource Network, Community Foundation of Mendocino County, FIRST 5 Mendocino, Healthy Mendocino, Mendocino Community Health Clinics, Mendocino County Health & Human Services Agency, Public Health Branch, Mendocino County Office of Education, North Coast Opportunities, Partnership HealthPlan of California, Redwood Community Services, Inc., Redwood Quality Management Company, and United Way of the Wine Country. The CHNA is a project of Healthy Mendocino, which facilitated the Planning Group.

The CHSA report highlights key data indicators organized into broad-based categories related to health and well-being.

The data categories included in this CHSA are as follows:

- Socioeconomic Characteristics

- Social Determinants of Health
- Behavioral Risk Factors
- Maternal Child and Adolescent Health
- Healthcare and Preventive Services
- Hospitalization and Emergency Room Utilization
- Dental Health
- Illness, Injury and Deaths

The remaining indicators are displayed in a data book as an addendum to this report.

Methodology and Limitations

The findings presented in this report highlight issues that impact the health status of the people of Mendocino County. The information comes from a variety of sources and is organized on the Healthy Mendocino website <http://www.healthymendocino.org/>.

The Healthy Mendocino website is produced in partnership between Mendocino County and the Conduent Healthy Communities Institute (HCI). Conduent HCI is a network of researchers, public health technology specialists, epidemiologists and public administrators, working to provide communities with easy to understand data, best practices, and funding source information to

drive community health improvement. The Healthy Mendocino website provides statistical indicators for 203 key subjects that describe aspects of the population used to measure health, environmental quality and quality of life. Indicators may include measurements of illness and disease, environmental and economic indicators, as well as behaviors and actions related to health.

Data found on the site comes from a variety of sources, including the National Cancer Institute, the Centers for Disease Control, the American Community Survey, the Census Bureau, Department of Justice, and other state-specific sources listed on the Healthy Mendocino website. (<http://www.healthymendocino.org>) Data is presented with comparisons to other California counties, along with averages for local or national values, changes over time and target goals for health outcomes from Healthy People 2020. (<http://www.healthypeople.gov>)

Reviewing key indicators on the Healthy Mendocino website that are highlighted in red, allows us to see at a glance areas of possible improvement to the health of the community. This report focuses on

key subjects with values less than the state averages, or ones that fail to meet the Healthy People 2020 objectives. These are areas where there are disparities in obtaining health care, increased incidence of illness, behavioral practices that negatively affect one's health, and/or societal determinants such as low employment or lack of transportation that adversely affect the health of a community.

The aim of statistical testing is to uncover significant differences. When using statistical measures, the larger the sample size the more certain researchers can be that the sample reliably reflects the population mean. However, smaller sample sizes can still detect differences across populations. In cases where the data reflects smaller sample sizes, we have added the notation that values may be statistically unstable and should be interpreted with caution. At the end of this report is a table of indicators that contains the statistics for Mendocino County and the corresponding values for the State and the U.S.

RESULTS

Demographic Information

Mendocino County Demographic Profile	Mendocino	California
Population, 2018	87,580	39,964,848
Population, 2010 (April 1 estimates)	87,841	37,254,503
Population, percent change - 2010 to 2019	>1%	7%
Persons under 5 years, percent	5.9%	6.2%
Persons under 17 years, percent	15.6%	16.6%
Persons 65 years and over, percent	21.7%	14.5%
Female persons, percent	50.3%	50.3%
Ethnicity, percent, 2019		
White alone, percent (a)	73.2%	54.7%
Black or African American alone (a)	0.8%	5.8%
American Indian and Alaska Native alone (a)	5.1%	0.97%
Asian alone (a)	2.0%	14.8%
Native Hawaiian and Other Pacific Islander alone (a)	0.2%	0.4%
Persons reporting two or more Races	22.9%	23.18%
Hispanic or Latino, percent (b)	26.1%	39.5%
Foreign born persons, percent, 2017	13.0%	27.00%
Language other than English spoken at home, percent of persons age 5+, 2010-2017	21.20%	44.00%
High school graduate or higher, percent of persons age 25+, 2010-2017	85.50%	86.90%
Bachelor's degree or higher, percent of persons age 25+, 2010-2017	32.60%	24.80%
Veterans, 2010-2017	6,357	1,661,433
Mean travel time to work (minutes), workers age 16+, 2010-2017	18.6	27.2

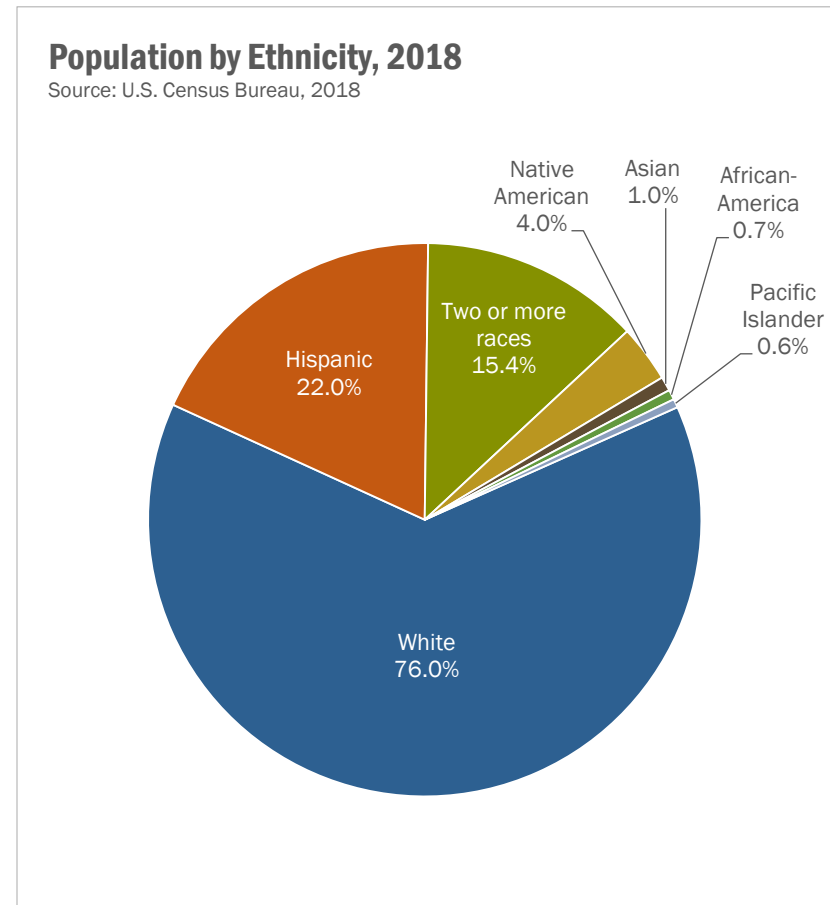
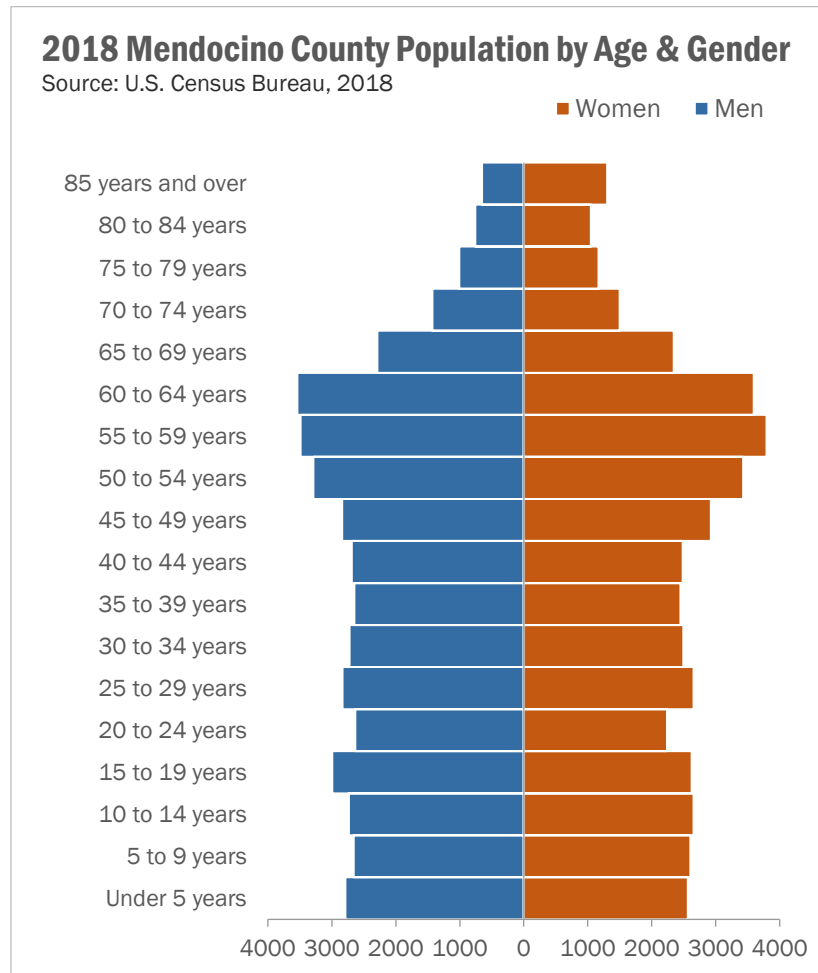
Mendocino County Demographic Profile	Mendocino	California
Housing units, 2017	41,107	14,176,670
Homeownership rate, 2009-2013	54.50%	59.20%
Housing units in multi-unit structures, percent, 2009-2013	12.50%	31.00%
Median value of owner-occupied housing units, 2013-2017	\$338,000	\$443,400
Households, 2013-2017	34,182	12,888,128
Persons per household, 2013-2017	2.50	2.96
Per capita money income in past 12 months (2017 dollars), 2013-2017	\$27,093	\$33,128
Median household income, 2009-2013	\$46,528	\$67,169
Persons below poverty level, percent, 2013-2017	16.3%	13.3%
Land area in square miles, 2010	3,506.34	155,779.22
Persons per square mile, 2010	25.1	239.1

Data Source: Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits(a) Includes persons reporting only one race. (b) Hispanics may be of any race, so also are included in applicable race categories.

Socioeconomic Characteristics

Mendocino County is a rural county in Northern California with a land area of 3,509 square miles. The estimated population in 2018 was 87,580. Slightly over one-half (55%) of the population live in urban areas, while 45% live in rural communities, farms or ranches.

The population pyramid clearly shows the “Baby Boomer” demographic aging into their 50’s to 60’s. Mendocino County has a slightly older median age of 42.3 years, compared with California’s median age of 36.4 years.



Population of Mendocino County below Federal Poverty Level, 2018*

*(In 2018, the Federal Poverty Level for individuals was calculated as a single person living on less than \$12,140 per year, and a family of four with income less than \$25,100.)

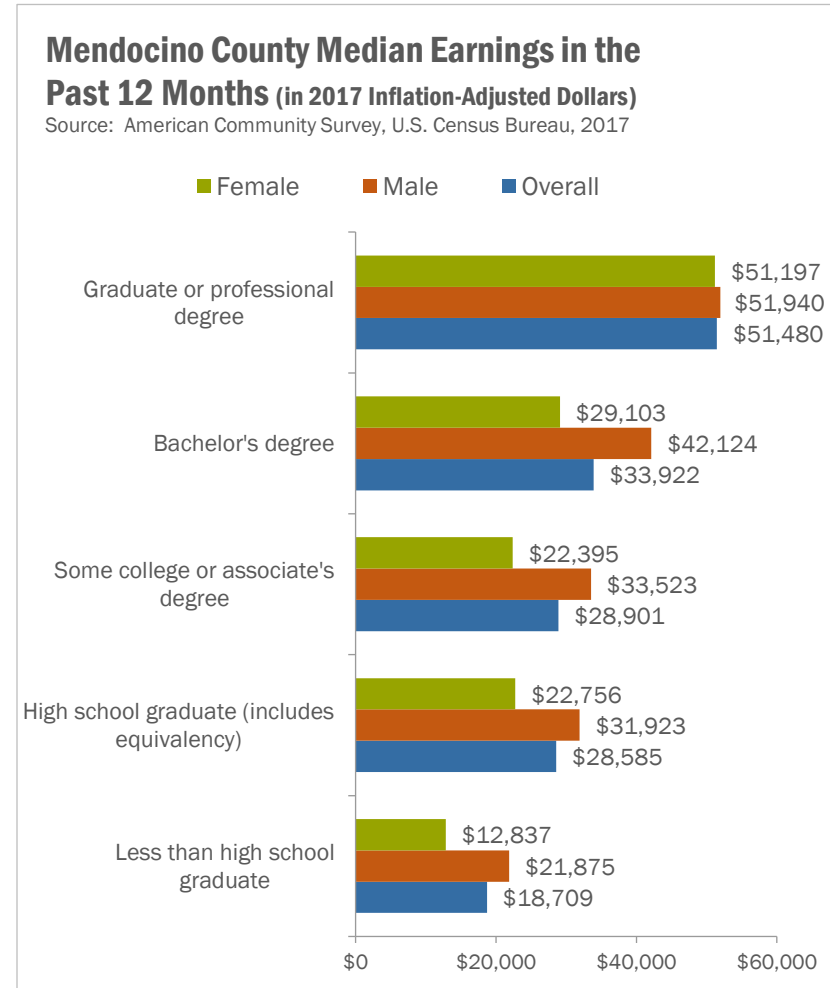
Data Source: U.S. Census Bureau, 2013-2018 American Community Survey 5-Year Estimates

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. The percentage of the population with incomes below 200% of the Federal Poverty Level (FPL) in 2018 was about 17% for men, and 21% for women. When categorized by race/ethnicity, 42% of African Americans living in Mendocino County in 2018 had incomes below 200% of the FPL, followed by Hispanic or Latinx 27%, Native Americans 25%, Caucasians 15%, Asians 14%, and Pacific Islanders 14%. For the years 2012 to 2016, 9% of people over 65 years were living below the FPL; 15% of families, and 24% of children.

People living in poverty have poorer health outcomes. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival. Nineteen percent of those whose income fell below the FPL worked either full or part-time during the 12 months of 2017. Educational achievement is closely associated with higher earning power. Twenty-five percent of those whose incomes fell below the FPL had less than a high school education in 2017.

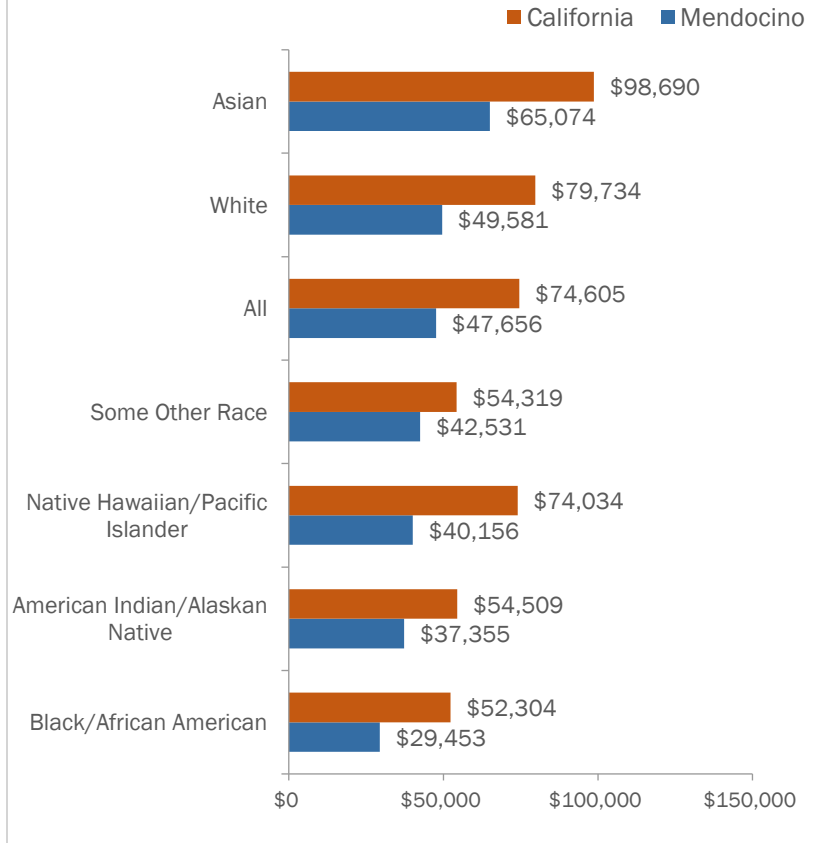
The previous CHNA identified the issue of poverty as an area for improvement in Mendocino County. A CHIP group was formed to

understand the underlying issues. The Poverty Action Team is working to create strategies to help people gain access to capital and markets, promote micro-enterprise within communities, offer classes to improve financial literacy including tax help and business planning, and promote education to learn new vocational skills.



Median Household Income by Race, 2017

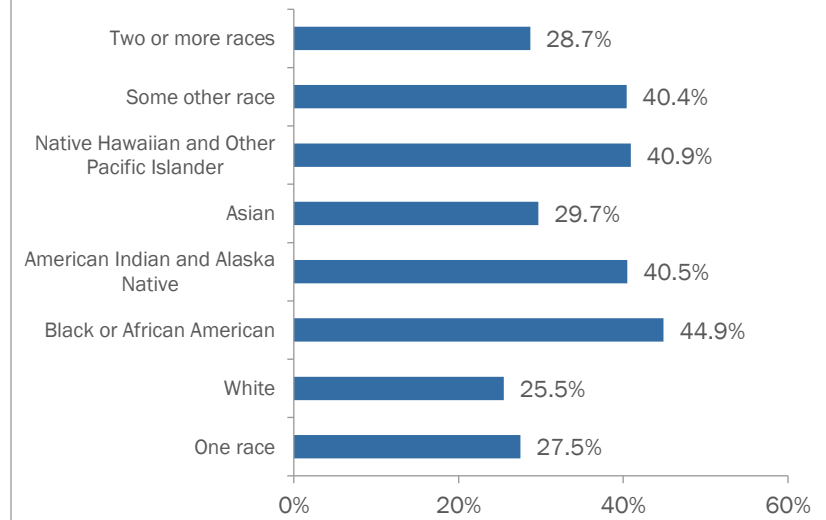
Source: U.S. Census Bureau, 2017



Family income has been shown to affect a child's well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems such as low birth weight or lead poisoning and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.

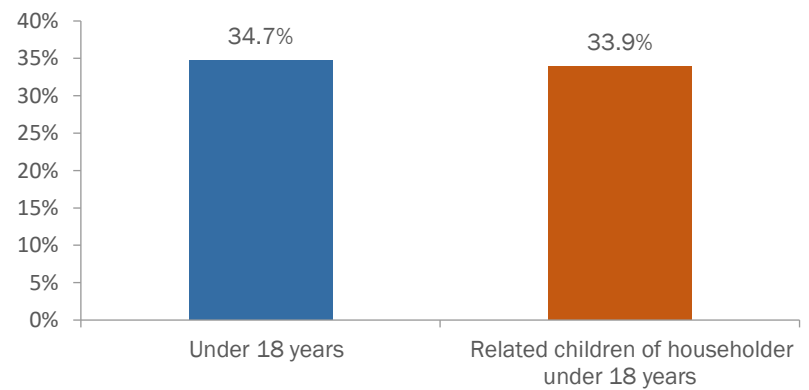
Persons Living Less than 125% of the Federal Poverty Level by Ethnicity

Source: US Bureau of the Census, 2017

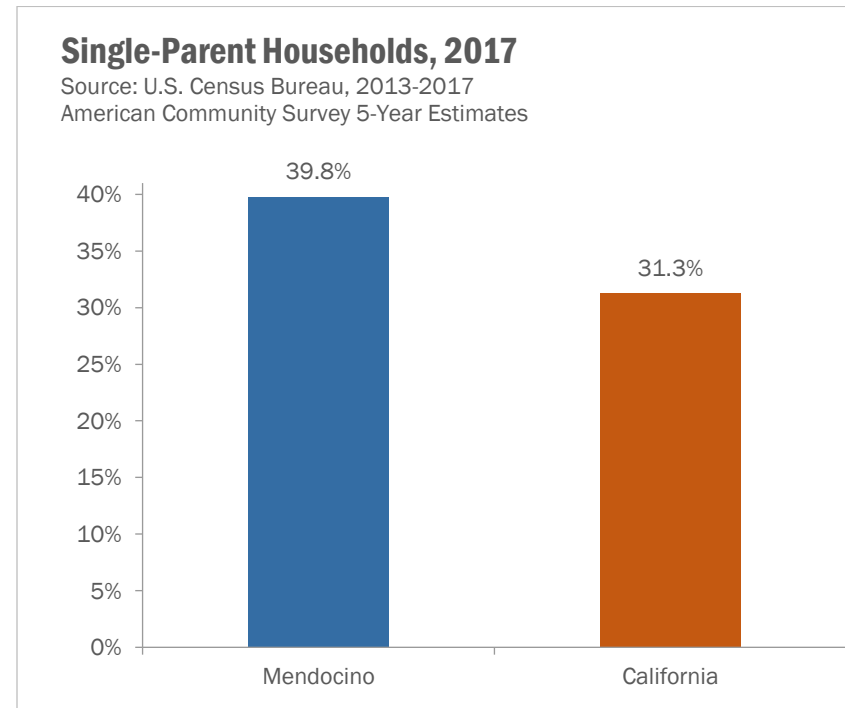
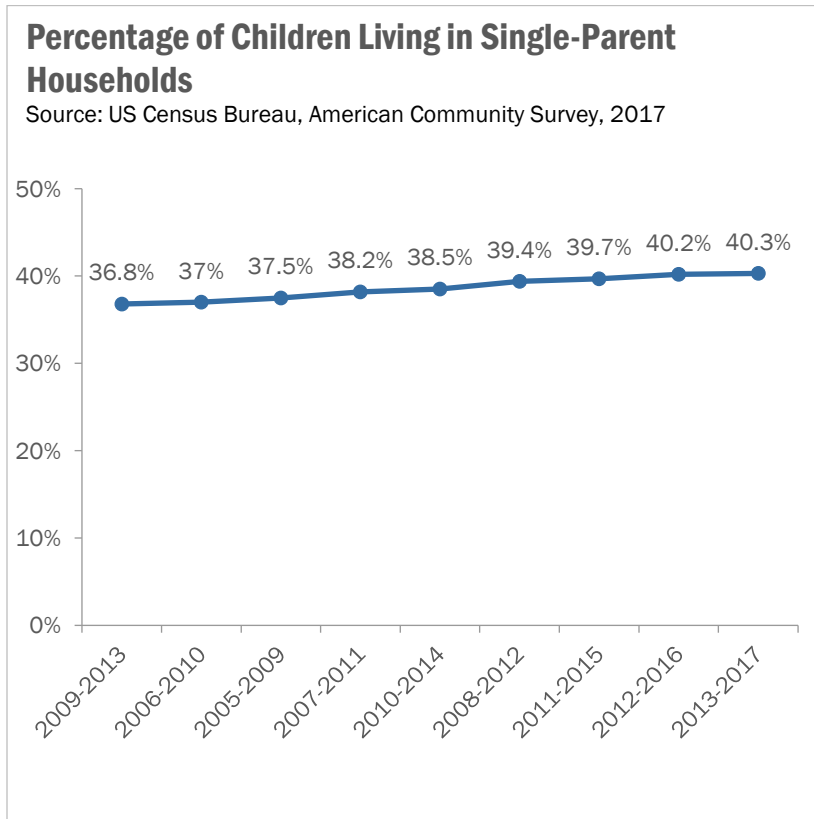


Children (<18 years) Living Below the Poverty Level, 2017

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

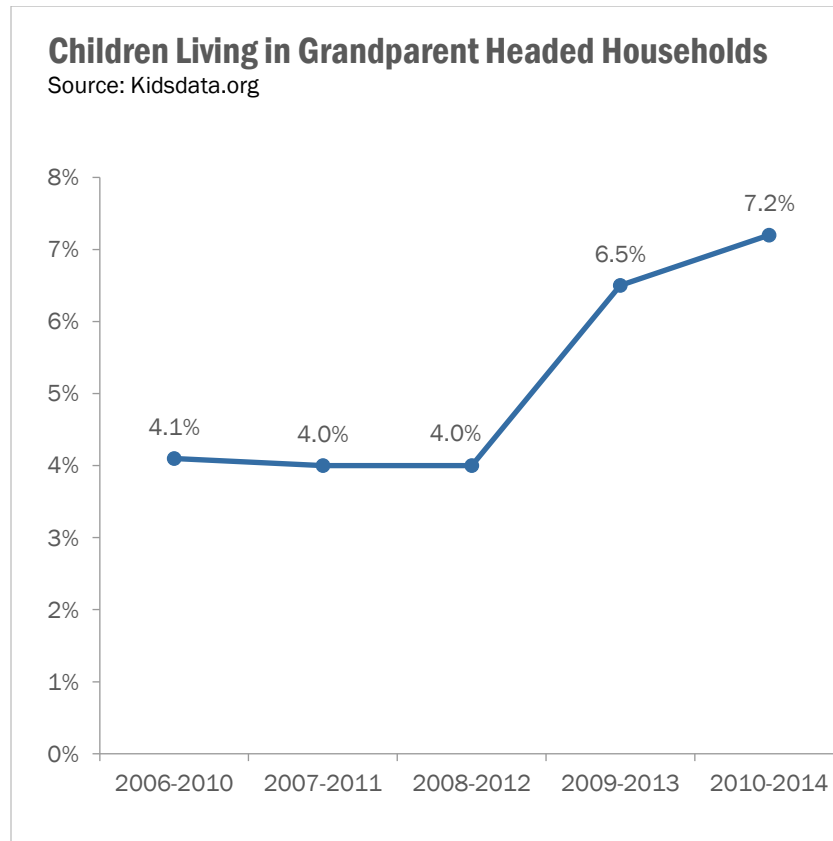


Single Parent Households, 2017



During 2017, 40% of Mendocino County households with children were headed by a single parent, compared to 31% for the State of California. Of these, 51% of single parent households in the county earned less than 125% of the FPL. Adults and children in single-parent households are at a higher risk for adverse health effects, such as emotional or behavioral problems, compared to their peers. Children in such households are more likely to develop depression, smoke, and abuse alcohol and other substances. Consequently, these children experience increased risk of morbidity and mortality of all causes. Similarly, single parents suffer from lower perceived health and higher risk of mortality.

Grandparent-Headed Households Responsible for Grandchildren under 18 Years

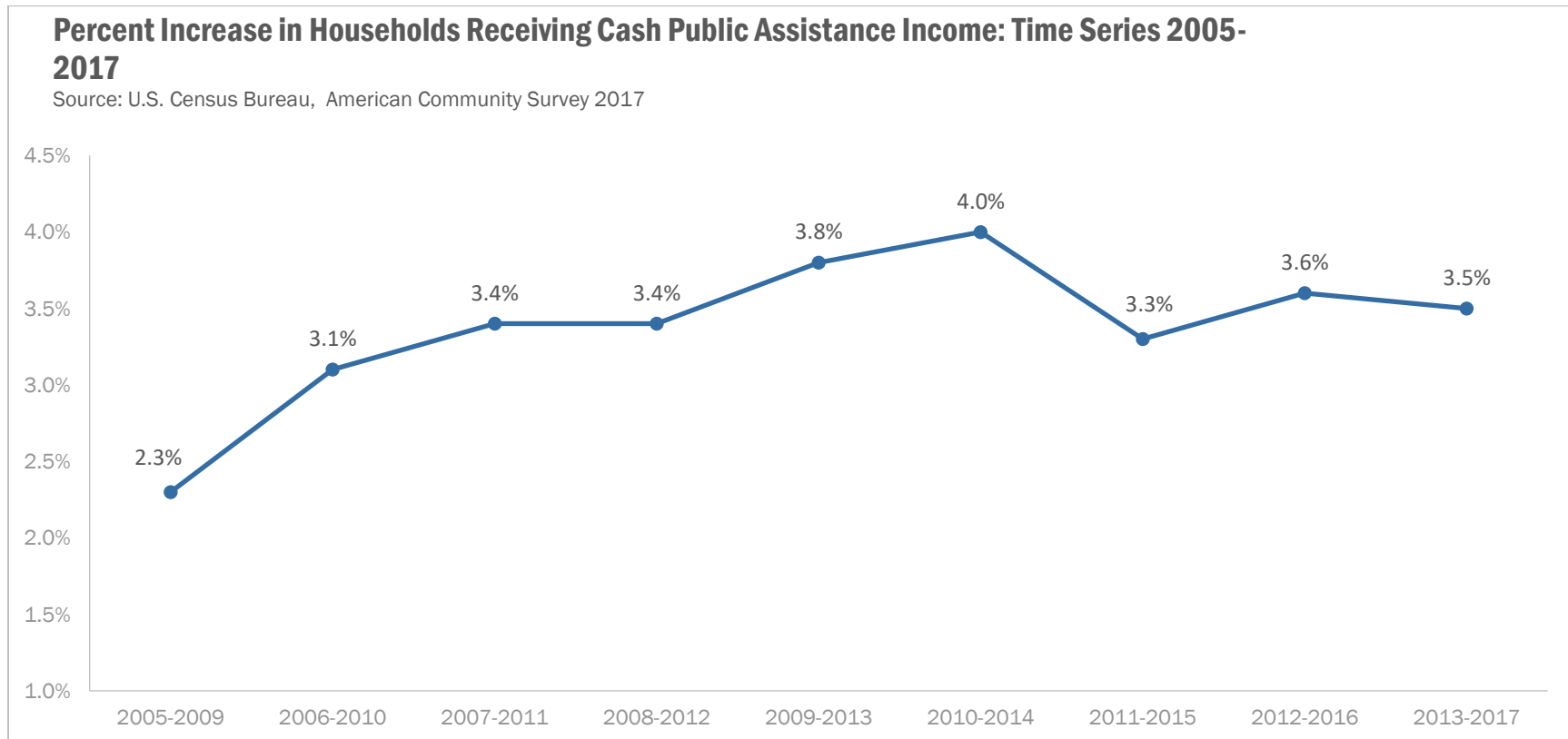


Grandparent-headed households have disproportionately high rates of poverty. Single, older women of racial and ethnic minority groups with low educational attainment disproportionately head grandparent-headed households. Children in grandparent-headed households are especially likely to display behavioral and emotional problems because

of the events leading up to the move into the grandparent's home, including economic crises, family conflict, neglect or abuse, and separation from one or both parents. High rates of attention deficit/hyperactivity disorder, depression, and anxiety have been observed in this population along with developmental, emotional, and behavioral problems often due to high rates of prenatal exposure to alcohol and other drugs in utero. Due to age and their own health status, grandparents may be less able than parents to adjust to the changing financial needs of co-resident children. Income meant to support one or two older adults suddenly must fulfill the needs of co-resident grandchildren and, in some cases, adult children. This is particularly true for those grandparents who previously exited the labor force through retirement and who rely on fixed incomes. Further, grandparents may be less able than parents to either return to work or to make adjustments in current work hours because of a greater likelihood of health limitations and disability than for parents. Such factors may inhibit the ability of caregivers in grandparent-headed households to adapt financially to the needs of co-resident children.

In Mendocino County, the number of grandparent-headed households has increased by more than 1,000 households in the five-year period between 2010 and 2014 (a 57% increase of 1,000 to 1,750).

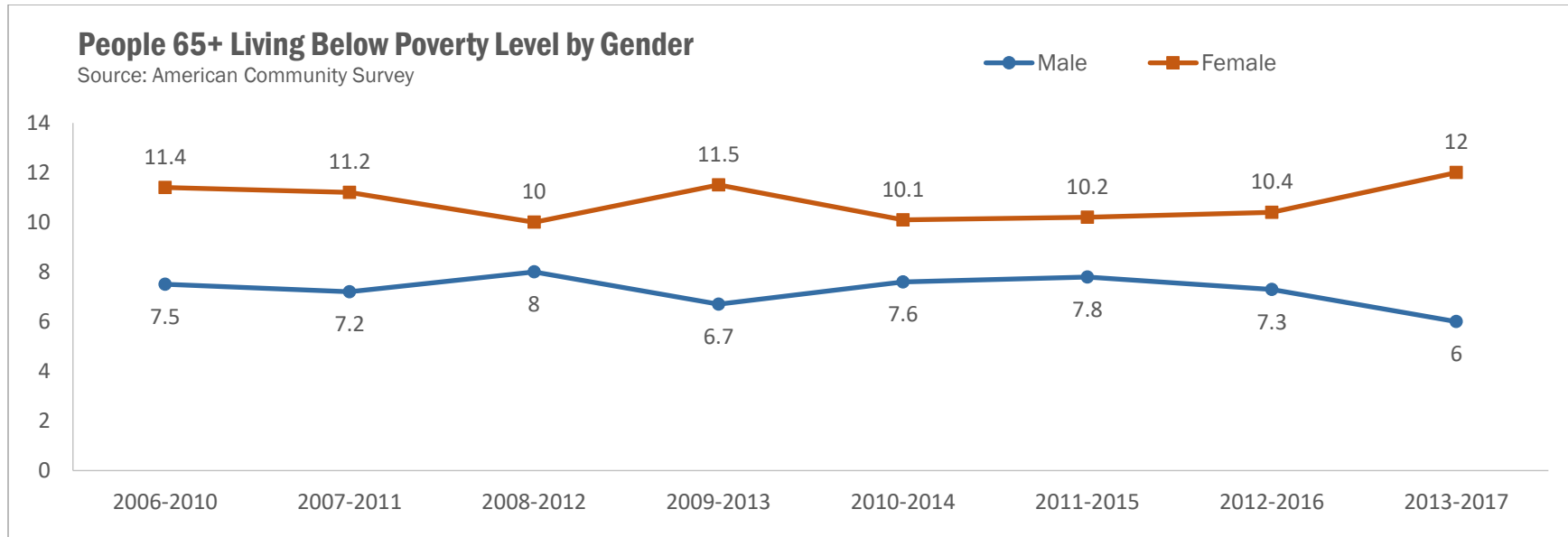
Households Receiving Cash Public Assistance



Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). It does not include Supplemental Security Income (SSI) or noncash benefits such as Food Stamps. Areas with more households on public assistance programs have higher poverty rates.

Estimates for 2013-2017 are that 3.5% of households in Mendocino County are receiving cash public assistance income, compared to the state rate of 3.6%.

Seniors

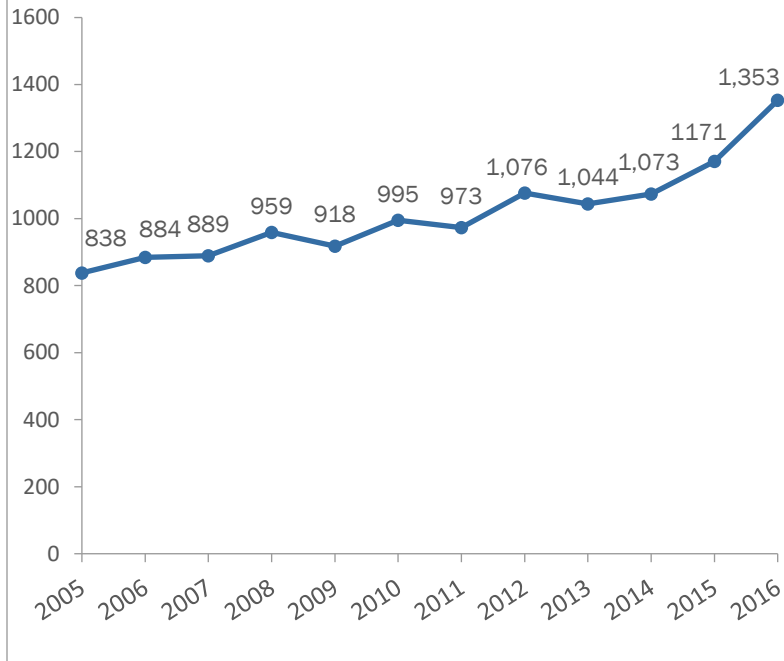


The population of people over 80 years old will increase by 206% between 2010 and 2060 making it the fastest growing demographic in Mendocino County. The American Community Survey estimates for the years 2012 to 2016, 9% of people over 65 years old in our county were living at or below the FPL for a single person. Older adults on fixed incomes struggle with rising housing costs, health care bills, inadequate nutrition, lack of transportation and isolation, diminished savings and job loss. For many older adults who are above the Federal Poverty Level, just one major adverse event can be catastrophic. Women are impacted at greater numbers because on average, they live longer than men, and women of color disproportionately feel the effects of poverty. Seniors need

increasing assistance with every-day tasks, and care for the elderly falls either on family members, or on supportive care aides, responsible for an estimated 70-80% of the paid hands-on care for older adults. These are some of the lowest paid of all U.S. workers. The role of caregiver is most often held by women, and frequently creates a pathway to financial hardship later in life. The majority of caregiving is provided informally by family or friends who take extended periods of time away from work to raise children or to care for an ailing loved one. The breaks in service and limited supports available to informal caregivers produces financial strain and reduces the individual's lifetime social security earnings as well as their ability to save.

Emergency Department Visits - Falls Among Senior Adults 65+

Source: California Department of Aging



Statistics show that:

- More than 40% of people hospitalized from hip fractures do not return home and are not capable of living independently again;
- 25% of those who have fallen pass away each year;
- On average, two older adults die from fall-related injuries every day in California.

Falls can result in hip fractures, head injuries or even death. In many cases, those who have experienced a fall have a hard time recovering and their overall health deteriorates.

In California alone, 1.3 million older adults experience an injury due to falling. A person is more likely to fall if s/he is age 80 or older or if s/he has previously fallen. Over time people may feel unsteady when walking due to changes in physical abilities such as vision, hearing, sensation, and balance. People who become fearful of falling may reduce their involvement in activities. Also, the environment may be designed or arranged in a way that makes a person feel unsafe.

Studies show that balance, flexibility, and strength training not only improve mobility, but also reduce the risk of falling. Statistics show that many older adults do not exercise regularly, and 35% of people over the age of 65 do not participate in any leisure physical activity. This lack of exercise only makes it harder for individuals to recover after a fall. Many people are afraid of falling again and reduce their physical activity even more. There are many creative and low-impact forms of physical activity for fall prevention, such as tai chi.

The environment can present many hazards. At home older adults are commonly concerned about falling in the bathtub or on steps. In the community there can be trip hazards such as uneven or cracked sidewalks. By making changes to the home and community environment a person can feel safer and less at risk of falling. For example, the bathroom can be modified by installing grab bars as in the shower or tub, having a place to sit, and having non-slip surfaces. Steps can have handrails, adequate lighting, and contrast between steps. Community sidewalks in disrepair can be reported to city officials for repair.ⁱ

Elder Abuse and Abuse of a Dependent Adult

Abuse of an elder or a dependent adult is abuse of:

- Someone 65 years old or older; or
- A dependent adult, who is someone between 18 and 64 that has certain mental or physical disabilities that keep him or her from being able to do normal activities or protect himself or herself.

Abuse is the physical, sexual, psychological, or financial harm or neglect of older people or dependent adults who may be unable to defend or fend for themselves. The incidence of elder abuse is expected to increase as the size of the older population grows, further straining the social service and criminal justice systems charged with protecting that population. As the majority of the older adult population, women are also the most frequent targets of elder abuse and exploitation. Women are more likely to spend their last years at home as widows, if they ever married, and later will make up the majority of residents in skilled nursing or residential care. The loss of independence and autonomy that can come with diminished health or mental capacity heighten an elder's vulnerability to abuse.

In California, as well as nationally, the estimate is that one out of ten older adults living at home suffers some form of abuse, neglect or exploitation. In Mendocino County, there are approximately 17,200 residents who were 65 years or older in 2018. During FY 2014-2015 there were 637 cases of elder abuse opened by Adult Protective Services. During FY 2017-2018 there were 1,029 cases of elder abuse opened, with 129 confirmed cases of abuse of an elder, and 42

confirmed cases of abuse of a dependent adult. In 2016, the District Attorney's Office prosecuted 27 elder or dependent adult abuse cases.ⁱⁱ

Social Determinants of Health

Understanding what affects our health

Social Determinants of Health (SDOH) are social, economic, and physical conditions in the environments in which people are born, live, learn, work, play, worship and age, that affect a wide range of health, functioning, quality-of-life outcomes and risks. Resources that enhance the quality of life can have a significant influence on population health outcomes, such as safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. In addition to the material attributes of the environment, patterns of social engagement and a sense of security and well-being are affected by where people live.

Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety

- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

Examples of physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)

Differences in the health of a population are striking in communities with poor SDOH, such as unstable housing, low income, unsafe neighborhoods, or substandard education. By applying what we know about SDOH, we can not only improve individual and population health but also advance health equity. The website Healthy People 2030 (<https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030>) highlights the importance of addressing SDOH by including “create social and

physical environments that promote good health for all” as one of the four overarching goals for the decade.

Healthy People 2030

Healthy People 2030 is a collaborative project developed under the leadership of the Federal Interagency Workgroup by the U. S. Department of Health and Human Services and other federal agencies, public stakeholders and an advisory committee. Its goals are to identify national health priorities, increase awareness of the determinants of health, provide measurable objectives and goals that are applicable to local levels in order to achieve health equity, eliminate disparities, promote healthy behaviors and improve the health of all groups.

Every decade, the Healthy People initiative develops a new set of science-based, 10-year national objectives with the goal of improving the health of all Americans. The development of Healthy People 2030 includes establishing a framework for the initiative—the vision, mission, foundational principles, plan of action, and overarching goals—and identifying new objectives.

Educational Achievement

High Quality Childcare and Early Childhood Education in Mendocino County

Research indicates that high quality childcare and early education have lasting positive effects including increased IQ scores, higher levels of behavioral and emotional functioning, school readiness, academic achievement, educational achievement including high

school graduation and higher earnings later in life. The gains are particularly pronounced for children from low-income families and those at risk for academic failure. In Mendocino County, there is an unmet demand for quality childcare. The California Child Care Resource & Referral Network estimates that in 2017, approximately 76% of the county's children ages 3-5 years old did not attend a preschool, a nursery school or Head Start program for at least 10 hours a week. In California, 77% of children did not have high quality childcare available.

The annual costs for childcare by age group and facility type, 2016

California	Amount	
	Infant	Preschooler
Child Care Center	\$16,452	\$11,202
Family Child Care Home	\$10,609	\$9,984

Mendocino County	Amount	
	Infant	Preschooler
Child Care Center	\$12,508	\$8,483
Family Child Care Home	\$8,540	\$8,043

Kindergartners with All Required Immunizations, 2016

Locations	Percent
California	92.8%
Mendocino County	87.4%

Educational Attainment Mendocino County, 2017

Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime.

Mendocino County, 2017	
Percent with an associate degree	9.20%
College Graduation Rate	22.00%
Percent with a graduate or professional degree	8.40%
High School Graduation Rate	85.20%
Percent who did not finish the 9th grade	6.90%
California, 2017	
Percent with an associate degree	7.80%
College Graduation Rate	30.70%
Percent with a graduate or professional degree	11.20%
High School Graduation Rate	81.20%
Percent who did not finish the 9th grade	10.20%

Housing and Homelessness

Housing

Mendocino County has been experiencing a housing crisis for many years, and it is being exacerbated by several factors. The Bay Area counties now have the highest housing costs in the United States, surpassing even Manhattan, NY. As rents are raised, families are being forced out and are moving to neighboring counties such as Mendocino. In 2016-2017, a series of wildfires destroyed thousands of homes across the State and in Mendocino County. Much of Mendocino is agricultural land, and either not suitable for or zoned for development. The U.S. Census Bureau estimates that over one-half of residents (52%) who rent in Mendocino County pay over a third (35%) of their total income for rent. Spending such a high percentage of household income on rent can create financial hardship and may not leave enough money for food, transportation or medical expenses. High rent also makes it difficult or impossible for families to save any of their income for future needs.

Safe and affordable housing is an essential component of healthy communities, and the effects of housing problems are widespread. Residents who do not have a kitchen in their home are more likely to depend on unhealthy convenience foods, and a lack of plumbing facilities increases the risk of infectious disease. Research has found that young children who live in crowded housing conditions are at increased risk of food insecurity, which may impede their academic performance. In areas where housing costs are high, low-income residents may be forced into substandard living conditions with an increased exposure to mold and mildew growth, pest infestation, and lead or other environmental hazards.

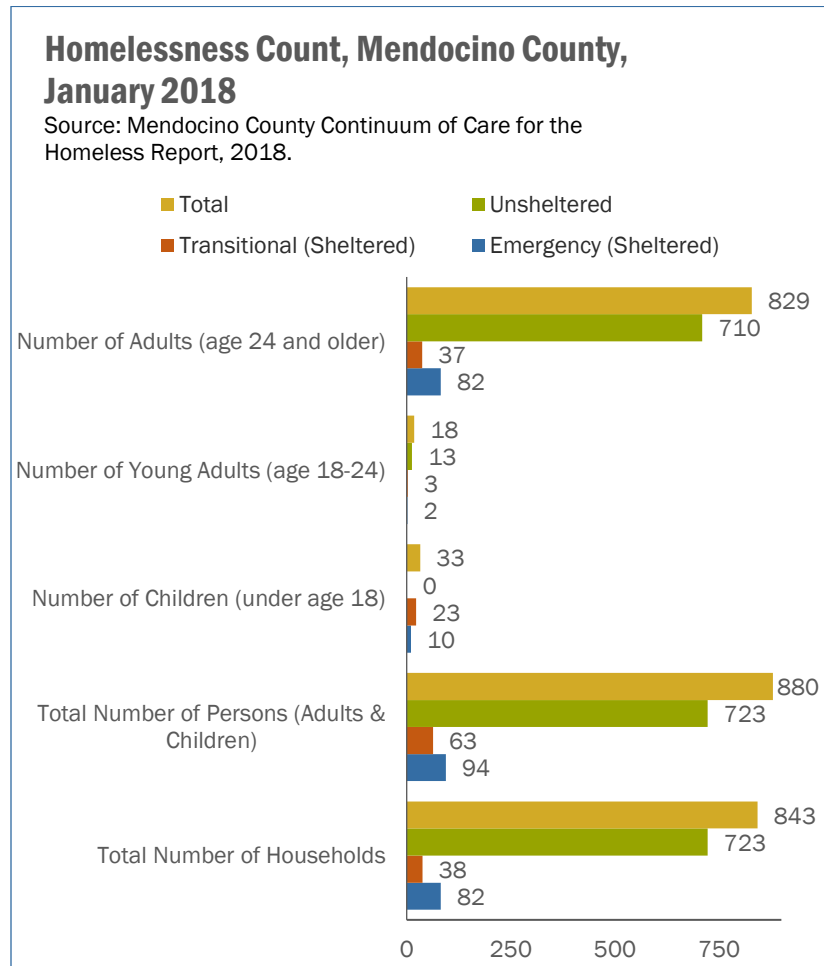
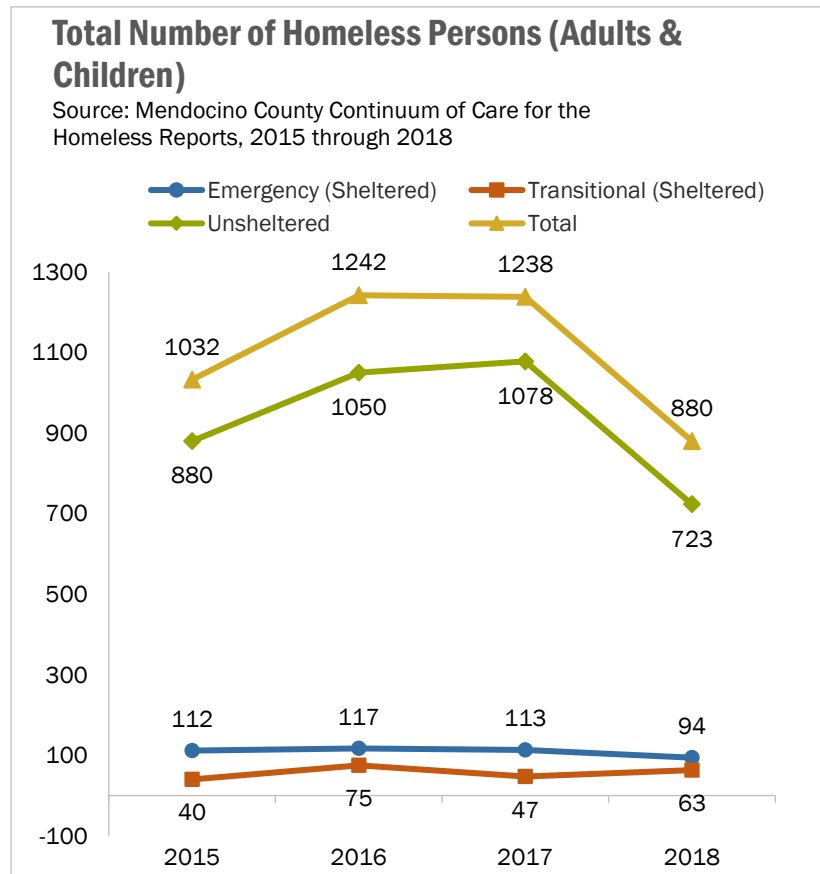
The CHIP Housing Action Team, which was formed as a response to the lack of housing, has been working with developers, city and county officials, and members of the community to identify solutions to this crisis. As a result of these efforts, new housing developments for both low- and middle-income families and farm labor families are being constructed across the county. Some of the cities have adopted ordinances to allow for additional units to be built in existing homes. In addition, a new housing development for people with mental or physical disabilities has opened in Ukiah.

Homelessness

Lack of affordable housing is not the only component of homelessness. Many people experiencing homelessness face serious challenges such as mental illness, substance abuse, disabilities, and/or lack of education. Combining housing assistance with other social services such as employment training, substance abuse treatment, childcare and coordinated case management have been shown to be effective in helping people live more stable and productive lives.

Addressing the issues around people experiencing homelessness takes a coordinated, community effort. The Mendocino County Homeless Services Continuum of Care (MCHSCoC) is a collaborative of multiple agencies throughout the county. Their activities include the “Point in Time Census and Survey” of individuals and families experiencing homelessness; “Coordinated Entry” which assesses the needs of those who are homeless and matches appropriate services to those individuals; ongoing cooperation focused on securing and maintaining funding resources to address homelessness and provide permanent housing.

The U.S. Department of Housing & Development (HUD) requires cities across the country to conduct “Point in Time” (PIT) counts. The unsheltered count of the homeless in Mendocino County occurs annually within the last 10 days of January. The count takes place at the same time across the county, so that a homeless person cannot be counted twice if they move their location during the day. The PIT count in 2017 estimated there were approximately 1,200 persons either in emergency or transitional housing, or “unsheltered”.



To better understand the dynamics of the homeless population Mendocino County Health and Human Services Agency contracted with Marbut Consulting in 2017 to conduct a Homeless Services Needs Assessment and to develop Strategic Action Recommendations to help the county improve its methods for decreasing homelessness. Dr. Robert Marbut, a well-known expert

on homelessness across the country, determined that the Mendocino County PIT data from the past few years seemed to overestimate the numbers of people experiencing homelessness. He stated that this was due to four different sub-groups of “street people” being categorized as one broad homeless population, including many individuals who are not actually experiencing homelessness as defined by HUD. These sub-groups are different in their homelessness origins and characteristics, needing customized actions specific to each group in order to address their needs. Three of the four groups met the definition of homelessness as per federal guidelines.

Marbut defined the four distinct groups as follows:

- Very-home grown (39%): year-round homeless who have deep family connections in the community and most attended local high schools;
- Somewhat home grown (23%): year-round homeless who followed their family to the county, but most attended high school elsewhere;
- Not from Mendocino County (38%): mostly year-round, homeless before arriving in the county,
- No family connections to the community. This 4th group is defined as “North-South Travelers” people NOT experiencing federally defined homelessness, but rather passing through, often on a seasonal basis.

Some interesting takeaways from Dr. Marbut’s data analyses of the street-level community indicate that the homeless situation in Mendocino County is similar to peer communities in some respects, but also revealed some significant differences.

- Males represented 61% and females represented 39%, which is 8-12% higher for females than expected.
- The average age was 44.4 years and the median was 46.0. Both are slightly younger than would be expected by 3-4 years. The average age an individual was first homeless, either in the county or before they moved here, was 39.6 years and the median age 41.0, both of which are younger than expected.
- Individuals experiencing street-level homelessness have lived in Mendocino County for 18.6 years on average, with a median of 14.5, which is once again uncommon. 60.5% of all individuals were already living in Mendocino County when they started to experience homelessness. Local family connectivity, compared to similar communities, was higher than expected with 51.4% of homeless individuals having family members living in Mendocino County. If deceased family members from the county were included the percentage increased to 61.9%.
- Chronic homelessness is defined by HUD as living on the streets for more than one year. 78% of the individuals surveyed by Dr. Marbut have been experiencing chronic homelessness. Of the 78%, 51.4% have been on the street for 1-4.99 years, and 26.7% for five or more years. 9.5% revealed that they have been living on the street for 10 or more years. This level of chronic homelessness, especially within the 1-5-year range, is uncharacteristic compared to peer communities.
- The street-level population of the county exhibits low mobility between cities and engages in only a limited amount of activities. 69.5% reported going to or utilizing 5 or fewer activities from a list of 20 places, programs, and activities. Individuals spend the majority of time at their “home-base”

and also venture away to get a meal. The only two activities that exceeded 50% utilization was partaking in at least one medical service during the last month (57.1%) and going to the library (51.4%). Of the 20 most chronic individuals (inbound or homegrown) only 5 were active in structured programming.

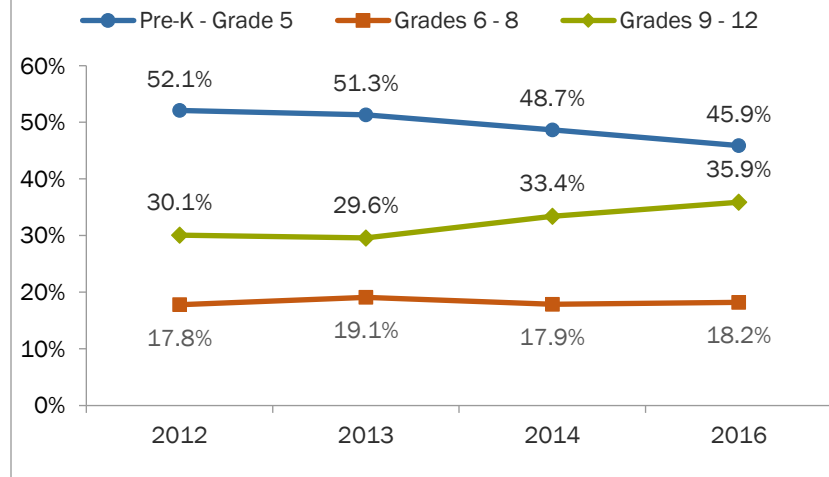
- 53.3% of all the individuals surveyed did not have a job in Mendocino County before experiencing homelessness, and 81.9% did not have a job when surveyed.
- The number of people living in vehicles was relatively low but indicated trends that could be useful for policy making. In general car-campers had family in the county (50%), would eat at community meals, and do not want to sleep in group settings. Van-Campers were mostly from outside Mendocino County and lived in groups of two or more.

Dr. Marbut’s report did note that many positives were already occurring in the county to address the homeless situation. As part of the scope of work, however, he provided multiple action items and suggestions for the county to consider and implement to improve the county’s ongoing homeless situation. He determined that many county agencies and service providers have been counting the different sub-groups as one large homeless population and have been treating them as such. Commingling of very different groups, under one designation blurs the real problems and thus the solutions. Many individuals included are not actually experiencing homelessness as defined by HUD. The homelessness situation in the county will not improve unless the policy makers, service providers, and community in general have a clear understanding of who is actually experiencing homelessness and who is not. Only then can different strategies be used to address the needs of the different

groups. There has also been wide-ranging duplication of services and efforts by multiple agencies within the county, without a more strategic overall system-wide plan to address homelessness issues. For the complete data analyses and recommendations provided by “Marbut Consulting” to the Board of Supervisors please refer to the final written report titled “Homelessness Needs Assessment and Action Steps for Mendocino County, March 19, 2018”.

Percentage of Public School Students Recorded as Homeless

Source: California Department of Education, 2017



(Data for 2015 not available) Definition: Percentage of public school students recorded as being homeless at any point during a school year, by grade level (e.g., among California students recorded as being homeless at some point during the 2016 school year, 52.3% were in grades Pre-K through 5). Footnote: Years presented are the final year of a school year (e.g., 2015-2016 is shown as 2016). Students are recorded as homeless if their nighttime residence is (i) shared housing with others due to loss of housing, economic hardship, or similar reason, (ii) a hotel or motel, (iii) a temporary shelter, or

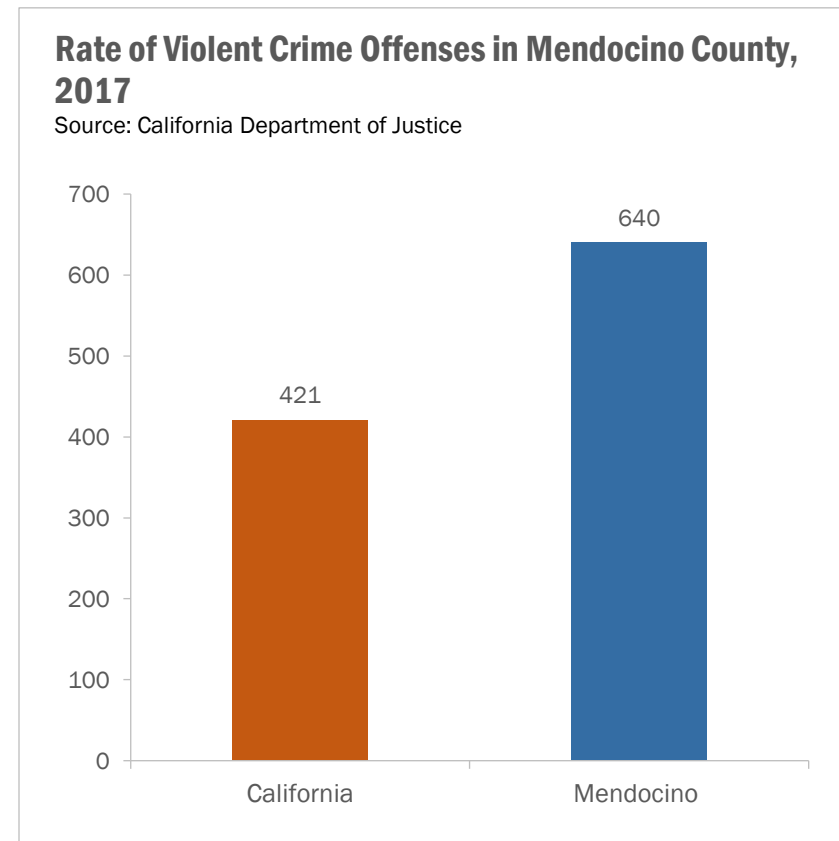
(iv) unsheltered. These data may include duplicate counts of homeless students; as homeless students move frequently; it is possible that the same student will be recorded by multiple school districts. Data for 2015 are not available due to changes in reporting. Note that percentages for county offices of education are less reliable than percentages for other school districts due to fluctuations in official enrollment.

Homelessness can mean sleeping on a relative's couch, a vehicle or trailer or in a shelter. Homelessness is associated with a myriad of poor health outcomes, especially for children. Homeless pregnant women are less likely to receive adequate prenatal care, are at greater risk for substance abuse, and their infants at greater risk of being prenatally exposed to alcohol and/or drugs. Homelessness causes severe trauma to children and youth, disrupting their relationships, putting their health and safety at risk, and hampering their development. Homeless children are more likely than other children to have physical and mental health problems, and experience hunger and malnutrition. Emotional distress, developmental delays, and decreased academic achievement are also more common in this population. Many of these children and youth experience deep poverty, instability and exposure to domestic violence before becoming homeless, and homelessness increases their vulnerability to additional trauma. In addition to the risks faced by homeless children, including increased vulnerability to sexual exploitation, youth without homes are far more likely than their peers to be infected with HIV and have other serious health problems.

Adult Arrests

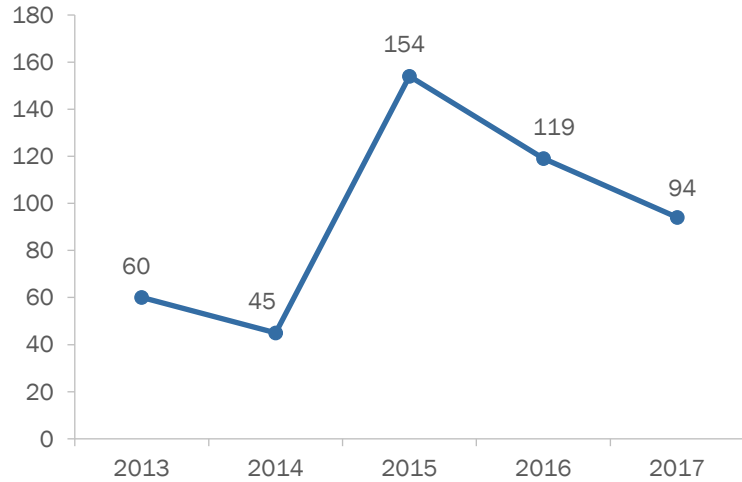
Crimes affect almost everyone in a community, including victims, offenders, their friends and families, and neighbors. Crimes diminish

community productivity and undermine social functioning. Residents of areas with high criminal activity feel less safe in their neighborhoods and may encounter obstacles to completing routine tasks. High crime rates can further lead to social factions and impede economic growth. Local governments may need to spend significant public funds for expanded police departments, prisons/jails, courts, and treatment programs.



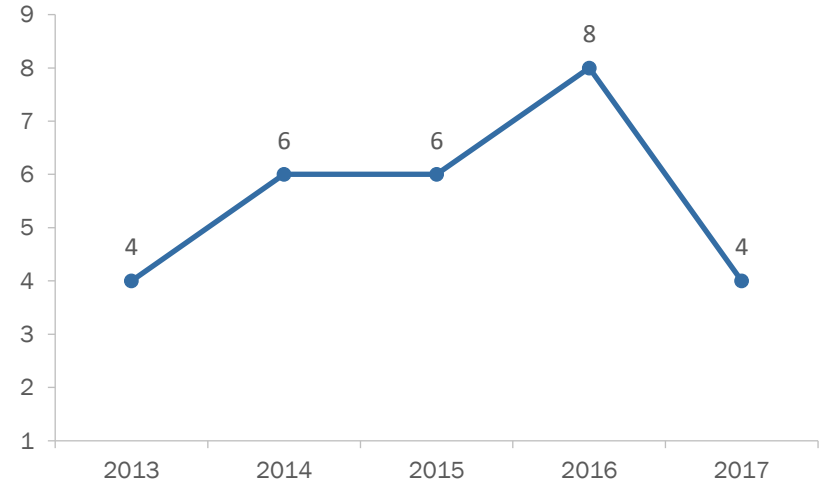
Number of Arrests for Rape by Year

Source: California Department of Justice



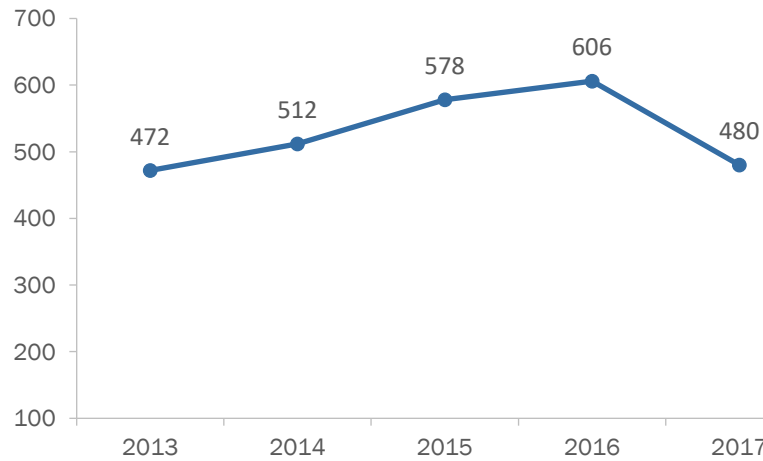
Number of Arrests for Homicide by Year

Source: California Department of Justice



Number of Arrests for Violent Crimes by Year

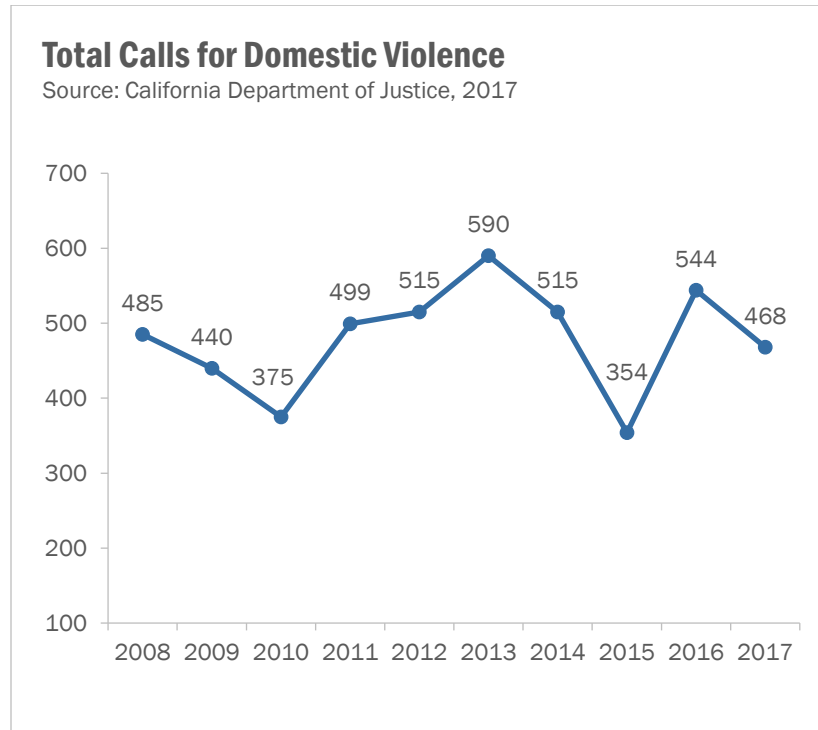
Source: California Department of Justice



Domestic Violence

Domestic violence may include physical, emotional, verbal, sexual, spiritual, and/or financial abuse. The impact of domestic violence affects everyone around it including family members, neighbors and the larger community. Children exposed to domestic violence can experience physical, emotional and behavioral responses which include feeling afraid, guilty and sad, having sleep disturbances, stomach aches and headaches, bedwetting, and inability to concentrate, among other problems. Studies have found a correlation between Adverse Childhood Experiences (ACEs) (including all types of domestic violence described above) and the increased incidence of chronic diseases including heart disease, lung

cancer, and diabetes, as well as depression and suicide amongst those individuals. In addition to their severe and lasting impact on the victims of domestic violence, these problems can affect both the health and wellness of our community, as well as the local economy.



Behavioral Risk Factors

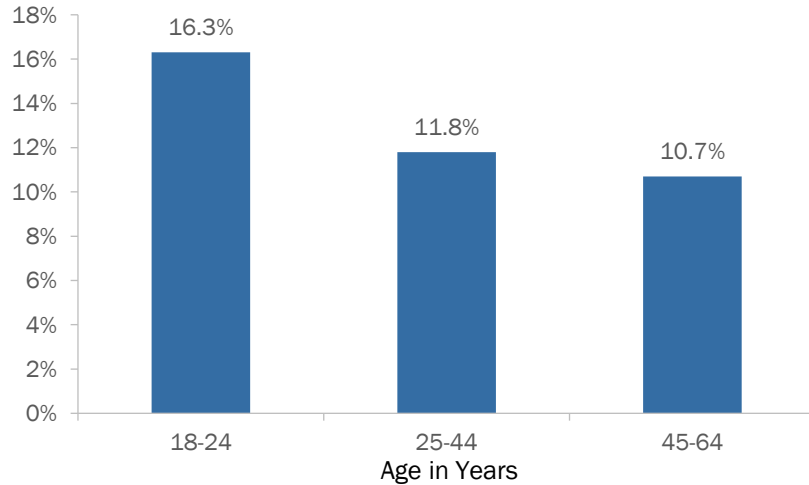
The 2015 Community Health Needs Assessment identified unmet mental health needs as a serious public health problem in Mendocino County. The Mental Health Services Act (MHSA) of 2005, provides

funding for the delivery of mental health services, and the county has a Community Program Planning (CPP) process for the development of mental health services. Stakeholders in the CPP include: individuals with mental illness, including children, youth, adults, and seniors; family members of consumers with mental illness; service providers; educators; law enforcement officials; veterans; substance use treatment providers; health care providers; community based organizations; and other concerned community members. The stakeholder list is updated regularly and based on community members, providers, and consumers’ interest in participating. The CPP holds regularly scheduled meetings to allow for input and planning in the on-going management and development of programs and services to meet the mental health needs of the community. Service delivery is coordinated through an Integrated Care Coordination Model of mental health services.

As services are increasingly integrated, more programs move from serving targeted populations, such as an age specific program, to a program that has the ability to serve consumers of all ages and needs, with a “no wrong door” approach. Outpatient care for individuals with emotional distress, substance abuse treatment needs or a severe mental illness is generally available in Mendocino County. There is currently no inpatient facility in the county, the previous inpatient psychiatric facility was closed in 1999. Individuals experiencing a mental health crisis are held either in the local jail or at a hospital emergency department until they can be transferred to a psychiatric inpatient facility out-of-county. In 2017, the voters approved Measure B, an initiative calling for a half-cent sales tax increase to fund inpatient mental health facilities. These facilities are in the planning stage.

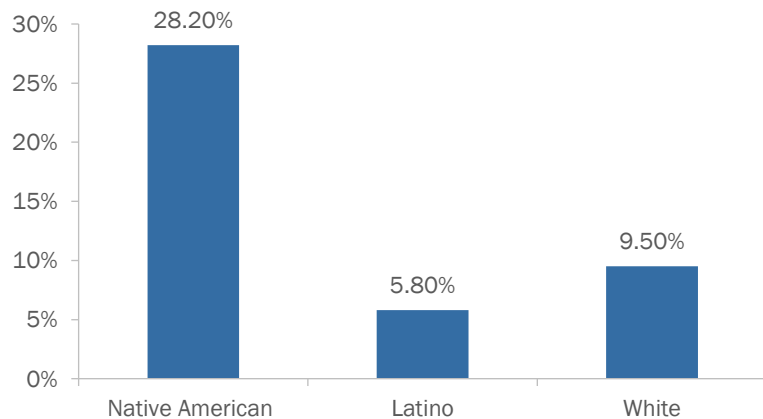
Adults with Likely Serious Psychological Distress (2013-2015)

Source: California Health Interview Survey



Adults Reporting Psychological Distress by Ethnicity, (2013-2015)

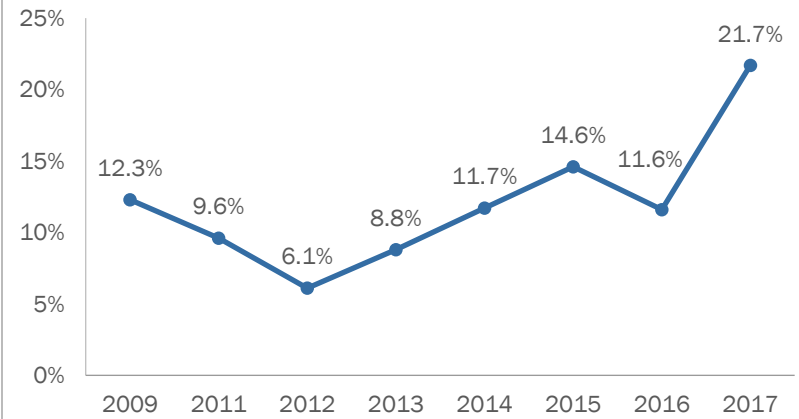
Source: California Health Interview Survey



The California Health Interview Survey for 2017 found that 22% of all Mendocino County residents who responded to the survey said they had thought about suicide at some point.

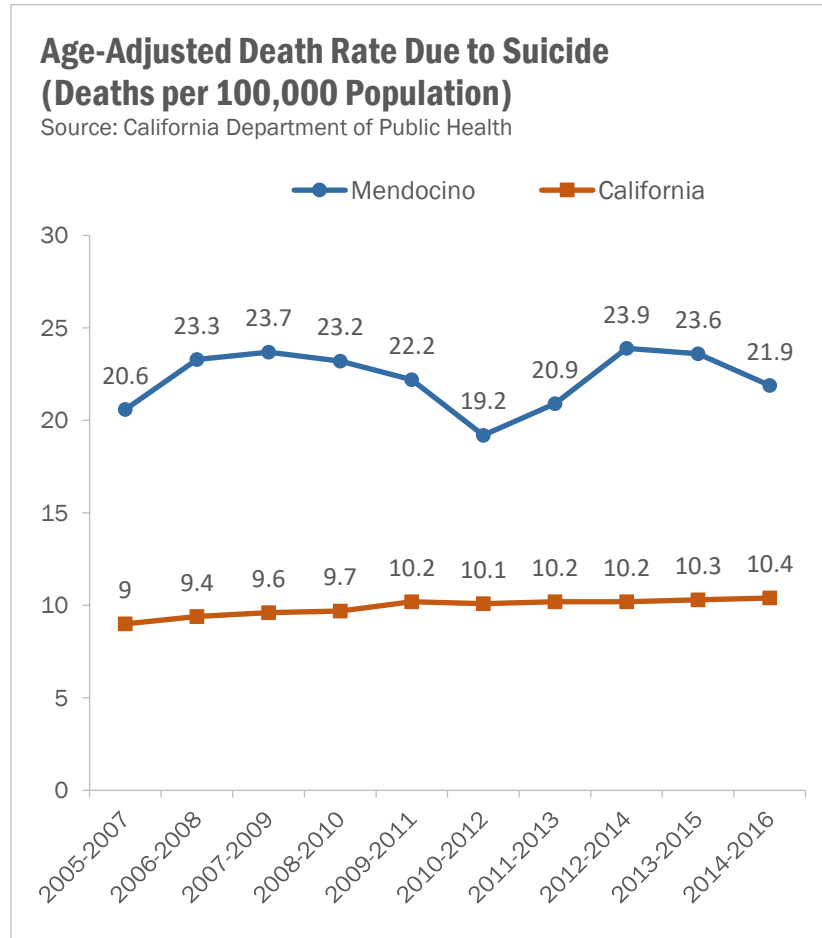
Ever Seriously Thought About Committing Suicide

Source: California Health Interview Survey



The age-adjusted death rate due to suicide in Mendocino County is twice that of the state.ⁱⁱⁱ Comparing all other counties in California, Mendocino County ranks 6th overall in the rate of suicides.^{iv} In response to this problem, Mendocino County in partnership with Adventist Health Ukiah Valley (AHUV), and lead by Marvel Harrison, PhD, has brought extensive County-wide education sessions of the suicide prevention program QPR: Question, Persuade, Refer. QPR is a national, evidence-based suicide prevention program. The program is designed to teach community members to recognize the warning signs of suicide, have the capacity to offer hope and understand the interventions available to a person considering suicide. Similar to CPR, QPR trains people to identify crisis and direct to proper care.

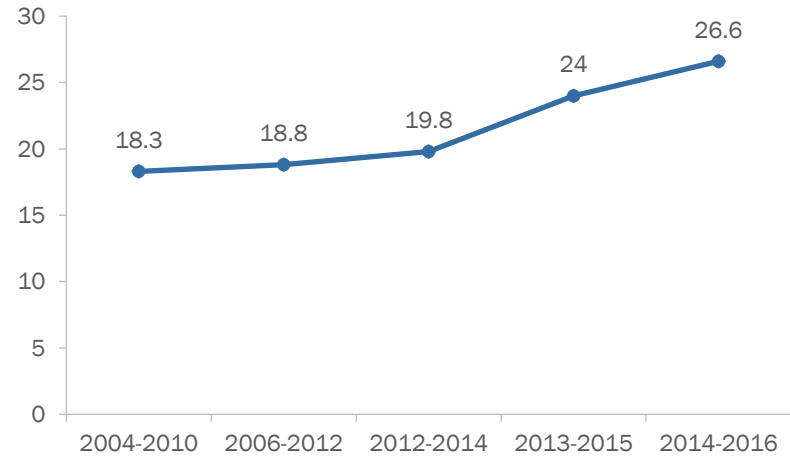
Like medical “herd immunity” the program aims for behavioral “community immunity”. Said Ms. Harrison, “There truly is safety in numbers. The more people we get trained in QPR, the more deaths by suicide we can prevent. By training as many community members as possible, we will be able to put far more people on the front line of suicide prevention. It takes what Mendocino County has for each other, courage, compassion and commitment.”



Drug Abuse

Death Rate due to Drug Poisoning Mendocino County (2004-2016)

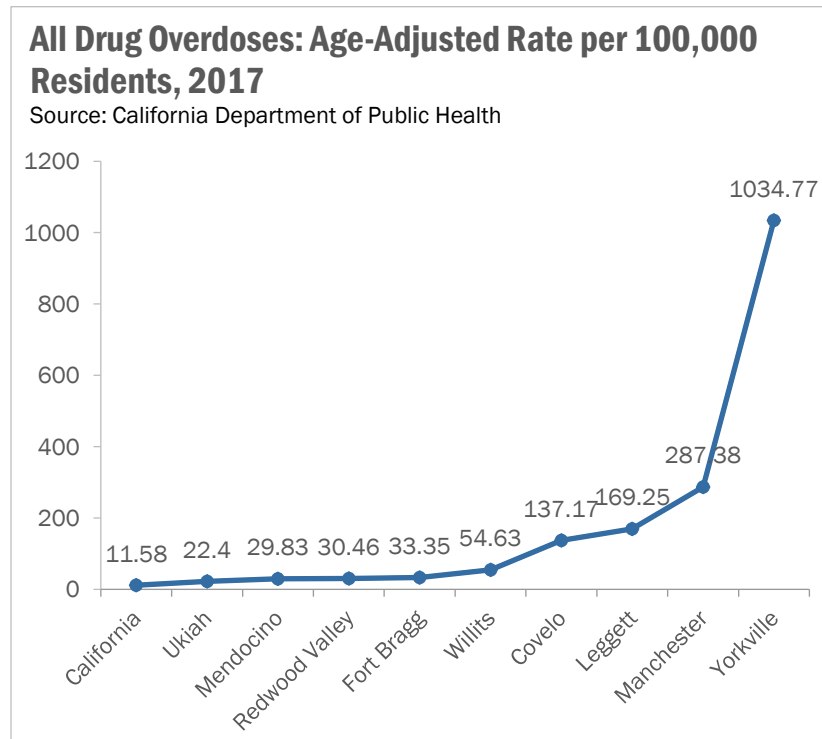
Source: California Department of Public Health



The death rate due to drug poisoning is rising. Mendocino County averages two deaths a month from unintentional prescription opioid overdose, per capita, twice the state average.^v

In response to this crisis, Mendocino County has formed the Safe Rx Mendocino Coalition promoting all efforts to build a healthy community that is free of opioid abuse and related stigma. In addition, the coalition is promoting the distribution of Narcan, (generic name Naloxone), a nasal spray that can help reverse opioid overdose. The Safe Rx Mendocino Coalition is composed of partners from local hospitals, clinics, first responders, tribes, family service agencies, addiction treatment facilities, and others, to educate the community about safe prescribing guidelines, alternative pain

management, encouraging chronic opioid users to participate in Medically Assisted Treatment (MAT) for addiction, proper disposal of medication and/or syringes and more. The Safe Rx Coalition has identified specific areas for needle disposal boxes, holds regular events where medications can be turned in for disposal, and offers drug lock-bags so family members can safely keep medications out of the hands of children or other family members.



This graph shows acute poisoning deaths involving opioids such as prescription opioid pain relievers (i.e. hydrocodone, oxycodone, and morphine) and heroin and opium.

Binge Drinking

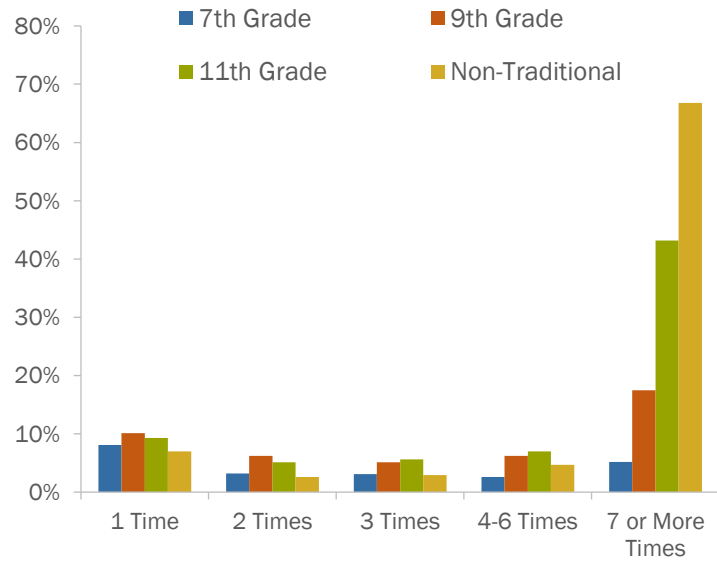
Binge drinking is a common form of excessive alcohol use in the United States. Binge drinking can be dangerous and may result in vomiting, loss of sensory perception, and blackouts. The prevalence of binge drinking among men is twice that of women. In addition, it was found that binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers. Alcohol abuse is associated with a variety of negative health and safety outcomes including alcohol-related traffic accidents and other injuries, other types of drug use, sexual assault, employment problems, legal difficulties, financial loss, family disputes and other interpersonal problems.

The percentage of adults in Mendocino County who admit to binge drinking over the past year has remained about the same between 30% to 45% from 2010 to 2017.

Alcohol is the most widely used substance among the nation's young people and binge drinking, in particular, has been linked to risky health behaviors (e.g., unprotected sex, smoking), injuries, motor vehicle accidents, impaired cognitive functioning, poor academic performance, physical violence, and suicide attempts. Drinking during adolescence increases the likelihood of alcohol dependence in adulthood, and excessive alcohol consumption can have long-term health consequences, including liver disease, cancer, and cardiovascular disease.

Alcohol Use in Lifetime by Grade Level, Mendocino County (2013-2016)

Source: California Department of Education



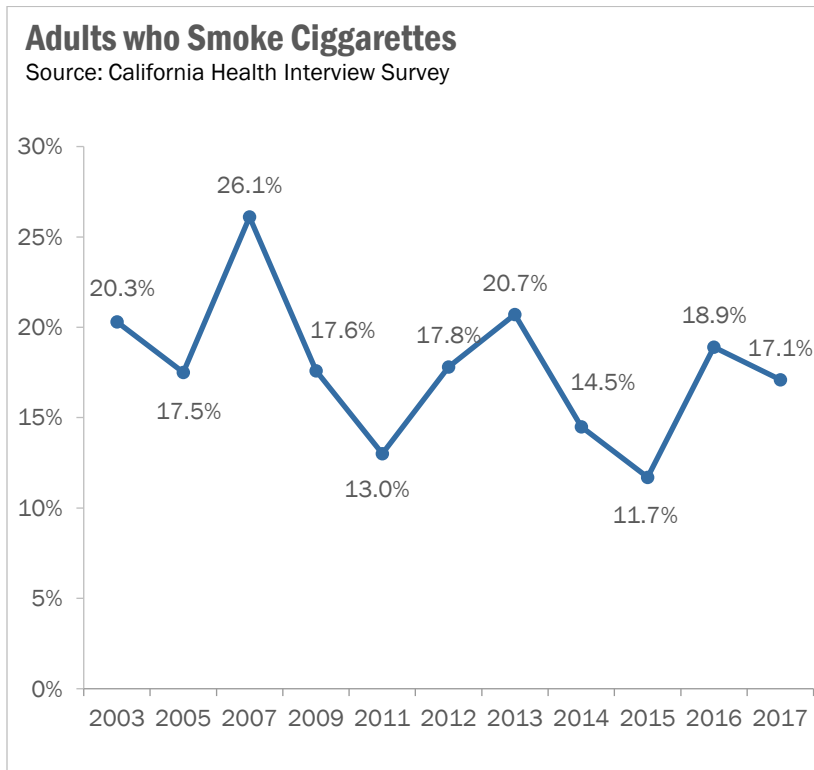
Smoking and Vaping

Tobacco is the agent most responsible for avoidable illness and death in America today. Tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers,

which can cause or exacerbate a wide range of adverse health effects including cancer, respiratory infections, and asthma. Health behavior patterns formed in adolescence play a crucial role in health throughout life. Those who start smoking young are more likely to have a long-term addiction to nicotine than people who start smoking later in life, putting them at greater risk for smoking-related illness and death. Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States. If smoking prevalence among adolescents persists, it is estimated that in the U.S., 5 million persons who are currently under the age of 18 will die prematurely from smoking-related diseases.

Tobacco use is considered a risk factor for numerous chronic diseases, including but not limited to cancer, cardiovascular disease, emphysema, chronic obstructive pulmonary disease, pneumonia, diabetes, and rheumatoid arthritis.^{vi} Exposure to tobacco smoke is a risk factor for chronic diseases and is considered a human carcinogen.^{vii} Acute effects of secondhand smoke are serious and include increased frequency and severity of asthma attacks, respiratory symptoms such as coughing and shortness of breath, and respiratory infections such as bronchitis and pneumonia. In addition, using tobacco or being exposed to tobacco smoke during pregnancy is detrimental in fetal development and increases the risk of sudden infant death syndrome.^{viii}

The State of California has led the way in legislating prohibitions for smoking. Smoking is no longer permitted in public buildings, farmer’s markets, foster and group homes, multi-unit housing, personal vehicles when a minor (<18 years of age) is present, public transportation, workplaces, correctional facilities, playgrounds, and schools.



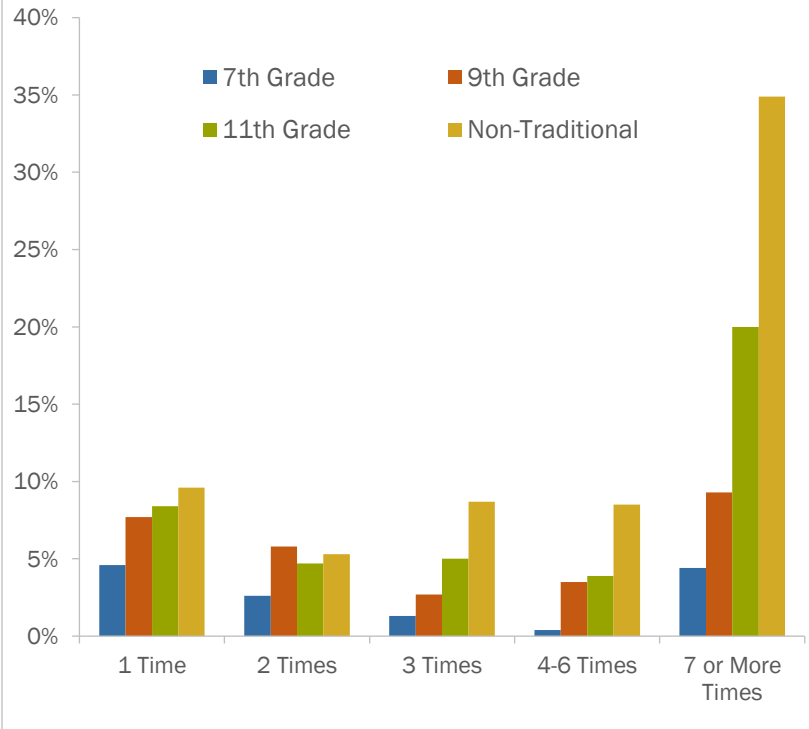
When it comes to tobacco use, cigarettes are considered a combusted or burned product. The cigarette has to be lit, the tobacco burned, and the smoke inhaled. Vaping, and E-Cigarettes on the other hand, involves no combustion or burning. Instead, these products release an aerosol that is inhaled.

Use of e-cigarettes increased dramatically over the past decade, making them the most common tobacco product used among youth. While many people make the mistake of assuming this aerosol is as harmless as water vapor, it actually consists of fine particles containing toxic chemicals, many of which have been linked to

cancer, as well as respiratory and heart diseases. Components of e-cigarette solutions generally include nicotine, flavoring chemicals, and other additives (including those unknown and/or unadvertised to the user). Currently, there are no federal quality standards to ensure the accuracy of e-cigarette constituents as advertised or labeled. Refillable cartridges allow the user to deliver other psychoactive substances, including marijuana. Numerous toxicants and carcinogens have been found in e-cigarette solutions, including aldehydes, tobacco-specific nitrosamines, metals, tobacco alkaloids, and polycyclic aromatic hydrocarbons. E-cigarette solution has also been shown to be cytotoxic to human embryonic stem cells. Nicotine is the major psychoactive component of e-cigarette solution. There are often wide discrepancies between the labeled amount and actual nicotine content within the solution. Reported nicotine concentration in e-cigarette solution ranges widely and, depending on how the product is used, can be comparable to or exceed the amount of nicotine in a single conventional cigarette. Nicotine is a highly addictive drug that can have lasting damaging effects on adolescent brain development and has been linked to a variety of adverse health outcomes, especially for the developing fetus. Nicotine has neurotoxic effects on the developing brain. In early adolescence, executive function and neurocognitive processes in the brain have not fully developed or matured. Adolescents are more likely to engage in experimentation with substances such as cigarettes, and they are also physiologically more vulnerable to addiction. The earlier in childhood an individual uses nicotine-containing products, the stronger the addiction and the more difficult it is to quit. The vast majority of adult smokers initiated tobacco use by 18 years of age.

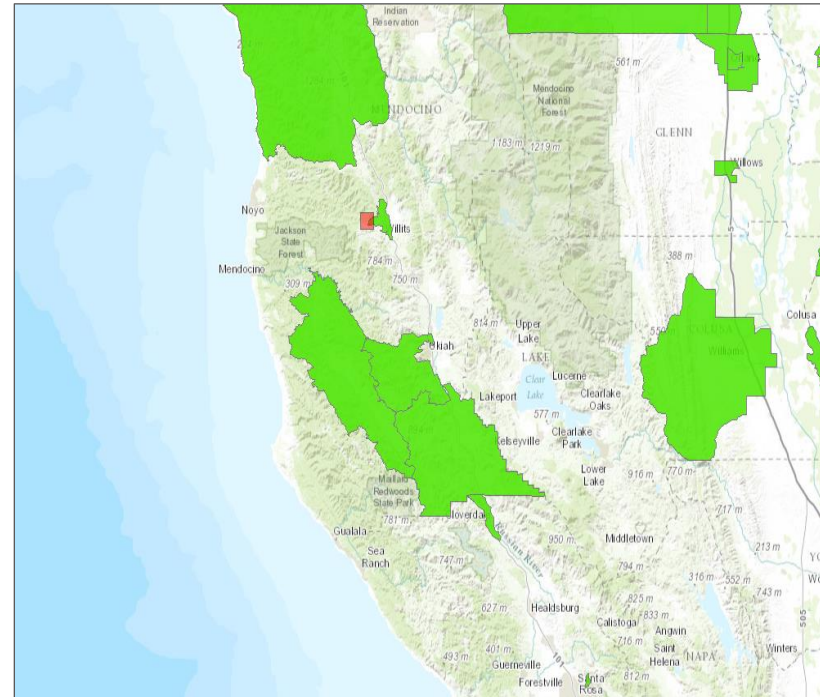
E-Cigg Use in Lifetime by Grade Level, Mendocino County

Source: California Department of Education



This chart (2012-2015) shows the estimated percentage of public school students in grades 7, 9, 11, and non-traditional programs who have ever used electronic cigarettes or other vaping devices, by grade level and number of occasions.

Healthy Weight

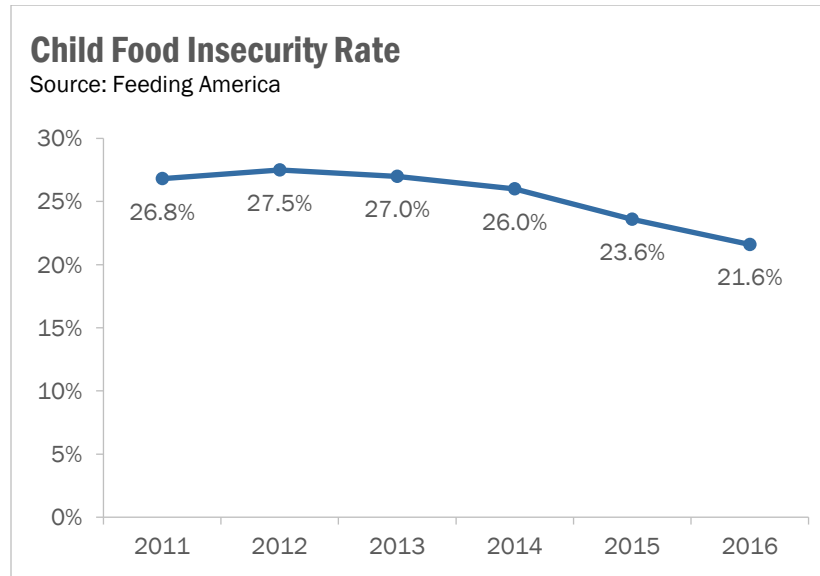


Data Source: U.S. Department of Agriculture

Mendocino County has large geographic areas that the U.S. Department of Agriculture (USDA) considers “food deserts.” These are census tracts with a high proportion of low-income residents who are 10 or more miles away from a supermarket. Limited access to supermarkets or grocery stores may make it harder for low income residents to eat a healthy diet. There is strong evidence that food deserts are correlated with high prevalence of overweight, obesity, and premature death as supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

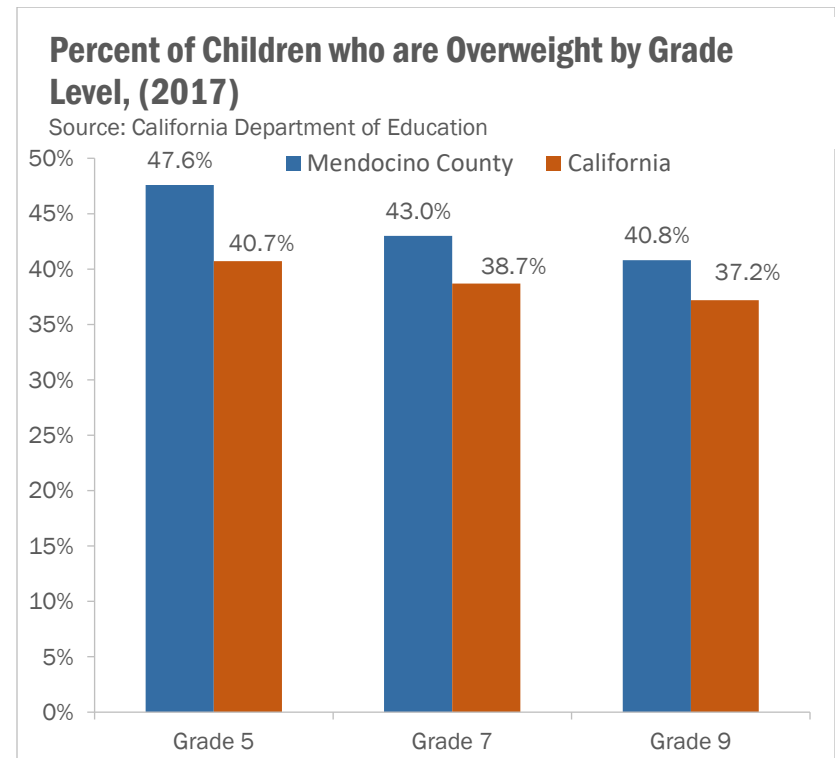
Additionally, those with low incomes may face barriers to accessing a consistent source of healthy food. Lacking constant access to food is related to negative health outcomes such as weight gain and premature mortality.

The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Children exposed to food insecurity are of particular concern given the potential impacts of scarce food resources on their health and development. Children who are food insecure are more likely to be hospitalized and may be at higher risk for developing obesity and asthma. Children who experience food insecurity also may be at higher risk for behavioral and social issues including fighting, hyperactivity, anxiety, and bullying. In Mendocino County, the rate of food insecurity for children has been steadily declining.



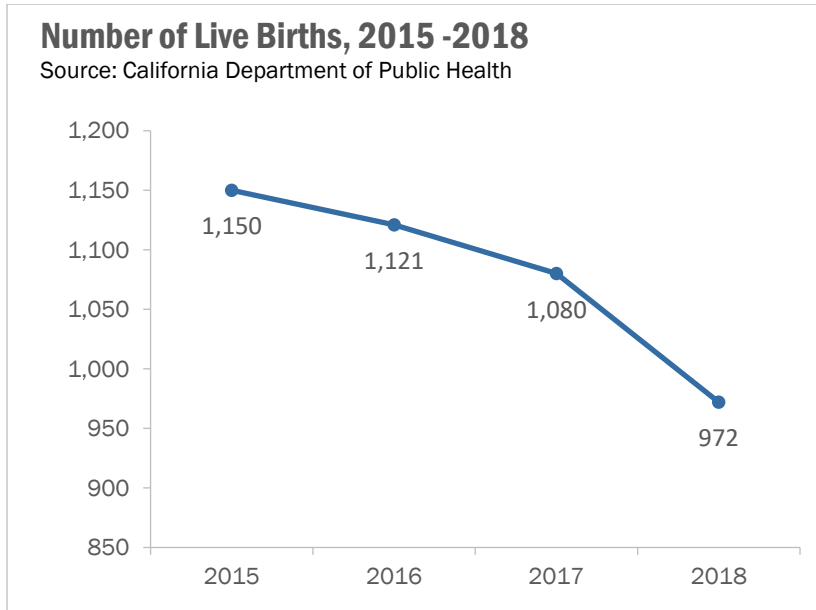
Obesity

Children who are overweight or obese are at higher risk for a range of health problems, including asthma, heart disease, stroke, and some types of cancer; they also are more likely to stay overweight or obese as adults.^{ix} Some obese children are diagnosed with illnesses previously considered “adult” conditions, such as high blood pressure and type-2 diabetes.^x In addition, children with obesity are at increased risk for joint and bone problems, sleep apnea, and social and emotional difficulties, such as stigmatization and low self-esteem.



Maternal Child Adolescent Health

The number of live births in Mendocino County shows a steady decline.



The Infant Mortality Rate for Mendocino County

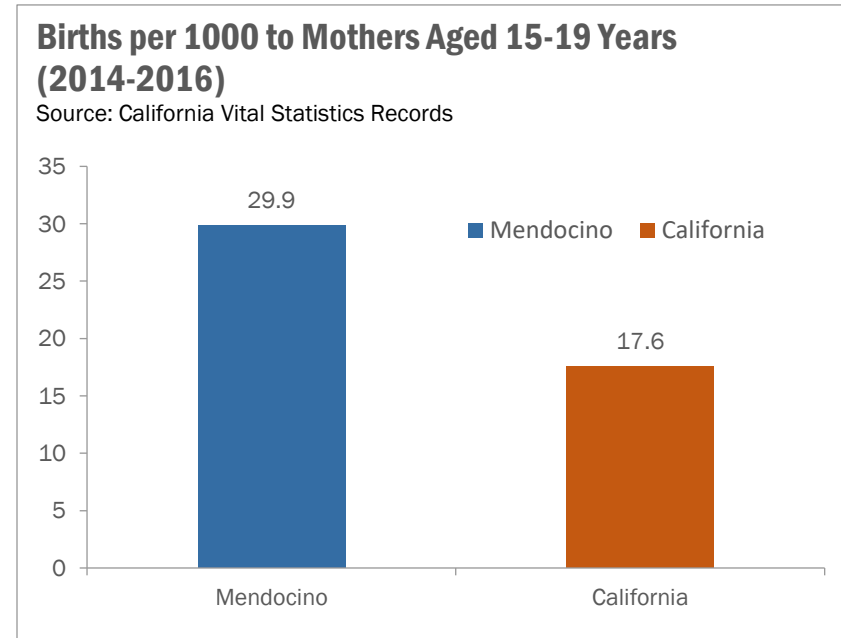
In 2018 the infant mortality rate was 7.4 per 1,000 infants. The California rate was 4.6 per 1,000 infants.

Age-Adjusted Child Death Rate

Between the years 2013-2015, the age-adjusted child death rate was 51.3 per 100,000 children under age 24 years, compared with California’s rate of 30.0 per 100,000. But by 2018, the age-adjusted child death rate in Mendocino County had fallen to 32.4 per 100,000.

Low-Birth Weight Infants (2014-2016)

Percent of low-birth rate infants in Mendocino County, 6.4%. California percentage 6.8%



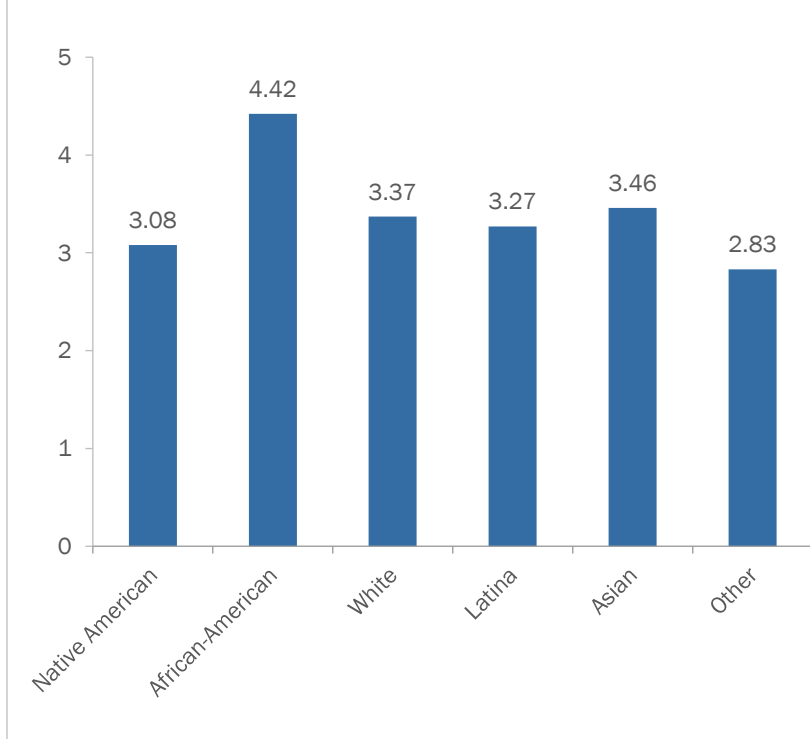
The age-specific rate of teen pregnancy was 29.9 per 1,000. Compared with the California rate of 17.6 per 1,000

Breast-feeding Initiation (2014-2016)

Mendocino County percent of mothers initiating breastfeeding was 96.3%, up from the previous percentage of 95.2%. The California percentage was 93.8%

Average Month Prenatal Care was Begun by Ethnicity (2015-2018)

Source: California Department of Public Health



Pregnant women, substance use, and its effects

Since 2010 the number of pregnant females, aged 15 to 44 years, with any diagnosis of substance abuse has been increasing at an

alarming rate in Mendocino County. Data show that drug and alcohol use among pregnant women in Mendocino County was more than twice the state level by 2015. Alcohol, tobacco, cannabis, and other drug exposures during pregnancy pose serious health risks for pregnant women and their unborn children.

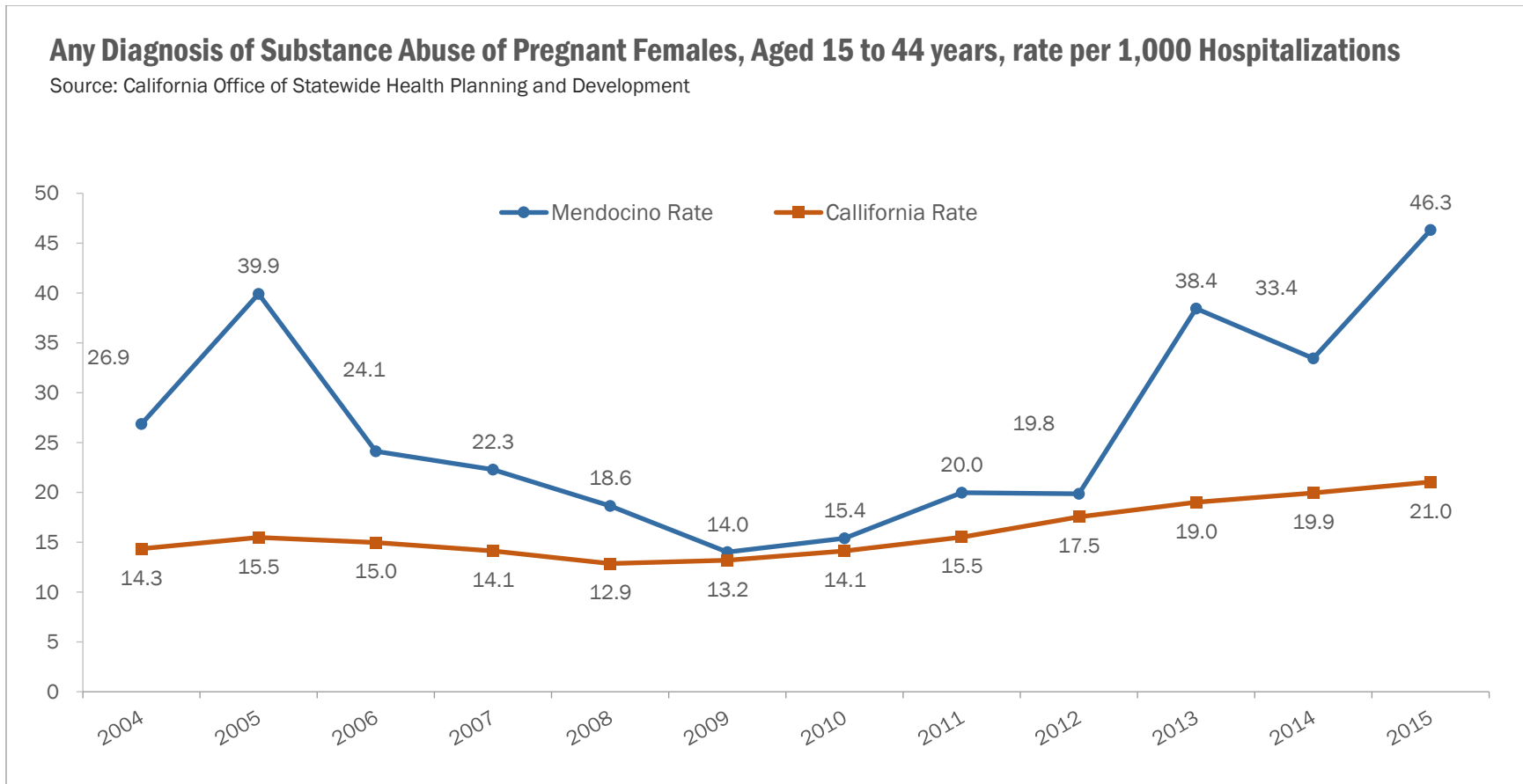
The adverse effects to the developing fetus and long-term effects on the child include: increased risk of miscarriage or fetal death, premature birth, low birth weight, birth defects, physical deformities, respiratory problems, heart defects, developmental disabilities, learning disabilities, and infant mortality. Repetitive use of certain drugs can cause neonatal abstinence syndrome (NAS) in which the baby goes through withdrawal symptoms after birth.

The most frequently used substance during pregnancy is tobacco, followed by alcohol, cannabis, and illegal substances. Misuse of prescription medications is also a problem. Many substance abusers use more than one drug or use a combination of substances, which increases the dangerous effects to both mother and fetus.

In the United States women comprise 40% of those with a lifetime drug use disorder and 26% of those who meet criteria for both an alcohol and drug use disorder during the prior 12-month period. Furthermore, women are at highest risk for developing a substance use disorder during their reproductive years, especially ages 18-29. This means that women who are pregnant or soon to become pregnant are at increased risk for substance abuse. Many women with substance use disorders are also diagnosed with mental disorders. Patients who exhibit both are often more resistant to treatment and may have more severe or persistent symptoms.

Any Diagnosis of Substance Abuse of Pregnant Females, Aged 15 to 44 years, rate per 1,000 Hospitalizations

Source: California Office of Statewide Health Planning and Development

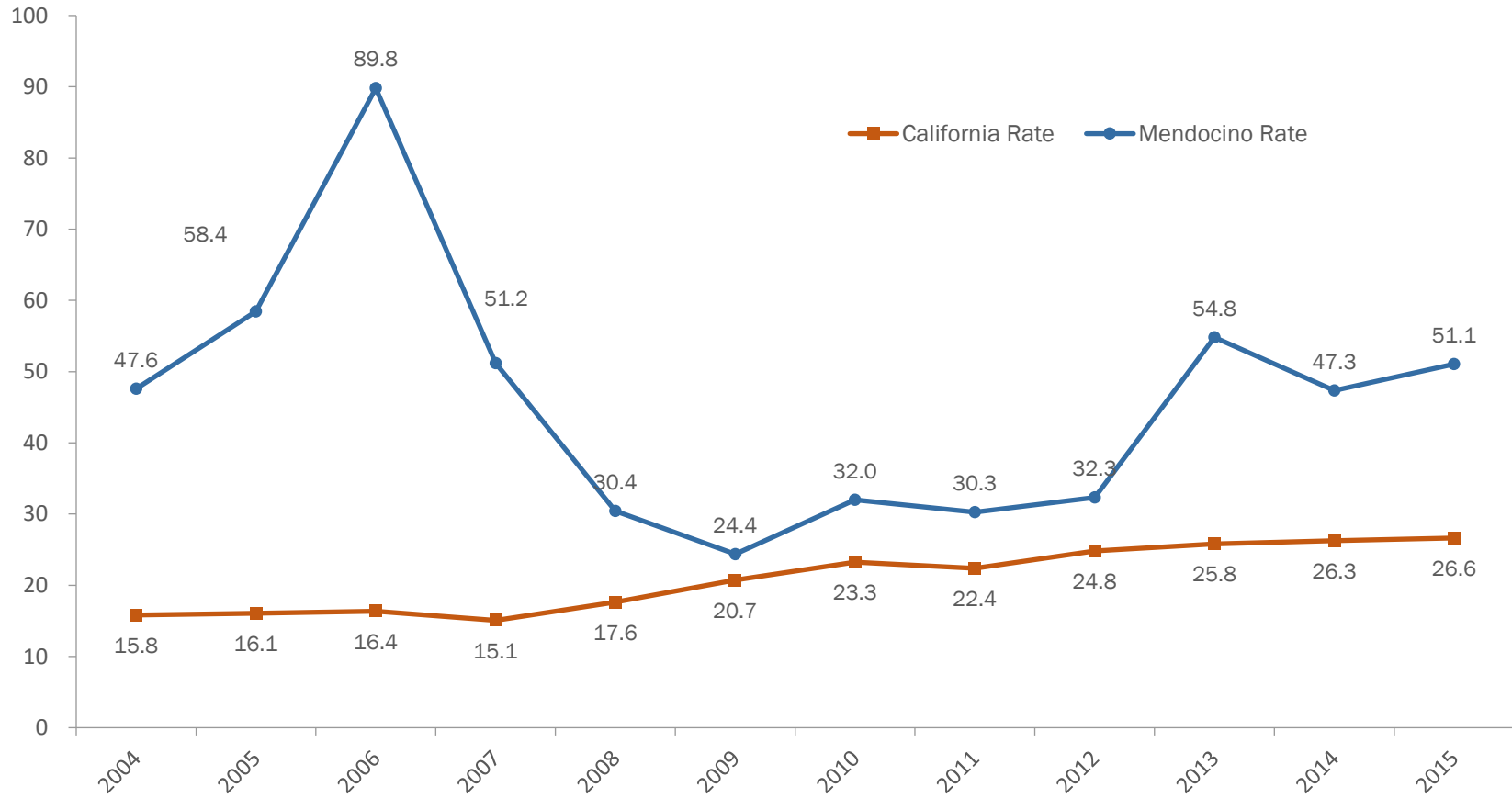


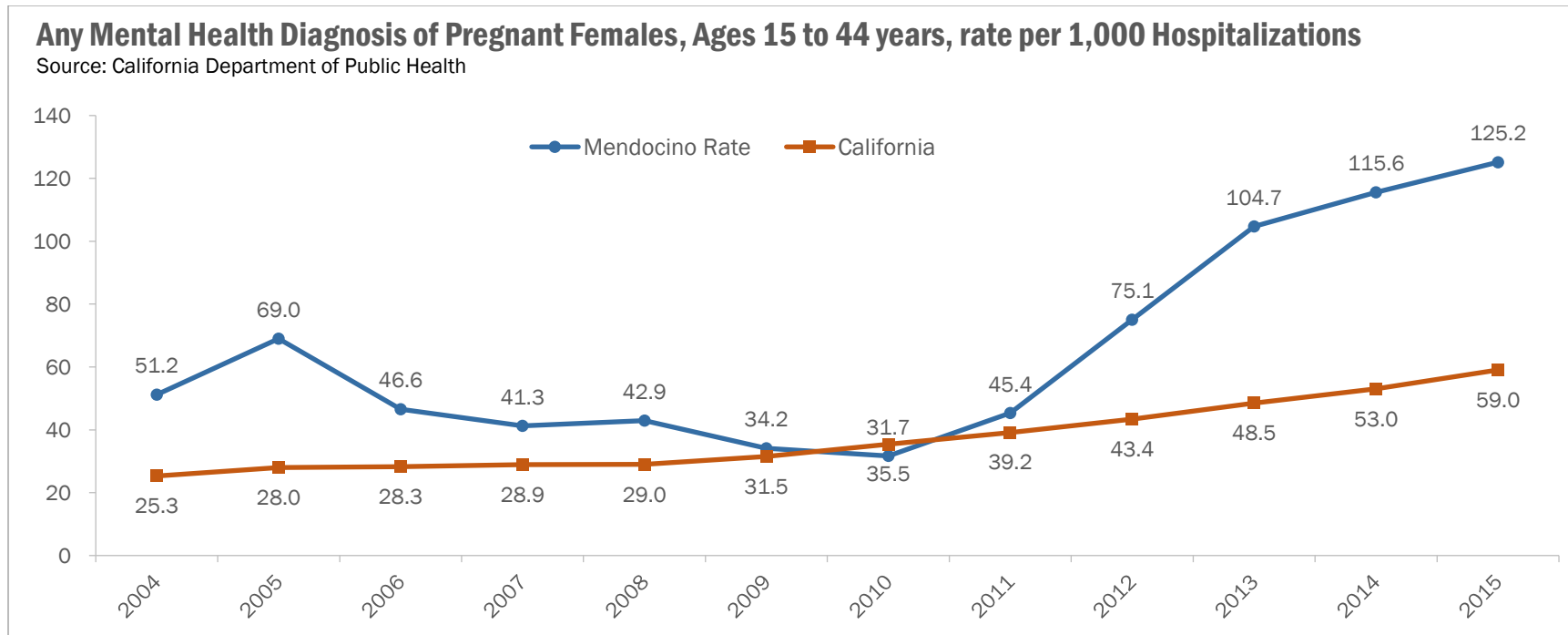
While most women attempt to discontinue substance use after learning that they are pregnant, approximately half of all pregnancies are unplanned, and women often do not realize that they are pregnant until 4 to 6 weeks after conception. This period of continued consumption of alcohol and other harmful substances puts the developing embryo or fetus at risk. Once the fact of pregnancy was known, however, most women reduced or stopped drug and alcohol use.

There are few existing treatments for pregnant women diagnosed with substance abuse. These mainly focus on behavioral counseling and psychosocial interventions. Education on the dangers and effects of drug use while pregnant needs to be implemented in the pre-teen years and needs to continue through public health outreach to all women of childbearing age, and to those in the most susceptible communities.

Infants (0 to 89 days old) with a Diagnosis of Substance Abuse, rate per 1,000 Hospitalizations

Source: California Department of Public Health





Many pregnant women experience psychiatric disorders in their childbearing years. Mental illness not only affects the mother's well-being but may also have significant effects on fetal outcomes. In California, 1 out of every 5 pregnant women or new mothers suffers from a pregnancy-related mental health issue such as depression, anxiety, or even psychosis. A mother's suffering can be so severe they may not be able to function properly or care for their infant, and in some cases if untreated, can lead to a mother's suicide or harming the newborn. Fortunately, these conditions are treatable and early detection by healthcare providers, family or friends can make a positive impact. Programs such as Care for Her offered by the Mendocino Community Health Center, The Blue Dot Project Maternal Mental Health Awareness campaign, and the Family Birth Center at

Adventist Health all offer support and education about maternal mental health issues. In addition, Healthy Families Mendocino is a free of charge, nationally recognized home visiting program for women who are pregnant or up to two-weeks postpartum, low-income and/or Medi-Cal eligible, and whose babies are at risk of *adverse childhood experiences* resulting from maltreatment, domestic violence, homelessness, or parental substance abuse, untreated mental illness, or trauma history. Enrolled families may continue receiving home visiting services until the child reaches three years of age. Community clinics, hospitals, family resource centers can refer clients to the program, but women may also self-refer by contacting the program directly.

Immunizations

(Source: EdSource: Highlighting Strategies for Student Success

<https://edsources.org/2019/vaccination-rates-by-school-in-california-2017-18/610790>)

School	2017-2018 Students	2017-2018 Up to date	2016-2017 Up to date	2017-2018 Medical	2016-2017 Medical	2017-2018 Belief	2016-2017 Belief	2017-2018 Other	2017-2018 Overdue
The Waldorf School of Mendocino County	27	44.44%	*	37.04%	*	0%	*	0%	0%
Laytonville Elementary	36	86.11%	89.66%	11.11%	0%	0%	3.45%	0%	0%
Mendocino K-8	27	70.37%	70.37%	11.11%	0%	0%	0%	0%	0%
Mendocino Unified									
Anderson Valley Elementary	39	> 95%	90%	< 5%	0%	< 5%	0%	< 5%	< 5%
St. Mary of the Angels	27	> 95%	> 95%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%
Arena Elementary	25	> 95%	> 95%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%
Point Arena Unified									
Potter Valley Elementary	22	> 95%	> 95%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%
River Oak Charter	42	76.19%	59.52%	9.52%	2.38%	0%	11.90%	0%	0%
Ukiah Unified									
Willits Elementary Charter	23	82.61%	68.18%	8.70%	0%	0%	0%	0%	0%
Tree of Life Charter	23	82.61%	> 95%	4.35%	< 5%	0%	< 5%	0%	0%
Ukiah Unified									
Frank Zeek Elementary	> 99	> 98%	94.74%	< 2%	0%	< 2%	0%	< 2%	< 2%
Ukiah Unified									
Nokomis Elementary	82	> 98%	97.22%	< 2%	0%	< 2%	0%	< 2%	< 2%
Ukiah Unified									
Redwood Elementary	134	74.63%	69.92%	0%	0%	0%	1.63%	0%	25.37%
Fort Bragg Unified									
Round Valley Elementary	42	83.33%	94.29%	0%	2.86%	0%	2.86%	0%	14.29%
Calpella Elementary	126	97.62%	94.44%	0%	0%	0%	0%	0%	0%
Ukiah Unified									

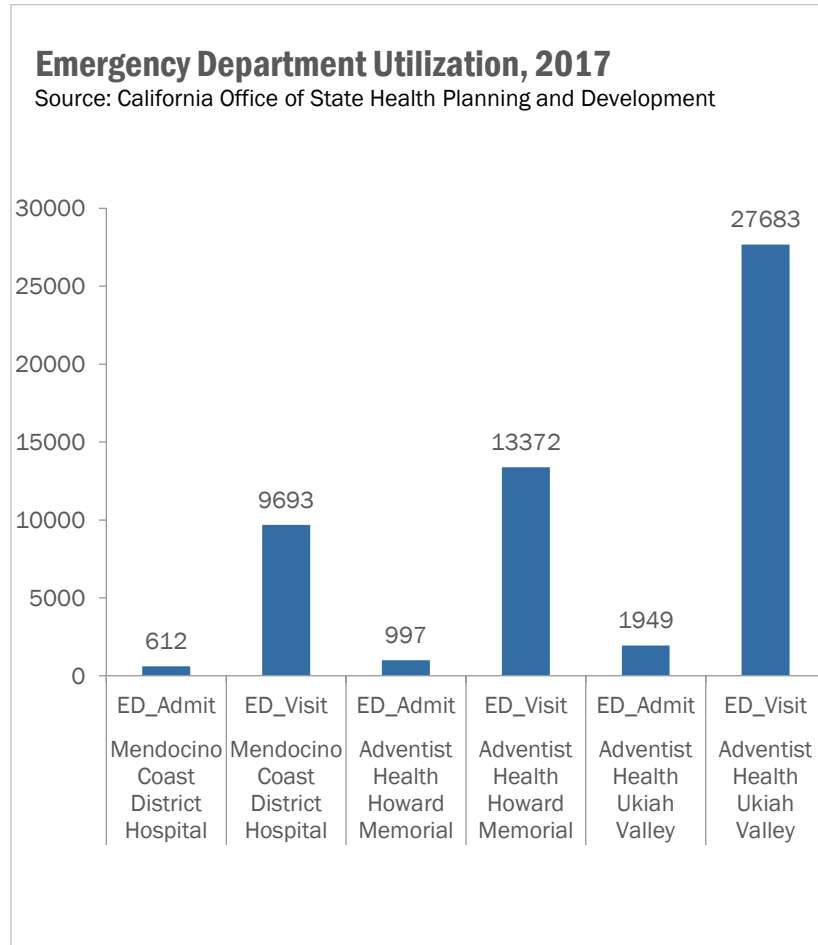
Grace Hudson Elementary	> 98	88.78%	94.74%	0%	0%	0%	0%	0%	0%
Ukiah Unified									
Oak Manor Elementary	96	91.67%	95.92%	0%	0%	0%	0%	0%	8.33%
Ukiah Unified									
Yokayo Elementary	83	95.18%	> 98%	0%	< 2%	0%	< 2%	2.41%	0%
Ukiah Unified									
Brookside Elementary	155	82.58%	90.73%	0%	0.66%	0%	1.32%	0%	17.42%
Willits Unified									

Definitions of column headers:

- School: School name, district (if available), and county.
- 2017-18 Students: Number of incoming kindergarten students in the 2017-18 school year.
- 2017-18 Up to date: Percentage of incoming kindergartners up to date on their vaccinations in the 2017-18 school year.
- 2016-17 Up to date: Percentage of incoming kindergartners up to date on their vaccinations in the 2016-17 school year.
- 2017-18 Medical: Percentage of incoming kindergartners claiming a Permanent Medical Exemption in the 2017-18 school year.
- 2016-17 Medical: Percentage of incoming kindergartners claiming a Permanent Medical Exemption in the 2016-17 school year.
- 2017-18 Belief: Percentage of incoming kindergartners claiming a Personal Belief Exemption in the 2017-18 school year.
- 2016-17 Belief: Percentage of incoming kindergartners claiming a Personal Belief Exemption in the 2016-17 school year.
- 2017-18 Overdue: Percentage of children who are overdue for one or more required immunizations in the 2017-18 school year.
- 2017-18 Other: Percentage of children who are not required to have immunizations because they attend a home school or an independent study program or receive special education services in the 2017-18 school year.
- An asterisk indicates that no data is available because the school did not submit its statistics.
- Percentages may not add up to 100 percent because one category, conditional exemptions, is not shown.
- A conditional exemption refers to students who have received some vaccines, but under immunization schedules must wait before their next vaccinations. They are admitted on the condition that they become up to date.

Healthcare and Preventative Services

Hospitalization and Emergency Room Utilization

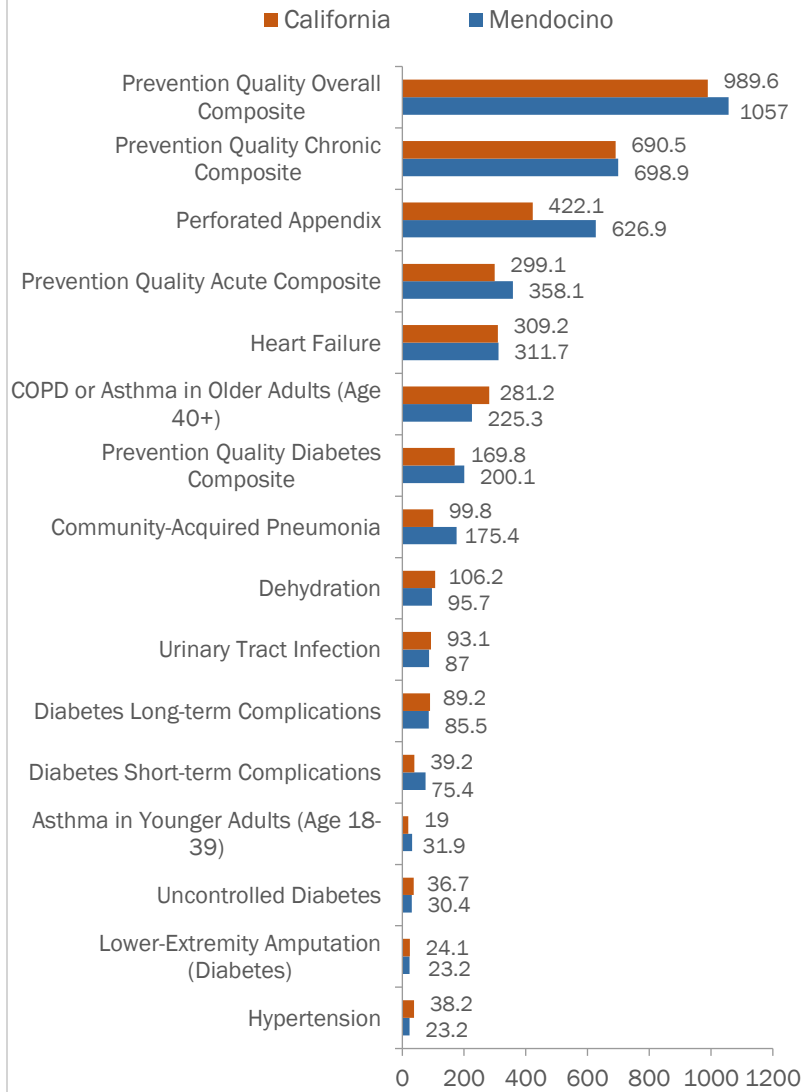


Safe Haven Wellness Center (SHWC)

Individuals admitted into Emergency Departments or Inpatient care for treatment and then released, may find themselves with limited options for post-hospital care. Patients are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning, so California Senate Bill 1152 requires each hospital to include a written patient discharge planning policy and process for homeless patients, and/or those with substance abuse issues. Prior to discharge the hospital shall determine that the patient has been fed, has adequate clothing, medications, disease screening and vaccinations, identified any mental health or behavioral health care services needed, and provides a “warm hand-off” from the hospital to the Safe Haven Wellness Center. SHWC is intended to address the intersection of homelessness and opioid addiction for individuals residing in Mendocino County.

Preventable* Hospitalizations by Condition, 2017 (Rate per 100,000 population)

Source: California Office of Statewide Planning and Development (OSHPD)



The Agency for Healthcare Research and Quality uses *Prevention Quality Indicators (PQIs) to measure adult hospital admissions for “ambulatory care-sensitive conditions”, hospitalizations that evidence suggest may have been avoided through access to high-quality outpatient care. The Prevention Quality *Composite* Indicators are those that include multiple conditions, such as a patient presenting with COPD, diabetes and hypertension.

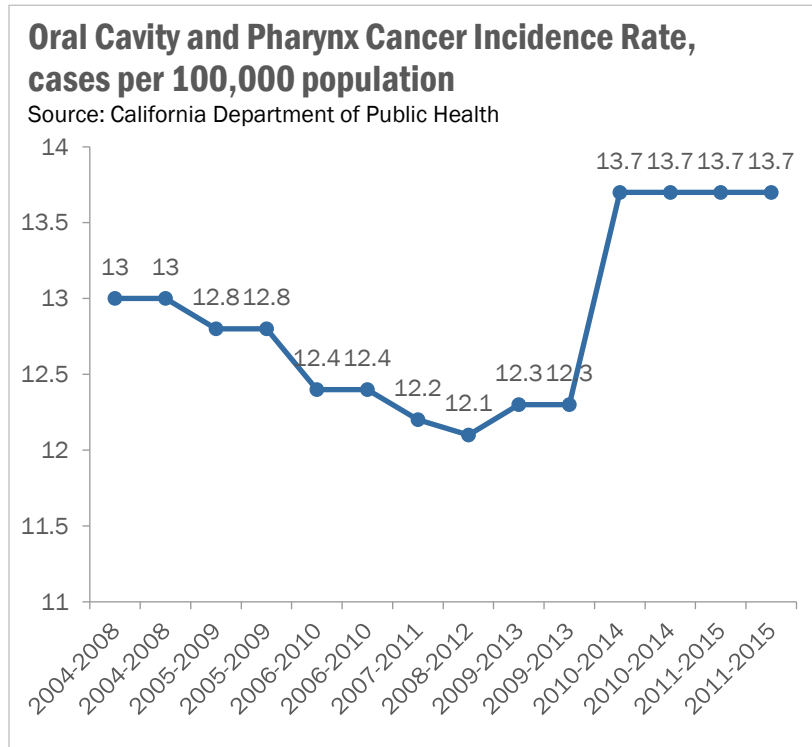
Medical Insurance and Uninsured Rates

The measurement of the uninsured is the percentage of the population under age 65 without health insurance coverage. Lack of health insurance coverage is a significant barrier to accessing needed health care and to maintaining financial security. It can contribute to delays in seeking medical care when a condition is treatable or controllable, for example in an out-patient setting, leading to higher levels of care and greater expense to treat more serious conditions at the Emergency Department or as an inpatient. Being uninsured can lead to dire financial consequences when patients are uninsured and are unable to pay their medical bills.

In Mendocino County estimates are that 10% of the population is uninsured, compared with California at 8%.

Dental Health

Oral health impacts overall health and well-being. Tooth-decay is one of the most prevalent chronic infectious diseases in the United States.



Individuals with poor oral health have higher rates of cardiovascular problems such as heart attack and stroke than people with good oral health. There are a number of theories about why this seems to be true^{xi} but it appears that the bacteria involved in periodontal disease may contribute to inflammation that worsens hypertension and atherosclerosis. In addition to cardiovascular

problems, periodic check-ups help detect oral cancers. The known risk factors for developing oral cancers are tobacco use and heavy alcohol consumption. The overall rate for oral cancers in California is 10.3 cases per 100,000, compared to Mendocino County at 13.7 cases per 100,000.

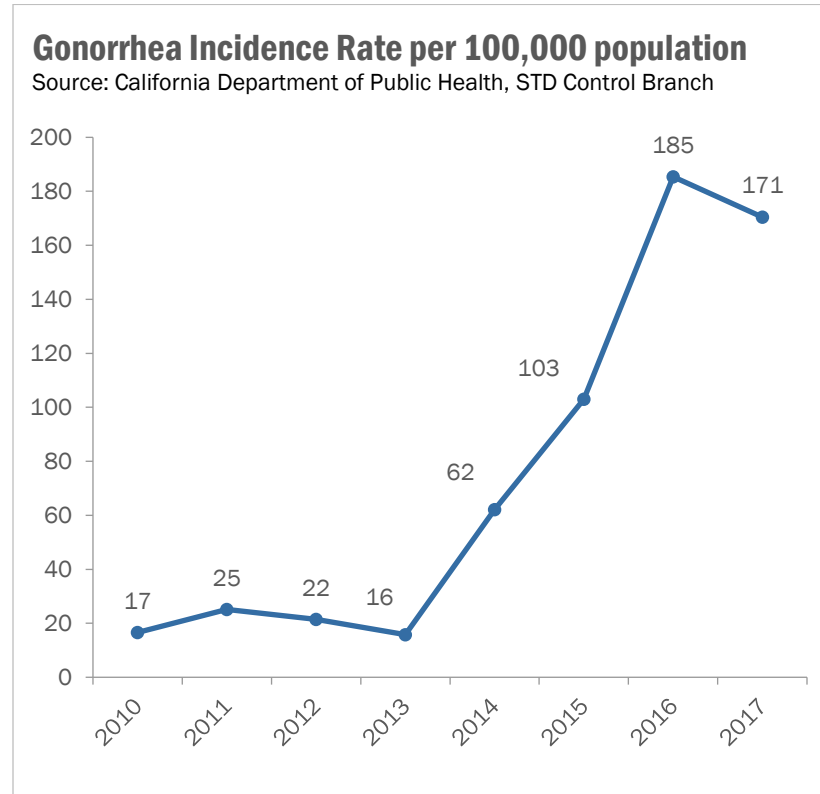
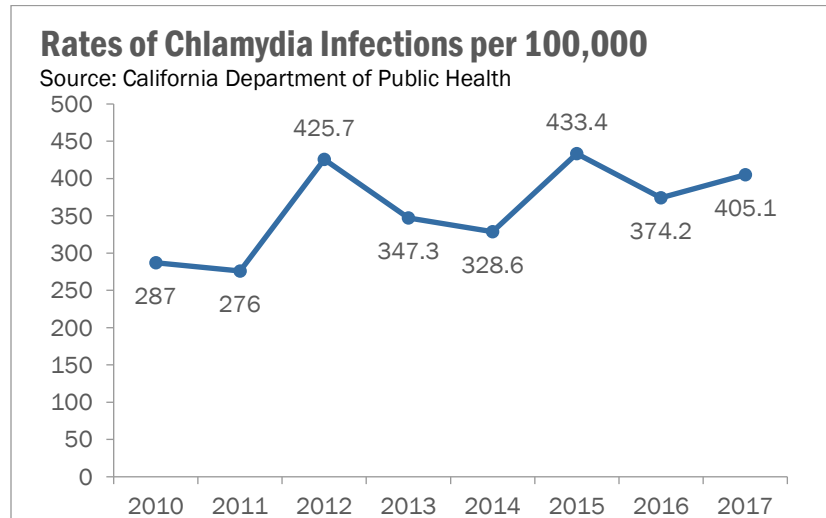
The ratio of dentists to the population of Mendocino County is 1,280:1, compared with the rate in California overall of 1,200:1. The rate in Mendocino County has declined from 2015, when it was 1,301:1. The populations most underserved are those individuals with no dental insurance or those with Medi-Cal dental insurance (Denti-Cal). Individuals with no dental insurance coverage are more likely to put off regular check-ups and seek care when dental caries become significantly infected and painful. Individuals with Denti-Cal insurance often have difficulty finding dentists who accept this coverage due to low reimbursement rates, and this insurance offers only limited treatment options. Of the estimated 19,000 children in Mendocino County, in 2016, only 39% of low-income children, ages 0 to 5, had visited a dentist in the past year.

In an effort to increase the availability of dental care and educate the public about the importance of starting oral health care for children early in life, Mendocino County launched an Oral Health Advisory Committee in March 2018. The overarching goal is to partner with school districts around the county to provide school-based services; classroom education, oral screenings, fluoride varnish and dental sealants. School-based services will provide the need for our young populations to have early dental care which in turn will reduce the number of missed school days due to oral problems and increase their overall health. Early oral health care can prevent future problems.

Death, Disease and Chronic Conditions

Sexually Transmitted Infections

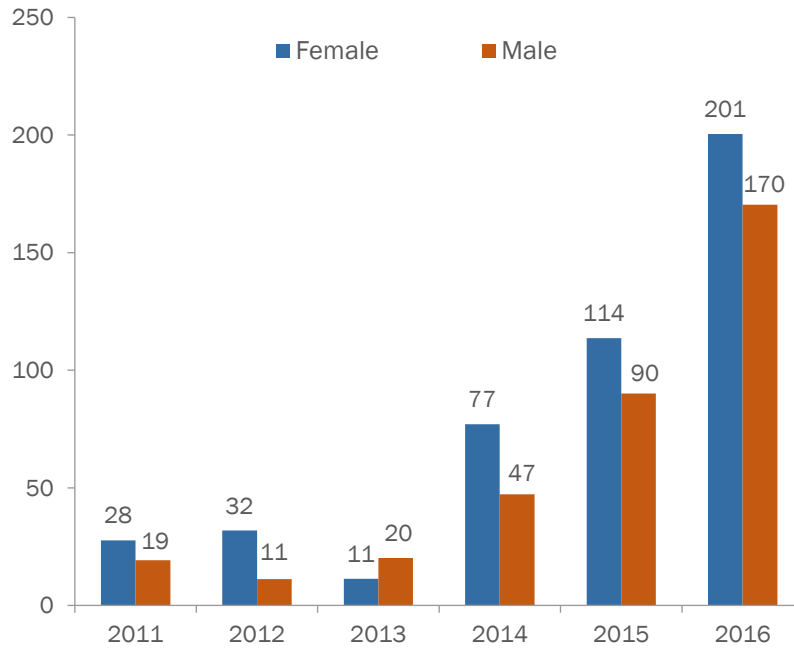
Chlamydia, the most frequently reported bacterial sexually transmitted infection (STI) in the United States, is caused by the bacterium, *Chlamydia trachomatis*. Although symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia can also cause discharge from the penis of an infected man. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Chlamydia infections, while also an indicator of non-safe sexual practices, make the individual more susceptible to infection by the HIV virus. In 2017, the overall rate for the State of California was 552.2 per 100,000 population.



Gonorrhea is an STI caused by *Neisseria gonorrhoeae*. It is typically asymptomatic, but easy to treat. However, gonorrhea has developed resistance to antibiotics over the years, complicating treatment. Many people with gonorrhea don't have any symptoms, but they can still spread the infection to others. Gonorrhea has progressively developed resistance to the antibiotic drugs prescribed to treat it. Following the spread of gonococcal fluoroquinolone resistance, the cephalosporin antibiotics have been the foundation of recommended treatment for gonorrhea.

Gonorrhea Incidence Rate per 100,000 population by Gender

Source: California Department of Public Health, STD Control Branch



Gonorrhea that is not treated can cause serious health problem in men and women. Pelvic inflammatory disease occurs in women when the gonorrhea infection affects their uterus or fallopian tubes. The most serious complication associated with pelvic inflammatory disease is infertility. Complications in men with gonorrhea include epididymitis (an inflammation of the tube that carries sperm) and infertility. Mendocino County has higher rates of infections than California at 190 cases per 100,000 population.

Illness, Injury and Deaths

Cause of Death per 100,000 population Source: CDPH	Mendocino County	California
All causes	727.1	610.3
All cancers	157.2	137.4
Colorectal cancer	13.9	12.5
Lung cancer	34	27.5
Female breast cancer	19.9	18.9
Prostate cancer	27.9	19.4
Diabetes	18.8	21.2
Coronary heart disease	11.8	35.7
Alzheimer's disease	85	87.4
Stroke	37.2	36.3
Influenza / Pneumonia	14.8	14.2
Chronic lower respiratory disease	40.1	32
Liver disease and cirrhosis	9.3	12.2
Accidents (Unintentional injury)	67.1	32.2
Motor vehicle traffic crashes	15.5	9.5
Suicide	21.3	10.4
Homicide	6	5.2
Firearm related deaths	14.3	7.9
Drug induced deaths	26.2	12.7

Life Expectancy

Most people are nowadays expected to live to about 75 years, (this is the accepted figure for the United States), so anyone who dies before this is considered to have died prematurely.

We measure premature mortality by estimating the average years a person would have lived, if he or she had not died prematurely. A person who dies at 65 has lost 10 years of potential life while a person who dies at age 1 has lost 74 years of potential life.

This measure is different from overall mortality, because premature mortality focuses on deaths that could have been prevented. This measure is called Years of Potential Life Lost (YPLL). YPLL emphasizes deaths of younger persons, whereas statistics that include all deaths are going to have more deaths of elderly people, and therefore not tell us about the rates of premature deaths. In order to be able to compare with other populations we use a rate per 100,000 people. By examining deaths in a community and using the YPLL, we can determine and rank the causes of premature death.

Most premature deaths may be preventable through lifestyle modifications such as smoking cessation or healthy eating and exercise.

Years of Potential Life Lost (YPLL)

Source: California Vital Statistics

2018	Rate per 100,000
California	5,734
Mendocino	7,606
2017	Rate per 100,000
California	5,674
Mendocino	7,922
2016	Rate per 100,000
California	5,528
Mendocino	7,619
2015	Rate per 100,000
California	5,609
Mendocino	7,323
2014	Rate per 100,000
California	5,590
Mendocino	8,390

Causes of Death by Year and Gender

Source: California Vital Statistics

2013	Number 1 Cause of Premature Death	Number 2 Cause of Premature Death
Females	Lung Cancer	Breast Cancer
Males	Lung Cancer	Atherosclerotic heart disease of native coronary artery
2014	Number 1 Cause of Premature Death	Number 2 Cause of Premature Death
Females	Lung Cancer	Chronic obstructive pulmonary disease
Males	Lung Cancer	Atherosclerotic heart disease of native coronary artery
2015	Number 1 Cause of Premature Death	Number 2 Cause of Premature Death
Females	Breast Cancer	Lung Cancer
Males	Lung Cancer	Atherosclerotic heart disease of native coronary artery
2016	Number 1 Cause of Premature Death	Number 2 Cause of Premature Death
Females	Lung Cancer	Chronic obstructive pulmonary disease
Males	Lung Cancer	Acute myocardial infarction

2017	Number 1 Cause of Premature Death	Number 2 Cause of Premature Death
Females	Lung Cancer	Breast Cancer
Males	Atherosclerotic heart disease of native coronary artery	Lung Cancer

Mendocino County Ranking

The Robert Wood Johnson Foundation evaluates California counties based on a series of indicators. The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

Mendocino ranks 41 out of 55 in overall health ranking. Marin County is number 1.

SOURCES

- Annie E. Casey Foundation <https://www.aecf.org/>
- Behavioral Risk Factor Surveillance System (BRFSS) (CDC) <https://www.cdc.gov/brfss/index.html>
- California Center for Rural Policy <http://www2.humboldt.edu/ccrp/>
- California Child Welfare Indicators Project http://cssr.berkeley.edu/ucb_childwelfare/
- California Department of Education (CDE) <http://www.cde.ca.gov/>
- California Department of Public Health (CDPH) <https://www.cdph.ca.gov/>
- California Department of Public Health, STD Control Branch <http://www.cdph.ca.gov/programs/std/Pages/default.aspx>
- California Department of Social Services, Adult Protective Services <http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm>
- California Department of Social Services, Children and Family Services Reports <http://www.cdss.ca.gov/inforesources/Information-Resources/Program-and-Legislative-Reports/Children-and-Family-Services-Reports>
- California Health Interview Survey (CHIS) <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>
- California Healthy Kids Survey <http://chks.wested.org/>
- California Office of Statewide Planning & Development (OSPD) <http://www.oshpd.ca.gov/>
- California Secretary of State <https://www.sos.ca.gov/>
- CDC National Environmental Public Health Tracking (CDC NEPHT) <https://www.cdc.gov/nceh/tracking/default.htm>
- CDC NVSS (National Vital Statistics System) <https://www.cdc.gov/nchs/nvss/index.htm>
- CDC's WISQARS (Web-based Injury Statistics Query and Reporting System) <https://www.cdc.gov/injury/wisqars/index.html>
- Center for Disease Control (CDC) <http://www.cdc.gov/>
- Child Care Aware of America (2014). Parents and the high cost of childcare: 2014 report <https://usa.childcareaware.org/wp-content/uploads/2016/12/costofcare20141.pdf>
- Child Welfare System / Child Case Management System (CWS / CMS) <https://www.cdss.ca.gov/inforesources/Child-Welfare-Services-Case-Management-System>
- County Health Rankings <http://www.countyhealthrankings.org/>
- County of Mendocino Coroner's Reports, 2014-2017.
- Family Health Outcomes Project (FHOP) <https://fhop.ucsf.edu/>
- FBI Uniform Crime Reports <https://www.fbi.gov/services/cjis/ucr>
- Feeding America <https://www.feedingamerica.org/>
- Healthy Mendocino <http://www.healthymendocino.org/>
- Parents and the High Cost of Child Care: A Report <http://usa.childcareaware.org/advocacy-public-policy/resources/reports-and-research/parents-and-the-high-cost-of-child-care>
- Child Welfare Services/Case Management System <https://www.hwcws.cahwnet.gov/>
- Institute for Health Metrics and Evaluation <http://www.healthdata.org/Kidsdata.org>
- Massachusetts Institute of Technology (MIT) <http://www.mit.edu/>
- Mendocino County Continuum of Care for the Homeless Report <http://www.co.mendocino.ca.us/hhsa/adult/coc.htm>
- National Cancer Institute (NCI) <https://www.cancer.gov/>
- National Center for Education Statistics <https://nces.ed.gov/>
- National Center for Health Outcomes Development https://www.cdc.gov/nchs/about/factsheets/factsheet_overview.htm
- The Dartmouth Institute for Health Policy and Clinical Practice (TDI) <https://tdi.dartmouth.edu/>
- U.S. Census Bureau <http://www.census.gov/>
- U.S. Census Bureau, American Community Survey (ACS) <https://www.census.gov/programs-surveys/acs/data.html>
- U.S. Department of Agriculture (USDA) <http://www.usda.gov/wps/portal/usda/usdahome>
- U.S. Department of Health and Human Services (DHHS) <https://www.hhs.gov/>
- US Department of Justice <https://www.justice.gov/>
- US Department of Labor <https://www.dol.gov/>

ADDENDUM

Data Dictionary

The following indicators are from the previous Community Health Needs Assessment of 2015-2016 and the most updated values as of 2019. The previous values are in black, and the most recent values are in **red for comparison**.

Overall, 48% of the indicators show a positive trend, 7% are the same, and 45% show a negative trend.

Indicator #	Socioeconomics	Mendocino County	CA	US	HP 2020	Sources
1	People Living Below Federal Poverty Level	21.00%	16.80%	15.90%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		20.20%	15.80%	15.10%		
		(2012-2017)	(2012-2017)	(2012-2017)		
2	Families Living Below Federal Poverty Level	14.50%	12.70%	11.70%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		14.70%	11.80%	11.00%		
		(2012-2016)	(2012-2016)	(2012-2016)		
3	People 65+ Living Below the Federal Poverty Level	9.60%	10.30%	9.50%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		9.20%	10.30%	9.30%		
		(2012-2016)	(2012-2016)	(2012-2016)		
4	Children Living Below Federal Poverty Level	30.08%	23.30%	22.40%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		24.40%	21.90%	21.20%		
		2017	(2012-2016)	(2012-2016)		
5	Unemployment Rate	6.60%	7.20%	6.00%	NA	US Dep Labor
		-2014	-2014	-2014		
		4.50%	4.20%	3.90%		
		2018	2018	2018		

6	Median Household Income	\$42,111	\$59,645	\$63,784	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		\$43,510	\$63,783	\$55,322		
		(2012-2016)	(2012-2016)	(2012-2016)		
7	Per Capita Income	\$23,880	\$29,103	\$27,884	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		\$25,278	\$31,485	\$29,829		
		(2012-2016)	(2012-2016)	(2012-2016)		
8	Living Wage- Annual income required to support household with one adult	\$19,132	\$23,295	NA	NA	MIT
		-2014	-2014			
		\$22,425	\$26,899			
		2018	2018			
9	Living Wage- Annual income required to support household with one adult and one child	\$42,052	\$47,212	NA	NA	MIT
		-2014	-2014			
		\$49,670	\$56,985			
		2018	2018			
10	Living Wage-Annual income required to support household with two adults and two children	\$40,885	\$46,063	NA	NA	MIT
		-2014	-2014			
		\$50,438	\$57,676			
		2018	2018			
11	Homeownership (percentage of housing units that are occupied by homeowners)	48.40%	49.90%	56.00%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		48.60%	49.80%	55.90%		
		(2012-2016)	(2012-2016)	(2012-2016)		
12	Proportion of housing tenure who are renters	43.30%	45.80%	36.00%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		42.90%	45.90%	36.40%		
		(2012-2016)	(2012-2016)	(2012-2016)		
13	Proportion of renters spending 30% or more of household income on rent	59.60%	57.40%	52.30%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		54.40%	56.50%	47.30%		
		(2012-2016)	(2012-2016)	(2012-2016)		

14	Households with Cash Public Assistance Income	36.00%	4.10%	2.90%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		3.60%	3.80%	2.70%		
		(2012-2016)	(2012-2016)	(2012-2016)		
15	Low-Income Persons who are Food Stamp/SNAP Participants	11.40%	9.00%	13.40%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		12.20%	8.90%	11.70%		
		(2012-2016)	(2012-2016)	(2012-2016)		
16	Percentage of the population that experienced food insecurity at some point during the year	16.2%	16.20%	15.90%	NA	CHIS/ BRFS
		-2012	-2012	-2012		
		14.50%	12.90%	15.20%		
		2016	2016	2016		
17	Percentage of children (<18 years of age) living in households that experienced food insecurity at some point during the year	27.50%	26.30%	21.60%	NA	Feeding America
		-2012	-2012	-2012		
		21.60%	19.00%	17.90%		
		2016	2016	2016		
18	Percent of the population that speak English less than "very well" (Language Spoken at home-Spanish)	8.80%	19.10%	8.60%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		10.10%	10.80%	5.70%		
		(2012-2016)	(2012-2016)	(2012-2016)		
19	Children receiving free or reduced-price meals at schools per 100 students	63.6	57.5	51.9	NA	USDA
		-2012	-2012	-2012		
		73.20%	58.60%	73.60%		
		2015	2015	2017		
20	Percent of adults age 25+ without high school diploma	13.80%	18.50%	13.70%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		12.48%	17.90%	12.00%		
		2017	2017	2017		
21	High School Graduation Rate	84.10%	83.80%	82.20%	NA	EDFacts
		(2011-2012)	(2011-2012)	(2011-2012)		
		85.20%	83.20%	84.00%		
		2017	2017	2017		

22	People 25+ with a bachelor's degree	14.30%	19.50%	18.20%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		17.66%	17.90%	18.80%		
		2018	2018	2018		
Indicator #	Social Determinants of Health	Mendocino County	CA	US	HP 2020	Sources
23	Voter Turnout (percentage of registered voters who voted in the last presidential election)	72.50%	72.40%	54.90%	NA	CA Secretary of State
		-2012	-2012	-2012		
		75.90%	75.30%	57.50%		
		2016	2016	2016		
24	Proportion of renter occupied households living in overcrowded environments (>1.5 persons/room)	1.50%	2.80%	1.00%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		1.80%	8.3%	1.10%		
		2017	2017	2017		
25	Householder living alone 65 years and over	12.80%	8.50%	9.80%	NA	ACS
		(2009-2013)	(2009-2013)	(2009-2013)		
		30.20%	23.10%	26.40%		
		(2012-2016)	(2012-2016)	(2012-2016)		
26	Student-to-Teacher Ratio	18.9: 1	23.4:1	16.0:1	NA	National Center for Education Statistics
		(2011-2012)	(2011-2012)	(2011-2012)		
		19:01	23.7:1	17.7:1		
		(2015-2016)	(2015-2016)	(2015-2016)		
27	Percent of fourth grade students who are proficient and above in English Language Arts (ELA) and Math	51% (ELA)	65% (ELA)	67% (ELA)	NA	CDE
		56% (Math)	72% (Math)	82% (Math)		
		-2013	-2013	-2013		
		33% (ELA)	45.06% (ELA)	48.56% (ELA)		
		26% (Math)	40.45% (Math)	37.56% (Math)		
		2017	2017	2017		
29	Percent of English language learners (K-12) who met California English Language Development Test (CELDT) criteria for proficiency	35%	39%	NA	NA	CDE
		-2014	-2014			
		34%	39%			
		(2016-2017)	(2016-2017)			

32	Percentage of 11th grade students reporting current gang involvement	5.50%	7.50%	7.90%	NA	Kidsdata
		(2011-2013)	(2011-2013)	(2011-2013)		
		6.10%	5.40%	9%		
		(2013-2015)	(2013-2015)	(2013-2015)		
33	Juvenile Arrest Rate (the number of felony and misdemeanor arrests per 1,000 adults ages 17 and under)	16.3	9.3	3.3	NA	CA DOJ
		-2013	-2013	-2013		
		5.3	9.6	NA		
		2015	2015	2015		
34	Number of domestic violence calls for assistance and rate per 1,000 population	6.8	3.9	5.6	NA	CA DOJ
		-2013	-2013	-2013		
		8.6	6	NA		
		2014	2014			
36	Arrest Rate (the number of felony and misdemeanor arrests per 1,000 youth ages 18+)	66.2	38.3	38.8	NA	FBI Uniform Crime Reports
		-2013	-2013	-2013		
		57.4	35.1	NA		
		2016	2016			
37	Fast Food Restaurant Density: Number of fast food restaurants per 100,000 population	59.2	74.92	72.74	NA	USDA
		-2013	-2013	-2013		
		59.2	72	73		
		2014	2014	2014		
38	WIC Authorized Grocery Stores per 100,000 population	22.84	15.8	15.6	NA	USDA
		-2011	-2011	-2011		
		14.7	15.5	15.8		
		2017	2017	2017		
39	Food Environment Index Score	15.88%	3.29%	5.02%	NA	County Health Rankings
		-2011	-2011	-2011		
		7.40%	8.80%	7.70%		
		2018	2018	2018		
40	Grocery Stores and Supermarkets, Rate (Per 100,000 Pop.)	54.65	21.7	21.2	NA	Census
		-2013	-2013	-2013		
		53	24	19		
		2015	2015	2015		

41	Liquor Stores per 100,000 population (see comment)	13.66	10.25	10.44	NA	Census
		-2013	-2013	-2013		
		11.4	10.1	10.5		
		2015	2015	2015		
42	Recreation and Fitness Facilities, Rate (Per 100,000 Pop.)	0.17 facilities/per 100,000	3 to 29 facilities /per 100,000	NA	NA	Census
		-2013	-2013	-2013		
		0.16 facilities / per 100,000	0.06 facilities per / 100,000	NA		
		2014	2014			
43	Percent of population living within 1/2 mile of a park	20.00%	27.60%	14%	NA	Census, ESRI
		-2010	-2010	-2010		
		NA	NA	NA		
		NA	NA	NA		
44	Workers Commuting by Public Transportation	0.70%	5.20%	5.10%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		0.50%	5.10%	5.10%		
		2016	2016	2016		
45	Workers who Drive Alone to Work	72.20%	73.30%	76.40%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		74.30%	73.60%	76.40%		
		2016	2016	2016		
46	Mean Travel Time to Work	18.3 minutes	27.5 minutes	25.7 minutes	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		17.6 minutes	26.9 minutes	25 minutes		
		2016	2016	2016		
47	Percentage of days exceeding emissions standards (particulate matter 2.5 level)	7.80%	4.20%	1.20%	NA	CDC NEPHN
		-2008	-2008	-2008		
		9.40%	NA	NA		
		2017	NA	NA		

Indicator #	Social and Mental Health	Mendocino County	CA	US	HP 2020	Sources
48	Ratio of population to mental health providers	468 to 1	623 to 1	753 to 1	NA	County Health Rankings
		-2013	-2013	-2013		
		180 to 1	320 to 1	330 to 1		
		2018	2017	2017		
49	Percent of adults with a physical, mental or emotional disability	31.10%	29.90%	22.40%	NA	CHIS/CDC
		(2011-2012)	(2011-2012)	(2011-2012)		
		28.90%	29.70%	20.60%		
		2016	2016	2015		
50	Percent of adults age 65+ with a physical, mental or emotional disability	50.30%	51.30%	36%	NA	CHIS/CDC
		(2011-2012)	(2011-2012)	(2011-2012)		
		38.90%	36.00%	35.80%		
		(2012-2016)	(2012-2016)	(2012-2016)		
51	Child Abuse Rate (the number of children under 18 years of age that experienced abuse or neglect in cases per 1,000 children)	19.4	9.3	9.2	NA	Child Welfare Dynamic Report System
		-2012	-2012	-2012		
		19.3	7.7	9		
		2017	2017	2017		
52	Substantiated allegations of child maltreatment per 1,000 children ages 0-17	17.1	9.2	9.2	≤8.5	CDSS-UCB
		-2013	-2013	-2013		
		19.2	7.5	9.1		
		2017	2017	2016		
53	Children with Entries to Foster Care per 1,000 children ages 0-17	8.4	3.4	5.1	NA	CDSS-UCB/DHHS
		-2013	-2013	-2013		
		12.3	5.8	NA		
		2015	2015	NA		
54	Percent of people who report being divorced	14.70%	8.20%	9.70%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		17%	10%	11%		
		2017	2017	22017		

55	Non-fatal emergency department visits for self-inflicted injuries among youth age 5-19 per 100,000 population	180.4	103.8	153.2	NA	OSHPD/ CDC WISQARS/Kidsdata.org
		-2014	-2014	-2013		
		267	147.4	210.01		
		2015	2015	2015		
Indicator #	Maternal, Child and Adolescent Health	Mendocino County	CA	US	HP 2020	Sources
56	Percent of mothers exclusively breastfeeding in the hospital	75.60%	64.80%	77%	≥81.9%	CDPH/ NVSS/CDC
		-2013	-2013	-2013		
		73.50%	68.80%	81%		
		2015	2015	2015		
57	Percent of WIC mothers exclusively breastfeeding at 6 months	31.50%	17.40%	45%	≥25.5%	Mendocino WIC/CDC
		-2013	-2013	-2013		
		48.80%	26.30%	24.90%		
		2017-18	2015	2015		
58	The number of live births per 1,000 females	76.7	63.6	62	NA	FHOP
		-2012	-2012	-2010		
		71	62	62.5		
		2015	2015	2015		
59	Percent of newborns with Low Birth Weight (less than 2,500 grams)	5.70%	6.70%	8.00%	≤7.8%	FHOP
		-2012	-2012	-2012		
		6.10%	6.80%	8.00%		
		2015	2015	2015		
60	Percent of newborns with very low birth rates (less than 1,500 grams)	0.70%	1.10%	1.40%	≤1.4%	FHOP
		-2012	-2012	-2012		
		1%	1%	1.50%		
		2015	2015	2015		
61	Percent of newborns with very heavy birth weights (more than 4,000 grams)	9.80%	8.30%	8.10%	NA	FHOP
		-2012	-2012	-2102		
		11.30%	8.00%	8%		
		2017	2017	2017		

62	Percent of female who received prenatal care in first trimester	68.20%	83.6	73.70%	≥77.9%	FHOP
		-2011	-2011	-2011		
		67.10%	83.20%	75%		
		2015	2015	2015		
63	Percent of women no prenatal care or prenatal care not starting until 3rd trimester	5.80%	3.20%	6.00%	NA	FHOP
		-2011	-2011	-2011		
		7.50%	3.9	6.20%		
		2015	2015	2015		
64	Prenatal care covered by Medi-Cal insurance per 100 live births	66.6	45.9	NA	≤23.9%	CDPH IPODR/ NVSS
		-2012	-2012			
		NA	NA			
65	Percent of unmarried women who had birth in the past 12 months (15 to 50 years old)	39.20%	33.90%	35.90%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		48%	39.00%	40.30%		
		2015	2015	2015		
66	Teen Birth Rate (birth rate in live births per 1,000 females aged 15-19 years)	27.50%	21.00%	24.30%	≤36.2	FHOP
		2013 - 2015	2013 - 2015	2013 - 2015		
		24.90%	17.60%	22%		
		2014-2016	2014-2016	2014-2016		
67	Teen Birth Rate (birth rate in live births per 1,000 females aged 18-19 years)	60.8	46.7	47.1	≤105.9	FHOP
		-2011	-2011	-2011		
		46.1	33.3	40.70%		
		2015	2015	2015		
68	Percent of pre-term births (< 37 weeks gestation)	8.4	9.5	3.4	≤11.4%	CDPH
		-2013	-2013	-2013		
		7.8	8.5	9.6		
		2015	2015	2015		
69	Percent of births by C-section to low risk women giving birth for the first time	21.40%	26.30%	32.70%	≤23.9%	CDPH IPODR/ NVSS
		(2009-2011)	(2009-2011)	(2009-2011)		
		21.15%	26%	26%		
		2016	2016	2016		

70	Delivery with MediCal insurance as anticipated payer per 100 live births	67.4	46.4	44.9	NA	CDPH IPODR/ NVSS
		-2012	-2012	-2010		
		NA	59% 2013	NA		
71	Infant deaths per 1,000 live births (within 1 year)	4.3	4.7	5.96	≤6.0	CDPH
		-2012	-2012	-2012		
		8.1 2015	4.5 2015	5.7 2015		
72	Young adult mortality, 20-24 years per 100,000	134.2	68.2	84.6	≤88.3	CDPH/CDC
		(2011-2012)	(2011-2012)	-2012		
		Suppressed 2013-2015	66.5 2013-2015	NA NA		
73	Female mortality, 15-44 years per 100,000	583.2	119.1	776.1	NA	CDPH/CDC
		(2011-2012)	(2011-2012)	-2012		
		648.7 2014	667.8 2014	777 2014		
Indicator #	Healthcare and Preventative Services	Mendocino County	CA	US	HP 2020	Sources
74	Percent of people with Health Insurance	81.80%	82.30%	85.20%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		90.10% 2017	93.20% 2017	91.20% 2017		
75	Percent of with Private Health Insurance	48.10%	60.10%	65.20%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		33.30% 2017	54.40% 2017	65.40% 2017		
76	Children with Health Insurance	91.50%	92.20%	92.70%	NA	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		98.10% 2017	97.50% 2017	95.20% 2017		
77	Percent of population without health insurance	18.20%	17.70%	14.80%	0.00%	ACS
		(2011-2013)	(2011-2013)	(2011-2013)		
		10.30% 2017	7.20% 2017	8.70% 2017		

78	Access to Primary Care Physicians Rate per 100,000	96.1	85.1	86.6	NA	Dept HHS
		-2012	-2012	-2012		
		90	78	75		
		2017	2017	2017		
79	Ratio of population to primary care physicians	1,042:1	1,057:1	1,355:1	NA	County Health Rankings
		-2011	-2011	-2011		
		1,070:1	1,280:1	1,040:1		
		2017	2017	2017		
80	Ambulatory Care Sensitive Conditions, Rate (Per 1,000 Medicare Enrollees)	35.97	45.3	59.2	NA	Dartmouth Atlas of Health Care
		-2012	-2012	-2012		
		NA	36.2	49.4		
		2015	2015	2015		
81	Annual Pneumonia Vaccination, Percent of Adults Age 65 +	58.70%	63.40%	67.50%	NA	BRFSS
		(2006-2012)	(2006-2012)	(2006-2012)		
		NA	76.80%	74.70%		
		2017	2017	2017		
82	Percent of kindergarteners with all required immunizations	75.40%	90.20%	>90%	NA	CDPH/CDC
		-2013	-2013	-2013		
		86.80%	95.10%	>90%		
		2017	2017	2017		
83	Percent of adults age 50+ who have ever had a sigmoidoscopy /colonoscopy	46.40%	57.90%	61.30%	≥70.5%	CHIS/NHIS
		(2006-2012)	(2006-2012)	(2006-2012)		
		68.40%	67%	69.80%		
		2016	2016	2016		
84	Cervical Cancer Screening (Past 3 Years), Percent of Women Age 18+	75.70%	78.30%	78.50%	≥93.0%	BRFSS
		(2006-2012)	(2006-2012)	(2006-2012)		
		72.10%	81.50%	79.90%		
		2015	2015	2015		
85	Mammogram (Past 2 Years), Percent of Female Medicare Enrollees, Age 67-69	58.40%	59.30%	63.00%	NA	Dartmouth Atlas of Health Care
		-2012	-2012	-2012		
		56.20%	59.50%	63.20%		
		2015	2015	2015		

86	Access to Dentists, Rate per 100,000	76.84	77.45	63.18	NA	Dept HHS
		-2013	-2013	-2013		
		78	82	67		
		2016	2016	2016		
87	Percent of Denti-Cal Recipients Without Dental Exam in Past 12 Months	27.70%	30.50%	30.20%	NA	Anne E Casey Foundation
		(2006-2012)	(2006-2012)	(2006-2012)		
		49.20%	49%	34%		
		2015	2015	2015		
Indicator #	Behavioral Risk Factors	Mendocino County	CA	US	HP 2020	Sources
88	Children Consuming 2+ Servings of Fruits/Vegetables per Day	72%	50.50%	NA	NA	CHIS
		(2011-2012)	(2011-2012)			
		66.00%	64.30%			
		2017	2017			
89	Children and Adolescents who Watch 3+ Hours of Television (percentage of children 3-18 who watch television or play videogames for three or more hours on weekends) (2018 - figures only available for 2 to <3 hours)	48.70%	52.70%	NA	NA	CHIS
		-2009	-2009			
		NA	NA			
		NA	NA			
90	Percent of 5th, 7th and 9th graders who are physically fit	56.5% **	61.70%	NA	NA	CDE
		-2014	-2014			
		65.10%	72.40%			
		2016-17	2016-17			
91	Percentage of Adults consuming fast food at least once in the past week	52.80%	64.80%	44%	NA	CHIS/CDC
		-2014	-2014	-2014		
		54.00%	65.60%	37.50%		
		2016	2016	2016		
92	Percentage of Children under 18 consuming fast food at least once in the past week	16.90%	56.30%	34%	NA	CHIS/CDC
		-2014	-2014	-2014		
		12.60%	37%	34%		
		2017	2016	2015		

93	Percent of adults binge drinking at least once in month prior.	22.90%	17.20%	16.90%	≤24.4%	BRFSS
		(2006-2012)	(2006-2012)	(2006-2012)		
		38.70%	24.70%	17%		
		2015	2015	2015		
94	Percent of 11th grade students drinking at least once in month prior	49.40%	31.30%	35.10%	NA	CA Healthy Kids Survey
		(2011-2013)	(2011-2013)	(2011-2013)		
		37%	29.10%	38%		
		(2014-2015)	(2014-2015)	(2014-2015)		
95	Percent of adults smoking cigarettes some days or every day	18.60%	12.80%	18.10%	≤12.0%	BRFSS
		(2006-2012)	(2006-2012)	(2006-2012)		
		15%	11%	17%		
		(2015-2016)	(2015-2016)	(2015-2016)		
Indicator #	Illness and Injury	Mendocino County	CA	US	HP 2020	Sources
96	Life Expectancy for Females in years	80.9	83.1	81.2	NA	CDC
		-2013	-2013	-2013		
		81.2	78.6	76.7		
		2014	2014	2014		
97	Life Expectancy for Males in years	75.6	78.3	76.4	NA	CDC
		-2013	-2013	-2013		
		76	78.6	76.7		
		2014	2014	2014		
98	Percent of adults (20+ years) who are overweight (BMI >25 and < 30)	58.70%	59.70%	69.00%	NA	CHIS
		-2014	-2014	-2014		
		46.70%	34.50%	71.60%		
		2017	2017	2017		
99	Percent of adults (20+ years) who are obese (BMI > 30)	22.20%	27.30%	27.10%	NA	CHIS
		-2014	-2012	-2012		
		21.00%	26.90%	39.80%		
		2017	2017	2017		
100	Percent of 5th, 7th and 9th graders who are overweight or obese	43.50%	38.30%	17.70%	NA	CDE
		-2014	-2014	-2014		
		43.80%	38.80%	20%		
		2017	2017	2017		

101	Percentage of Adults with Asthma (Lifetime Asthma Prevalence Percent)	13.22%	14.21%	13.36%	NA	CDC
		(2011-2012)	(2011-2012)	(2011-2012)		
		18.00%	14.90%	14.00%		
		2015-2016	2015-2016	2015-2016		
102	Percent of children with Asthma (Lifetime Asthma Prevalence Percent)	7.00%	15.40%	12.70%	NA	CHIS
		(2011-2012)	(2011-2012)	-2013		
		21.10%	13.70%	10%		
		2016	2016	2016		
103	Percentage of Adults with Diabetes (20+ years of age)	7.20%	8.10%	9.10%	NA	CHIS/CDC
		-2012	-2012	-2012		
		6.70%	8.70%	9.70%		
		2014	2014	2014		
104	Percent of adults who have coronary heart disease	3.81%	3.45%	4.40%	NA	CHIS/ NHANES
		(2011-2012)	(2011-2012)	(2011-2012)		
		7.80%	5.90%	NA		
		2014	2014	NA		
105	Prevalence of chronic obstructive pulmonary disease among adults	4.10%	4.60%	5.70%	NA	American Lung Association/CDC
		-2012	-2012	-2012		
		4.10%	3.40%	6.30%		
		2017	2017	2017		
106	Percent of adults who have ever been diagnosed with high blood pressure	23.50%	26.20%	28.20%	≤26.9%	CHIS
		(2006-2012)	(2006-2012)	(2006-2012)		
		31.50%	28.40%	30.90%		
		2016	2016	2016		
107	Breast Cancer Incidence Rate (per 100,000 females)	125	122.4	122.7	≤40.9	NCI
		(2007-2011)	(2007-2011)	(2007-2011)		
		105.8	121.5	124.7		
		(2011-2015)	(2011-2015)	(2011-2015)		
108	Cervical Cancer Incidence Rate (per 100,000 females)	12.1	7.8	7.8	≤ 7.1	NCI
		(2007-2011)	(2007-2011)	(2007-2011)		
		10.9	7.2	7.5		
		(2011-2015)	(2011-2015)	(2011-2015)		
109	Colorectal Cancer Incidence Rate per 100,000	41.6	41.5	43.3	≤38.7	NCI
		(2007-2011)	(2007-2011)	(2007-2011)		
		31.7	36.2	39.2		
		(2011-2015)	(2011-2015)	(2011-2015)		

110	Lung and Bronchus Cancer Incidence Rate per 100,000	59.1	49.5	64.9	NA	NCI
		(2007-2011)	(2007-2011)	(2007-2011)		
		49.2	43.3	60.2		
		(2011-2015)	(2011-2015)	(2011-2015)		
111	Prostate Cancer Incidence Rate (per 100,000 males)	131.5	136.4	142.3	NA	NCI
		(2007-2011)	(2007-2011)	(2007-2011)		
		87	101.2	109		
		(2011-2015)	(2011-2015)	(2011-2015)		
112	Gonorrhea Incidence Rate (per 100,000 population)	150.8	100.4	106.1	NA	CDPH/CDC
		-2013	-2013	-2013		
		170.5	190.3	126.6		
		2017	2017	2017		
113	Syphilis Incidence Rate (Primary & Secondary)	3.4	9.3	5.5	NA	CDPH/CDC
		-2013	-2013	-2013		
		4.5	16.8	8.7		
		2017	2017	2017		
114	Chlamydia Incidence Rate	347.3	439.9	446.6	NA	CDPH/CDC
		-2013	-2013	-2013		
		405.1	552.2	476.1		
		2017	2017	(2014-2016)		
115	Chronic Hepatitis C Prevalence Rate per 100,000 population	140.8	81.9	0.6	NA	CDPH/CDC
		-2013	-2013	-2013		
		119.9	86.4	1.1		
		2015	2015	2015		
116	HIV Prevalence Rate	27.1	13.3	15.3	NA	CDPH/CDC
		-2012	-2012	-2012		
		28.4	119.7	13.5		
		2013	2013	2013		
117	HIV Incidence (newly diagnosed cases) rates per 100,000 population	2.3	12.3	19.6/100,000	≤ 13	Mendocino PH/CDPH/ CDC
		-2013	-2013	-2013		
		3.4	12.9	12.3		
		2016	2016	2016		

118	Non-fatal emergency department visits for fall related injuries among adults 65 to 106 years (Age-Adjusted Rate per 1,000)	5.7	4.1	4.3	≤ 4.7	CDPH EpiCenter/ CDC NCHS
		-2012	-2012	-2012		
		3.2	1.9	NA		
		2014	2014	NA		
119	Non-fatal emergency department visits for motor vehicle crash injuries (occupants) per 100,000	628	483	806	NA	CDPH EpiCenter/ CDC WISQARS
		-2012	-2012	-2012		
		511.1	506.6	905		
		2014	2014	2014		
120	Non-fatal emergency department visits for unintentional MVT collision with bicyclist per 100,000	11.3	25	147.9	NA	140
		-2013	-2013	-2013		
		17	32.7	140		
		2015	2015	2015		
Indicator #	Healthcare Cost/ Medicare Beneficiaries	Mendocino County	CA	US	HP 2020	Sources
121	Standardized Cost Breakdown of Medicare beneficiaries who were treated for inpatient care	\$1,796	\$2,459	\$2,595	NA	CMS
		-2012	-2012	-2012		
		\$2,134	\$2,610	\$2,689		
		2016	2016	2016		
122	Standardized Cost Breakdown of Medicare beneficiaries who were treated for post-acute care	\$758	\$1,477	\$1,648	NA	CMS
		-2012	-2012	-2012		
		\$866	\$1,553	\$1,664		
		2016	2016	2016		
123	Standardized Cost Breakdown of Medicare beneficiaries who were treated for hospice care	\$75	\$231	\$317	NA	CMS
		-2012	-2012	-2012		
		\$110	\$293	\$329		
		2016	2016	2016		
124	Standardized Cost Breakdown of Medicare beneficiaries who were treated for physician /OPD /Tests /Imaging	\$2,423	\$3,219	\$3,329	NA	CMS
		-2012	-2012	-2012		
		\$3,042	\$3,580	\$3,711		
		2016	2016	2016		

125	Standardized Cost Breakdown of Medicare beneficiaries who were treated for durable medical equipment	\$165	\$205	\$236	NA	CMS
		-2012	-2012	-2012		
		\$124	\$160	\$181		
		2016	2016	2016		
126	Standardized Cost Breakdown of Medicare beneficiaries who were treated for Part B Drug	\$220	\$353	\$318	NA	CMS
		-2012	-2012	-2012		
		\$200	\$443	\$429		
		2016	2016	2016		
127	Standardized Cost Breakdown of Medicare beneficiaries who were treated for outpatient dialysis facility	\$160	\$301	\$245	NA	CMS
		-2012	-2012	-2012		
		NA	NA	\$260		
				2016		
128	Actual per capita Medicare costs	\$5,957	\$8,889	\$9,221	NA	CMS
		-2012	-2012	-2012		
		\$6,853	\$9,164	\$9,533		
		2016	2016	2016		
129	Percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia	6.10%	9.40%	9.80%	NA	CMS
		-2012	-2012	-2012		
		6.40%	9.30%	9.90%		
		2015	2015	2015		
130	Percentage of Medicare beneficiaries who were treated for asthma	4.10%	5.20%	4.90%	NA	CMS
		-2012	-2012	-2012		
		6.50%	7.50%	8.20%		
		2015	2015	2015		
131	Percentage of Medicare beneficiaries who were treated for atrial fibrillation	6.90%	7.20%	7.60%	NA	CMS
		-2012	-2012	-2012		
		7.00%	7.30%	6.90%		
		2015	2015	2015		
132	Percentage of Medicare beneficiaries who were treated for kidney disease	10.90%	15.60%	15.50%	NA	CMS
		-2012	-2012	-2012		
		11.90%	17.90%	18.10%		
		2015	2015	2015		
133	Percentage of Medicare beneficiaries who were treated for high cholesterol	33.50%	42.10%	44.80%	NA	CMS
		-2012	-2012	-2012		
		31.80%	41.50%	44.60%		
		2015	2015	2015		

134	Percentage of Medicare beneficiaries who were treated for chronic kidney disease	10.90%	15.60%	15.50%	NA	CMS
		-2012	-2012	-2012		
		11.90%	17.90%	18.10%		
		2015	2015	2015		
135	Percentage of Medicare beneficiaries who were treated for chronic obstructive pulmonary disease (COPD)	8.70%	9.40%	11.30%	NA	CMS
		-2012	-2012	-2012		
		8.70%	8.90%	11.20%		
		2015	2015	2015		
136	Percentage of Medicare beneficiaries who were treated for depression	15.20%	13.40%	15.50%	NA	CMS
		-2012	-2012	-2012		
		15.60%	14.30%	16.70%		
		2015	2015	2015		
137	Percentage of Medicare beneficiaries who were treated for diabetes	19%	26.60%	27.00%	NA	CMS
		-2012	-2012	-2012		
		18.60%	25.30%	16.50%		
		2015	2015	2015		
138	Percentage of Medicare beneficiaries who were treated for heart failure	9.70%	14.30%	14.60%	NA	CMS
		-2012	-2012	-2012		
		9.30%	12.90%	13.50%		
		2015	2015	2015		
139	Percentage of Medicare beneficiaries who were treated for hypertension	43.80%	51.20%	55.50%	NA	CMS
		-2012	-2012	-2012		
		42.90%	49.60%	55.00%		
		2015	2015	2015		
140	Percentage of Medicare beneficiaries who were treated for ischemic heart disease	17.80%	26.10%	28.60%	NA	CMS
		-2012	-2012	-2012		
		15.90%	23.60%	26.50%		
		2015	2015	2015		
141	Percentage of Medicare beneficiaries who were treated for osteoporosis	4.70%	7.40%	6.40%	NA	CMS
		-2012	-2012	-2012		
		3.70%	6.70%	6.00%		
		2015	2015	2015		
142	Percentage of Medicare beneficiaries who were treated for rheumatoid arthritis	20.50%	27.40%	29.00%	NA	CMS
		-2012	-2012	-2012		
		22.90%	27.60%	30.00%		
		2015	2015	2015		

143	Percentage of Medicare beneficiaries who were treated for stroke	2.50%	3.60%	3.80%	NA	CMS
		-2012	-2012	-2012		
		3.10%	3.70%	4.00%		
		2015	2015	2015		
Indicator #	Causes of Death	Mendocino County	CA	US	HP 2020	Sources
144	Age adjusted death rate; all causes per 100,000	724.4	641.5	732.8	NA	CDPH
		2010-2012	2010-2012	-2012		
		734.8	608.5	728.8		
		2018	2018	2016		
145	Alzheimer's disease age adjusted mortality rate per 100,000	17.4	30	23.8	NA	CDPH
		2010-2012	2010-2012	-2012		
		12.6	34.3	34.4		
		2018	2018	2015		
146	All cancers age adjusted mortality rate per 100,000	164.4	153.3	166.5	≤ 161.4	CDPH/NCI
		2010-2012	2010-2012	-2012		
		159.9	140.2	163.5		
		2015	2015	2015		
147	Breast cancer age adjusted mortality rate per 100,000	20.6	20.9	21.5	≤ 20.7	CDPH/NCI
		2010-2012	2010-2012	-2011		
		18.9	19.1	20.9		
		2015	2015	2015		
148	Colorectal cancer age adjusted mortality rate per 100,000	15.6	14.2	15.1	≤ 14.5	CDPH/NCI
		2010-2012	2010-2012	-2011		
		17.3	12.8	14.5		
		2015	2015	2015		
149	Lung cancer age adjusted mortality rate per 100,000	42.2	34.8	46	≤ 45.5	CDPH/NCI
		(2010-2012)	(2010-2012)	-2011		
		35.8	28.9	43.4		
		2015	2015	2015		
150	Prostate cancer age adjusted mortality rate per 100,000	15.2	19.8	20.8	≤ 21.8	CDPH/NCI
		2010-2012	2010-2012	-2011		
		29.2	19.6	19.5		
		2015	2015	2015		

151	Stroke age adjusted mortality rate per 100,000	33.5	36.6	36.9	≤ 34.8	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		36.7	35.3	37.2		
		2015	2015	2015		
152	Heart disease age adjusted mortality rate per 100,000	105.5	106.2	170.5	≤ 103.4	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		90.5	89.1	96.8		
		2015	2015	2015		
153	Diabetes age adjusted mortality rate per 100,000	17.0	19.9	21.2	≤ 66.6	CDPH/CDC
		2010-2012	2010-2012	-2012		
		17.3	25.3	26.5		
		2015	2015	2015		
154	Influenza mortality rate per 100,000	12.2	16.1	14.4	NA	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		13.7	14.3	14.6		
		2018	2018	2018		
155	Chronic Liver Disease and Cirrhosis per 100,000	13.9	11.5	9.9	≤ 8.2	CDPH/CDC
		2010-2012	2010-2012	-2012		
		12.9	12.2	12.8		
		2018	2018	2018		
156	Chronic Lower Respiratory Disease per 100,000	50	36.2	41.5	NA	CDPH/CDC
		2010-2012	2010-2012	-2012		
		40.2	32.1	40.9		
		2018	2015	2018		
157	Drug-Induced mortality rate per 100,000	14.4	10.8	10.2	≤ 11.3	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		26.2	12.2	20.90%		
		2018	2018	2016		
158	Homicide mortality rate per 100,000	5.8	5.2	5.4	≤ 5.5	CDPH/NVSS
		(2010-2012)	(2010-2012)	-2012		
		5.9	5	5		
		2018	2018	2016		

159	Firearm-Related mortality rate per 100,000	14.8	7.6	10.4	≤ 9.2	CDPH/NVSS
		2016	2016	-2013		
		12.2	7.6	11.9		
		2018	2018	2016		
160	Suicide death rate per 100,000	19.2	10.1	12.6	≤ 10.2	CDPH
		(2010-2012)	(2010-2012)	-2012		
		23.6	10.3	12.9		
		(2013-2015)	(2013-2015)	(2013-2015)		
161	Motor vehicle crash death rate per 100,000	16.5	7.3	7.55	≤ 12.4	CDPH/NVSS
		(2010-2012)	(2010-2012)	(2008-2010)		
		15.3	8.8	11		
		(2014-2016)	(2014-2016)	(2014-2016)		
162	Pedestrian motor vehicle death rate per 100,000	1.9	1.8	1.38	≤ 1.4	CDPH/NVSS
		(2010-2012)	(2011-2013)	(2008-2010)		
		NA	NA	NA		
163	Alcohol Impaired Driving Deaths: Percentage of motor vehicle crash deaths with alcohol involvement	33.30%	31.30%	32.00%	NA	County Health Rankings
		(2008-2012)	(2008-2012)	(2008-2012)		
		32%	29%	13%		
		2018	2018	2018		
164	Unintentional injury mortality rate (age adjusted) per 100,000	51.2	27.3	39.1	≤ 36.0	CDPH/CDC
		(2010-2012)	(2010-2012)	-2012		
		61.6	30.3	40		
		2018	2018	2018		
165	Years of Potential Life Lost Before Age 75, All Causes	7,947	5,594	6,851	NA	CDPH/CDC
		(2008-2010)	(2008-2010)	(2008-2010)		
		8,000	5,200	5,300		
		(2014-2016)	(2014-2016)	(2014-2016)		

Footnotes

ⁱ USC Leonard Davis School of Gerontology, Fall Prevention StopFalls.org

ⁱⁱ U.S. Government Accountability Office
http://www.gao.gov/key_issues/elder_abuse/issue_summary

U.S. Department of Justice <https://www.justice.gov/>

California Department of Social Services, Adult Protective Services
<http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm>

ⁱⁱⁱ California Department of Public Health, Epicenter
<http://epicenter.cdph.ca.gov/>

^{iv} California Department Public Health (2019). Preventing Violence in California: Data Brief 1: Overview of Homicide and Suicide Deaths in California. Sacramento, CA: California Department of Public Health

^v California Department of Public Health, Epicenter
<http://epicenter.cdph.ca.gov/>

^{vi} U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014. <https://www.ncbi.nlm.nih.gov/pubmed/24455788>

^{vii} U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center

for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006
<https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/the-health-consequences-of-involuntary-exposure-to>

^{viii} U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006
<https://www.ncbi.nlm.nih.gov/books/NBK44324/>

^{ix} Centers for Disease Control and Prevention. (2018). Childhood obesity facts. Retrieved from:
<http://www.cdc.gov/healthyschools/obesity/facts.htm>

^x Centers for Disease Control and Prevention. (2016). Childhood obesity causes & consequences. Retrieved from:
<http://www.cdc.gov/obesity/childhood/causes.html>

^{xi} De Oliveira C, Watt R, Hamer M. Toothbrushing, inflammation, and risk of cardiovascular disease. Results from Scottish Health Survey. *BMJ*. 2010;340:c2451. <https://www.bmj.com/content/340/bmj.c2451.full>

^{ix} American Heart Association. Oral hygiene and Cardiovascular Disease. <https://newsroom.heart.org/news/poor-oral-health-linked-to-higher-blood-pressure-worse-blood-pressure-control>